

**NATIONAL RURAL HEALTH MISSION**  
**REPRODUCTIVE & CHILD HEALTH PROGRAMME**  
**PHASE II**  
**8<sup>TH</sup> JOINT REVIEW MISSION**  
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**AIDE MÈMOIRE**

**DONOR COORDINATION DIVISION**  
**MINISTRY OF HEALTH & FAMILY WELFARE**  
**GOVERNMENT OF INDIA**

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## ANNEXES ATTACHED TO THIS AIDE MEMOIRE

### ANNEX NO

- A RESULTS MATRIX FOR ASSESSING PERFORMANCE OF RCH – II, INDIA 2005-2009
- B STATE VISIT REPORTS
  - Jammu & Kashmir
  - Madhya Pradesh
  - Meghalaya
  - Maharashtra
  - Paschim Banga

The cover is a reproduction of a Jamini Roy painting titled "Mother and Child". Courtesy - National Gallery of Modern Art, New Delhi

## LIST OF ABBREVIATIONS

AHS	:	Annual Health Survey
ANC	:	Antenatal Check
ANM	:	Auxiliary Nurse Midwife
ARI	:	Acute Respiratory Infection
ARSH	:	Adolescent Reproductive and Sexual Health
ASHA	:	Accredited Social Health Activist
AWC	:	Anganwadi Centre
AWW	:	Anganwadi Worker
AYUSH	:	Ayurveda, Yoga, Unani, Siddha and Homeopathy
BCC	:	Behaviour Change Communication
BEmOC	:	Basic Emergency Obstetric Care
BPL	:	Below Poverty Line
CEmOC	:	Comprehensive Emergency Obstetric Care
CES	:	Coverage Evaluation Survey
CH	:	Child Health
CHC	:	Community Health Centre
CNAA	:	Community Needs Assessment Approach
CRM	:	Common Review Mission (for NRHM)
CTP	:	Comprehensive Training Plan
DCGI	:	Drug Controller General of India
DH	:	District Hospital
DHAP	:	District Health Action Plan
DHFW	:	Department of Health and Family Welfare
DLHS	:	District Level Household Survey
DP	:	Development Partner
DPM	:	District Programme Manager
DPMU	:	District Programme Management Unit
DQAC	:	District Quality Assurance Committee
DRCHO	:	District Reproductive and Child Health Officer
DWCD	:	Department of Women and Child Development
EAG	:	Empowered Action Group
EC	:	Emergency Contraception
ECR	:	Eligible Couple Register
ELA	:	Expected Level of Achievement
EmOC	:	Emergency Obstetric Care
EPW	:	Empowered Procurement Wing
F-IMNCI	:	Facility Based Integrated Management of Neonatal and Childhood Illness
FMG	:	Finance Management Group
FMR	:	Financial Management Report
FP	:	Family Planning
FRU	:	First Referral Unit
GM	:	Gender Mainstreaming
GMP	:	Good Manufacturing Practices
GMSD	:	Government Medical Supplies Department
GoI	:	Government of India
HMIS	:	Health Management Information System
HP	:	Himachal Pradesh
HR	:	Human Resources
HRD	:	Human Resource Development

## LIST OF ABBREVIATIONS (CONTD...)

ICDS	:	Integrated Child Development Services
IEC	:	Information, Education and Communication
IMEP	:	Infection Management and Environment Plan
IMNCI	:	Integrated Management of Neonatal and Childhood Illness
IMR	:	Infant Mortality Rate
IPAI	:	Institute of Public Auditors of India
IPC	:	Interpersonal Communication
IPHS	:	Indian Public Health Standards
IUD	:	Intra Uterine Device
J&K	:	Jammu & Kashmir
JE	:	Janani Express
JRM	:	Joint Review Mission
JSK	:	Jansankhya Sthirta Kosh
JSSK	:	Janani Shishu Suraksha Karyakram
JSY	:	Janani Suraksha Yojana
LSAS	:	Life Saving Anaesthesia Skills
M&E	:	Monitoring and Evaluation
MCH	:	Maternal & Child Health
MCTS	:	Mother and Child Tracking System (for pregnant women & children)
MDG	:	Millennium Development Goal
MDR	:	Maternal Death Review
MH	:	Maternal Health
MMR	:	Maternal Mortality Ratio
MNGO	:	Mother NGO
MO	:	Medical Officer
MoHFW	:	Ministry of Health and Family Welfare
MTP	:	Medical Termination of Pregnancy
MTR	:	Mid-term Review
NABH	:	National Accreditation Board for Hospitals
NACO	:	National AIDS Control Organisation
NHSRC	:	National Health Systems Resource Centre
NIHFW	:	National Institute of Health and Family Welfare
NMR	:	Neonatal Mortality Rate
NRHM	:	National Rural Health Mission
NSSK	:	Navjaat Shishu Suraksha Karyakram
PCPNDT	:	Pre-conception and Pre-natal Diagnostic Techniques
PHC	:	Primary Health Centre
PHFI	:	Public Health Foundation of India
PIP	:	Programme Implementation Plan
PMU	:	Programme Management Unit
PP	:	Post Partum
PPIUCD	:	Post Partum Intra Uterine Contraceptive Device
PPP	:	Public Private Partnership
QA	:	Quality Assurance
RBF	:	Results Based Financing
RCH	:	Reproductive and Child Health
RKS	:	Rogi Kalyan Samiti
RTI	:	Reproductive Tract Infection
SAA	:	State Appropriate Authority

### LIST OF ABBREVIATIONS (CONTD...)

SAC	:	State Advisory Committee
SBA	:	Skilled Birth Attendant
SBCC	:	Social and Behaviour Change Communication
SC & ST	:	Schedule Caste and Scheduled Tribe
SFT	:	State Facilitation Team
SHC	:	Sub Health centre
SHSRC	:	State Health Systems Resource Centre
SIHFW	:	State Institute of Health and Family Welfare
SN	:	Staff Nurse
SNCU	:	Sick Newborn Care Unit
SOP	:	Standard Operating Protocol
SPMU	:	State Programme Management Unit
SRS	:	Sample Registration System
SSB	:	State Supervisory Board
STI	:	Sexually Transmitted Infection
TA	:	Technical Assistance
TFR	:	Total Fertility Rate
TMSA	:	Technical & Management Support Agency
TNMSC	:	Tamil Nadu Medical Services Corporation
TOT	:	Training of Trainers
TRG	:	Technical Resource Group
U5MR	:	Under 5 Mortality Rate
UNFPA	:	United Nations Population Fund
UNOPS	:	United Nations Office for Project Services
UT	:	Union Territory
VHND	:	Village Health & Nutrition Day
VHSC	:	Village Health and Sanitation Committee

**REPRODUCTIVE & CHILD HEALTH PROGRAMME, PHASE II**  
**8<sup>th</sup> JOINT REVIEW MISSION**

**AIDE MEMOIRÈ**

**1. INTRODUCTION**

The Eighth Joint Review Mission (JRM-8) of Reproductive and Child Health Programme Phase II (RCH II) primarily assessed progress on programme management and supervisory structures, quality, HMIS and data management and gender and social equity. Agreements on the way forward were reached within the core principles of RCH II that include a strong pro-poor focus to reduce disparities in health, gender mainstreaming, state ownership through bottom-up planning, promoting evidence based interventions to ensure quality of care and strengthening results measurement.

The JRM-8 held during July 19 – September 16, 2011 was led by the Ministry of Health and Family Welfare (MoHFW) and included state representatives and all development partners (DP) supporting the RCH II programme. Field visits were made to five states, i.e. Jammu & Kashmir, Maharashtra, Madhya Pradesh, Meghalaya and West Bengal. This Aide Memoirè summarizes the findings of the JRM and recommendations on actions to be taken.

**2. EXECUTIVE SUMMARY**

**Progress**

India's MMR at 212 (SRS 2007-09) has improved significantly from 254 (SRS 2004-06), IMR at 47 (SRS 2010) has improved from 50 (SRS2009), while TFR at 2.6 (SRS 2009) has improved from 3.0 (SRS 2003).

The number of states /UTs achieving the RCH II /NRHM goal<sup>1</sup> for MMR, IMR and TFR are 2, 12 and 14 respectively. Two states i.e Kerala and Tamil Nadu have achieved all the three RCH/ NRHM goals. These figures do not reflect the full impact of RCH.

Off take of selected services amongst SC, ST, lowest wealth quintile and EAG states has been better than the national average:

- 12-23 months children fully immunized, overall increase (CES- 2009 over DLHS-2) is 15.2 percentage points where as for SC it is 17 percentage points, for lowest wealth quintile 16 percentage points and for EAG states 18.2 percentage points.
- Similarly % of eligible couples using modern contraceptive methods the overall increase (DLHS-3 over DLHS-2) is 1.4 percentage points, whereas for SC and ST it is 6 and 3 percentage points respectively.

***At the national level***

*Programme management*

- Management of RCH at the central level has become much more "hands-on" resulting in a continous search for innovative solutions and improvement. MH, CH and FP have had one

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<sup>1</sup> By 2012 : MMR : <100; IMR : <30; TFR : < 2,1

workshop each with state level counterparts, while ARSH has had two (workshops); a system of periodic, thematic in-depth reviews of groups of states has been initiated; dedicated teams for visits to states / high focus districts have been set up and 34 high focus districts have been visited. Monthly review Meetings with the State Program officers of MH, CH, Immunisation and FP are also being undertaken by National Program Officers particularly for high focus states. 2 state level workshops on Comprehensive Abortion Care have been organised in the states of MP and Chhattisgarh in November and December 2011.

- Janani Shishu Suraksha Karyakram (JSSK): In an effort to eliminate out of pocket expenses incurred by pregnant women and parents of sick new- born, MoHFW launched Janani Shishu Suraksha Karyakram (JSSK) on 1st June, 2011. Field visits noted satisfactory progress in rolling out of JSSK. JSSK seeks to finance facilities based on a standard costing of agreed inputs to ensure free and cashless deliveries; and hence, is a move towards “results based financing” (RBF) and also rights based entitlement .
- The system of allocating flexi funds to states, preparation and appraisal of state PIPs and preparation of quarterly variance analysis reports for major states has shown further improvement. Efforts have been made to reduce overlaps between RCH and Mission Flexi pools. The quarterly variance analysis report for each state , now also provides an assessment of performance of high focus districts. The Operating Manual for preparation and monitoring of state PIPs has been strengthened to also address HR productivity, facility level service delivery, quality and health systems/ management imperatives.

#### *Technical strategies*

- Various maternal health guidelines including SBA training material have been up dated. A training video has also been produced and disseminated.
- Mother and Child Protection card (MCP ) has been jointly introduced by MoHFW and DWCD. Implementation is well underway.
- Module 6 and 7 for ASHAs aimed at building their capacity in postnatal and newborn care has been rolled out. Circular has been issued by MoHFW on incentivizing post natal home based visits to ASHAs.
- Development of separate training materials for doctors, ANM, AWW and ASHA and operational guidelines for IMNCI, F-IMNCI and home based newborn care.
- MoHFW is also reviving post partum FP services by initiating the post partum intra-uterine contraceptive device (PP IUCD) programme.
- To improve access to contraceptives for the eligible couples, a scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries.
- MoHFW has rolled out a new scheme for promotion of menstrual hygiene aimed at ensuring that adolescent girls (10- 19 years) in rural areas have adequate knowledge and information about menstrual hygiene and the use of sanitary napkins.

#### *Other cross-cutting strategies*

- The proposal for setting up the central procurement agency (CPA) in the form of a registered society has been approved by the Government.
- A PPP course has been established at the National Institute of Health and Family Welfare (NIHFW) in partnership with DPs. It currently offers an annual course for strengthening the PPP capacity of state and district managers, and has mechanisms for follow-up of trainees and/or providing TA support to states for developing appropriate PPPs.

- As part of the efforts to build national and state level BCC capacity, a new DP supported initiative -Improving Healthy Behavior Program (IHBP) has been launched.
- Establishment of a system and culture of quarterly financial reporting has resulted in improvement in the timeliness of financial reporting by states.

### ***At the state level***

#### *Programme management*

- Several states (eg Rajasthan, Karnataka, Orissa, J&K) have created teams for more intense supportive supervision. DPs are providing TA/ supportive supervision in selected high focus districts.
- Shortage of HR in rural areas is receiving increased attention across states. Chhattisgarh and Rajasthan have created a special cadre with a mix of financial and non-financial incentives. Haryana, Tamil Nadu and Maharashtra have shown that employment of regular directorate staff can be quick and “strategies for attraction and retention of skilled professionals in rural and remote areas” do not necessarily have to be only through contractual services only.

#### *Technical strategies*

- States have prepared a list of delivery points in the districts where adequate deliveries are being conducted. These delivery points are to be prioritized and operationalized for providing assured wide ranging RCH services (MH, CH, FP and AH).
- Quality of services (equipments/ drugs): Field visits indicate that essential MH drugs are now available in the system. There is more awareness about avoiding routine episiotomy and other such practices. It is encouraging to note increasing practice of AMTSL and maintenance of partograph especially in Madhya Pradesh, West Bengal and Maharashtra among the States visited by JRM states.
- States are taking steps to include drugs for Medical Abortions into their EDL (Essential Drug List) and supply these drugs at least at identified delivery points where comprehensive RCH services are planned to be provided.
- All the states have institutionalised the MDR process and have been provided with a monthly monitoring tool to report on the progress being made.
- Training:
  - Skilled Attendance at birth (domiciliary & health facilities): 32291 nursing and Midwifery personnel (Staff Nurse, ANM/LHV) have been trained in SBA, as on Sep, 2011.
  - Multi-skilling of doctors - 1070 Medical Officers have been trained in LSAS and 601 Medical Officers have been trained in Comprehensive EmOC which includes C-section, as on Sep, 2011.
  - Ten- day training on Basic Emergency Obstetric Care (BEmOC) Skills has been initiated in the states. Master trainers are now available in most states.
  - MTP training - A total of 3,588 Medical Officers have been trained on Medical Termination of Pregnancy (MTP) across states during 2009-10 and 2010-11 (till February 2011, as per HMIS data).
  - Ten- day training on Basic Emergency Obstetric Care (BEmOC) Skills for MOs has been initiated in the states. Master trainers are now available in all states. Numbers of MOs

trained in some States are : UP (327), Assam (135), Bihar (81), Rajasthan (62), MP (631), Karnataka (1117), Tripura (10), Nagaland (12)

- A total of 516 providers are reported to have received training in Medical Termination of Pregnancy (MTP) across States during April- November 2011 (HMIS), with maximum number trained in Maharashtra followed by UP and MP
- Provision of Emergency Obstetric Care- 2891 FRUs and 9107 24X7 PHCs were operational in the country as on March 2011 (NRHM MIS-2010-11). Private sector is also a major player in many states.
- In most states, adaptation and dissemination of guidelines for facility-based management of severely malnourished children, promoting Zinc as an adjunct therapy with ORS for diarrhea and actively combating early childhood anemia have been initiated.
- More than 3000 adolescent friendly health clinics across District Hospitals, CHCs and PHCs are functional. 5527 Medical Officers and 16728 ANM/LHV/Counsellors have been trained on offering adolescent friendly health services across the country.

#### *Other cross cutting issues*

- Assam, Karnataka, Jharkhand, Lakshdweep, Tamil Nadu, West Bengal, Mizoram, Goa, Andaman & Nicobar, Gujarat, Bihar, Kerala and Rajasthan have already set-up state level procurement agencies. States have been mainly procuring CH and MH equipment but some states have also procured drugs, medical supplies and minor civil works.
- The quality of data in the web based HMIS has shown steady improvement. All 35 states and UTs are uploading data from block level, while several states have commenced facility level data entry. MCTS is being implemented in all the districts visited by JRM.
- QA committees constituted and notified at the state level in all States. Many states (e.g. MP, Maharashtra) have developed checklists for monitoring.
- There is encouraging movement towards making services more accessible to women and vulnerable groups particularly in hilly and difficult to reach areas. The state PIPs and annual budgets demonstrate a stronger focus on reaching vulnerable groups.
- Several states have initiated PPPs for addressing critical barriers such as geographical access, gaps in human resources for health, referral transport, and diagnostic and ancillary services. There are several PPPs that have been deployed for strengthening referral transport, contracting in of services at public health facilities, contracting out service delivery to private institutions, social marketing, and developing provider networks. West Bengal and Rajasthan have a PPP policy for health in place.

#### *Utilization of funds*

- Audited RCHII expenditure increased 3.5 times in 3 years: from Rs. 885 crores in 2006-07 to Rs. 3124 crores in 2009-10. Reported expenditure for 2010-11 is Rs. 3711.02 crores which is 108% of the release for the year (as against 94% last year).
- The above includes JSY expenditure which increased by about 4.4 times from Rs 256 crores in 2006-07 to Rs. 1137 crores in 2009-10 and Rs. 1619 crores in 2010-11 respectively. The non-JSY expenditure has increased by more than 3 times (over 2006-07 to 2009-10). In 2010-11 reported non- JSY expenditure is Rs.2092 crores.

## Areas requiring attention

### *At the national level*

- Different aspects of RCH have been under different administrative heads for different periods during the programme.
- Reporting and coordination across cross cutting functions (IEC, M&E, and procurement etc.) could be more effective in meeting RCH programme needs.
- RBF has the potential to ensure more efficient use of funds as well as provide the impetus to achieve necessary results. Steps towards RBF would need to address several issues including: (1) transfer mechanisms from states to districts and onwards to facilities and blocks; (2) autonomy for districts and facilities to spend funds to achieve results; (3) maintenance of supply chains; (4) human resource issues; (5) use of private sector capacity; (6) robust contracts/MOUs with strong monitoring; (7) independent verification systems; (8) agreement on a package of services; (9) costing of packages; (10) incentives for quality and equity.
- There is lack of integration of MCTS with HMIS; MCTS is seen as an additional exercise. There is also lack of consistency in recording formats within the state and between states. Some states have as many as 38 registers at sub-centre level.
- IEC/BCC continues to remain an isolated function at the national and state levels, and the output of the IEC department is rarely integrated into the larger programmatic processes.

### *State level*

- Tenure and stability of persons holding key posts under NRHM is still an issue across many states.
- Convergence and coordination with technical officers in State Health Directorate is still not adequate and there is a need to improve it urgently so that quality of technical part of the program improves.
- Though the number of contractual staff has increased sharply, their productivity and morale could be better. Key underlying factors include: delay in renewal of contracts, poor service conditions and increments, ineffective appraisal system, reluctance to nominate them for longer skill based training, and a wide distinction between contractual and regular staff performing the same tasks.
- The management of training across states remains weak. Comprehensive Training Plans (CTPs) submitted by states are typically prepared in isolation and not aligned with infrastructure upgradation and the HR plans resulting in highly trained resources (MOs trained in LSAS and CEmOC) being confined to facilities where they are not in a position to practice their skills. Database of trained staff is typically not available. Moreover, training needs across all programs are not harmonised. A systematic assessment of impact of training on job performance and skill development is not carried out.
- Quality Certification of facilities could be more efficient: States are going in for expensive certification processes ignoring strengthening of their own quality assurance cells and committees. Outside certification is difficult to sustain in the long run and the standards tends to get diluted after certification. The states needs to prioritize certification through in-house quality assurance system and continuous monitoring for the same. Moreover, in some states, both external (ISO/NABH) and internal certification takes place.

- Use of HMIS data is sub optimal. Though there are some efforts in most states to analyze the information from HMIS, and use the analysis for preparation of PIP, the HMIS is typically not being used for monitoring the program at PHC, block, district or state level.
- The existing capacity of undertaking BCC efforts is quite poor in states. Field visits reported need for more efforts at Sub-district Hospital and District Hospital. It also reiterated the need to look at BCC as being beyond stand-alone materials. The visits also identified the need for more focused BCC to be undertaken for improving utilization of services by clients. In some states, teams reported the absence of any communication materials in most facilities.

#### *Technical strategies*

- Poor quality of ANC services during VHNDs is a concern. Surveys have also indicated that women generally tend to bypass VHNDs for ANC. The women are asked to go to higher facilities for lab examinations/ sonography/ HIV screening. In many states, the VHND does not provide comprehensive services, and remain restricted to immunization.
- Bio-medical waste management: Bio-medical waste management and Segregation of waste at the point of generation is not taking place in the prescribed manner. Sometimes bags are not collected as per agreed frequency.
- IMNCI training has been slow. Around 400 districts have initiated IMNCI but only around one third of these have completed the required training. Even in districts, where IMNCI training has been rolled out, implementation has lagged behind. Even though tools for recording and monitoring quality of trainings have been developed, they have not been used universally resulting in compromised quality monitoring of implementation.
- PPIUCD services are available at select Medical Colleges only. Moreover, huge increase in institutional deliveries is not being adequately tapped for providing post partum (PP) counselling and family planning (FP) services. IUCD services are not being provided at Sub-centers.

#### **Key recommendations**

##### *Cross cutting strategies*

- Given the positive experience in the last one year, all technical divisions related to RCH at the central level should continue to remain under a single administrative authority. Strengthen reporting and coordination across cross cutting functions and plan for institutional restructuring in line with the contours of the XIIth plan, in particular possible results based funding of states; appropriately reflect newer functions eg gender & equity, PPPs and bio-medical waste management.
- Consider expanding the “results based financing” approach in the next five year plan cycle as it makes a more efficient use of funds as well as provides the impetus to achieve the necessary results. RCH II already has a demand side financing mechanism that has increased demand for services, i.e., the JSY. The move to introduce supply side models for results based financing would help improve quality and efficiency of services.
- Set up a task force to strengthen HMIS with representation from the state Monitoring and Evaluation division to integrate HMIS and MCTS; and also to standardize and simplify recording registers to capture the required information. MoHFW should continue to use the data in the HMIS for state program reviews; this would encourage states to do the same and hence catalyse validation and use of data for monitoring and planning purposes. Develop

and disseminate a set of dash board indicators to monitor program progress at PHC, block, district and state level

- States to make efforts to ensure that the tenure of key positions is for a minimum period of three years.
- MoHFW should bring a universal policy for extending the retirement age of govt doctors in all States to overcome the shortage of critical HR in the health system. It should also initiate dialogue with the States for stopping private practice by the Government doctors.
- The SIHFW/ nodal agency for training should be headed by a training professional with adequate tenure and adequately staffed. Strengthen the state's CTP to ensure that training plans are aligned with facility operationalization priorities and take into account training capacities in both public and private sectors. Steps to improve quality of training, monitoring, use of skills post training and mentoring programs to give practitioners confidence after skill development should be integral components of the CTP.
- The existing dual system of quality certification - internal (through SQAC) and external (through NABH/ISO) needs to be revisited.
- States should focus on developing evidence based BCC strategy and prioritize the range of behaviors they want to impact. A Monitoring and Evaluation framework for BCC needs to be established.

#### *Technical strategies*

- MoHFW needs to reassess the utility of VHNDs as a platform for ANC. States to develop and implement detailed micro-planning processes including for improved coordination between health and ICDS and ensure intensive monitoring to ensure that the VHND provides full complement of services. Full potential of VHSC and PRI in mobilizing community needs to be realized through adequate training/ sensitisation.
  - IMNCI implementation is to be fast tracked. States need to ensure micro planning for IMNCI implementation, organize periodic refresher training and strengthen supportive supervision for IMNCI. Pre-service training for IMNCI also needs to be institutionalized.
  - FP division to prepare a roll-out plan for PPIUCD training and services in other states/facilities. States to develop Human Resource Management Information Systems (HRMIS) on trained service providers and their postings, for rational human resource deployment. GOI needs to send directions to the states for holding fixed day IUCD services at subcenters. States may choose any two days in the week for the purpose and make a trained ANM available at sub-center for the IUCD services.
- Bio-medical waste management wherever it has been outsourced to private agency needs to be managed better through e.g. clear specifications for services to be delivered. Also there should be closer co-ordination with State Environment Pollution Prevention Board, which is responsible for adherence to standards for bio medical waste disposal as per the Act.

### 3. PROGRESS TOWARDS PROGRAM OBJECTIVES

#### RCH II Goals

India's MMR at 212 (SRS 2007-09) has improved significantly from 254 (SRS 2004-06), IMR at 47 (SRS 2010) has improved from 50 (SRS2009), while TFR at 2.6 (SRS 2009) has improved from 2.9 (SRS 2004):

RCH II GOAL INDICATOR	ALL INDIA STATUS (year & source)			RCHII/NRHM (2012) goal
Maternal Mortality Ratio (MMR)	301 (SRS 2001-03)	254 (SRS 2004-06)	212 (SRS 07-09)	<100
Infant Mortality Rate (IMR)	58 (SRS 2004)	53/50 (SRS 2008/2009)	47 (SRS 2010)	<30
Total Fertility Rate (TFR)	2.9 (SRS 2004)	2.6 (SRS 2008)	2.6 (SRS 2009)	2.1

Kerala and Tamil Nadu have achieved the RCH/NRHM 2012 goal for MMR. 12 States and UTs (Kerala, Goa, Tamil Nadu, Manipur, Nagaland, A&N islands, Chandigarh, Daman & Diu, Lakshadweep, Puducherry, Maharashtra and Tripura) have achieved the goal for IMR whereas Delhi and Sikkim have IMR of 30. Fourteen states and UTs have achieved national goal for TFR (Tamil Nadu, Kerala, Himachal Pradesh, Andhra Pradesh, West Bengal, Maharashtra, Karnataka, Punjab, Goa, Chandigarh, Puducherry, Andaman & Nicobar Islands, Sikkim and Delhi). Only Kerala and Tamil Nadu have achieved all the three RCH goals. However, the results do not reflect the full impact of RCH-II interventions.

MMR trend analysis<sup>2</sup> shows accelerated progress in RCH II period in Assam, UP/Uttarakhand, Rajasthan, Madhya Pradesh/Chhattisgarh, Karnataka, Haryana, Maharashtra and Punjab. Some of the states are closer to the RCH goals than others e.g. 4 states i.e. Andhra Pradesh, West Bengal, Gujarat and Haryana have MMR ranging from 134-153 (SRS 2007-09); eight states/UTs (Karnataka, Punjab, West Bengal, Arunachal Pradesh, Himachal Pradesh, Mizoram, Uttarakhand and DNH) have IMR ranging from 31 to 40(SRS 2010); five states (J & K, Haryana, Gujarat, Odisha and Assam)have TFR ranging from 2.2 to 2.6(SRS 2009).

#### RCH II Outcomes

Disaggregated data analysis (for SC, ST, lowest wealth quintile and EAG states) shows that for some of the indicators the percentage increase is greater for SC, ST, lowest wealth quintile and EAG states:

- For percentage of 12-23 months children fully immunized, overall increase (CES- 2009 over DLHS-2) is 15.2 percentage points where as for SC it is 17 percentage points, for lowest wealth quintile 16 percentage points and for EAG states 18.2 percentage points.
- Similarly for % of eligible couples using modern contraceptive methods the overall increase (DLHS-3 over DLHS-2) is 1.4 percentage points, whereas for SC it is 6%points and 3% points for ST.

<sup>2</sup> Comparison of SRS 2001-03 to 2004-06 an 2004-06 to 2007-09

The detailed progress in terms of goals, outcomes and outputs along with disaggregated data analysis (where applicable) has been provided in Annex- A (Results Matrix for Assessing Performance of RCH – II, India 2005-2009).

#### **4. PROGRAMME MANAGEMENT AND SUPERVISORY STRUCTURES**

##### **Progress**

##### ***National level***

- Management of RCH at the central level has become much more “hands-on” resulting in a continuous search for innovative solutions and improvement. MH, CH and FP have had one workshop each with state level counterparts, while ARSH has had two (workshops); a system of periodic, thematic indepth reviews of groups of states has been initiated; dedicated teams for supportive supervision to states / high focus districts have been set up and 34 high focus districts have been visited.
- Janani Shishu Suraksha Karyakram (JSSK): In an effort to eliminate out of pocket expenses incurred by pregnant women and parents of sick new- born, MoHFW launched Janani Shishu Suraksha Karyakram (JSSK) on 1st June, 2011. Field visits noted satisfactory progress in implementation rolling out of JSSK. The JSSK seeks to finance facilities based on a standard costing of agreed inputs to ensure free and cashless deliveries; and hence, is a move towards “results based financing” (RBF)<sup>3</sup> where outputs are financed rather than provision of inputs irrespective of the need at the facility level.
- Key technical components of RCH i.e MH, CH, Immunisation, Family Planning and ARSH are administratively under a single head. Capacities of program divisions at the central level have been strengthened with dedicated Deputy Commissioners for MH, CH, FP and Immunisation supported by over 60 consultants on contract. The Technical and Management Support Agency (TMSA) is functioning well.
- The system of allocating flexi funds to states, preparation and appraisal of state PIPs and preparation of quarterly variance analysis reports for major states has shown further improvement. Efforts have been made to reduce overlaps between RCH and Mission Flexi pools. Apart from providing an analysis of state performance in terms of service delivery, outputs and expenditure vis-à-vis the approved PIP, the quarterly variance analysis report, now also provides an assessment of performance of high focus districts. The Operating Manual for preparation and monitoring of state PIPs has been strengthened to also address HR productivity, facility level service delivery, quality and health systems/ management imperatives.

##### ***State level***

- Practically all states have used the flexibility provided under RCH II to strengthen staffing levels through establishment of state and district program management support units and this has contributed to the increase in absorptive capacity/ expenditure. High attrition rate

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<sup>3</sup> The RCH II program had envisaged a performance based bonus to states based on achievement of 3 suggested indicators related to utilization of funds, institutional deliveries and immunization. These were to be started in the fiscal year 2007-08, after the institutional mobilization phase. However, with the increased financing made available under the NRHM, the use of this model of performance based financing was not considered as a relevant model for implementation.

in both SPMU and DPMU has been arrested in some states (eg Bihar, Orissa) through increased compensation.

- There are overall systematic district planning processes in place in most states, and there has been continuous progress in the quality and number of District Health Action Plans with the number increasing from 284 in 2006-07, to 488 in 2007-08 to 636/640 in 2011.
- Several states (eg Gujarat, MP, Orissa) are using extensive consultations at district and sub-district levels in the preparation of the PIP
- Several states (eg Rajasthan, Karnataka, Orissa, J&K) have also created teams for more intense supportive supervision. DPs are providing TA/ supportive supervision in selected high focus districts.

Key issues	Recommendations
<p><b>National level</b></p> <p>Further steps towards results based financing would need to address several issues including: (1) transfer mechanisms from states to districts and onwards to facilities and blocks; (2) autonomy for districts and facilities to spend funds to achieve results; (3) maintenance of supply chains; (4) human resource issues; (5) use of private sector capacity; (6) robust contracts/MOUs with strong monitoring; (7) independent verification systems; (8) agreement on a package of services; (9) costing of packages; (10) incentives for quality and equity.</p>	<p>Consider expanding the “results based financing” approach in the next five year plan cycle as it makes a more efficient use of funds as well as provides the impetus to achieve the necessary results. RCH II already has a demand side financing mechanism that has increased demand for services, i.e., the JSY. The move to introduce supply side models for results based financing would help improve quality and efficiency of services. There have been different models that have been used globally, many in Latin America and some in Africa, which pertain to maternal and child health (for example, Plan NACER in Argentina). It is important that these models are studied for their adaptation to the Indian context.</p> <p>With the recent advent of health insurance schemes in India, it is also important to see how any new program will finance facilities based on package of services.</p>
<p>Different aspects of RCH have been under different administrative heads for different periods during the program. Reporting and coordination across cross cutting functions (IEC, Finance, M&amp;E, procurement) could be more effective in meeting RCH program needs.</p> <p>Given the functional emphasis across technical areas rather than a geographical focus, accountability for delivering results and decision making to deliver a package of services (such as post natal care following institutional deliveries) is diffused.</p>	<p>All technical divisions related to RCH should continue to remain under a single administrative authority. Strengthen reporting and coordination across cross cutting functions and plan for institutional restructuring in line with the the XIIth Plan strategies, in particular possible results based funding of states; appropriately reflect newer functions eg gender &amp; equity, PPPs and bio-medical waste management; strengthen geographical supervision of high focus states and districts building on the concept of State Facilitation Teams (SFTs). SFTs to have enough technical staff representing all programs, if NRHM is being supported as a whole. Senior administrative / technical staff could perform functional roles as well as be responsible for geographical supervision.</p>

Key issues	Recommendations
<p>The annual state PIP preparation and approval process could be more efficient.</p> <p>Many a times there have been delays in approval of state PIPs (for various reasons) which results in delayed release of funds from the centre to the states, which affects implementation.</p>	<p>Consider (1) Realigning funds within three areas i.e RCH including immunization; Disease control programmes and Health Systems (2) Each state prepares a five year PIP and on annual basis provides a detailed workplan and budget and highlights changes in the PIP (3) The 5 year PIP to have a results frame work in terms of key indicators i.e goals, outcomes and outputs as well as process (in particular for health systems); this could act as a basis for a MOU with each state/ performance based disbursement of funds (4) Booking of costs should be such that information on allocations/ expenditure is readily available by (a) natural heads eg HR, drugs and supplies, civil infrastructure, equipment, etc (b) programme eg MH, CH, FP,etc (c) special categories eg tribal areas, vulnerable groups, urban, etc. and (d) organisational responsibilities (e) provision of larger proportion of funds as 'flexible funds' for states to enable them to plan and use them as per their specific needs.</p> <p>Reasons for delays in release of funds should be analyzed, and corrective action taken.</p>
<p><i>NHSRC/SHRC</i></p> <p>Role of NHSRC with an RCH II focus has not seen as much progress as originally envisaged. Also, coordination between NHSRC and key RCH program divisions needs to improve. DP involvement in NHSRC has been limited, as the Partnership Council has met infrequently.</p> <p>While SHSRCs have been set up in most states, the functionality and quality of TA provided varies. In some states, technical capacity has been added through SPMUs rather than through SHRCs. The roles of SIHFWs and the SHRCs are not clear in many states.</p>	<p>Establish a coordination mechanism between NHSRC and RCH program divisions. The originally envisaged provision of technical support by NHSRC to National and State Level needs to be ensured.</p> <p>States to clarify relative roles of SHRCs, SPMUs, state Directorates and SIHFW and accordingly build necessary capacity. If necessary, TMSA can provide TA.</p>
<p><b>State level</b></p> <p>Tenure and stability of persons holding key posts under NRHM is still an issue across many states.</p> <p>There is considerable variation across states in terms of:</p> <ul style="list-style-type: none"> <li>• Placement of a dedicated person at state level for key areas such as MH, CH, FP and adolescent health</li> <li>• Total number of consultants (SPMU) at state level: varies from over 15 to nil</li> <li>• Ratio of number of consultants to departmental</li> </ul>	<p>States to make efforts to ensure that the tenure of key positions is for a minimum period of three years.</p> <p>States to appropriately strengthen structure and staffing levels. Ensure better coordination between PMUs and Directorate through training and preparation of job-descriptions with indicators of performance. TMSA to provide technical assistance if required.</p>

Key issues	Recommendations
<p>staff</p> <ul style="list-style-type: none"> <li>• Emphasis to key technical/ programmatic aspects of RCH.</li> <li>• Supportive supervision processes e.g. responsibility for groups of high focus districts, extent of travel; supervision checklists and follow up action.</li> <li>• Coordination between the S/DPMU staff and the Directorate Officers.</li> </ul>	<p>Role of SHSRC is diluted because of multiple agencies and its utility and continuation needs to be discussed.</p> <p>States to continue to strengthen and align Directorates and SPMUs towards geographical supervision and to increase accountability towards achieving results.</p>
<p>Typically, state NRHM /RCH II PIPs are not live documents and primarily seen as a means to obtain approval for funds.</p>	<p>State PIPs should bring out as to how it fits into the overall health sector plan and how the RCH/NRHM funds complement and strengthens state's own efforts. Ideally, the NRHM/RCHII PIP should be a sub set of the state's own overall health sector plan.</p>
<p>While quality of district plans has improved over the years, there is considerable variation across states and in general, the full potential of district plans as a management tool is yet to be realized.</p>	<p>All states should (1) articulate resource allocation criteria i.e districts should be allocated resources in line with health indicators and not population (2) provide a financial envelope with certain percentage (say, 15%) of funds for district specific schemes (3) articulate process of appraisal of district plans (4) ensure post sanction revision of plans in line with the actual allocation to facilitate implementation and subsequent review (5) Establish systems for monitoring performance of districts vis-a-vis DHAPs including through use of state's own HMIS as well as field visits and action taken reports.</p> <p>The DHAP guidelines should be revisited to incorporate lessons learnt, developments such as the HMIS and XIIth Plan strategies.</p>

## 5. HR DEVELOPMENT

### Progress

- Shortage of HR in rural areas is receiving increased attention across states.
- Chhattisgarh and Rajasthan, have created a special cadre with a mix of financial and non-financial incentives.
- Rural service bonds for medical students and weightage for serving in rural areas in PG admission have been initiated in eg MP, Gujarat and Karnataka.
- Haryana, Tamil Nadu and Maharashtra have shown that employment of regular directorate staff can be quick and strategies for attraction and retention of skilled professionals in rural and remote areas do not necessarily have to be only through contractual services only.

- In Meghalaya, a combination of rural service bonds for sponsored candidates and contractual appointments have reduced its vacancy situation in PHCs to zero.
- Locally based selection and special short term expansion of nursing school capacity under PPPs have led to clearing 10,000 ANM vacancies within four years in West Bengal.
- Chhattisgarh and Assam have introduced a three year medical course for rural practitioners. Sikkim has looked at measures that address professional and social isolation by building a positive workforce environment through CME programs and making PHCs into social hubs.
- Innovative HR developments are seen in Rajasthan where assistants in the anganwadi centres under the Department of Women and Child Development (originally called sahayoginis) have been renamed ASHA Sahayoginis. ASHA Sahayoginis are paid a monthly stipend of Rs. 500 (over and above which they receive incentives for different tasks); they are required to visit 10 households daily; and they function out of the Anganwadi Centre. This has not only expanded the workforce but also led to better integration of ICDS and health, greater accountability and greater coordination of ASHAs with Anganwadi Workers. On an average, an ASHA thus earns around Rs. 2000 a month.
- In Madhya Pradesh, enhancement of retirement age to 65 years and opening recruitment to skilled professionals from other states, starting up nursing schools in high focus districts, the enforcement of a rural service bond for doctors, employing AYUSH doctors in PHCs, and the provision of a “difficult area” allowance for health providers is the package of innovations through which the problem of skilled professionals is being addressed. Most of these schemes are in their infancy and there is still some distance to go, before results are seen. Similarly Bihar has also increased the retirement age to 65 years.

Key issues	Recommendations
<p>Though the number of contractual staff has increased sharply, their productivity and morale in many states could be better. Key underlying factors include: delay in renewal of contracts, poor service conditions and increments, ineffective appraisal system, reluctance to nominate them for longer skill based training, and a wide distinction between contractual and regular staff performing the same tasks. For example the regular ANM would get approximately Rs 16,000 per month at the start of the scale and the second contractual ANM would get about Rs 6000- for the same job description- and thus the second ANM becomes the working assistant to the first.</p>	<p>Establish a HR function for contractual staff, either by appointing a dedicated HR specialist/ team or outsourcing the function. Design and introduce formal performance evaluation systems and link these to incentives. Appraisal process should be initiated well before the end of the contract in order to improve performance.</p> <p>Job descriptions with indicators of performance are a must. Plan for attrition, by maintaining a data bank of candidates.</p>
<p>In some states especially Jharkhand, Nagaland, Rajasthan, Uttarakhand and Uttar Pradesh there are still a large number of vacancies. The available pool for recruitment in such states is also very low. These states are deploying AYUSH doctors in PHCs, but, as a stand-alone policy this is quite inadequate. The training for AYUSH doctors to play the role of medical officers is not in place.</p>	<p>MoHFW should bring a universal policy for extending the retirement age of govt doctors in all States to over come the shortage of critical HR in the health system.</p> <p>MoHFW to rigorously evaluate HR practices being implemented in other states; and disseminate the same.</p>

Key issues	Recommendations
<p>Some states (eg Taminadu and Himachal) have taken a decision to post MOs as DPMs after completion of training in Public Health Management. On the other hand, virtually all states have large vacancy positions for MOs. Use of regular MOs for DPM position is perhaps not be most optimal use of scare technical human resources.</p>	<p>The strategy to post MOs as DPMs needs to be revisited.</p>
<p>Training management:</p> <p>The management of training across states remains weak. Comprehensive Training Plans (CTPs) submitted by states are typically prepared in isolation and not aligned with the infrastructure up gradation and the HR plans resulting in highly trained resources (MOs trained in LSAS and CEmOC) being confined to facilities where they are not in a position to practice their skills. Database of trained staff is typically not available. Moreover, training needs across all programs are not harmonised. A systematic assessment of impact of training on job performance and skill development is not carried out.</p>	<p>The SIHFW/ nodal agency for training should be headed by a training professional with adequate tenure and adequately staffed.</p> <p>Strengthen the state’s CTP to ensure that training plans are aligned with facility operationalisation priorities and take into account training capacities in both public and private sectors. Steps to improve monitoring quality of training, use of skills post training and mentoring programs to give practitioners confidence after skill development should be integral components of the CTP.</p>

## 6. HMIS AND DATA MANAGEMENT

### Background

The RCH II National PIP acknowledged the deficiencies in Management Information Systems and noted that “the monitoring and evaluation system was not very effective and took a backseat during the first phase of RCH project.”

There were several concerns: the first was that Community Needs Assessment Approach (CNAA) that formed the basis of service delivery planning was not implemented in its true spirit. Secondly, multiplicity of registers compounded by complex reporting mechanism on variety of RCH indicators without much program relevance added to the burden of the field functionaries. Thirdly, routinely and periodically collected information was rarely used for reviewing the program. Further, feedback mechanism remained the missing link.

Some of the strategies proposed to improve the MIES were:

- Simplified CNAA will be used for planning at the ground level
- All registers will be simplified and indicators will be made fewer
- Data validation will be initiated to triangulate the data for improving quality of data
- For assessing quality of services an integrated (internal and independent) system involving M&E cell and medical colleges will be instituted.

- From PHC above, data entry and flow will be computerized.

In addition, it was proposed that independent surveys such as District Level Household Surveys will be conducted for program evaluation. Subsequently, MOHFW also launched an ambitious name based monitoring and tracking system to capture information on every “beneficiary” and track them from pregnancy to one year of age.

### Progress

- There has been progress in computerizing the HMIS that has resulted in transparent and faster flow of data, at-least from block upwards. 22 States/UTs have shifted to facility based reporting and they are uploading data at either block or PHC level while rest of the 13 States/UTs are uploading data from district level.
- The quality of data has shown steady improvement.
- There is some evidence of use of HMIS data for preparation of PIPs and subsequent monitoring of progress.
- MCTS is being implemented in all the districts visited.

Key issues	Recommendations
<p>Physical record keeping yet to be rationalized:</p> <ul style="list-style-type: none"> <li>• There are as many as 38 registers at the sub-center level that an ANM has to maintain even now. In West Bengal, an ANM had to maintain a separate register for each method of family planning! While Eligible Couple Registers (ECR) are in use at some places, their linkages with other recording registers is not consistent. The facility registers do not capture all the required information: for example, in J &amp; K, in the facilities visited, the registers in the labour room did not have columns capturing complications. In absence of these columns in the recording registers, it is difficult to envisage how the states report on these parameters!</li> <li>• There is a lack of consistency of recording formats within the state and between the states. There is also persistent confusion between what is to be reported: services delivered by the sub-center or all services delivered to the population within the sub-center area, irrespective of the source.</li> <li>• In all districts visited, some form of CNAA was conducted at the beginning of year; but the ECR is not used for planning</li> </ul>	<p>MoHFW should continue to use the data in the HMIS for state program reviews; this would encourage states to do the same and hence catalyse validation and use of data for monitoring and planning purposes.</p> <p>Set up a task force to strengthen HMIS with representation from the state Monitoring and Evaluation division and Population Research centres.</p> <p>Abolish all the vertical reporting systems.</p> <p>Standardize and simplify recording registers to capture the required information. Ensure consistency with the HMIS formats.</p> <p>Develop and disseminate a set of dash board indicators to monitor program progress at PHC, block, district and state level</p> <p>Prepare and share clear guidelines for data validation on the ground</p> <p>Capture the best practices in quality monitoring and disseminate to all the states</p>
<p>The HMIS is yet to stabilise:</p> <ul style="list-style-type: none"> <li>• Facility level data entry is yet to gain momentum. None of the States visited in JRM have initiated</li> </ul>	<p>Strengthen the Monitoring and Evaluation Cells in all states, with better linkages between the directorate staff and NRHM staff</p>

Key issues	Recommendations
<p>data entry at the PHC level. Only Karnataka, Goa and Delhi are uploading data from PHC level. Most places had inadequate data entry operators, and some face technical problems in uploading the data.</p> <ul style="list-style-type: none"> <li>• Weak data validation: In West Bengal, Block PHNs are conducting data validation. However, in all other states visited, there are no efforts at data validation at facility level. This resulted in observation of several instances of mismatch between what is recorded, what is reported and what is uploaded on the HMIS. Feedback on the data is the weakest link in the HMIS.</li> <li>• Sub optimal use of HMIS data: There appear to be some efforts in most states to analyze the information from HMIS, and use the analysis for preparation of PIP. However, the HMIS is not being used for monitoring the program at PHC, block, district or state level</li> </ul>	
<ul style="list-style-type: none"> <li>• No initiatives to capture information on quality of services were seen during the field visits. However, the state of Rajasthan has institutionalized monitoring of quality of maternal-newborn care through concurrent monitoring cell established in the directorate.</li> </ul>	
<p>In the states visited, the MCTS is yet to be fully functional:</p> <ul style="list-style-type: none"> <li>• Registers/ recording formats yet to be standardized.</li> <li>• Inadequate training of the users: especially of the ANMs in use of the system for tracking and follow-up</li> <li>• Difficulty in using the software for recording and tracking. There are hardware issues related to uploading of the data</li> <li>• There also appears to be lack of integration of MCTS with HMIS; MCTS is seen as an additional exercise rather than integrated with HMIS.</li> <li>• Tracking of a woman through antenatal to postnatal is not well established.</li> </ul>	

## 7. QUALITY ASSURANCE SYSTEMS

### Background

National PIP refers to Quality Assurance as an integral component of Monitoring and Evaluation framework for the RCH II programme. The District Health Action Plan Manual makes a strong reference to establishing QA systems in districts, so as to ensure maintaining service quality as well as quality of training. Earlier, MoHFW issued a guidance note in 2009, expanding the scope of District Level Family Planning QA committee to include maternal health & child health in its mandate.

## Progress

### State level

- QA committees constituted and notified at the state level in all States.
- In Maharashtra, a State QA consultant (Nodal Officer) has been appointed to focus on Quality Assurance issues. An orientation workshop for QA was organized at the State Level for State Officials. The programme has been implemented in 12 districts with further plans for scaling up in the remaining districts.
- Meghalaya has piloted facility based quality assurance mechanism through a state level facility based Quality Assurance Grading. On a quarterly basis this group visits health facilities in the two pilot districts (East Khasi and West Garo) and grades the facilities based on their performance.
- In MP, Divisonal level QA committees have been constituted. It appears that these divisional level committees are largely entrusted with task of monitoring programme implementation.
- In J & K the State has taken up NABH accreditation through QCI.

### District level

- District level QA committees have been set up in J & K, WB, MP and Maharashtra.
- In MP, checklists have been developed and used for mentoring visits to MCH centers, services in Labour room, SNCUs, NRCs and VHND. State directives on quality have been issued. To build capacity of QAC members, workshops have been planned.
- In Maharashtra, District QA committees are set up in all 33 districts. The DRCHO (District Reproductive and Child Health Officer) has been appointed as the District Nodal Officer for QA. Each district has identified 20-24 officials to be members of the DQAG. Comprehensive checklist for monitoring of quality at Sub centre, PHC and FRU has been developed. The checklist is designed in a different color for different levels of facilities.

Key issues	Recommendations
Though states are fully aware of the expanded scope of QA committee, there has been no attempt to orient committee members about their role.	Orientation of State and District QAC to be undertaken. GoI and DP support to be provided wherever required. Apart from MH, CH and FP interventions, MDR should also be part of QA.
Quality Certification of facilities could be more efficient: In some states, both external (ISO/NABH) and internal certification takes place.  The IPHS coordinators in some states are working in isolation. There is lack of coordination between the QA committee and IPHS	The existing dual system - internal (through DQAC) and external (through NABH/ISO) needs to be revisited by MoHFW.  IPHS coordinators should be integrated into the state and district level QA teams.  QA of VHNDs/ SHCs should also be brought under the purview of the QA system. JSSK

coordinator.	provisions can also be monitored through such mechanisms.
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## 8. GENDER AND SOCIAL EQUITY

### Background

RCH II has an explicit pro-poor focus. It aims to use evidence to prioritize interventions and use resources where health is the worst and need the greatest, and to do 'bottom-up' contextual planning for this purpose. Its strategy regarding gender is to mainstream it in all dimensions of the programme, particularly, planning and monitoring, service delivery and quality, HR efforts including training, communications, and implementation of the PCPNDT Act.

#### *Key Indicators*

No gender or social disaggregations were reported in JRM documents for the programme's key outcome indicators, such as IMR or NMR. The Coverage Evaluation Survey (2009-10) is the most recent available source of other disaggregations. In addition to state-wise and rural/urban data, it provides some information by caste and wealth quintile. For example, full immunization at the national level was about 48% among the poorest quintile and 75% among the richest, and 50% for STs, 59% for SCs, 60% for OBCs, and 65% for others. The place of immunization, also varied by these social categories. Similar variations are seen in the state CES reports. As the MTR of RCH II reported, the DLHS-3 indicated that inequities persist in many key health indicators (including access to health services), which are particularly poor for STs and SCs, among the urban poor and some minorities. While DLHS data showed low differences between boys and girls for free services such as immunization, sex differentials were found in services that may require expenditure, such as treatment of ARIs or diarrhoea.

### Progress

- **Gender and Equity in Planning and Monitoring:** The state PIPs and annual budgets demonstrate a stronger focus on reaching vulnerable groups, but with some variations in approach. West Bengal looks at both vulnerable social groups as well as high priority districts, while Jammu & Kashmir and Meghalaya focus largely on high priority districts. There are also good indications that some states (such as MP) are adopting a bottom-up approach to planning service delivery, with village health plans being incorporated into block and district plans.
- **Gender and Equity issues in Service Delivery -Difficult Area:** The state visit reports bring out several areas of service delivery in which G&E issues need to be addressed proactively. There are encouraging movements towards making services more accessible to women and vulnerable groups particularly in hilly and difficult to reach areas. For example, J&K plans to provide waiting rooms for pregnant women in hilly and tribal areas of high focus districts - a dormitory with basic amenities will be set up adjoining PHCs/CHCs. Pregnant women from areas with low or no connectivity can stay here prior to their EDDs and return home after delivery. Several states provide incentives and allowances for staff to work in difficult areas.
- **Care in the Village.** At the village level, the locations of VHND sites were generally found to be acceptable in terms of allowing access to under-served groups.

- **Getting to a Health Facility** Amongst delivery related facilities, the greatest improvement is seen in transport facilities, including vehicles and call centre systems. Attention is being paid to the problem of dropping women back home. For example, Meghalaya is developing an ambulance scheme to reach remote areas, and providing mobile services for migrant populations close to their work places. The availability of transport has also facilitated referral to an appropriate facility, which is more readily done now than earlier. The JSSK is another key initiative in this context.
- There appear to be signs of improvement in general facilities that are important for gender-friendly services. Signage and information displays at health facilities, IEC materials and drug supplies appear to be improving. In MP, special efforts have been made to provide privacy and clean toilets.
- **Implementation of PCPNDT Act** The JRM focused on the institutional arrangements for planning, implementation and monitoring of compliance with the PCPNDT Act including a State Appropriate Authority (SAA), State Supervisory Board (SSB), State Advisory Committee (SAC), PCPNDT Cell and Inspection and Monitoring Committee (SIMC). In addition to constitution of these bodies, the checklist of questions focused on whether they hold and minute regular meetings, and whether action is taken and reported on these minutes. The SIMC is expected to inspect ultrasound clinics. Other activities to be monitored are: cases filed and their outcomes, appeals, suspensions of doctors, listing of registered clinics, centers, etc. by the SAA, reporting by suppliers of equipment (to the SAA). A state Action Plan for PCPNDT activities is expected to be prepared, and budget sanctioned and utilized. This could include relevant IEC/BCC activities, training, and sensitization activities.

Key issues	Recommendations
<p>As the National PIP clearly articulates ‘gender mainstreaming’ (GM) as one of its strategies, nodal persons need to be actively engaged in promoting a gender perspective in the health departments at least at the national and state levels, planning necessary activities, and overseeing their implementation. A gender consultant has been hired at the national level, but there were no focal points found at the state level for gender mainstreaming.</p>	<p>States to select/ engage a nodal person with relevant expertise and experience for GM.</p>
<p><b>Training and Capacity Building - Participation in decision-making</b> : Although women and SC/STs are represented in the VHSCs, the RKSs, SHSs, the Health Departments, etc., evidence of their influence on planning and implementation in favour of the groups they represent is still inadequate. Several reasons are found: they may have inadequate knowledge of needs, strategies or the ‘how’ of implementation; they may lack confidence to assert themselves for their constituencies, or conform to traditional norms to remain in the background; the attitudes of men and upper classes may not be supportive, etc.</p>	<p>The centre and states should engage appropriate agencies to develop good G&amp;E sensitization and training (GEST) modules for all levels and carry out TOTs at least to the point where adequate trainers are available to continue the work. It must be recognized that GEST would be an on-going program because of the scale of coverage required, turnover of personnel, and diverse and changing needs.</p> <p>As the discussion below on service delivery implies, members of Quality Assurance Committees at state and district levels would also require GEST as a gender and equity</p>

Key issues	Recommendations
	<p>perspective must be built into QA from its inception.</p> <p>The capacity of SHSRCs must be built so that they play a central role in G&amp;E in the programme as a whole, and particularly in training.</p> <p>Improvements in communications, particularly IPC among staff such as ASHAs, ANMs, Nurses and Doctors at all health facilities, are critical both to enhance service delivery to women and the roles and status of women health providers. Communication must also be focused on addressing gender disparities within families and communities.</p>
<p>To achieve equity goals there must be purposeful planning for them. For such planning to be evidence-based, disaggregated data (DD) are required to view the gaps in coverage/use of services by different groups, in addition to geographic variations and gender gaps (in certain services). Some DD are available from surveys (at national, state and (in some cases) district levels) which are useful to give a broad picture of progress but these are not adequate for planning and monitoring purposes. Currently the SPIPs and DHAPs address some gender issues and have some approaches to reaching vulnerable groups, but these are proving to be inadequate to the immense task involved, as continuing gaps attest.</p>	<p>The HMIS should collect disaggregated data and these should be used in decentralized planning, implementation and monitoring (PIM). Other sources of DD could be the MCTS and RIMS.</p> <p>Another approach that could be revived and used as above is the Community Needs Assessment, as knowledge of community needs could be a sound basis for local level planning.</p>
<p>Very few indicators have been broken down by social group – the Annual Health Survey (2010) (AHS) has not yet provided such disaggregated data, <i>which it should do in future</i>. The AHS shows wide rural-urban gaps across the nine states in terms of CBR, CDR, IMR, NMR, U5MR). For example, the rural CDR in UP is 9.1 compared with 6.9 in urban areas, and the rural IMR is 74 compared to 54 in urban areas of the state. There are also wide variations among (and rural-urban differences in) districts - remote districts continue to have poor levels in these indicators, including in infant survival and maternal health. For example, in J&amp;K, districts such as Poonch, Doda, Rajouri, Udhampur, Kargil, Kupwara and Baramulla are low performers in maternal health. Sex differentials also persist in infant and under-five mortality (in addition to the problem</p>	<p>The NRHM strategy of ‘high focus’ districts could be fine tuned to concentrate on ‘high focus blocks’ and villages for planning and implementation because it is observed that even in HFDs there is a gradation of activity with most effort and resources being concentrated in the better-off parts/towns of the district.</p>

Key issues	Recommendations
of sex ratio at birth which is dealt with in the section on PCPNDT below).	
An important dimension is the impact of actions under the PCPNDT Act on women's access to safe abortion services. Some state reports suggest that there has been a negative effect, with staff even at legitimate facilities being fearful of performing MTPs.	This needs to be rectified urgently.

## 9. MATERNAL HEALTH

### Progress

- **Skilled Attendance at Birth:** Revised SBA training module with standard PowerPoint presentation, SBA quality protocol posters along-with standardised SBA training videos have been prepared and disseminated to the States.
- States have prepared a list of delivery points in the districts where adequate deliveries are being conducted. These delivery points are to be prioritized and operationalized for providing assured wide ranging RCH services (MH, CH, FP and AH).
- MCP card has been jointly introduced by MoHFW and DWCD. Implementation is well underway.
- **Intra Partum:** Under conditional cash transfer scheme of JSY more than 11 million women delivered in institutions in 2010-2011.
- **Post Partum:** Module 6 and 7 for ASHAs aimed at building their capacity in postnatal and newborn care has been rolled out. Recent circular from GOI on incentivizing post natal home based visits to ASHAs is likely to increase coverage considerably.
- **Quality of services (equipments/ drugs):** Field visits indicate that essential MH drugs are now available in the system. There is more awareness about avoiding routine episiotomy and other such practices. It is encouraging to note practice of AMTSL and maintenance of partograph especially in Madhya Pradesh, West Bengal and Maharashtra.
- **Training: Skilled Attendance at birth** (domiciliary & health facilities): 32291 nursing and Midwifery personnel (Staff Nurse, ANM/LHV) have been trained in SBA, as on Sep, 2011.
- **Multi-skilling of doctors** - 1070 Medical Officers have been trained in LSAS and 601 Medical Officers have been trained in Comprehensive EmOC which includes C-section, as on Sep, 2011.
- Ten- day training on Basic Emergency Obstetric Care (BEmOC) Skills has been initiated in the states. Master trainers are now available in all states.
- MH division has set up a centre at MGMIS Wardha to monitor quality of in service training. Some states are in the process of developing comprehensive database of trained doctors and their performance. An assessment commissioned by MH division, supported by UNFPA in 2010, recommended key follow up actions.

- MH Division is actively involved in strengthening quality of nursing and midwifery education and training in the country particularly for 10 high focus states. A 5 year Road map in this regard has been developed for strengthening of pre-service training of ANM/GNM along-with strengthening of ANM/ GNM training institutions in terms of facility upgradation, skills lab, computer lab, library and quality training as per the defined protocols.
- **Provision of Emergency Obstetric Care-** 2891 FRUs and 9107 24X7 PHCs were operational in the country as on March 2011. (NRHM MIS-2010-11); however, regional inequalities persist. Private sector is also a major player in many states.
- **Access to early & safe abortion-** A total of 516 providers are reported to have received training in Medical Termination of Pregnancy (MTP) across States during April- November 2011 (HMIS), with maximum number trained in Maharashtra followed by UP and MP. During the same period, the total number of reported MTPs (at public and private health facilities) in the country is 3,125,61 (HMIS).

2 state level workshops on Comprehensive Abortion Care have been organised in the states of MP and Chhattisgarh in November and December 2011.

States have taken steps to include drugs for Medical Abortion into their EDL (Essential Drug List) and supply these drugs alongwith MVA/EVA equipment on priority at identified delivery points where comprehensive RCH services are planned to be provided.

States have been provided with a six- monthly monitoring tool to report on the progress made in delivery of CAC services.

- **Maternal Death Review :** Guidelines have been provided to the states to conduct Community based and Facility based reviews of Maternal Deaths. All the states have institutionalised the MDR process and have been provided with a monthly monitoring tool to report on the progress being made.
- **Provision of RTIs/STIs prevention and management** - NACO is overseeing implementation of STI/RTI control programme along with MOHFW. In collaboration with NRHM, joint technical guidelines for STI/RTI services are in place. NACO has procured and supplied color-coded drug kits for syndromic STI/RTI management at the PHCs and CHCs under NRHM. A series of regional workshops for Training of Trainers have been completed. 5975 MOs,3337 LTs,4793 SNs have been trained till Sept 2011.
- **Referral Transport systems** -Funds for referral transport of mother have been provided to all the states under Janani Suraksha Yojana. Under Janani Shishu Suraksha Karyakram (JSSK) referral from home to facility, in between facilities and drop back home is to be ensured. Various State specific referral transport schemes have been initiated by the States.

Key issues	Recommendations
<p><b>VHNDs</b>  <b>Quality of ANC services:</b> Poor quality of ANC services during VHNDs is a concern. Examination tables are not available at AWCs. In Madhya Pradesh, Mission noted lack of per abdominal examination as it is difficult to ensure privacy in the AWCs. Surveys have also indicated that</p>	<p>MoHFW to reassess the utility of VHNDs as a platform for ANC.</p>

Key issues	Recommendations
<p>women generally tend to bypass VHNDs for ANC. The women are asked to go to higher facilities for lab examinations/ sonography/ HIV screening.</p>	
<p>In many states, the VHND does not provide comprehensive services, and remain restricted to immunization.</p> <p>Lack of coordination between AWW and ANM is leading to poor utilization of services. The ICDS component is not built in other than providing the Anganwadi Center as a venue. Provision of food in the form of Take Home Rations (THR) to children under three and for pregnant and lactating women, another important function of the VHNDs was accorded low priority during the VHND.</p>	<p>States to develop and implement detailed microplanning processes including for improved coordination between health and ICDS and ensure intensive monitoring to ensure that the VHND provides full complement of services.</p>
<p>Full potential of VHSC and PRI is yet to be realized.</p>	<p>States to jointly train PRI/ VHSC members and health/ ICDS staff in planning and implementation including roles of different players, mobilization of target population and fund availability.</p> <p>MoHFW to consider allocation of additional funds for convergence activities</p>
<p><b>EmOC and LSAs trained Doctors: Deployment and performance</b> -Mostly trained doctors are either not deployed or there is no monitoring of performance.</p> <p><b>BEmOC</b>- Complete package of services may not be fully available. BEmOC trained doctors at times find it difficult to apply newly learnt skills to eg manage assisted deliveries/ complications. Further, at training sites, ventouse (for assisted delivery) is not available.</p>	<p>MoHFW to inform/impress upon the states on the need to:</p> <ul style="list-style-type: none"> <li>- Issue the posting orders of the doctors prior to commencement of EmOC/LSAS training.</li> <li>- Support continuing medical education programmes for such doctors using e-learning formats and peer based learning.</li> <li>- Provide site support for the newly trained Doctors needs to be initiated.</li> </ul>
<p>In some hospitals (e.g. Nadia District Hospital), C-section rates are as high as 30%. Given the very high work load, sometimes doctors find it convenient not to wait for progress of delivery and resort to C-section at the first available opportunity.</p>	<p>States need to monitor C-section rates and ensure that they are carried out only as EmOC and not because of convenience.</p>
<p>Though MDR has been initiated there is underreporting and quality of analysis could be much better. While most reported deaths had been investigated, detailed review is not taking place in all districts. There is a lack of understanding of the concept of MDR and casual approach of the officials was observed in some states and districts.</p>	<p>Reorientation training in MDR needs to be stressed by MoHFW. Regular review by monitoring teams is required to assimilate MDR in the system.</p>

Key issues	Recommendations
Janani Suraksha Yojana (JSY): Public health facilities especially the district hospitals are overcrowded which often leads to compromise in the quality of service.	Accreditation of private facilities in the areas where the public facilities are not available or are inadequate needs to be taken up urgently.
There are wide variations in labour room registers format. Obstetric complications though supposed to be reported in HMIS are not being recorded in all the facilities uniformly.	Labour room registers and reporting formats need to be standardized.
Janani Express(JE) vehicles are not suitable for transfer of obstetric emergency such as bleeding and convulsions	Existing JE vehicles should be retrofitted with necessary equipments so that these vehicles can be used for transport of serious cases.
<b>Infection Prevention</b> Segregation of waste at the point of generation is taking place in the prescribed manner except during VHNDs. However, an area of concern is management of vendors contracted out to dispose waste as per guidelines. Sometimes bags are not collected as per agreed frequency.	There is a need to manage the PPPs better. Also there should be closer co-ordination with State Environment Pollution Prevention Board, which is responsible for adherence to standard BWD as per the Act.

## 10. CHILD HEALTH

### Progress

- Development of separate training materials for doctors, ANM, AWW and ASHA and operational guidelines for IMNCI, F-IMNCI and home based newborn care.
- In most states, adaptation and dissemination of guidelines for facility-based management of severely malnourished children, promoting Zinc as an adjunct therapy with ORS for diarrhea and actively combating early childhood anemia have been initiated.
- IMNCI is being implemented in 433 districts and 4.9 lakh personnel have been trained so far. F – IMNCI launched to multi skill doctors and staff nurses with special skills, required to manage new born and child hood illnesses at facilities.
- In several states, initiatives have been taken to incorporate 'Integrated Management of Neonatal and Childhood Illness' in the curriculum of medical and nursing undergraduates and auxiliary nurse mid-wives. It has been introduced in the curriculum of 79 Medical colleges and more than 4000 medical students have been trained on various aspects of IMNCI.
- Under the Navajati Shishu Suraksha Karyakram (NSSK) launched to address issues of care at birth and to reduce neonatal mortality, 44977 health personnels have been trained.
- The progress of establishment of newborn care units all over the country is satisfactory. At present 293 sick new born care units (SNCUs), 1134 stabilization units and 8582 new born care corners have been established.

Key issues	Recommendations
<b>Issues related to Household/ Community level services</b>	
Poor access to management of common	• States to develop a training plan for immediate

Key issues	Recommendations
<p>ailments during childhood</p> <p>Around 400 districts have initiated IMNCI but only around one third of these have completed the required trainings. Even though tools for recording and monitoring quality of trainings have been developed, they have not been used universally resulting in compromised quality monitoring of implementation.</p> <p>In districts, where IMNCI training has been rolled out, implementation has lagged behind. Home visits (3 visits in first 10 days) to provide Home Based Newborn Care has not yet reached the 50% mark and lack of adequate supportive supervision and quality of services provided remain areas of concern.</p>	<p>rollover of the training of ASHA on module 6 &amp; 7</p> <ul style="list-style-type: none"> <li>• Role of ASHA to be expanded to include management of pneumonia</li> <li>• Operationalize subcenter clinics</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Ensure micro planning for IMNCI implementation</li> <li>• Provision of periodic refresher training</li> <li>• Strengthen supportive supervision for IMNCI</li> <li>• Institutionalize pre-service training for IMNCI</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Review supply chain management at state level and take corrective measures</li> <li>• Decentralization of authorities for procurements</li> <li>• Remove bottlenecks in procurement</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Define and clarify roles of various frontline workers</li> </ul>
<p>Childhood malnutrition remains a neglected area. Various surveys show that rates of key nutrition-related indicators remain quite low - initiation of breast feeding within an hour of birth: 33.5 %; exclusive breast feeding for six months: 36.8%; vitamin A dose received within the last six months: 59.6%). Field visits indicate missed opportunities.</p>	<ul style="list-style-type: none"> <li>• Enhance functioning of VHNDs to include comprehensive nutrition service delivery; Ensure microplanning for VHND</li> <li>• Develop guidelines for community-based care for children with moderate and severe malnutrition</li> <li>• Strong BCC efforts during postpartum period to improve breastfeeding practices</li> </ul>
<b>Issues related to facility level services</b>	
<p>High case load in some of the health facilities with inadequate staff</p>	<ul style="list-style-type: none"> <li>• Rationalization of posting of medical and paramedical staff at various health facilities</li> <li>• Transfer and posting decisions to be decentralized to districts.</li> </ul>

## 11. FAMILY PLANNING

### Progress

#### *At the national level*

- A national consultation meeting on “Repositioning Family Planning as an Intervention to Improve Maternal and Child Health” was held. State Family Planning Program Officers from across the country, subject matter experts, representatives from Development Partners (DPs) and local organizations attended the meeting.
- Work on introduction of new contraceptives (e.g. DMPA, Implanon, NetEn, and Cyclofem) is at various stages.
- To expand contraceptive choices, a long term continuation study to understand service provider perspectives on following-up with Cu IUCD 375 has been completed with support

from USAID. Government of India has plans to introduce Cu IUCD 375 in the program shortly.

- To reinvigorate IUCD, GOI introduced alternative training methodology for training on IUCD services. About fifty thousand service providers have been trained across the country using the new technology.
- To improve availability of IUCD services, GOI is encouraging the States to initiate fixed day IUCD services at sub-centers and PHCs twice a week.
- In order to increase the pool of trained service providers providing sterilization services, GOI is promoting training of medical officers on minilap sterilization procedures and focussing on increasing the minilap and post-partum sterilization services.

**At the state level**

- States have been conducting the “Family Planning Fortnight” successfully as part of celebration of World Population Day.
- Some states have initiated social marketing of contraceptives with support from DPs.
- Some high focus states have gained momentum in delivering FP services such as Madhya Pradesh and Bihar.
- Some states have developed good local, mid and mass media communication campaigns on FP that can be replicated for wider use.

Key issues	Recommendations
PPIUCD services are available at select Medical Colleges only. These services to be expanded across all states and select District Hospitals also. Moreover, huge increase in institutional deliveries is not being adequately tapped for providing post partum (PP) counselling and family planning (FP) services.	FP division to prepare a roll-out plan for PPIUCD training and services in other states/facilities. States to develop Human Resource Management Information Systems (HRMIS) on trained service providers and their postings, for rational human resource deployment.
IUCD services are not being provided at Sub-centers.	GOI needs to send directions to the states for holding fixed day IUCD services at subcenters. States may choose any two days in the week for the purpose and make a trained ANM available at sub-center for the IUCD services.
There is no designated space for provision of FP services at District Hospitals and Community Health Centers (CHCs).	GOI to issue directions to the states for provision of dedicated FP Cell/space for provision of FP services with trained staff.
There is shortage of trained IUCD providers.	To increase the pool of service providers providing IUCD services, training of providers to be taken up vigorously.
As a follow up to the international consultation on repositioning of FP, there is a need to develop an “Integration of FP into MCH services” package which identifies all opportunities for integrating FP into MCH service provision and how to.	By March 2012, the FP division to develop an “Integration of FP into MCH services” package.  DPs to provide necessary support.

Key issues	Recommendations
ELA tool has been provided to the states, however the understanding is variable.	Supportive supervision to be provided to the states for effective use of ELA.
There are concerns over (1) Quality of contraceptive supplies (2) engagement of private providers in the family planning program (3) social franchising of family planning services (4) on sterilization failures	MoHFW to initiate assessments with support of DPs

## 12. ADOLESCENT HEALTH

### Progress

- As of 2011, there are almost 3000 adolescent friendly health clinics across District Hospitals, CHCs and PHCs.
- 5527 Medical Officers and 16728 ANM/LHV/Counsellors have been trained on offering adolescent friendly health services across the country
- MoHFW has rolled out a new scheme for the promotion of menstrual hygiene aimed at ensuring that adolescent girls (10- 19 years) in rural areas have adequate knowledge and information about menstrual hygiene and the use of sanitary napkins. This scheme is being launched in 152 districts across 20 states in the first phase. The Ministry is procuring sanitary napkin packs from M/s HLL for 107 districts to be supplied at the block level. In the balance 45 districts, States are in the process of procuring sanitary napkin packs from women SHGs. Funds for procurement from SHGs have been allocated in the state annual PIPs. The NRHM brand of sanitary napkins – Freedays, will be sold to the girls by the ASHA at Rs. 6/- for a pack of 6 napkins at the village level.
- A pilot on creating peer educator by the name 'Maitri' in Maharashtra has been started. Civil/General Hospital, Satara has set up ARSH clinic and has support of 430 peer group members.
- In J &K in the VHND it was observed that issues concerning adolescent girls are discussed regularly by the AWW and the ANM.

Key issues	Recommendations
ARSH still not a priority especially in EAG states.	<p>Nodal officer for ARSH should be identified. This officer should also be made responsible for School Health Programme, Menstrual hygiene scheme and IFA supplementation for effective management of cross-cutting interventions.</p> <p>Prioritization of ARSH should be reflected in the PIP –a well-developed section on ARSH covering 5 essential elements of ARSH viz training, operationalization of clinics, outreach, convergence and IEC should be clearly laid out.</p>

Key issues	Recommendations
<p>Case load at places in AFHS clinics is very low. Anvesha Clinics in West Bengal is an extension of the ANC Clinic and has focus only on clinical aspects. There are no male clients at the clinic. There are no linkages with the School Health Programme.</p> <p>Quality of services being provided needs improvement. Psycho-social and behavioral issues not being addressed properly. Proper signage, IEC material or contraceptive not available.</p>	<p>States to plan for demand generation / outreach activities with appropriate engagement of ASHA and peer educators.</p> <p>VHNSD can also be utilized as a platform for outreach activities</p> <p>For Sabla pilot districts it is suggested that their peer group educators may be used to increase the client base</p> <p>Referrals from school health programme would also ensure better utilization of AFHS.</p> <p>Counselors need to be appointed – Active convergence is suggested with the existing ICTC clinics as well as using the service of ICTC counselors (in high prevalence states)</p> <p>Developing stand-alone clinics headed by a counselor is also suggested for states where ICTC centers are not strong or do not exist .</p> <p>As an alternative strategy ANM/SNs need to be trained in adolescent counseling. Male counselors wherever needed needs to be appointed.</p>

### 13. PRIVATE SECTOR INVOLVEMENT/PPPs

#### Progress

Several states have initiated PPPs for addressing critical barriers such as geographical access, gaps in human resources for health, referral transport, and diagnostic and ancillary services. There are several PPPs that have been deployed for strengthening referral transport, contracting in of services at public health facilities, contracting out service delivery to private institutions, social marketing, and developing provider networks.

In 2010-11, private accredited health institutions accounted for 25% of institutional deliveries in both public and private accredited facilities, the corresponding share for MTPs and sterilisation services being 31 % and 16% respectively. These are primarily purchase of services from the private sector, to a large extent fuelled by Janani Suraksha Yojana and government compensation for sterilisation.

MoHFW has issued guidelines for accreditation of private sector providers for maternal and child health and family planning services.

A PPP course has been established at the National Institute of Health and Family Welfare (NIHFW) in partnership with DPs. It currently offers an annual course for strengthening the PPP capacity of state and district managers, and has mechanisms for follow-up of trainees and/or providing TA support to states for developing appropriate PPPs.

West Bengal and Rajasthan have a PPP policy for health in place.

Key issues	Recommendations
<p>PPP initiatives are very often fragmented and tend to focus on service delivery and lack a comprehensive sector approach. The public sector tends to largely operate as a stand-alone system without satisfactory integration with the private sector.</p>	<p>Strengthen capacity to develop comprehensive district and state PIPs reflecting the key opportunities and barriers in both the public and private health sub-systems.</p> <p>PPPs should be considered not only for expanding service delivery efforts but also for areas such as training of healthcare providers and demand creation.</p>
<p>Advocacy efforts for building a positive environment for effective engagement of private sector are limited.</p> <p>Limited efforts have been made to strengthen the capacity of the government at the national, state and district level for effective management of PPPs.</p> <p>However, fund management, disbursement, monitoring are often key bottlenecks in implementation of PPPs.</p>	<p>Develop a comprehensive national policy for PPPs in the health sector.</p> <p>Designate a senior-level nodal officer for PPPs at MOHFW.</p> <p>Establish and staff state level PPP units for design, management and monitoring of PPPs</p>
<p>There is wide skepticism of the variable quality of private sector service provision.</p>	<p>Develop quality standards for engagement of private healthcare providers for provision of RCH services. These standards should be uniform for both public and private sector providers.</p>

## 14. BEHAVIOR CHANGE COMMUNICATION

### Progress

- The MOHFW reinstated the annual national-level meeting for all State IEC officers. The second such National BCC workshop was organized by the MoHFW and Indian Institute of Health and Family Welfare at Hyderabad from 23-25 March 2011, where IEC officers from 18 states participated.
- As part of the efforts to build national and state level BCC capacity, a new DP supported initiative -Improving Healthy Behaviours Program (IHBP) has been launched.
- Steps have also been taken for optimum use of mass communication and make media campaigns more interactive and participative by giving inter personal communication a major push by roping in Dte.of Field Publicity and Song and Drama Division of Min.of Information and Broadcasting.
- A number of other initiatives are underway with DP support:
  - Mapping of academic and learning centres with potential for undertaking capacity building for Social and Behaviour Change Communication (SBCC); development of Social and Behavior Change Communication (SBCC) curriculum with focus on Maternal and Child Health.
  - Establishment of BCC cells as part of System Strengthening efforts in select districts, as institutional mechanisms for promoting inter-departmental convergence for communication planning, implementation and monitoring.

- A draft "communication operational plan for intensification of routine immunization in India"
- Behavior change communication campaign including communication material.
- Mass media campaign for Jansankhya Sthirta Kosh (JSK), aiming to promote information/ counselling seeking behaviour for reproductive health amongst youth and married couples.
- A 360 degree campaign on maternal mortality in Rajasthan; communication and programme persons jointly map communication opportunities, barriers, needs and achievements on the larger programme delivery matrix. Design of a communication campaign for promoting a public-private partnership scheme using vouchers in Uttarakhand.
- Mass Media and Mid-Media initiatives- Kyunki Jeena Isi Ka Naam Hai, an entertainment education TV serial which addresses issues of child health and maternal health, is a daily soap opera, watched by over 145 million Indians, with 61.4% of underserved women in the age group of 15-35. Quantitative research across six Hindi speaking states reveals that the serial has had an impact on the knowledge and attitudes of the viewers. The percentage of women who knew that colostrum should be fed to the newborn increased from 82 per cent during the baseline to 91 per cent during the midterm assessment carried out in March 2010.
- Development of a series of Fact for Life videos for small group viewing and facilitated discussions on maternal and child health issues during weekly group meetings organized by frontline workers – AWWs, ASHAs or ANMs. The videos are being rolled out in select districts in UP, Bihar, Jharkhand and Rajasthan with women's groups.
- The need for consolidating the IEC portfolio has been identified at the central level for better planning, economies of scale etc through integration of the IEC functions across various programs including RCH, RNTCP, National Blindness Control, communicable diseases, tobacco etc. A Technical Resource Group (TRG) on BCC with six external experts from Public Health Foundation of India (PHFI), DPs, National Film Development Corporation (NFDC), to help consolidate the BCC function of MOHFW was also instituted..

Key issues	Recommendations
<p>There is little evidence to prove that IEC/BCC initiatives undertaken for public health systems and programmes have significantly improved service delivery and uptake in RCH-2. This is because IEC/BCC continues to remain an isolated function at the national and state levels, and the output of the IEC department is rarely integrated into the larger programmatic processes.</p>	<p><b>Re-position the IEC department as Communication Bureau with a dedicated Director</b></p> <ul style="list-style-type: none"> <li>• Build overarching competency spanning various facets of Communication - external and internal</li> <li>• Review the TORs of various functions required within the IEC Department and make changes that would help support the recommendations made in this document</li> <li>• Establish a mechanism for close and proactive dovetailing into other communication-led functions like Advocacy and Public Relations</li> <li>• Organizational structure issues need to be also addressed in most states with dedicated staff and updated job descriptions (Refer to 2007-2008 study report for recommendations)</li> </ul>
<p>The focus of NRHM had been on the supply side issues and greater emphasis could have</p>	<p><b>Define and establish a cross-cutting role for communication in effective service delivery</b></p>

Key issues	Recommendations
<p>been given to BCC in program planning, implementation and evaluation</p>	<ul style="list-style-type: none"> <li>• Reiterate the need for integrating communication into programme planning and implementation</li> <li>• Use communication-led outcomes to evaluate programme implementation success, and vice-versa</li> <li>• Make the head of the Communication Department report directly to the health official overseeing all thematic areas</li> <li>• Establish better linkages between BCC efforts and service delivery efforts such as the Village Health Nutrition Days and institutional deliveries under the Janani Suraksha Yojana (JSY)</li> </ul>
<p>There could be greater effort from MoHFW in looking at communication in a more comprehensive way.</p>	<p><b>Establish Communication as a key function within the programmatic skill and expertise matrix</b></p> <ul style="list-style-type: none"> <li>• Broaden the scope and span of communication to make planners and programme staff recognise BCC as a powerful programme tool</li> <li>• Strengthen in-house working knowledge of the various allied areas subsumed in Communication (E.g. strategy development, BCC/IEC/IPC, media planning, outreach, brand building, advocacy and public relations, publications and websites, capacity building, monitoring &amp; evaluation)</li> </ul>
<p>The existing capacity of undertaking BCC efforts is quite poor in states.</p> <p>Field visits reported need for more efforts at Sub-district Hospital and District Hospital. It also reiterated the need to look at BCC as being beyond stand-alone materials. The visits also identified the need for more focused BCC to be undertaken for improving utilization of services by clients. The West Bengal team reported the absence of any communication materials in most facilities. Whatever communication materials available were mostly locally prepared.</p>	<p><b>Maximise professional quality of communication-led outputs</b></p> <ul style="list-style-type: none"> <li>• Re-configure and re-activate the multi-agency thematic communication groups and have regular interactions between these groups</li> <li>• Bundle health issues into thematic clusters and prioritize focus on clusters and cluster components on the basis of a 3-year plan</li> <li>• Focus not only on mass media but on mid-media and interpersonal communication as well. A multi-media communication approach is required</li> <li>• When outsourcing campaigns, designs, research, etc., select professional agencies/consultants with weightage to technical expertise and track record</li> <li>• A Monitoring and Evaluation framework for BCC needs to be established. Investment in independent professional evaluation of projects and programs, and on building institutional knowledge necessary.</li> <li>• States should focus on developing an evidence based BCC strategy and prioritize the range of behaviors they want to impact</li> </ul>
<p>The Technical Resource Group (TRG) on BCC had only two meetings.No progress has been made.</p>	<p>There is need to reconstitute and re-invigorate the TRG, so that discussions on integrating communication into program planning and across different departments could continue</p>

## 15. PROCUREMENT

### Progress

All the supplies under the contracts issued by UNOPS for the procurement of RCH Kit A, Kit B and other kits during 2009-10 have been completed. RITES, the new procurement agent, has till now (October 2011) issued contracts totalling to about Rs.1.73 billion for procurement of Kit A and items for other kits. These supplies are expected to start reaching the consignees by December 2011.

On the institutional development front, the proposal for setting up the central procurement agency (CPA) in the form of a registered society has been approved by the Government. Once CPA is set-up, the procurement in health sector (both directly procured by MOHFW as well as procured by the states under central financing) could be streamlined.

Assam, Karnataka, Jharkhand, Lakshdweep, Tamil Nadu, West Bengal, Mizoram, Goa, Andaman & Nicobar, Gujarat, Bihar, Kerala and Rajasthan have already set-up state level procurement agencies. States have been mainly procuring CH and MH equipment but some states have also procured drugs, medical supplies and minor civil works.

Key issues	Recommendations
Delays in procurement process	Expedite the setting up of CPA to take over the central level procurement and monitor the decentralized procurement and supply management. Even after the completion of RCH-II, the development partners may be in position to provide limited technical assistance, if needed in initial stage of CPA. In the interim, it may be helpful to continue with a professional procurement agent who could, as a minimum, handle indents for 2011-12 in case of (a) RNTCP, (b) NVBDCP and (c) requirements of OPV under pulse polio campaign. States which have set up a procurement agency need to be sensitised to take up the responsibility by adding necessary sufficient capacity including for verifying compliance with GMP requirements through visit to manufacturing facilities of recommended bidders. .
Quality related problems	Till the time capacity is strengthened, the existing practice of verifying compliance with GMP requirements through visits to the manufacturing facilities of recommended bidders should be continued. Also, training may be provided to drug inspectors on the technical notes prepared for revised schedule M. It is also proposed that zonal workshops for improving GMP practices to the level of WHO GMP may be organized under DCG(I) so that the State Drugs Inspectors are involved in carrying out GMP inspections prior to award of NOAs..
Procurement audit	Priority for procurement audit should be given to the States that have historically poor track record and do not have a professional CPA type agency.
Procurement MIS and Monitoring	ProMIS was piloted in 10 states. There is a need to roll out PROMIS in all the states and also follow-up on data entry. The asset management module may be added in PROMIS. Facility for receiving complaints is provided on EPW website and the same may also be included in CPA website (including back-end recording and monitoring of disposal of complaints). Once CPA is set-up, it will take over the implementation of ProMIS from MOHFW.

Key issues	Recommendations
Procurement approach for Kit A, Kit B and other kits	As sufficient experience is available in procurement of kits, MOHFW needs to decide on best approach for future procurement. Some of the options are (a) procurement of items constituting the kits and supplying these to states, who may form the kits if needed; (b) procurement of high value/low volume or high quality risk items at central level and allow procurement of remaining items at state level; (c) fully decentralize procurement of kits; (d) procurement of items constituting the kits and use a kitting agent to prepare and supply the kits; (e) continue with the current practice of central level procurement of Kit A/B and items for remaining kits. In case of decentralized procurement, CPA will coordinate with the states to help them choosing the best option to procure the kits.
Strengthening of warehouses and storage facilities	CPA proposes to set up 50 warehouses to augment storage capacity and linkage through ProMIS. If required, a consultant may be hired to prepare a detailed action plan. This will help in considerably improving the situation.
Inventory Monitoring and Asset tracking	Engage a professional firm for management of inventory as well as for downstream supply chain management for critical items (on the line of TB project). This will be taken care of by CPA.
Moving to e-Procurement	Accelerate the process of moving to e-Procurement (MOHFW was briefly assessed under e-Bharat and it was decided that the assessment will resume once PROMIS is operational), which will reduce scope for human intervention in the procurement process. If required, DPs may provide limited technical assistance in this area. Once CPA is incorporated, this activity will also be under its purview.

## 16. FINANCIAL MANAGEMENT

### Progress

- Establishment of a further strengthened Financial Management Group (FMG) within MOHFW headed by the Director (Finance).
- Some success in selected states which have similar institutional structure for financial management. This has resulted in focussed attention and better financial oversight in MOHFW, especially in the areas of financial reporting and external audit. This has been supplemented by infusion of large number of accountants in states, districts and blocks.
- Improvement in the timeliness of funds transfers and overall reduction in lag, albeit with variations across states in terms of transfer to lower level implementing units
- Establishment of a system and culture of quarterly financial reporting and improvement in the timeliness of financial reporting by states
- Improvement in the scope of external audit and selection of audit firms through open tender.
- Initiatives for e- banking for electronic fund management & monitoring, roll out of common accounting software (TALLY) across the program and simple accounting handbooks for block, CHC, RKS and VHSCs.
- There has been an infusion of a large number of accounting staff at state, district and sub district levels, numbers being significantly higher than what was originally envisaged. In addition MoHFW has requested the creation of a post of Director (Finance & Accounts) in State Health

Societies to be manned by deputation of officers from either the central government or state government finance cadre. This has been created to address the issue of inadequate internal check mechanism and to provide leadership to new finance and accounts personnel who have been laterally infused into the system.

Key issues	Recommendations
<p><b>Financial management structure &amp; capacity building</b></p> <p>The creation and strengthening of FMG has been very beneficial to the program in providing leadership &amp; attention to financial management aspects. However, the support of development partners to finance the FM consultants is likely to end in March 2012, MOHFW should expedite fresh contracting sources and funding to ensure that institutional structure is continued.</p> <p>Retention of the contractual professionals is difficult, primarily due to short contract duration, inadequate remuneration and lack of a system of performance evaluation. Large vacancies were noticed especially in Madhya Pradesh and Jammu &amp; Kashmir<sup>4</sup>.</p> <p>Overloading of the responsibilities at the State and District level due to new responsibilities for the broader NRHM programme – which along with JSY and untied funds, includes increased fund flows to many more entities coupled with increase in volume of transactions.</p>	<p>Develop &amp; implement strategy to sustain FMG beyond March 31, 2012. In addition, MOHFW may also use the opportunity to expand the team in FMG to support scale up of initiatives such as e-banking.</p> <p>At the state level, there are capacity constraints and simply filling up vacancies may not be adequate. Technical assistance &amp; support from FMG is necessary particularly in some of the high focus states, where problems are deep seated and persistent. In certain other states where problems exist but are not as severe, consider utilizing services of local CA firms as financial management technical support consultants as well as for providing continuous accounting support and training of lower level staff.</p>
<p><b>Funds flow</b></p> <p>There have been significant improvements in the flow of funds from MoHFW to the States. However, in some states, delays continue to occur in the transfer of funds to sub implementing units below the districts/ blocks and in some states<sup>5</sup> funds continue to be released activity wise thereby increasing both the number of transfers and risk of either unspent funds in one activity and delays in payment for another or the risk of fund diversion from one activity to another.</p>	<p>Continue to expand the scope of electronic fund transfer to units below the blocks and scale up e-banking initiative piloted in Karnataka.</p> <p>Identify and reduce the number of bank accounts at all levels, especially those which are in-operative.</p>
<p><b>Accounting and reporting</b></p> <p>While the FMG has (i) updated the FM manual in an effort to integrate the reporting requirements of NRHM and RCH-II by providing updated financial reporting formats; (ii) rolled out simplified accounting handbooks for use by blocks, CHC/PHC, RKS, VHSCs and sub centers and (iii) encouraged</p>	<p>States should build accounting and reporting system from the overall FM manual, and the model financial &amp; accounting handbooks for each level implementing units (sub centre, PHC/BPHC, RKS, District and State). This would serve both as a training module as well as guidance to field level</p>

<sup>4</sup> In J&K SHS, it was observed that first two months salary is retained as deposit which is forfeited in case the contractual staff leaves within 1 year.

<sup>5</sup> West Bengal & J&K.

Key issues	Recommendations
<p>states to procure the customized accounting software from TALLY, the quality of accounting continues to be an area of concern in many states especially at units below the districts/ blocks. The field visit also indicated that:</p> <ul style="list-style-type: none"> <li>• Implementation of TALLY has been uneven; while it has made reasonable progress in West Bengal (upto block level) and Madhya Pradesh (district level), it is significantly delayed in Meghalaya (not implemented) and Jammu &amp; Kashmir (only at state level). In the absence of an IT based accounting system, the consolidation of expenditures from various levels for in-year financial reporting (FMRs) is being largely compiled off line in spreadsheets and not necessarily from the basic accounting records increasing risk of reporting errors and excess reporting as evidenced by the variance between the expenditures as per the FMR and audited financial statements (both at an aggregate level and within activities) for FY 2009-10. Although there has been much improvement seen through a reduction in such variance, there is a need for further progress to be made. This is undermining the investment in such accounting packages and resulting in maintenance of parallel manual or spreadsheet based systems for reporting purposes.</li> <li>• States have not yet translated the accounting handbooks for blocks etc in vernacular language and rolled it out.</li> <li>• While efforts have been made to streamline and avoid duplication of reporting heads between NRHM and RCH-II, there continues to be a lack of adequate clarity on some heads such as contractual staff salaries, incentives, program management etc.</li> </ul>	<p>accounting personnel. These handbooks could also be translated in local languages.</p> <p>For states with limited internal capacity, the engagement of CA firms for accounting support and month end and year end closing, inter unit and bank reconciliation needs to be considered.</p> <p>Need to pay focussed attention to scale up and complete implementation of TALLY and/or E-Banking initiative in a time bound manner. Also with e-banking and TALLY implementation, there is a scope for reducing the number of reporting heads in the FMR submitted to MOHFW with detailed heads being used to support state level decision making.</p>
<p><b><i>Internal control &amp; internal audit</i></b></p> <p>Internal control remains an area of concern. The field visit findings, internal &amp; external audit reports of states indicate that financial controls need strengthening in states/ districts. Control weaknesses include lack of timely &amp; regular bank and inter unit reconciliations, un-reconciled fund transfers, lack of control over advances with significant amounts lying as advances with districts and sub districts, other implementing units and individuals coupled with weak monitoring, lack of deduction and/or non payment of TDS. While the</p>	<p>MOHFW may consider requiring state societies to contract the internal auditors for the district units; this will address the issue of quality of internal auditors; the TOR may be expanded to include physical verification of sample of assets/ equipment and drugs in facilities;</p> <p>For ensuring basic financial controls and adherence to month end procedures, states may require districts and blocks to attach a completed checklist</p>

<b>Key issues</b>	<b>Recommendations</b>
<p>system of concurrent/ internal audit has been put in place in many states there is a need to build on this initiative to ensure quality &amp; timeliness of internal audit and develop a follow up mechanism (audit committee) at the State. In the absence of such a mechanism, the accountability mechanism will remain incomplete.</p>	<p>which confirms actions related to bank reconciliations, inter unit fund transfers, advances monitoring and receipt of SOE/ UCs from units below the block.</p>
<p><b><i>External audit &amp; transparency</i></b>  This is an area where good progress has been made in the program. The standardized TOR including the minimum number of block level units to be covered, various checklists to be completed and basis of selection of auditors has improved the quality of external audit and consistency of the disclosure in the financial statements. The improved selection process has, as expected in the short term, resulted in identification of significant control issues in selected states. These need to be followed up by States and MOHFW especially the systemic control issues. In the last few months, MoHFW has taken up the issue of financial strengthening with the states. Letters have been written by MoHFW to State Mission Directors to give priority to financial streamlining, especially follow up and compliance of audit issues.</p>	<p>To support greater financial transparency &amp; disclosure, MOHFW may consider disclosure of critical financial information such as fund utilization, audit reports and actions taken, in MoHFW and or State Society web sites.</p>

## **ANNEX A**

# **RESULTS MATRIX FOR ASSESSING PERFORMANCE OF RCH – II, INDIA 2005-2009**

**Results Matrix for Assessing Performance of RCH – II, India 2005-2009**

Indicators	Disaggregation	Baseline (2003-04)	Year 3 (2006-07)		Year 5 (2009-10)	Year 7 (2011-12)		Frequency of reporting	Means of Verification	Remarks
			Target	Achievement		Target	Achievement			
<b>GOALS</b>										
Infant Mortality Rate	Overall	58		55	50	< 30		SRS (2004, 2007 & 2009)		
	EAG States <sup>6</sup>	68		65	59					
Maternal Mortality Ratio	Overall	301		254	212	< 100		MMR figures are for the period 2001-03, 2004-06 and 2007-09		
	EAG States <sup>1</sup>	438*		375*	308*					
Total Fertility Rate	Overall	2.9		2.7	2.6	< 2.1		SRS (2004, 2007 & 2009)		
	EAG States <sup>1</sup>	4.0		3.6	3.5					
Polio Eradication (Indicator ?)										
<b>OUTCOMES</b>										
% of eligible couples using any modern contraceptive method <sup>7</sup>	Permanent	35.2		35.0	? (AHS)			DLHS-2 (2002-04), DLHS-3 (2007-08)  & AHS, (2010)	Results from DLHS IV not likely to be available till 2013, hence AHS for 9 EAG states to be considered as proxy	
	Spacing	10.3		12.0	?					
	Overall	45.7		47.1	?					
	SC	43.0		49.0	?					
	ST	39.0		42.0	?					
	Lowest Wealth Quintile <sup>8</sup>	36.4		34.0	?					
	EAG States <sup>1</sup>	34.0		37.7	?					

<sup>6</sup> Combined estimates of indicators for EAG states are derived using appropriate external weights (for example, estimated number of births for IMR, delivery by skilled personnel and immunization and estimated number of eligible couples for TFR and use of modern methods of contraception)

<sup>7</sup> Among currently married women 15-44

<sup>8</sup> For DELH-2, this refer to the 'Low' category of Standard of living index

\* For EAG states, MMR figure also includes Assam

Indicators	Disaggregation	Baseline (2003-04)	Year 3 (2006-07)		Year 5 (2009-10)	Year 7 (2011-12)		Frequency of reporting	Means of Verification	Remarks
			Target	Achievement		Target	Achievement			
% of deliveries conducted by skilled providers	Overall	47.6		52.7	76.2 (CES)				DLHS-2 (2002-04), DLHS-3 (2007-08)  & <b>CES, (2009) AHS, (2010)</b>	For 2009, in the absence of AHS indicators, CES is used as alternative source of information
	SC	39.6		47.7	75.0					
	ST	28.4		37.6	61.3					
	Lowest Wealth Quintile <sup>2</sup>	27.5		23.6	59.0					
	EAG States <sup>1</sup>	32.6		36.8	65.6					
<b>GOALS</b>										
% of 12-23 months children fully Immunized	Female	44.9		52.3	59.9 (CES)					For 2009, in the absence of AHS indicators, CES is used as alternative source of information
	Male	46.6		54.6	61.9					
	Overall	45.8		54.0	61.0					
	SC	41.9		52.6	58.9					
	ST	36.5		45.5	49.8					
	Lowest Wealth Quintile <sup>2</sup>	31.3		35.6	47.3					
	EAG States <sup>1</sup>	29.3		40.2	47.5					
<b>Additional Indicators</b>										
% of children received no vaccination	Female	21.0		4.7	7.2 (CES)				DLHS-2 (2002-04), DLHS-3 (2007-08) & <b>CES, (2009) AHS, (2010)</b>	For 2009, in the absence of AHS indicators, CES is used as alternative source of information
	Male	18.8		4.5	7.9					
	Overall	19.8		4.5	7.6					
	SC	23.0		4.4	7.8					
	ST	21.0		9.4	9.9					
	Lowest Wealth Quintile <sup>2</sup>	30.4		9.0	13.7					

Indicators	Disaggregation	Baseline (2003-04)	Year 3 (2006-07)		Year 5 (2009-10)	Year 7 (2011-12)		Frequency of reporting	Means of Verification	Remarks
			Target	Achievement		Target	Achievement			
	EAG States <sup>1</sup>	32.3		5.2	13.4					
% of children under 3 years breastfed within one hour of birth	Overall	43.8 <sup>9</sup>		40.5	33.5 (CES)				DLHS-2 (2002-04), DLHS-3 (2007-08) & CES, (2009) AHS, (2010)	For 2009, in the absence of AHS indicators, CES is used as alternative source of information
% of mothers and newborns visited within 2 weeks of delivery by a trained worker	Overall	NA		49.7	? (AHS)					
	SC	NA		45.7	?					
	ST	NA		36.1	?					
	Lowest Wealth Quintile <sup>2</sup>	NA		24.8	?					
At least 80% of households with eligible children covered during national and sub-national immunization days in high risk districts	Overall					80%	Above 98% in 2010		NPSP	..
<b>OUTPUTS</b>										
<b>Component I</b>										
Number of states / UTs successfully completing institutional mobilization phase		N.A	35	34	35/35	35	35	Quarterly	NRHM Quarterly reports and PIP	
% of State plans with specific activities to reach vulnerable groups			100%	86.5%	100%	100%	100%	Annual	PIP	
% of States reporting quarterly financial performance / annual					97%	100%	97%	Quarterly	NRHM reports	

<sup>9</sup> For DLHS-2, this indicator is 'children breastfed within two hours of birth'

Indicators	Disaggregation	Baseline (2003-04)	Year 3 (2006-07)		Year 5 (2009-10)	Year 7 (2011-12)		Frequency of reporting	Means of Verification	Remarks
			Target	Achievement		Target	Achievement			
audit reports in time										
% of district not having at least one month stock of critical inputs										
% of 24 hrs. PHCs conducting more than 10 deliveries per month							36.8		HMIS (Jan – March, 2011)	
% of district hospitals conducting at least 20 C-section in a quarter	EAG + Assam						51.7		HMIS (Jan – March, 2011)	
% of district in which at least one sub-district hospital conducting 10 C-section in a quarter	EAG + Assam						16.0		HMIS (Jan – March, 2011)	
% of upgraded FRUs offering 24 hrs. emergency obstetric care										DLHS provides 3 indicators separately, Since a combined indicator on Em.O.C is not available, FRU conducting CS has been used for tracking progress
% of districts conducted SBA training in the last three months							55.2		HMIS (Jan – March, 2011)	
% of districts conducted training on IMNCI in the last three months							35.0		HMIS (Jan – March, 2011)	
Number of states / UTs contracting non-government sector to improve delivery of essential RCH services				80%	100%	100%	100%		PIP, Innovation directory	

Indicators	Disaggregation	Baseline (2003-04)	Year 3 (2006-07)		Year 5 (2009-10)	Year 7 (2011-12)		Frequency of reporting	Means of Verification	Remarks
			Target	Achievement		Target	Achievement			
<b>Component II</b>										
Institutional arrangements for NHSRC finalized										
% of EAG and NE states visited by the MOHFW State facilitation teams					100%	100%	100%		Gol orders	
Timely completion of mid and end line surveys and studies										
<b>Component III</b>										
Non-polio acute flaccid paralysis rate of at least one per 100,000 children below 15 years						>1	11.08% (As up to 22 <sup>nd</sup> Oct 2011)			
Stool Samples collected from at least 80% of acute flaccid paralysis cases within 14 days						>80%	84% (as up to 22 <sup>nd</sup> Oct 11)			

## **ANNEX B**

### **JRM8: STATE VISIT REPORTS**

# **JRM8: STATE VISIT REPORT**

## **JAMMU & KASHMIR**

## STATE VISIT REPORT: JAMMU & KASHMIR, SEPT. 12-16, 2011

### INTRODUCTION

A Joint Review Mission led by Dr. Suresh Mohammed, Director RCH-DC, MoHFW, GoI comprising GoI consultants, TMSA and development partners visited Jammu & Kashmir during September 12-16, 2011 to review the implementation of the Reproductive and Child Health II Program (RCH-II). The team was also joined by senior officers from the Department of Health & Family Welfare, Government of J&K. Details of mission members are in Annex-1.

The main objective of JRM-8 was to assess the progress made in four focus areas i.e. Programme management including supportive supervision, Quality Assurance system and Quality of care, HMIS and data management, and Gender including PC&PNDDT.

Dr. Yashpal Sharma, Mission Director NRHM, Government of J &K, chaired the briefing meeting on 12<sup>th</sup> September 2011, in Jammu which was attended by officers and consultants of SHS and districts. Dr. Salim Ur Rahman, Director Health Services, Kashmir Region briefed the team at Srinagar.

After the opening remarks by Dr. Suresh Mohammed, Director (RCH), Government of India, on the objectives of 8<sup>th</sup> JRM, a detailed presentation was made by Dr. Yashpal Sharma highlighting the progress made by the State in JRM focus areas and the new initiatives being taken by the state.

The Mission visited two districts, Udhampur and Baramulla. The details of the facilities visited are in Annex 2 and 3 respectively.

The Mission had a de-briefing session on 16<sup>th</sup> September 2011 at Srinagar, which was chaired by Mr. G.A. Peer, Commissioner/Secretary Health and Medical Education Dept, J &K. The Secretary and his whole team informed that necessary corrective action shall be taken based on the shortcomings observed by the team.

The team would like to acknowledge the efforts made by Government of J &K for facilitating the review and appropriately responding to various issues raised by the JRM members.

### BACKGROUND

#### Progress on RCH II Goals & Outcomes

Jammu & Kashmir's IMR (SRS 2009) at 45 is lower than the national average of 50, but much higher than the target of 30 for the year 2012. With a TFR of 2.2 (SRS 2008), the state is close to the target of 2.1 for the year 2012. SRS data on MMR is not available for the state. The State Directorate of Economics and Statistics, had furnished an interim report based on the registered deaths events for the year 2008 which puts MMR at 70.

The Coverage Evaluation Survey (CES2009) results show mixed trends over the mid-line (DLHS-3) results:

(All figures are in %)

Indicators	DLHS-3 (2007-08)	CES (2009)
Mothers who had 3 or more Ante Natal Check-ups	73.5	87.0
Mothers who had full Ante Natal Check-up	29.3	43.5
Institutional delivery	55.0	80.9

Indicators	DLHS-3 (2007-08)	CES (2009)
Children 12-23 months fully immunized	62.5	66.6
Early Initiation of breast feeding (within one hour of birth) #	55.2	20.4
Children under 2 years of age who had diarrhoea in preceding 2 weeks who received ORS*	53.1	79.8
Married women aged 15-49 years using any modern contraceptive	41.2	NA
Total unmet need for family planning	21.6	NA

(# For DLHS 2 – within 2 hours of birth; \* For CES 2009 - ORT or increased fluids)

## RCH expenditure

Audited expenditure increased from Rs. 1.24 crores in 2005-06 to Rs. 5.20 crores in 2006-07, Rs. 11.11 crores in 2007-08, and Rs. 12.87 crores in 2008-09; reported expenditure in 2009-10 is Rs. 24.14 crores i.e. 57.2% of allocation (Rs. 42.19 crores) where as reported expenditure in 2010-11 is 37.91 crores i.e. 73% of annual budget.

## KEY FINDINGS

The team visited two districts, Udhampur and Baramulla. Udhampur is a high focus district where as Baramulla is a better performing district. The key findings are based on the observations in these districts (facility-wise detailed findings, are provided at Annex 2 and Annex 3).

## Programme Management Structures

### *Overall Leadership*

Dynamic and passionate leadership at the State level (Secretary and Mission Director) backed up by strong political will has rejuvenated NRHM in the last 2 years. Facility in charges, ANMs and even ASHAs conveyed that NRHM initiatives have picked up pace in recent years. The Mission Director himself being a doctor takes part in all technical discussions and at the same time disseminates the messages to the masses including ASHAs and PRIs through NRHM sammelans at State, district and block levels. The political leadership is also very proactive and most of the State review meetings are chaired by the Minister himself.

### *Functioning of SHS, DHS, RKS and VHSC*

Governing body meetings of State Health Society (SHS) are held regularly. The State shared the minutes of the Governing Body meeting held under chairmanship of Chief Secretary J &K. However it seems that State is not holding the meetings of Executive body (SHS) regularly.

The teams were given to understand that meetings of District Health Societies (DHS) are held regularly under the chairpersonship of the Deputy Commissioners. It primarily reviews the progress under NRHM.

The JRM teams both at Jammu and Kashmir met young, aspiring programme managers at State, district and block level with sincere attitude towards job assigned. The State has also taken steps to nominate Nodal officers at State level for each component e.g. JSSK, ARSH etc. which is commendable.

The Rogi Kalyan Samitis at facilities are headed by MLA of the constituency at District Hospitals, FRUs and CHCs, and by the President of local body/Sarpanch in PHCs. The RKS meets often whenever there is a requirement to make a decision regarding expenditure.

The Village Health and Sanitation Committees are yet to be fully functional as PRI elections have been held in the State recently after a long gap.

### **Relative roles and co-ordination**

The major problem in programme management structure appears to be the existence of a separate post of Director FW who looks after family planning and immunization and is not under Mission Director. The Deputy CMOs from the district report directly to the Director FW which creates dual reporting structure and leads to dilution of accountability. NRHM/RCH recommends a single person with overall responsibility and accountability for meeting NRHM goals which is lacking in J&K.

The State Health Society has a post of Deputy Director Planning and Schemes where an officer from Planning and Schemes department has been deputed. This is a good co-ordinating mechanism. However at district level there is a post of assistant director planning who doesn't report to Deputy Director (Planning) under MD but to another Deputy Director placed under Director Health services. Moreover the Assistant director planning at district level looks only after state funds and NRHM infrastructure funds for planning though all the monitoring reports come to him.

The co-ordinating mechanisms in the State esp for ensuring co-ordination with Directors of Health Services (both Jammu and Kashmir), Director FW and Regional Director from Gol seems weak.

### **HRD aspects**

Considerable shortage of medical staff was noted. Low salary levels in the health sector and weak training facilities were cited as reasons for the same. Staff shortage was presented in June 2011 as:

<b>staff category</b>	<b>sanctioned positions</b>	<b>filled positions</b>
Specialists	65	32
MBBS doctors	467	256
Staff Nurses	876	488
ANMs	2031	1799

As regards programme management unit under NRHM recruitment and selection procedures needs to be strengthened so as to select right people for the right job. Programme management staffs without adequate and relevant qualification, skills and attitude is of little use in a time bound programme. Large number of vacancies in Baramulla, at block level is also of concern.

The understanding of the role of SPMU and DPMU amongst the programme management staff themselves and Department of Health staff at state and district levels needs more clarity. The main role assigned to SPM is of monitoring of HMIS. The SPM should be involved in overall NRHM activities and not only HMIS. There is a need to strengthen the job descriptions of PMU by including indicators of performance, reporting relationships and basis for assessment of performance.

There is lack of induction training of the new programme management staff leading to inadequate understanding of the functioning of the government system and lack of awareness of do's and don'ts

for facilitating their acceptance. On one hand, in some places there is aloofness leading to very limited role of programme managers and on the other extreme there is overshadowing of regular staffs who at times feel alienated.

State has initiated performance appraisal of all contractual staff which is used as the basis for renewal of contract. Performance appraisal system is not linked to reward and disincentives.

The salary of the PMU staff is due for revision. The lower salary has resulted in high turnover of qualified and experienced staff. The State needs to look into its HR practices too. There seems to be no maternity leave for contractual staff.

The State also needs to rationalise the HR placed in facilities. The JRM team came across a sub-centre with 3 ANMs and 1 pharmacist with nominal OPD and no delivery. At other places the team noticed Sub Centres with a single ANM conducting deliveries and running the health facility. The team noticed that pharmacist was provided in all Sub Centres with sub optimal work load.

***Recommendations:***

- The State needs to have a Mission Director, NRHM who should be responsible for entire NRHM including FW. The State needs to reconsider its current structure, study the existing structures in other states and come up with a structure suitable to its local context, which should eliminate dual/multiple reporting at various levels.
- The State needs to ensure regular meetings of the Executive Committee of the State Health Society. It may include director FW, director Health Services and regional director in the Executive Body of SHS for ensuring better coordination.
- Director planning at State level and Assistant directors at district level have many years of experience which should be utilised for making better and comprehensive plans for entire State/district.
- Rogi Kalyan samitis and VHSC members should be provided orientation training so that they understand the bigger picture of health and work towards overall development of the facility/village.
- State needs to have an HR cell at State level to look into recruitment, selection, orientation and training of NRHM staff esp. programme managers at various levels. The programme managers should have preferably some background in health. The vacancies should be filled urgently. The State/district may maintain a waiting list for specified period (as per State rules) for immediate replacement. Performance appraisal system needs to be linked to incentives/disincentives. Salary of staff needs to be revised urgently. State should make provisions for adequate maternity leave with salary.
- There is also a need for a good comprehensive training programme for all programme managers which should include detailed orientation on the various NRHM components, financial/ accounting procedures, and government procedures (e.g. government filing system and note-sheets, administrative procedures).
- Through proper orientation training and constant mentoring thereafter, the State needs ensure a balance where regular and contractual staff together work towards NRHM/RCH goals.
- The State needs to rationalise the facilities and staff as per utilization of services. Work allotment for the pharmacist in Sub Centres may be redefined giving him more responsibilities commensurate to his qualifications and skills.

## **Planning and Monitoring**

### ***Quality of state PIPs/DHAPs***

The State PIP is based on the aggregation of district plans/DHAPs. The State issues clear guidelines to the district for implementation of plans and has simplified the process. Once the approved plan is sent to the district by the State, it does not need approval of DC.

However the district –wise differential planning which NRHM/RCH aspires is yet to be achieved. The DHAPs are template based (i.e. based on a model plan with fixed heads given by the State) and there is very little scope for innovation by district.

### ***Mechanism for tracking progress***

The State has communicated the approved RoP to all the districts. The State and districts monitors financial and physical progress separately but is it yet to establish NRHM/ RCH II planning and monitoring systems to enable districts/ state to holistically plan and report both physical progress and expenditure vis-à-vis the activities and outcomes indicated in the PIP. The data / information put up for review in the districts do not have targets or denominators.

It was observed that the programme management staffs are generally not visiting health facilities. SPMU, DPMU and BPMUs are supposed be monitoring the facilities closely and provide support wherever required.

However the team was given to understand that divisional nodal officers routinely go on visits and many a times on surprise checks too. State shared the soft copies of their visit reports which cover all the areas of RCH including procurement and availability of drugs.

### ***Recommendation***

The State needs to come up with differential plans which reflect the need of the facilities, block and districts. As discussed in the debriefing meeting in Srinagar, technical and management support can be provided to the State, if it desires so.

The State and districts need to set up monitoring systems to enable districts/ state to holistically report both physical progress and expenditure vis-à-vis the activities and outcomes indicated in the PIP. The PMU staff should make the number of stipulated field visits. The State and districts should also make efforts to use the evidence from field visit reports and checklists for future course correction.

### **Supportive Supervision**

Supportive supervision in the district is mainly in the form of monthly review meetings which are being held regularly by the CMO and the BMOs. Even though monthly meetings have been held regularly by the CMO Udhampur, minutes of these meetings were not available for the past 4 months (i.e. from May- August 2011). Follow up action on the decisions taken during these meetings are only possible if proceedings of the meetings are recorded and minutes are issued.

As regards supervisory visits, the NRHM operational manual issued by the Department of Health and Family Welfare lays down that the CMO of a district should visit all the CHCs, and at least 50% of all PHCs and at least 25% of all Health Sub Centre in his jurisdiction at least once every quarter. Similarly the BMO should visit all the PHCs, and at least 50% of all Health Sub Centre in his jurisdiction at least

once every quarter. The MO of a PHC should visit all the Health Sub Centres in his jurisdiction at least once every month. However, it was observed that supervisory visits were few and were not being performed as per the laid down guidelines. Even though a check list for supervisory visits was available it was seen that the officers performing the supervisory visits are not following this at all. On perusal of the files on tour diaries of officers, it was observed that there was no system of prior approval of these visits. Further, it was found that the tour diaries contain notes which are extremely superficial with no recommendations for follow up action. Thus the element of support and supervision was found to be missing from these tour diaries.

Another matter of concern was the lack of supervisory visits by other paramedical staff such as the Chief Health Officer and the LHVs. Further it was observed that in many instances staff from the Programme Management Unit such as DPM and BPMs are not conducting any field visits as part of supportive supervision. Lack of field knowledge of the PMU would be detrimental to the programme, especially during the planning and formulation of the annual PIP. This was observed as a major gap in the programme.

It is recommended that supportive supervisory meetings and visits at the level of CMO, BMOs and MOs as well as CHO & LHV and staff of the PMU be strengthened so that the programme may reap the benefits of the same.

## **TRAINING & HR**

### **In-service Training**

Trainings at the Medical College are the backbone of RCH interventions in J &K when it comes to imparting skills in LSAS, EmOC, BEmOC and NSV. There is evidently greater need for SBA, MTP, NSV, MVA and RCH training than the Medical College can provide. Subsequently, RCH training achievements remained at a low level and do not entirely match the requirements of the RCH II programme. Detailed observations on specific training programmes have been covered under subsequent sections of maternal health, child health, family planning, ARSH etc under Quality.

### ***Management of in –service Training***

A training databank is fragmented, does not contain skills information from the Medical College, nor is training information synchronized from the Department Health, Department of Family Welfare and NRHM Department.

No training plans and annual calendars were found in Baramulla, Udhampur did provide a modest training plan for 2011-12. The PIP shows that number of training requests were insufficient.

The capacity for planning of training appears to require strengthening. Conduct of training programmes seems very ad-hoc. Trained staff is not always deployed in a matching work environment where newly acquired skills are needed. It was observed that staff who was trained in LSAS was shifted to an entirely different task shortly after the training.

### **Pre-service Training**

The training institutes visited in the districts of Udhampur and Baramulla were:

- TRegional Institute of Health and Family Welfare (RIHFW) in Nagrota, Jammu,
- ANMTC Udhampur,
- Regional Institute of Health and Family Welfare (RIHFW) in Firozpora, Baramulla
- ANMTC GNMTTC in Baramulla

In the overall situation training in the two districts appeared to be a weak and a neglected area. In most of the training institutions, training plans and annual calendars for trainings could not be found. Udhampur provided a training plan containing trainings for SBA, BeMOC, NSSK and IMNCI, RTI/STI, Gender and Equity, IUCD and Minilap Techniques for the year 2011/12, a definition of batch sizes is not mentioned, but number of batches per district range between 1 and 2.

### ***HR in training schools***

The ANM TC at Udhampur is attached to the DH and provides good exposure to students. It runs courses for ANM, ophthalmic assistants, dental assistants, pharmacists and laboratory assistants. In this institution, training is provided through internally nominated staff. Different from this approach the RIHFW, which has not yet filled its sanctioned posts, relies on externally contracted consultants to conduct courses on National Programmes, ASHA TOTs, or pre-service training of medical and para-medical staff. In both cases, such flexibilities are welcome steps to keep up training in the state. It would be even more welcome to see in near future that the RIHFW is beginning to be utilized for RCH trainings which are so far neglected.

In general there is dearth of required manpower at all the training centres. Even sanctioned posts are lying vacant, such as in the Baramulla ANM TC where only 4 of 16 sanctioned staff is available. The Udhampur DH staff for training is "on call". This approach encompasses some weaknesses. Their availability at the training center during stress hours at the hospital is limited. Coupled with a lack of incentives for the training work, it is hard to find volunteers or the required inputs at scheduled training hours in the ANMTC in order to ensure regular training. Given this background, low expenditure in this head is of concern, for example, the ANMTC Baramulla has an unspent balance of 3.82 lakhs out of 4.5 lakhs received in 2010-11.

Similarly, the GNM Nursing School in Baramulla has not been able position its faculty as per the sanctioned staff strength. It is running its regular courses through faculty drawn from the Medical Colleges, experts from the districts and other guest faculty. However it is more of routine rather than exception.

The study situation for the students of both the districts are far from optimal. Until very recently, many students were selected on the basis of nominations and not on merit, however, this practice has been stopped by decree of the Chief Minister in July 2011. Students of both ANMTCs, in Udhampur and in Baramulla, face housing problems as no hostel facilities are available, though the Udhampur authorities have requested for permission to build one.

### **Affiliation**

The State has a "State Medical Faculty", which certifies and regulates all medical and paramedical institutions. Given the number of institutions and nursing staff required, the State needs to have a State Nursing Council at the earliest which can liaise with Indian Nursing Council to enhance the quality of training. Only few of the GNMTC/ANMTCs are affiliated to INC or are being run under Centrally Sponsored Scheme. School having no affiliations to INC do not follow standard syllabus and modules.

### **Infrastructure, Equipment and library**

The RIHW TC (Baramulla), GNM Nursing School in Baramulla and ANMTC Udhampur have good infrastructure. The State needs to look into the utilization of these schools for various RCH training as most of the schools seemed underutilized due to many reasons, though primarily due to lack of

tutors. ANMTC, Udampur had limited study models and library is just a haphazard collection of donated books from the doctors. It only has one PC terminal.

### **Recommendations**

- Develop training plans and calendars that integrate RCH training as envisaged under NRHM/RCH, for State and districts. A well coordinated training databank would provide the required overview of skill set and trained HR available as well as number and identity of trainees.
- Ensure adequate training allocation in the district and state health action plan in numbers and contents of RCH trainings as per NRHM/RCH II policy.
- Coordinate and cooperate with Directorate/NRHM to ensure proper deployment of trained staff to matching positions and/or prevent transfers shortly after training if the position requires newly trained skills. A means to effective deployment is the utilisation of a human resources databank for the district/state.
- Fill in sanctioned posts, eventually by developing an incentive scheme for staff trainers also, consider position for librarian of Training centres. Salary levels need revision to get talented teachers and ensure retention.
- State needs to have its own Nursing Council and should also establish affiliation with Indian Nursing Council
- Develop properly equipped library with reading materials, study models and internet access for research and access to repositories
- Facilitate accommodation for students, if not in own or rented hostel then with private households in the vicinity through specific lease contracts

### **STORES**

Management of stores was assessed in some facilities though this was not part of the JRM-8 focus areas. The important observations were as follows:

- Stores were overall in a good condition;
- Bin-cards, which have manufacturing and expiry dates of medicines including batch numbers were maintained at the facilities.
- Except 1-2 facilities, daily consumption register is maintained properly, which provides section wise utilisation of a particular medicine.
- Facilities are maintaining list of available medicines on period basis; however, same is not displayed at prominent places.
- Supplies were recently made; hence there was no bulk stock out. However, certain key drugs were not available at some of the facilities



- During the discussion with store keepers at each of the facility, it was noted that, supply from state is not as per the demand of the district/ facility and mostly a push-system of supply is used. Under this system, state procures certain medicines and divides them equally for each facility without considering facility output, type of disease treated in particular area etc.
- There is no system for a planned / periodic indenting for supply from facility level; this was on ad-hoc basis.
- Drugs past expiry dates were not being condemned/disposed off in a timely manner.

The State informed that they are in the process of setting up a Directorate of Procurement under the Department of Health and Family Welfare which will help streamlining procurement and supply chain processes. Further, it was informed that warehouses are being set up at regional level to improve supply chain and distribution mechanism. However details of the same were not available.

## QUALITY SYSTEMS AND QUALITY OF SERVICES

### Quality assurance committee

Details regarding the functioning of QAC were available only in Udhampur district and hence findings are based on only one district:

- QAC was established in 2007; however, only against specified of 9 members by Gol, it has only 5 members.
- The QAC is not meeting regularly and only one meeting has been held so far.
- District QAC chairman, who is the Deputy CMO in State of J &K is not aware of QAC manual and other such guidelines prepared by Gol.
- It was also noted that QAC is not conducting regular visits to government and private facilities as per the norm.
- The scope of the QAC has been widened to include all services coming under the purview of Reproductive and Child Health programme, and not just the Family Planning component.

However, it was noted that this enhanced role of the QAC has not been implemented in the State.

### Quality of services: Key observations

#### Maternal health services

##### *JSSK*

- State has been implementing a scheme “Maa Tujhe Salaam” which has now being expanded under Janani Shishu Suraksha Karyakram (JSSK) for free cashless delivery for pregnant women and sick neonate up to 30 days after birth.

In Baramulla, free drugs & consumables, free diagnostics including ultrasound, free blood, free treatment of sick neonates up to 30 days after birth and referral to higher institutions and drop back home, was being provided. However full entitlements stipulated under JSSK like free diet, free referral transport from home to institution and exemption of user charges were still to be implemented. In Udhampur, it was observed that free diagnostics are being provided to the pregnant women, however none of the other entitlements under JSSK were being provided. Free entitlements are widely displayed at all health facilities in Baramulla and some facilities in Udhampur.

Nodal person for JSSK and for grievance redressal in the districts are yet to be nominated.

### ***Delivery Points***

- There has been a steady rise in Institutional deliveries over a period of time. Institutional deliveries in Baramulla rose from 8322 on 09-10 to 8865 in 2010-11 and C sections from 1100 to 1500 in 2010-11.
- There are a total of 102 functional delivery points in the state (J&K) out of the 2386 health facilities. 33 designated FRUs and 2 district hospitals are not conducting any C –section. Only 24 of the 156 PHCs which are 24x7 are conducting more than 10 deliveries per month.
- There are a total of 12 delivery points in Baramulla (1 SC, 3 PHCs, 5 FRUs, 1DH, 1 MCH, 1 PHF) while 7 delivery points are functional in Udhampur (1DH, 2CHC/FRU, 424X7 PHC). Out of 5 FRUs in Baramulla, one FRU was not conducting C section while another CHC does not have the requisite manpower, infrastructure though it has been upgraded to a CHC. Some of the delivery points lack proper infrastructure eg. No toilet is available in a subcentre (SC) in Baramulla which has 1 ANM and where deliveries are being conducted. District Hospitals (DH) in both districts were found to be overcrowded. While DH Baramulla conducted an average of 300 normal deliveries and 80 C-sections per month in 2010-11 in Udhampur, an average of 250 deliveries were conducted of which 70-80 are C sections. It was noted that there is a trend for elective C- sections since more women are demanding C sections. Overcrowding has resulted in shortage of beds and sometimes two pregnant women have to share a single bed. In such circumstances the post-delivery stay is often less than 12 hours which has affected counselling on breast-feeding, nutrition, family planning and immunization
- Postnatal follow up was found to be weak in both the districts.

### ***Labour Rooms***

- Labour rooms were generally maintained, clean and provided privacy. The LR at CHC Chenani was very well maintained with good interiors, privacy and equipments. In the labour rooms in Baramulla adequate stocks of essential medicines and consumables were available. However, in Udhampur Inj. Magnesium Sulphate was not available.
- Partographs were not in use in the labour rooms across the facilities both in Baramulla and Udhampur (except at CHC Kreeri in Baramulla).

### ***Maternal Death Review***

- Maternal Death Review (MDR) reporting has been initiated but community based reporting was yet to be implemented in both the districts. Trainings on MDR yet to take place.

### ***MTP***

- State has not taken up MTP training including comprehensive abortion care (CAC) and manual vacuum aspiration (MVA). Lack of trained providers, lack of MVA equipments and MMA drugs and lack of advertisements on availability of these services at the health facilities was observed and has been resulting in low utilization of these services. MTPs being done are D & E only. DH, Udhampur provides MTP services only if the woman agrees to take up post MTP FP.

### ***RTI /STI Services***

- It was noticed that provision of RTI/STI services was limited to District Hospitals. There is a need to train MOs and Nurses in Sub District facilities on syndromic management of RTI/STI. Further color coded drug kits need to be supplied to the facilities. Adequate audio-visual privacy has to be provided for patient examination in all clinics.

### ***Blood Storage Centres***

- MOs and LTs were not trained on blood banking. Licensing issues for blood storage centres at CHCs need to be urgently tied up with drug authorities and Blood Safety officials of SACS.

### ***Referral Linkages/Referral Transport***

- The PHCs and other higher facilities have Ambulances which were used for patient referrals from one facility to the higher facility. Recently these services were extended for providing drop back for pregnant women after delivery to their homes. At places, MPs, MLAs have donated ambulances for health facilities and they are used for patient referrals. There is no central call centre in districts or at State and ambulances are not GPS fitted.

### ***Accreditation of Health Facilities***

- The State has taken up NABH accreditation through QCI. The accreditation process has been started for following institutions- Kashmir Division: Lal Ded Hospital Srinagar, MMABH Hospital Anantnag, JLNH Hospital Srinagar, District Hospital Baramulla & Sub District Hospital Chadoora. Jammu Division: SMGS Hospital Jammu, Govt. Gandhi Nagar Hospital Jammu, District Hospital Udhampur, District Hospital Kathua & CHC Akhnoor.

### ***Other MH activities***

- The joint MCP Card has not been printed and implemented for ANC, PNC and Immunization. As informed by the state, tenders have been called for printing. The delay in implementing MCP card is noted with concern.
- Outreach activities for ANC, PNC and Immunization are conducted via VHNDs at the Anganwadi centres at the village level.
- High risk pregnancies such as cases of severe anaemia, hypertension, etc were not being monitored and followed up at the SCs and 24x7 PHCs.
- Pregnant women were seen to be given separate prick for HIV test at the ICTCs. It needs to be ensured that blood for HIV test is collected along with blood collection for other tests such as Hb, Blood Sugar, VDRL etc in the general laboratory. It would be better if the ICTC laboratory technician is shifted to the general laboratory to ensure this.

### ***MH trainings***

- Training component was weak overall and most MOs, ANMs, SNs, etc. have not received the RCH trainings. In absence of a training calendar, and lack of proper planning, training of MOs and SNs/ANMs on basis of the need for the facility and district is missing.
- District Hospital, Baramulla is the SBA training centre for the district. Though the two trainees knew about SBA procedures, had conducted deliveries and the Gynaecologist had been training them sincerely, . It lacked the latest SBA training manuals and proper training curriculum. Partograph was not being taught and trainees were not provided any training manual. There was no accommodation available for the trainees.

### ***Recommendations***

- Preparation of proper training calendar, providing training material and guidelines, strengthening of the training sites and nomination of suitable candidates and rational posting of the same needs to be implemented on priority.
- SBA and NSSK training of all ANMs /SNs posted at the delivery points to be conducted on priority
- Availability of quality protocol posters and maintenance of Partographs in the labour rooms and Gynaec wards

- Printing and dissemination of joint MCP card to all health facilities
- Strengthening of the delivery points in terms of infrastructure, manpower, equipments and other logistics
- Follow up with SACS & State Drug Authorities for licensing issue of blood storage centres in the two districts, conduct of blood banking training of MOs / LTs working in the BBs / BSCs .
- Focus needed on identification, monitoring and prioritization of high risk pregnancies and providing proper care and treatment.

### **Janani Suraksha Yojana (JSY)**

Major observations based on the field visits in Udhampur and Baramulla districts are as follows:

#### ***General Observations:***

- Jammu and Kashmir is categorised under Low Performing States and the State is providing cash assistance @ Rs. 1400 and @ Rs. 1000 to pregnant woman delivering in a government health facility or in an accredited private health institution which is in accordance with Central JSY guidelines.
- In District Baramulla, incentive under JSY is paid in the institution except for those who deliver in a Sub Centre. However, in Udhampur district, it was observed that payments to some JSY beneficiaries were made at Block level which has resulted into a delay of 2-8 weeks. Further, it was observed that conditionalities like ANC check-ups, TT injections etc. were imposed for making payments under JSY which needs to be avoided. All the payments are made through cheques. Good IEC on JSY was visible in all health facilities and there was a good awareness of JSY within community. However, in Udhampur it was observed that all the sign boards were in English. It needs to be ensured that these are changed into the local language.
- It was also observed that 48 hour stay at facility is not being emphasized.
- Names of JSY beneficiaries were displayed in most of the facilities. However, grievance redressal mechanism as stipulated under JSY does not exist in the both the districts.

#### ***Fund Flow Arrangements***

- All the facilities have sufficient amount of money under JSY. JSY amount is paid in advance to the facilities as per their performance and the amount is recouped on submission of SoE (Statement of Expenditure). JSY incentive to pregnant woman as well as to ASHAs is provided through cheques. Interaction with the beneficiaries revealed that they received the JSY incentive in full as per the entitlement and they were not asked for extra money for the health services.

#### ***Referral Transport***

- It was observed that the beneficiaries were spending out of their pocket to come to the health facility for delivery. However, the transport assistance of Rs. 250/- available under ASHA incentive is being paid to the ASHAs uniformly, regardless of the fact that the pregnant women had used her own money to reach the health facility.

#### ***Monitoring and supervision***

- Monitoring and supervision of the scheme is not being done by the health department. Moreover, physical verification of beneficiaries as stipulated under JSY is neither being done nor the health officials knew about it. Joint Mother & Child Protection Card (MCP) which

serves as an important monitoring tool for tracking ANC, PNC and for immunization of mother and children, has not been implemented in Jammu & Kashmir.

### **Recommendations**

- Payments under JSY should be made at the health facility before the beneficiary being discharged. The system of paying beneficiaries at the Block level which is prevalent in some facilities needs to be decentralized.
- 48-hour stay of the mother should be emphasised. It was noticed that the tertiary care facilities such as District Hospital were overcrowded with pregnant women sharing beds. On the other hand, in 24X7 PHCs there was underutilization of facility and services. There is a need to streamline the system so that 24X7 facilities are optimally utilized by providing Basic Obstetric Care. Similarly the system of referral to higher facilities need to be rationalized to avoid overcrowding. This will ensure that there are no hurdles to availing 48 hour post natal stay by pregnant mothers.
- Referral transport assistance of Rs. 250/- available under ASHA incentive should be provided to the mother in case ASHA does not arrange for her referral from home to the facility.
- State should implement the MCP card and link it with the payments under JSY.
- Conditionalities like ANC, TT etc. need to be avoided for making payment to the pregnant women.
- Monitoring and supervision visits need to be conducted regularly. There should be random verification of beneficiaries.
- Grievance redressal mechanisms as stipulated under JSY guidelines needs to be activated at the district and state levels.

### **Child health**

As per Sample Registration Survey of the Registrar General of India, Infant Mortality Rate in the state of J & K stands at 45 per thousand live births in comparison to all India figures of 50. However, Neonatal Mortality Rate for the state of J & K is 37 in comparison to all India figures of 34 per thousand live births.

#### **Facility Based New Born Care:**

Staff working in newborn care facilities was aware that radiant warmer has to be used for all the new-borns to essential new born care. Medicines for newborn were available in adequate quantity at most of the facilities. Iron folic acid tablets and Vitamin A were available in adequate quantity and importance of counselling on Breast feeding initiation within 1 hour, exclusive BF till six month of age and complementary feeding was known; however, practices of the same was found to be poor.

The concept of Facility based newborn care was not very well understood and implemented in the state. As per GoI norms, SNCU has 12-20 beds, NBSU has 4 and NBCC (radiant warmer) should be in place at all delivery points (e.g. SNCU at DH has 5 beds). Secondly, the GoI norm for setting up SNCU (Rs 51 lakh), NBSU (Rs 7.5 lakh) and NBCC (Rs 1 lakh) including maintenance cost was not known. Dedicated staff (Medical officer and Staff Nurse) was not available for SNCU. The medical officer and Staff Nurse are posted in Paediatric ward and thus find it very difficult to handle Ward, SNCU and emergencies. Newborns record sheets were poorly maintained.

In the labour rooms and facilities providing newborn care services, the room Temperature was maintained at 21<sup>0</sup>C, which should have been between 26- 28<sup>0</sup>C. There was lack of understanding for

handling of equipments and availability of basic support system. Bag and mask was available at most of the facilities but it was rarely used for neonatal resuscitation. This implies that even if the equipments are available they are not put in use in absence of either poor knowledge or poor motivation to use.

Orientation on immunization (zero dose), counselling on breast feeding and follow up of discharged newborns from SNCU/ NBSU is lacking. It was informed that some of the staff handling NBCC is trained in NSSK; however, implementation of the same is not being done.

At most of the facilities a separate space / room has been created for NBCC, which is not required and open space within labour room may be used for the same. Sepsis prevention protocols are not observed e.g. Hand washing steps not known to some health staff, cleaning the radiant warmer, oxygen tubes is not being done.

As per NFHS III (2005-06), there are 14.8% wasted children in the state. It seems state has not come up with a concrete strategy on addressing malnutrition problem e.g. there is no Nutrition Rehabilitation Centre and malnourished children are usually treated in DH in Paediatric ward.

### ***Child Health trainings***

In the state, IMNCI is being implemented in 11 districts in the state with around 706 health workers trained so far. 192 Medical officers and Staff Nurses have been trained in F-IMNCI and around 272 in NSSK. The state has 2 operational SNCUs but no NBSU and NBCC is currently reported to be operational. However, during the visit the team noted that some of the facilities have recently been provided with necessary equipments. The district of Udhampur and Baramulla are yet to scale up CH trainings like IMNCI, F-IMNCI and NSSK.

### ***Recommendations***

- FBNC training (4 + 12 day observership) can be conducted at PGIMER Chandigarh which is a regional collaborative centre.
- FBNC Operational guidelines dissemination at all levels.
- Ensuring immunization, counselling on BF and follow-up of newborn discharged from SNCU/NBSU.
- Long duration AMC for equipment related to Newborn care services.
- Re-orientation/ fresh training of all staff (MO and SNs) in NSSK may be organised.
- Staff should also be trained in IMNCI and F-IMNCI.
- Infant Young and Childhood feeding practices can be strongly advocated by using IEC methods and also by counselling from the health workers side.

### **Immunization**

#### ***Key issue/ points***

Staff is well aware of vaccination techniques, site, dose and route, this is of importance since there were changes in vaccination technique of few vaccines. Routine Immunisation (RI) stocks (vaccines, diluents, syringes etc) and registers are available and well maintained.

Cold chain equipment (such as ice lined refrigerator and deep freezer) are working in good condition which is essential for maintaining quality of vaccine. However, temperature log sheet is poorly maintained at all facilities and at some places even thermometers were broken. This is of importance since a good ILR or DF would not be useful if proper temperature recording is not being done. It was observed that cold chain handlers were having good understanding of preparing vaccine carriers for RI sessions at different site.

Waste management is poor across facilities and State pollution control board/ NPCB guidelines are not being followed. It was observed that at some facilities safety pits were constructed but these were not covered, this defeats the very purpose of keeping these dangerous wastes away from public contact.



Time of reconstitution of BCG and Measles and date of opening of Vitamin A bottle is not mentioned at most of the facilities visited. Open vials of reconstituted BCG and Measles were kept in ILR at some of the facilities which might lead to adverse events following immunization (AEFI) in children. Frozen vaccines vials of DPT were found at one facility. During the discussion with the ANM it was noted that they are aware of correct dose of Vitamin A; however, duration till it can be used was not known.

Alternate Vaccine Delivery System: ANMs are working as AVDs and they collect the vaccine carrier from PHCs. This seriously hampers the time she can devote for conducting RI sessions and face difficulty in hilly terrains. **FRU Ramnagar: RI session was due on 14.9.2011 but vaccines have been issued on 13.09.2011 for Bari, Kela and Majua. The team was informed that as these sites are at a distance of 15 km, so they are being issued one day before. It was observed that RI micro plan is not being followed strictly.**

#### **Recommendations:**

- RI orientation training may be conducted for all the staff
- Concerned staff/ officials supervising RI programme should also be trained/ re-oriented in correct methods/ techniques of various vaccinations
- Waste management system needs to be adhered strictly as per SPCB/ NPCB.

#### **Family Planning:**

##### **Best Practices Observed:**

- Facilities are providing Fixed Day services for laparoscopic sterilisation services in both districts. It was understood that days have been fixed at each facility and on that day clients can avail sterilisation services. All 3 facilities providing fixed day FP services in Udhampur were having functional laparoscopes.
- Staffs up to the sub-center levels and ASHAs were aware of entitlements under FP programme. Staff were asked about compensation and insurance scheme and their understanding was found to be good.

- Udhampur district is reporting good number of NSV cases; in 2010-11 out of total 1969 sterilisations conducted, 475 were NSVs which is 24% and very commendable

**Progress:**

- As per data reported by both the districts, sterilisation performance in both the districts has declined in 2010-11:
- Above chart also reflects that there is consistent decline in sterilisation performance of Udhampur district.
- Baramulla district is using more of IUD services compared to sterilisation services; however, there was a sharp decline in these services in 2009-10.
- Udhampur district has reported an increase in IUD service delivery.
- An analysis of Estimated Eligible Couples in both the districts vis-a-vis unmet need (limiting) shows that neither of the districts are not able to provide services to clients as per their needs:

Indicators	Udhampur	Baramulla
Population (Census 2011)	555357	1015503
Eligible Couples (17% of the population)	94411	172636
Unmet Need (Limiting)	17.5	21.9
Eligible Couples for Limiting	16522	37807
Average Sterilisations reported (3 yrs)	2125	605
% against Eligible Couples for Limiting	12.86	1.60

- Udhampur is reporting better service delivery for sterilisation that Baramulla. The team was given to understand that socio-religious issues are main hindrance in delivering sterilisation services in Baramulla district. However, as evident from DLHS-3 survey that around 22% of eligible couples is demanding sterilisation services.
- Both the districts need to analyse their service delivery mechanism and ensure that unmet need is addressed via all means. The need for advocacy efforts among religious leaders is particularly emphasized.

**Limiting Methods:**

- It was observed in Udhampur district that predominantly laparoscopic sterilisation is conducted. Gynaecologists and anaesthetists are available at 2 FRUs and the DH to conduct laparoscopic sterilisation; however, in absence of minilap services clients have to primarily rely on camp mode of services in various rural areas. Further, in Baramulla, abdominal tubectomy (conventional) is carried out which again requires specialists services and same is reflected in their sub optimal sterilisation performance (see chart above).
- Further number of sterilisations per gynaecologist seems to be very low:

Sn.	Facility	Number of Gynec.	Number of Female Sterilisation (2010-11)*	Per Gynec output
1	DH Udhampur	2	285	11 per month
2	CHC Ramnagar	1	327	27 per month
3	CHC Chenani	2	431	18 per month

\* This includes both camp and fixed day service delivery.

- After a detailed discussion during the PIP formulation, state was advised to propose for Minilap training and budget for same was approved in the RoP. However, state is yet to initiate this training citing reasons of non-availability of trainers in Jammu Medical College.

***Spacing Methods:***

- None of the ANMs are conducting IUD insertion in Udhampur district, though it was noted that some ANMs were already trained in this technique. It was observed that at most of the facilities IUD clients are being brought to camps (at FRUs) and doctors are inserting IUD.
- In Baramulla districts, although ANMs are inserting IUDs though they were not trained in the 'Alternate Training Methodology'. It was discussed with the district officials that untrained ANMs inserting IUD might lead to some complications in women. During discussion the team was informed that desired case load was not there at facilities for training of personnel.
- Training of ANMs in IUD insertion seems to be ad-hoc since training load is communicated from state level and there is no pre-planned training calendar at district level.
- Supplies of oral and emergency contraceptives were available everywhere; however, their off take is quite low (@ some SC/PHC 1-2 ECP/ month & 4-5 OCP/ month). Offtake of condoms was also observed to be low. Further proper documentation of the same was not available in many facilities

***Others:***

- At every facility, staff was aware of insurance scheme and payment to failure case were being made; however, there was no effort to find out reasons for failure cases. There was no evidence that QAC conducts proper audit of these cases except completing the formality of documentation and processing it to ensure company.
- As per the mandate of QAC, all the private / NGO hospitals providing sterilisation services need to be accredited; however, same has not been carried out in Udhampur district. Further, these hospitals were not paid any compensation money for male and female sterilisations they conduct.
- QAC has not empanelled doctors who provide sterilisation services in the district. This is mandatory for both govt and private doctors and needs to be taken up by the State urgently.
- Although awareness regarding entitlements was there, there was no knowledge of various guidelines to manage the programme at the district level.
- A fixed formula has been communicated to all the districts to calculate ELA; however, unmet need of the district is not considered while calculating the ELA. The absence of this is leading to a false sense of achievement which might not be based on actual need of the community.
- During the VHND it was observed that ASHA, AWW, ANM etc are not using proper IPC mechanism.

***Recommendations:***

- District level planning including training, service delivery mechanism, target setting etc is emphasized and these should be driven by the district needs and not by state needs as was noticed. For this, use of HMIS data at both district and actual facility level need to be promoted.
- State to focus on Minilap training and if it is not possible within the state, proposal may be sent to Gol to organise the same outside state.

- Status of QACs needs to be reviewed across districts and re-orientation of QAC members to be organised.
- Various guidelines are available on ministry website (<http://mohfw.nic.in/NRHM/FP/index.htm>); key guidelines may be reprinted and circulated to all the districts for their use.
- Training of ANMs in IUD insertions to be planned on urgent basis and if it is not possible within the district, state may think using facilities with high case load in other districts to organize such trainings. State has to undertake proactive steps to ensure that field functionaries such as ANMs are encouraged to do IUD insertion as laid out in the GoI guidelines.

## **ARSH**

Though nodal officers have been separately identified for the ARSH programme both in the Jammu and Srinagar Divisions, it was noted with concern that ARSH nodal officers are not yet in place the district level. It was also noted that linkages of the programme with the SABLA programme, HIV/AIDS Control Programme, NYKS teen clubs and the Adolescent Education Programme has to be intensified. Further, the linkage with the existing School Health Programme needs to be strengthened to address adolescent health needs by screening school children of adolescent age group for reproductive and sexual health problems, behavioural problems and substance abuse. In the district of Baramulla where the Menstrual Hygiene programme is being rolled out, awareness and enthusiasm for the programme among frontline health functionaries has to be improved. In the VHND it was observed that issues concerning adolescent girls are discussed regularly by the AWW and the ANM and this is a best practice in the making.

The ARSH Clinic was found to be functional both in Udhampur and Baramulla. Both clinics had adequate audiovisual privacy. A female counsellor was present in both the facilities. Client load was found to be satisfactory. However it was observed that virtually all clients were adolescent girls who were referred from the nearby OBG OPD. Further, it was observed that condoms, IFA tablets, OC pills etc were not available in these clinics. The counsellors are yet to be trained under the 5 day training module developed by the MOHFW. Further, it was noted that outreach activities of the counsellors are confined to schools and colleges only. There is a need to focus on out of school/college girls and boys. Monitoring formats developed by the State were being used in the Clinic. The State should now adopt new registers and reporting formats which have recently been circulated by the MoHFW.

The following recommendations are made:

- Nodal officers to be identified for ARSH at the district level;
- Linkages between ARSH Programme and SABLA, NACO/SACS, NYKS, AEP & SHP needs to be strengthened;
- Counsellors in ARSH clinics to be trained immediately;
- Items such as condoms, OC pills as well as IFA tablets to be made available in ARSH clinics;
- Linkages to be established between ARSH clinic and other services such as STI Clinic, ICTC, Medical/Skin OPD etc.
- Outreach by counsellor should be focussed on out of school/college girls and boys;

ARSH Clinics should use registers and reporting formats which have been circulated recently by the MoHFW

## **HMIS & Data Management**

### ***Data Collection***

- The uploading of data from SC, PHCs and CHCs is done at the block level by Block Monitoring & Evaluation Officer.
- District hospital level data is uploaded at district headquarter and the data from private hospital is uploaded at CMO's office.
- Block level HMIS has been activated since December 2009 and Facility wise data is being uploaded since May, 2011. The HMIS data for districts are delayed at places due to codes being not provided to all the facilities. It is understood that these are teething problems and the State is taking steps to overcome them
- At places the infrastructure available for HMIS is not adequate. Some of the blocks still have problems of internet connectivity which hampers the timely uploading of data. Availability and retention of trained human resources for HMIS is also a constraint.

### ***Monitoring and validation of data***

- HMIS is monitored by DHOs (District health officers) and CHOs. According to district officials, on 26<sup>th</sup> of every month, BMOs meet CMO where HMIS along with all other components are evaluated and any unusual trend is taken care of.
- Due to separate reporting nodes and route of FP and immunization data, the block and district level programme managers have to very painstakingly check the reporting from various facilities to avoid mismatch in HMIS.
- At times there is delay in HMIS reporting due to lack of co-operation from MOs in PHC. The BMIEO at times do not get response on time.
- Validation and use of data at facility level has lot of scope for improvement. All the entries being sent to block should be rechecked and validated by the facility incharges. Facilitated by district and block, the data being sent needs to be understood and used by facility.

### ***Record-Keeping in facilities***

- In recordkeeping the teams came across mixed scenario. At places the records were very well- maintained where as at some facilities registers lacked uniformity and all the necessary columns (e.g. in a delivery register, there was no column for complications/comments) were not available.
- Eligible couple register was seen in both the districts; however care should be taken to keep it updated and live.
- In field, formats at SC and PHC level were collected. The formats were cross verified and the team found that there was variation in the data sent by SC Salamabaad Dachi and one which was uploaded at HMIS (Annexure-2). The variation reflects the status of supervision in the district which is a weak area.

### ***State Innovation in HMIS***

- HMIS is not the only source of information. The State's work-done report which has many components including the doctor's work history is a step worth emulating by other states. The State has State specific formats which includes New and old OPD cases, Major and minor IPD cases, lab tests (including urine test, sputum test, sputum positive test, X-ray, ECG and USG), Medico legal cases, status of hospital development funds, communicable and non communicable diseases, snake bite and maternal deaths at rural level etc. The timely uploading is monitored by the SPMU at State level under guidance of Mission Director. All

the information is available publicly and may be seen at state's the website [www.jkhealth.org](http://www.jkhealth.org) and [www.jknrh.com](http://www.jknrh.com).

### **Recommendations:**

- State needs to ensure that facility and blocks wherever the data is being uploaded have adequate infrastructure esp.proper internet facility and trained human resources. The personnel engaged in data collection should be given orientation to understand the significance of all the entries being made.
- The block monitoring and evaluation officers should visit the facilities of the block (all the facilities to be covered once in a quarter) to check the registers and process of data entry/reporting. The State needs to arrange vehicle or provide travel allowance. The visits may also be clubbed with visits of BMO or other officers
- The State needs to explore options where State data requirements and HMIS entry requirements can be met easily and their advantages maintained without duplication. State may discuss this with the software companies and look for a smarter solution.
- Eligible couple Registers are basic source of information. Care should be taken to keep the registers updated. The officers visiting the SCs should check it from time to time.
- All kinds of registers which are in use in the facilities need to be standardized, so that data captured is comparable.

### **MCTS**

#### **Key issues/ Points:**

MCP (Mother and Child Protection) card and Mother and Child Tracking format are available and data is being captured at all levels and regularly uploaded. It was informed during the visit that training of data personnel has been conducted up to block level. However, it was noted that there was no formal training / orientation conducted of ANMs (who collects primary data for MCTS).

Data entry is being done at the level of PHC and above. There is lack of clarity in understanding and generating Identity number and utilization of MCTS to track at risk mother and children is very poor. It was observed at many facilities that for the same beneficiary, duplicate Id number is being generated (at different time of visits), which creates issues in terms of complete follow-up of a beneficiary.

It was observed that knowledge of service providers and data managers regarding Haemoglobin and Age of marriage w.r.t. MCTS for follow up of pregnant women and children is very poor. Therefore even if data is correctly entered it is not being used for proper tracking and management.

#### **An MCTS case-study : Kamlesh**

23 yr old female w/o Pritam Chand R/o SC Battal PHC Majalta (ANM: Ms. Kamlesh, ASHA: Ms. Vijay Rani) LMP 18.3.2011, EDD 26.12.2011. TT Booster was given on 29.03.2011. This pregnant female was tracked from SC to PHC and then to District. At SC level (as per the available information) her Hb was 6.8 gm% but no IFA was provided for till date of visit. At PHC level, it was informed that she was given Iron Sucrose inj. on 17.06.2011. However, records of the same were not available in the tracking system/ register. This is serious concern since pregnant lady is severely anemic; however, her current status is not known. Further, this case was followed-up at District level in CMO office and as per the information entered in MCTS, status of the lady is not known.

This makes it clear that a lady with Hb level of 6.8 gm is not followed-up properly, which is undermine the purpose of MCTS. If these types of cases are tracked properly, management of high-risk pregnancies and new-borns would be much easier.

### **Recommendations**

- There is a need for orientation/ re-orientation of service providers as well as data managers up to the lowest level to ensure proper use of MCTS.
- Available data under MCTS to be used by officials at all the levels

### **Gender and Equity**

- It was noted that a complaints redressal mechanism as envisaged under the guidelines laid out by the Hon'ble Supreme Court (in the case of Vishaka vs State of Rajasthan -1997) is in place in the district of Baramulla to address the issue of complaints of sexual harassment. The system does not seem to be active as no complaints have been registered. This mechanism is however, not in place in the district of Udhampur. It needs to be ensured that a time bound complaints mechanism headed by women should be established in EVERY health facility across the State.
- Even though separate toilets were available for men and women in tertiary and secondary facilities, the same were not there in PHCs etc. Cleanliness levels were satisfactory. It was noted with concern that offices of the Chief Medical Officer in the districts visited do not have separate toilets for women.
- The labour rooms were generally in good condition. However, in some labour rooms curtains were not provided between labour tables in order to ensure privacy. Labour rooms had attached toilets with running water in almost all facilities visited by the team. Even though the OBG OPD in District Hospitals had adequate curtains to provide privacy, the heavy load of pregnant women on ANC days (~ 200 per ANC) would mean that all norms of privacy were being violated. Similarly in OBG wards in the District Hospital it was seen that pregnant mothers were sharing beds on account of heavy load. It is imperative on the State to improve antenatal services in PHCs and CHCs so as to de-congest the District Hospitals and Medical Colleges. Every pregnant mother has a right for adequate privacy during antenatal check up, delivery and the post natal period.
- The team noted that there has been no training of MOs, especially lady MOs to recognize signs of domestic violence among patients during triage in an OPD/Casualty. Routine screening, assessment and triage for domestic violence should be made part of regular outpatient/casualty triage by Medical Officers of female patients. The State Government should include this as part of the curriculum of regular induction/refresher training of Medical Officers. Similarly gender prioritization needs to be emphasized during the process of planning and formulation of the District as well as State PIPs.

### **PC-PNDT**

- The State Supervisory Board, which is the highest policy and implementation review body under the PNDT Act, was constituted in J &K in the year 2002 under the Chairmanship of Health Minister with Commissioner & Secretary Health as Vice-chairman and the Director Family Welfare as Member Secretary. Other members include the Heads of the Department of Obstetrics and Gynecology, Pediatrics and Social Science, representatives from NGO sector and members nominated by the Hon'ble Health Minister. Appropriate authority for the State has been constituted at the divisional level in March 2008, with the Director of Health Jammu and Kashmir as appropriate authorities of the divisions of Jammu and Kashmir respectively. However, inspections by the appropriate authorities are yet to gather momentum in the State. A multimember advisory committee has been set up in the District of Udhampur under the chairpersonship of the District Collector with representatives as envisaged under the Act. This committee has met only once so far and it has to be ensured

that quarterly meetings are held. Nevertheless, such an advisory committee is yet to be set up in Baramulla District.

- Registration of Ultrasonography Clinics in the State is a matter of concern. The team observed that while the Government run Ultrasonography Clinics were registered/are in the process of being registered, large number of private clinics are to be registered. In the district of Baramulla there are 25 private clinics of which only 5 are registered under PC & PNDT act and 17 have applied for registration. All the 17 have been inspected by the appropriate authorities. In Udhampur the CMO informed that there are totally 5 clinics of which 3 are in the government and 2 are in the private sector and all clinics have been registered/are in the process of being registered. It was noted, that the District authorities have taken some action as per PC PNDT act and have recommended cancellation of license of 2 clinics for violation of rules.
- Even though sign boards on PC-PNDT were available in all the health facilities visited such as DH, CHCs and PHCs, the team noted the lack of mass media/mid media campaigns to spread awareness amongst the general public to stop the menace of sex selection. In a State with a declining child sex ratio, this is a matter of concern.
- Certain commendable recent initiatives of the State Government for more effective implementation of the PC-PNDT Act were noted and are as follows:
  - There has been special focus on PC-PNDT Act and its effective implementation in the District NRHM Sammelans organized by the Health and Family Welfare Department.
  - The innovative scheme of the State Government of rewarding Rs. 25,000 for informants has already shown results. While the JRM team was in the State, a case was booked under PC-PNDT Act in Jammu District against an Ultrasonography Clinic based on information provided by an informant.
  - About 400 religious leaders were mobilized to educate the masses and engage in advocacy efforts to improve the sex ratio.
  - A one day orientation workshop on PC-PNDT Act is being organized for health staff on 18<sup>th</sup> & 20<sup>th</sup> September at Jammu and Kashmir divisions respectively.

### **Major Findings from the group discussions**

- The JRM8 being the penultimate JRM is also focussing on the progress since its inception, hence its methodology suggested holding group discussions with ANMs, ASHAs and beneficiaries to probe into views of the stakeholders as a group esp regarding the existing problems and how the programme can be improved further. The relationship between ANM, AWW and ASHA too was probed into.
- The group in Udhampur district conducted 4 group discussions, two with ASHAs ( Majalta and Chenani), ANMs (Ramnagar) and beneficiaries (at VHND in ):

#### *Group Discussions with ASHA:*

- The concept of ASHA was a welcome one for all (ANMs, ASHA, AWW and beneficiaries). ASHA was seen as first port of call and is sought for getting all sorts of advice particularly on RCH issues (ranging from FP, where to go for institutional delivery, immunization etc.). ANMs conveyed that ASHAs major role is in mobilising clients for various services esp for village health and nutrition days (VHNDs) which is very important in a hilly state like J&K where hamlets are at times difficult to cover. ANMs informed that ASHAs have contributed much in FP client mobilization.

- However the selection criteria of ASHA was said to be non-transparent and lacked set norms. The team was informed of a village with 1500 population having three ASHAs where as another village having 3000 population had only one ASHA.
- ASHAs from far-flung areas have difficulty accompanying pregnant women to higher facilities. At times they are away from home for three to four days and the incentive received in lieu is not enough to cover the costs.
- At places, many women do not want to go to nearby sub-centre or PHC and opt for FRUs, as going to SC/PHC means walking for half an hour or more where as local transport for going to nearest FRU is easily available (cost varies from Rs.5-10) . This has led to more clients coming to FRU.
- ASHAs generally compared their incentives with AWWs perceived their incentive to be inadequate despite spending major part of their time in helping the clients.They informed that they have respond to clients at all times (including late nights) and give priority over their family.
- At higher facilities ASHAs are seen as someone who comes to get the incentive and are given due respect.( They were called “lifafewaalis’ by regular staff in DH, a term perceived to be derogatory by ASHAs)
- Some ASHAs have confusion about their long term career. At places they expressed desire to learn certain paramedical skills e.g. administering injections

*Group Discussions with ANMs:*

- ANMs informed that NRHM brought greater amount of funds with the flexibility to spend it as per local requirements. They have used the untied funds for getting the SC painted,small repairs, buying fridge, stretchers,shelves and equipments. They also told that NRHM has improved the availability of drugs in the system though at times there are delays in supply.
- Problems encountered by ANMs include infrastructure of SC, ever increasing work load esp paper work after NRHM was implemented, Sub centres at many places were in very small rented facility and does not have basic amenities like electricity, water and toilet. The pharmacist posted at SC only looks after the OPD and does not support the ANM in any other work/paper work. ANMs complained that some of the ASHAs from well off families do not listen to them.
- It was noted with concern that even after 7 years of NRHM the ANMs were not being promoted timely. Some of the ANMs have worked on the same post same scale for their entire work life and are about to retire.
- Regarding co-operation between ANM,AWW and ASHA the majority in the group conceded that they had good working relation. Roles were clear to most of the functionaries. ANM as service provider, ASHA as mobilise and AWW as a stable point providing platform for service delivery with village. However after withdrawal of incentives for AWW from this year (April 2011 onwards) the co-operation seems to have diminished at some places.

**Recommendations**

- Team building (between ANM, AWW and ASHA) needs to be supported by PHC and incharges. ANM should be seen as the leader of the team. At places BMOs compare ANM and ASHAs work (e.g. FP case mobilization) which will give rise to unhealthy rivalry and is not desirable.

- ANMs should be promoted timely. This will ensure that the State has enough local LHVs for supportive supervision in all the districts. Currently there are very few LHVs who are transferred from one place to another.
- ASHA should be given due respect by all the staff in the health facilities. The DH Udampur had a room exclusively for ASHA. State should plan for such rooms in higher facilities where ASHAs from far flung areas can stay when they come with PW. The room should be comfortable, easily accessible and should remain open for use by ASHAs 24x7.
- ASHAs with proper qualification and aspiration should be sponsored by State/NRHM for ANM courses. This would be a good career progression for ASHA and at the same time State will get local ANM.
- The State may come up with plans to address the problem of adequate incentive for ASHAs living in hard to reach areas with a very small population to cater to.

### FINANCIAL MANAGEMENT:

As part of the team visiting State of Jammu & Kashmir under 8<sup>th</sup> JRM, the undersigned visited following centers under Baramulla District and SHS, J & K Kashmir Office for financial review:

1. Sub Centre Dachi ( under CHC Uri ),
2. CHC Uri,
3. 24X 7 PHC Buniyar,
4. PHC Dangi Waacha,
5. CHC Kreeri, and
6. State Health Society, J & K- Kashmir Office.

Financial Management is being managed by FMG comprising Financial Advisor/ CAO Mr Rajesh Talwar and other staff. The allocation, release and expenditure in respect of J & K State is given below:

#### State Level :

#### RCH Flexible Pool

(Rs. in crore)				
Year	Allocation	Release	Expenditure	Exp./Release %
2005-06	13.79	6.05	1.24	20.5
2006-07	15.05	10.53	5.20	49.38
2007-08	12.22	9.12	11.11	121.82
2008-09	30.51	28.74	12.87	44.78
2009-10	37.34	37.27	25.21	67.64
2010-11	42.40	42.40	37.91	89.41
2011-12 ( Till 30.6.11)	46.91	0.00	10.69	N/A
<b>TOTAL</b>	<b>198.22</b>	<b>134.11</b>	<b>104.23</b>	<b>77.72</b>

**Mission Flexible Pool****(Rs. in crore)**

<b>Year</b>	<b>Allocation</b>	<b>Release</b>	<b>Expenditure</b>	<b>Exp/ Release %</b>
2005-06	0.00	18.68	0.11	0.59
2006-07	13.78	31.39	3.54	11.28
2007-08	24.08	122.05	37.08	30.38
2008-09	20.31	20.18	70.25	348.17
2009-10	39.94	39.94	86.94	217.68
2010-11	47.02	77.02	122.15	158.60
2011-12( Till 30.6.11)	57.76	28.88	3.00	10.39
<b>Total</b>	<b>202.89</b>	<b>338.14</b>	<b>323.07</b>	<b>95.54</b>

**Routine Immunization****(Rs. in crore)**

<b>Year</b>	<b>Allocation</b>	<b>Release</b>	<b>Expenditure</b>	<b>Exp/Release %</b>
2005-06	1.39	1.10	0.09	8.18
2006-07	1.26	0.61	0.81	132.78
2007-08	1.00	0.73	0.91	124.66
2008-09	0.90	0	2.27	NA
2009-10	2.84	2.84	1.41	49.65
2010-11	2.37	2.37	1.59	67.09
2011-12( Till 30.6.11)	2.38	1.22	0.10	81.97
<b>Total</b>	<b>12.14</b>	<b>8.87</b>	<b>7.18</b>	<b>80.95</b>

Statement showing Releases made by State Health Society and Expenditure of District Health Society Baramulla								
								(Rs in Lakh)
Year	Releases			Total	Expenditure			Total
	RCH Flexipool	Mission Flexipool	Routine Immunization		RCH Flexipool	Mission Flexipool	Routine Immunization	
2005-06	19.24	2.49	1.78	23.51	10.45	-	0.60	11.05
2006-07	48.55	59.50	8.90	116.95	16.87	18.23	3.29	38.39
2007-08	74.17	134.73	4.46	213.36	84.68	161.78	7.52	253.98
2008-09	118.13	182.25	24.93	325.31	35.86	208.96	19.38	264.20
2009-10	144.73	290.17	9.43	444.33	170.63	307.10	8.73	486.46
2010-11	242.81	408.77	8.52	660.10	242.42	409.93	7.76	660.11
2011-12 (Till July 2011)	370.72	133.99	4.13	508.84	109.03	36.21	1.82	147.06
<b>Total</b>	<b>1,018.35</b>	<b>1,211.90</b>	<b>62.15</b>	<b>2,292.40</b>	<b>669.94</b>	<b>1,142.21</b>	<b>49.10</b>	<b>1,861.25</b>

Statement showing Releases made by State Health Society and Expenditure of District Health Society Udhampur								
								(Rs in Lakh)
Year	Releases			Total	Expenditure			Total
	RCH Flexipool	Mission Flexipool	Routine Immunization		RCH Flexipool	Mission Flexipool	Routine Immunization	
2005-06	18.13	1.84	1.57	21.54	3.77	1.34	0.03	5.14
2006-07	48.59	64.64	7.07	120.30	29.31	20.75	4.99	55.05
2007-08	76.92	122.24	5.72	204.88	70.56	28.07	8.78	107.41
2008-09	116.05	170.70	20.88	307.63	56.58	108.61	10.90	176.09
2009-10	84.45	206.73	6.77	297.95	84.58	182.97	8.59	276.14
2010-11	126.64	273.92	9.01	409.57	156.58	334.66	8.53	499.77
2011-12 (Till July 2011)	159.29	83.69	2.28	245.26	70.07	6.78	1.68	78.53
<b>Total</b>	<b>630.07</b>	<b>923.76</b>	<b>53.30</b>	<b>1,607.13</b>	<b>471.45</b>	<b>683.18</b>	<b>43.50</b>	<b>1,198.13</b>

### Statement of Funds Position as on 30<sup>th</sup> June, 2011:

The State has outstanding advances of Rs. 68.87 crore pending for settlement under Mission Flexible Pool and Rs. 36.29 crore under RCH Flexible Pool.

#### Major Observations:

- At State and District accounting and reporting has improved as also at each CHC, PHC & Blocks, it was noticed that a proper cash book was maintained and written up to date on manual basis. Tally ERP.9 is at implementation stage at State Level only. Due to the resignation of the concerned official the progress has stalled.
- Fixed Assets Registers are being maintained at every centre.
- Well maintained separate register has been maintained for payment under JSY Scheme consisting of list of beneficiaries and their prominent display at the Notice Board of the Centers.
- IEC Works carried out by the state to promote Institutional Delivery under JSY Scheme through advertisement made through print & electronic Media including cable network.
- Funds given down the line are being treated as advances and only actual expenditures are being reported.
- Advance Monitoring System has been implemented by State & District only partially.
- Maximum utilization of Funds has taken place under JSY, Infrastructure Development, Procurement and Human Resources.
- RCH -I Unspent Balance available at the State level : Rs 36,06,037.50 (MNGOs)
- RCH -I Unspent Balance available at the District level : Rs Rs 6,57,855/-
- State share year-wise contributed by State Govt. and credited to the Bank A/c of SHS.

Year	Amounts required on basis of releases (Rs. in Crore)	Amount Credited in SHS Bank A/C (Rs. in Crore)	Short/ (Excess) (Rs. In Crore)
2007-08	28.31	Nil	28.31
2008-09	13.50	12.46	1.04
2009-10	23.05	Nil	23.05
2010-11	27.17	61.16 (previous year sanctioned amount credited in 2010-11)	-33.99
Total	92.03	73.62	18.41

- The financial data not uploaded on the HMIS portal for the year 2010-11 by the State/Districts.
- Concurrent Audit has not improved the internal control system as Bank accounts are not being reconciled on regular basis. The intervening period for Reconciliation varies from 3 months to 6 months. Further there is no periodic reconciliation of advances and age-wise analysis of advances.

- Each CHC/PHC/ Block has sanctioned post of Block Accounts Manager but vacancy exists at CHC Uri, CHC Kreeri, PHC Dangiwachha and 24x7 PHC Buniyar .In the absence of BAM, other officials like Health Educator/ BHW are maintaining books of accounts as additional charge.
- The immediate fall out of the Vacant Posts is that there is no interaction with District Accounts Managers and the consequent poor monitoring.

#### **Audit Quality:**

- Since the launch of open tender system for annual appointment of Statutory Auditor and coverage of at least 40% Blocks, the quality of Audit has improved in the State as a whole.

#### **E Banking:**

- With the introduction of e-banking solution under progress funds are being transferred online, it has become quite smooth to monitor them besides faster transfer of funds. All the 22 Districts of the State are on E Banking Platform. If e-banking solution becomes fully operational up to SC level and further subordinate institutions level, the monitoring of funds and expenditure will be more effective.

#### **Sound Practices:**

Joint signatories for all cheque payments at every level and one nodal Bank- J & K Bank throughout the State.

With the inception of RCH-II/ NRHM in the year 2005-06 there is good improvement in the matter of accounting and reporting of expenditures. The level of funds utilization has increased. The maintenance of a single Bank Account at J & K Bank and one single Cash Book at Block level for the programmes viz.RCH, Mission, Immunization etc. is appreciable as it gives a consolidated picture at one place and total funds available at each level.

RKS funds are being maintained in a separate bank account with a separate cash book.

Further, State is releasing funds activity wise and getting reports accordingly. A review of the system of releasing funds activity-wise appears to be sound as it gives a clear-cut demarcation for the district and blocks and getting report of utilization also becomes easier for every one.

#### **Tax Deduction at Source:**

For payments to consultants and suppliers, TDS at applicable rate has to be deducted. TDS is being deducted at State Level but not at District level/Block level which is a serious issue.

#### **Other Comments:**

1. Finance & Accounts Training of Staff should be a priority. A number of staff members are doing accounting work as additional charge and have no knowledge of Double Entry System.
2. Concurrent Auditor of the Baramulla District, Mr Rashid Latif, Chartered Accountant highlighted the need for more effective reporting & follow up.
3. Proper age-wise analysis of the advances should be done; Concurrent Auditor has a greater role to play in this regard.

4. ANMs are regular in maintaining their accounting records but reluctant in incurring expenditure on various items they can incur. They need required training & proper orientation.
5. Remuneration/ Consultancy fee of the Staff under NRHM is very low. Doctors are just getting Rs 16,000/- p.m and they are totally demoralized. A no. of staff members are working at the same remuneration of Rs 10,000/- p.m for the past 4-5 years without any increment.
6. At SHS, J & K, Kashmir Office, the remuneration of first 2 months of the contractual staff is being held as security which is forfeited in case they resign from the organization before completing 1 year. The practice is unethical.
7. There is no vertical integration of NDCPs programmes.

**General Recommendations:**

1. Initiate steps for electronic transfer of funds from District to Blocks/ CHC/ PHC/SC/VHSC to avoid delay in funds availability.
2. Initiate process of integration of NDCPs with State Health Society by passing a resolution in the Governing body meeting of SHS & holding joint meetings with all stakeholders.
3. Expedite appointment of Director (Finance) for enhanced supervision and more visits by SPM /SAM/DPM/DAM/ Internal Audit Manager and monthly review meetings.
4. Ensure timely appointment of auditors (covering NDCPs) and obtain compliance with the audit observations given by statutory and concurrent auditors.
5. Implement Tally ERP customized accounting software at DHS/ Block levels.
6. Strict adherence to NRHM Financial guidelines specially about cash withdrawals and cash retention in hand at DHS/ Block/CHC/ PHC /SC / VHSC levels.
7. Timelines for submission of SOE/ FMR / U.C. to be strictly followed at all levels.
8. Ensure regular meetings, recording of minutes and audit of the accounts of all RKS registered in the state.
9. Procurement Guidelines to be distributed at District and Sub-district levels and training to be imparted in procurement procedures.
10. Implement advance monitoring system as detailed in the Model accounting handbooks
11. Ensure that cash/ bank books are closed on daily basis and signed by the concerned Accountants and MOIC.
12. Physical verification of cash and fixed assets must be carried out every year.
13. Ensure that correct information is uploaded on HMIS portal within prescribed timelines.

## **Key findings at each centre:**

### **Visit to SC Dachi under CHC Uri**

- 1 No quotations invited for expenditure of Rs 6541/- for white washing & painting thro M/S A R Traders, voucher no. 770 dated 8.12.2010.
- 2 Bank Reconciliation not carried out since April, 2011.
- 3 Cash Book being closed monthly.
- 4 Pharmacist, Mr Nisar is looking after the Accounts work.

### **Visit to CHC Uri**

- E transfer facility introduced wef 1.4.2011.
- JSY payments being made thro crossed cheques and all the beneficiaries' records being maintained properly. Test checked by calling 4-5 recipients.
- Bank Reconciliation not carried out since April, 2011.
- Involvement of Revenue Deptt. In RKS Fund operation is rather a bottleneck as Niak Tahsildar's absence leads to postponement of meeting.
- Cash Book being closed twice a week.
- Post of Data Evaluation & Monitoring Operator lying vacant. Health Educator Mr Riyaz Quareshi looking after the same.
- Governing body meetings are very irregular and are held only when the funds are received. Minutes of the meeting are being maintained.

### **24X 7 PHC Buniyar**

- RKS earned a profit of Rs 3.50 lakh for the year ending 31.3.2011 and Rs 1,49,880/- between 1.4.11 to 31.8.11. The only PHC to have an exceptional achievement.
- Governing body RKS meetings are being held with a 6 months gap, when the funds are received.
- The interaction with District Accounts Manager is once in 6 months.
- The post of Block Accountant is lying vacant.
- Cash Book being closed once a month.
- Bank Reconciliation pending since April, 2011.

### **PHC Dangi Waacha**

- JSY payments being made thro crossed cheques and all the beneficiaries' records being maintained properly. Test checked by calling 4-5 recipients.
- Incentive payment pending for 40 cases @ Rs 600/- under ASHA for the period April, 2011 till August 2011 amounting to Rs 24,000/-.
- Governing body RKS meetings are being held with a long gap, when the funds are received. Last meeting was held on 12.10.2010.

- No interaction with District Accounts Manager and no monitoring by him for utilization of funds.
- The posts of Block Accountant & Block Health Manager are lying vacant. BHW Mr Ahmed is looking after Finance & Accounts as additional charge.
- Cash Book being closed once a month.
- Bank Reconciliation pending since April, 2011.

#### **CHC Kreeri**

- JSY payments being made thro crossed cheques and all the beneficiaries' records being maintained properly. Test checked by calling 4-5 recipients.
- Incentive payment pending for 85 cases @ Rs 150/- p.m for 6 months under ASHA for the period 2010-11 amounting to Rs 76,500/- .Pending amount towards immunization for the period April,2011 till August 2011 is Rs 7,500/-.( 50 cases@ Rs 150/-).
- Outstanding Rent for 6 Sub centres Bulgam, Chinnad, Athoora, Sheikhpura, Dudbug & Wulraman since March, 2010 @ Rs 3200/-p.a. i.e Rs 267/- p.m.
- Governing body RKS meetings are being held with a long gap, when the funds are received. Last meeting was held on 10.9.11 after January, 2011.
- The post of Block Accountant is lying vacant since the termination of previous Accountant in May, 2011. BHW Mr Mohd. Jaffar is looking after Finance & Accounts as additional charge.
- Cash Book being closed daily.
- Bank Reconciliation pending since April, 2011.

#### **State Health Society, J & K- Kashmir Office**

- It was observed that hiring charges of Rs 1000/- per day were being made for Xylo Mahindra E 8 vehicle used in the office irrespective of usage.
- It was noted that the SHS is not inviting any tender or quotations for its procurement of Office Equipments, expenditure for which is to the tune of Rs 2 lakh. On the other hand, procurement is through DGS &D rate contract which may be higher than the market rates..
- The remuneration of first 2 months of the contractual staff is being held as security which is forfeited in case they resign from the organization before completing 1 year. The practice is unethical.
- Bank Balance has not been reconciled since April, 2011.
- Cash Book is being closed daily.

**JRM 8: TEAM COMPOSITION**

**Team leader:** Dr. Suresh Mohammed, Director RCH- DC, MoHFW, Gol

**MoHFW Consultants**

- Dr. Pushkar Kumar,
- Mr. Rahul Pandey,
- Mr. Vipin Garg,
- Dr. Manpreet Singh Khurmi,
- Ms. Anamika Saxena,
- Dr. Nitasha Manpreet Kaur,
- Mr. Ravi Sawlani,

**TMSA**

- Ms. Mona Gupta,

**Development Partners**

- Dr. Ute Schumann-EU,
- Ms. Melanie Kengen- EU,

**Regional Office Gol**

- Dr. Shazia Wafai,

**State officials**

- Dr. Manoj Bhagat,
- Mr. Sadiq Khan,
- Dr. Harjeet Rai,
- Dr. Mushtaq Ahmed,
- Dr. Niyaz Jan,
- Dr. Kewal Krishan,
- Mr. Munir Parray,

**FACILITY WISE REPORT – UDHAMPUR, JAMMU & KASHMIR**  
**JRM-8 VISIT: SEPTEMBER 12-16, 2011**

**Facility:** District Hospital Udhampur  
**Date:** 12/09/2011 (DAY-1)  
**In-charge:** Medical Superintendent Dr. Chandra Prakash

- Citizens Charter & User charges;  
 Citizen Charter, entitlements for pregnant women under the JSY scheme as well as JSSK (Maa Tujhe Salaam) and details of user charges were displayed at the hospital entrance. On enquiry it was found user charges are not levied from pregnant mothers and newborns.
- Blood Bank:  
 The Blood Bank infrastructure was not upto the mark and requires repairs. It was informed that no HIV +ve case has been found in samples tested in more than 2 years. This needs to be investigated further.
- Immunization:
  - The ANM is trained in cold chain handling
  - Open vials of DPT were kept in ILR
  - Temperature log sheet of ILR and DF was poorly maintained
  - Vaccines and diluents and syringes are available in adequate quantity
  - Stabilizer is working properly (One stabilizer for ILR and DF)
  - Electricity supply is usually for 24 hours
  - Ice pack properly conditioned
- Laboratory
  - Regularly conducting tests of such as Hb, GBP, TLC, DLC, Platelet count, Serum bilirubin etc
  - One newborn Gudiya, case of Neonatal jaundice, admitted on 29.08.2011 with Serum bilirubin 8.6 was discharged to GMC Jammu.
- Labour room:
  - There are about 250 deliveries a month of which ~ 70-80 are C-Section. It was informed that women demand for C-sections, even if not medically indicated, and are given the service. Delivery services are available 24 hours
  - The number of deliveries in the hospital is on the increase. Whereas it was 829 deliveries in 2008/09, by August in the current year the number was already at 980. Postnatal visits are not organised from the DH. There have been 3 instances of maternal death in the hospital so far in the current year.
  - The number of laboratory investigations was on the increase. In 2009/10 they were 9936, in 2010/11, 38236 and the number of lab investigations this year 2011-12, August has reached 45904.
  - Radiant warmer is used for all newborns to provide essential newborn care

- Availability of **equipment and drugs** is satisfactory. Instead of an oxygen bottle, there was an oxygen concentrator, with mask. The present staff demonstrated the handling of the machine. The labour room had normal delivery kits and emergency drugs, however, magnesium sulphate was missing, then quickly brought from the market. This DH does not have a partograph, but maintains partogrammes on file. The Assistant surgeon was aware of the technical difference. Equipment for assisted vacuum delivery was not available, instead, forceps are used. MVA was not available. There was no curtain in between the labour room tables.
- All essential laboratory services are provided:  
Referral services are established.
- Maternity Wards:
  - Maternity wards were overcrowded and had double-occupancies
  - Women with c-section deliveries were accommodated in the common maternity ward, though separate c-section ward is available
  - 48 hours stay is not maintained, instead most women leave after 24 hours of stay, encouraged by the facility as there is shortage of beds,
- JSY and entitlements under JSSK:
  - It was observed that only pregnant women from Udhampur town are paid the entitlements under JSY in this hospital. All referred cases from rural were being asked to collect their JSY entitlements from the respective Block PHCs. There was delay of 1-3 weeks in payment of beneficiaries. Further it was noted that hospital staff were insisting that JSY benefits would accrue only if the pregnant women underwent at least 3 antenatal check up and had a TT dose. These restrictions were found to be an impediment in pregnant women getting their rightful entitlements under the JSY scheme.
  - Interviews with pregnant mothers who had delivered in the facility revealed that they had to incur out of pocket expenditure for drugs, transportation and diet during their stay in the hospital. Interviews also revealed that pregnant women from rural areas were more aware of their entitlements under JSY as compared to pregnant women from Udhampur town.
- SNCU:
  - Radiant warmers: 5 + 1 (Labour room)
  - HR: 2 MO, 10 SN (Dedicated staff for SNCU not available)
  - Temperature of AC: 30 degree Celsius, advised to keep between 26-28
  - Protocols are being observed
  - Rs 55 lakh has already been spent of construction; GoI Norm is Rs 41 lakh for a 12 bedded unit. Medicines for newborn are available. FBNC training for MO and SN is urgently required
- Family Planning:
  - FP services are offered on fixed day basis on every Tuesday and Friday. Two gynaecologists are placed in the hospital with 2 laparoscopes two provide these services. However, facility output is low (around 147 sterilisations and 60 IUD insertions carried out during 2010-11. The Staff are aware of all entitlements under FP programme.

- Other Issues:
  - Accommodation for staff not available (only 4 govt. quarters). Only 15 day casual leave is available
  - Thermometer is not available, temperature check by touch
  - Nursing students are available who do weight and anthropometry of children
  - Patients not properly managed at PHCs, so increased load in District Hospital
  - It was informed by the account personnel that there has been decline in state support ever since RKS funds were provided to district hospital. Further, meeting of RKS is very irregular and not as per norm of Gol
  - Cash book was maintained properly.

**Facility: District Hospital Udhampur**

**Date: 13/09/2011 (DAY-2)**

**In-charge: Medical Superintendent- Dr. Chandra Prakash**

- ICTC/PPTCT:
  - Counsellor post is vacant.
  - HIV report are given on 2nd in the pretext that Coombs test kits require more number of samples. LT was strictly instructed to give results within half an hour of the drawal of sample. It was found that HIV kits are not kept in refrigerator and this will compromise cold chain and make the kits ineffective. It was noted with concern that pregnant women are pricked separately for HIV test in the ICTC laboratory and then subsequently they are again pricked for tests such as Blood Sugar, VDRL etc in the general laboratory.
  - Centrifuge and refrigerator not available in the ICTC but in the general laboratory. Hence it is recommended that the ICTC LT be shifted to the general laboratory. Further, this will ensure that blood is drawn for HIV test and all other required biochemistry/pathological tests such as sugar, VDRL etc with one single prick.
  - It was noted that there is hesitation among hospital staff to do HIV+ve delivery. Further, there was no NVP available in the labour room. Hospital authorities need to ensure that safe delivery kits are provided to providers such as doctors and nurses to conduct HIV+ve delivery. Similarly NVP should be immediately procured through RKS/HDF.
- ARSH Clinic:
  - Adequate audio-visual privacy is there.
  - The Counselor is not trained in ARSH
  - Clients present for many complaints such as include emotional changes, physical changes, violence issues, STI etc.,
  - IFA, Condoms and OCP are not available with counsellor, they take from Gynaecologist, if required.
  - Penis model not available
  - Flip chart available
  - All clients are female which points to the need for concerted outreach activities to generate demand among adolescent boys.

- Community visit to schools usually 2-3 in a month. There should be outreach visits to generate demand among out of school/college adolescents also.
- Registers were available. Recently circulated formats by MoHFW need to be adopted for Registers and Monthly reports.
- Training:
  - The training record of the staff was reviewed. It was noted that only staff nurses were trained in SBA, and only the Medical superintendent was trained in IMNCI, no one was trained in comprehensive abortion care or MVA, one training was given on blood banking, the Lab Technician was trained on RTI/STI, the Gynaecologists were assumed to know about IUCD but not trained, same applied for the Minilap/Lap, the surgeons were assumed to know about NSV, but not trained recently, there was no training on EmOC and the Anaesthetists were assumed to know Live Saving Anaesthesia Skills, but were not trained recently
- Stock of medicine:
  - Nevirapine tablets as well as syrup and injection Mag Sulph are not available
  - From the store room, it was confirmed that there is available stocks of medicines for one month at least
  - Misoprostol was stocked in the Family Planning section
  - All “three critical inputs”: gloves, OCP and measles vaccines, were stocked for at least a month
- ANMTC:
  - The state of J &K does not have State Nursing Council to certify the ANM training school. State Medical Faculty (SMF) does the certification and hence these trained personnel cannot apply for jobs outside J&K.
  - No sanctioned post of tutors or other staff available in the school and only 2 tutors available (one male and one female). These 2 tutors manage 6 course viz. ANM, Lab Tech, X-Ray, Dental, Ophthalmology and Pharmacy.
  - Community visit is not taking place, but training at the bedside is the backbone of this institution
  - Tutors from DH are on call; however, they are not paid any incentive.
  - The tutors are not aware of new developments in the programme and hence old methods of various techniques (such as IUD insertions) are being taught.
  - Training often takes place in the same hall for several batches of students together
  - Laboratory training of the ongoing batch took place only once since beginning (in last two months)
  - There is no training material available in the school
  - The library contains a haphazard collection of hand books and lacks regular staff so that access to the library is difficult for students
  - There is no hostel accommodation available for the students

**Facility:** Health Sub Centre, Battal, Udhampur

**Date:** 13/09/2011

**In-charge:** Ms. Geeta Devi - ANM

- There are 3 ANMs and one Pharmacist posted at the Sub-Centre. The SC has many other government health facilities in its vicinity and hence virtually very low work load (PHC is around 4-5 km and there are 2-3 sub-centres nearby). Around 51 ANCs and 459 OPD attendees between April 01 and September 07, 2011. There is a need to rationalize staffing pattern of Sub Centres so that posting of staff is as per patient load/services carried out in the facility.
- No delivery has been conducted at the facility. None of the 3 ANMs posted have been trained as skill birth attendants.
- Immunization services are being provided in the facility.
- Even though the SC has a BP apparatus it was found to be non-functional. It was informed by the staff that the BP apparatus is not working for more than 2 months. However in ANC records, it was noted that BP of patients was updated till date. This is a matter of concern. Bag and Mask are not available in the facility. There is no to check the Hb of antenatal cases. Thermometer is available.
- Medicines were available in the facility. Pharmacist is seeing patients for common ailments and prescribing medicines for these. Medical officer from the nearby PHC is conducting OPD on Wednesday.
- The team observed that there were 150 expired Nischay pregnancy detection kits in the SC. These need to be disposed off as per procedure.
- Formats for mother and child tracking were noted by the team. A pregnant lady (Ms. Kamlesh w/o Pritam Chand 23 years old) with haemoglobin 6.8 was not prescribed IFA at the SC. The SC staff was not able to provide any proper reasons for this. Later reports were verified in PHC Majalta and it was noted that this patient was given Iron Sucrose inj on 17.06.2011. This points to the need for more coordinated and accurate tracking of antenatal cases.
- While examining utilization of untied funds in the facility, it was noted that some bulk purchase like Rs. 8000 for iron ladder was carried out while basic things for patient care such as BP Apparatus and Haemoglobinometer was not functional/available in the centre.
- VHSCs have not been constituted in any of the villages falling in the jurisdiction of this SC.

**Facility:** PHC, Majalta, Udhampur

**Date:** 13/09/2011

**In-charge:** Dr. Som Singh- Block Medical Officer

- 3 MBBS doctor, 2 ISM, 1 SN, 2 ANM, 2 lab tech and 3 pharmacists are posted at the PHC.
- 1 ANM is trained in SBA; however, she is not conducting any delivery.
- Last laproscopy camp was organised during World Population Day (11<sup>th</sup>-24<sup>th</sup> July, 2011) and around 26 sterilisations carried out during June-July, 2011.
- Doctors are conducting IUD insertions and no training of ANM/ SN has been done in recent past.

- Institutional delivery at the facility increased from 185 in 2009-10 to 372 in 2010-11; however, the number of deliveries are still quite low considering number of staff present at the facility.
- Separate room is being used for radiant warmer, which is not necessary. It seemed that radiant warmer and Bag and Mask have never been used as the staff was having sub-optimal knowledge.
- MCTS: The patient Kamlesh status was not updated on MCTS with respect to Hemoglobin. Rests of the parameters were entered.
- Lab technician records were verified and he informed that user charges were being levied for various tests. When informed about JSSK programme, he mentioned that the team should inform BMO, staff and ASHA regarding this initiative and only then it would be implemented fully.
- The PHC map (Annexed) was discussed and it was seen that there are 9 sub-centres under this PHC, out of which 3 are within close proximity to SC Battalion.
- In 2010 and 2011 two meetings of RKS were conducted while in 2008 and 2009 only one meeting has been conducted. Main expenditure of RKS had been on curtains, electricity repairs, painting etc. Nevertheless account books are maintained properly.

**Facility:** CHC/FRU, Ramnagar, Udhampur

**Date:** 13/09/2011

**In-charge:** Dr. Rajesh Gupta – Block Medical Officer

- The FRU covers a population of 1,32,00 and has the following facilities in its purview 4 PHCs, 2 ADs, 25 SCs and 4 MACs under its purview.
- Ambulances: 1 – Ramnagar and 3 at PHCs. Currently 2 ambulances are being used for FRU.
- Beds: 30
- OPD load: 200 – 250 (per day)
- Deliveries: 57 (per month) of which on an average 3 are C-sections.
- Physician, surgeon, gynaecologist available; MOs: 8 and SNs: 7
- There is a well maintained labour room with partition between each labour table, curtains for privacy etc.
- Labour room registers were examined and it was noted that records are not being maintained for provision of breast feeding within 1 hour and outcome of labour is terms of resuscitation required or not.
- NBCC: it was noted that NBCC is not being used as staff was having sub-optimal information of using Radiant warmer. Oxygen concentrator has been installed 2 years back but is rarely being used. Bag and mask is available but it appears that it has not been used.
- One MO is trained in NSSK and another in IMNCI, but they are not practicing their trainings
- JSSK rollout: Pregnant women had paid money out of their pockets for transportation. They had also incurred expenditure for some drugs. it was informed by BMO that they would not be able to provide provision of free diet. Nearest blood line is 1-2 hours away in DH, Udhampur
- Hand washing steps were not known.
- Cold chain handler has been trained in RI in 2008-09. Temperature log sheet: ILR: Poorly maintained (everyday temperature 4 degree Celsius), DF: Temp log sheet not maintained.

- RI session is due on 14.9.2011 but vaccines have been issued on 13.09.2011 for Bari, Kela and Majua. It was told that as these places are at a distance of 15 km, so they are being issued one day before.
- Immunization tracking and MCTs: lack of clarity. Data entry for MCTS is not uniform for some of the cases 2<sup>nd</sup> and 3<sup>rd</sup> ANC carried out but not reported in MCTS.
- Vaccines and diluents were available in adequate quantity
- AMC of equipments is not being done
- Safety pit is available
- It was observed that weight of the newborn is mentioned in round figure, which raises suspicion whether, weight of new born taken properly or not.
- Gynaecologist at the FRU is not confident of conducting laparoscopic sterilisation; while, BMO is conducting regular NSVs.
- Supply of drugs from PMS is not on basis of demand rather a pro-rata distribution system is maintained from state level.

**Facility:** PHC, Tikri, Udhampur

**Date:** 13/09/2011

**In-charge:** Dr. A.M. Bhat

- This is a 24 x 7 PHC. OP and IP load is very low. About 15 deliveries has taken place since April, 2011 till date
- At the time of visit, no patient was admitted as IP. Even though the hospital caters to accident cases on the main highway, the team felt that overall the utilization of the facility by public is very low.
- Radiant warmer, Bag and Mask not available in the labour room. The ladies toilet next to the labour room was in a decrepit condition and was unusable.

**Facility:** CHC/ FRU, Chenani, Udhampur

**Date:** 14/09/2011

**In-charge:** Dr. M L Rana

- This FRU caters to a population of 1.8 lakh and has 3 PHCs, 2 ADs, 26 Sub Centres and 3 MACS under its jurisdiction.
- The OPD load is about 500 per day.
- Deliveries: 60-70 per month of which around 5 are C-sections.
- Surgeon, gynaecologist, anaesthetist, paediatrician available. The facility has 4 MOs and 6 SNs.
- MCTS: lack of understanding for Hemoglobin and at risk mothers and children although data is being captured.
- Labour room/OT:
  - The LR had two tables which were not separated by curtains for privacy, otherwise the LR does provide a greater degree of privacy than any other visited facility
  - Drugs were available, standard emergency drugs included. Those which were missing in other facilities, like magnesium sulphate, were substituted here, like with Phenyntone.

- Blood transfusions are provided; Blood Storage Centre is yet to be licensed.
- Partographs are not kept, but manual partogrammes produced on file
- C-sections are said to be conducted only on medical indication, in 2011/12, on average per month there are 5 C-sections and a total of 13 gynaecological or obstetrical operations
- The attached toilet was kept neat and clean.
- Maternity Ward
  - The MW contained six bed, was well maintained and also allowed a minimum of privacy
  - Maximum length of stay is 24 hours, leave is then encouraged due to lack of beds
- Immunization:
  - Knowledge adequate for site, route and angle of vaccination.
  - However, staff not trained in RI
  - Thermometer not available to monitor ILR and DF
  - Spirit swab is being used
  - Date of opening not mentioned on Vit A and staff was not aware till how many weeks it can be used.
- NBSU
  - AC kept at temperature of 21oC. The oxygen concentrator not been used for more than 1 year as filter has not gathered dust. Classification of hypothermia was not known. Radiant warmer is not working (skin probe broken). Bag and mask not been used
- Staff were not trained in NSSK, F-IMNCI or FBNC
- Staff oriented to initiate BF within 1 hour of birth, immunize children for BCG and OPV before discharge including follow up.
- Family Planning:
  - Abdominal tubectomy conducted and IUD insertions are being carried out at the facility.
  - Stock of other contraceptives available; around 40-50 EC Pills used every month.
  - IUD insertion cases are paid (Rs. 12-client; Rs. 3-Doctor; Rs. 2-Motivator and Rs. 3-Dressing etc)
  - There is no proper IUD training conducted; ANMs are called to FRU for ad-hoc training in IUD by gynaecologist.
- Stores:
  - Very well managed store with all the stocks nicely kept in racks with Bin-cards. Mg-sulph not available since last 2 years and not even purchased.
- Only 3 RKS meetings conducted in past 2 years.
- Human Resources
  - SBA training started only last month in Udampur, this facility did not yet have any staff with these skills
  - IMNCI training was given to four staff nurses
  - MTP training is needed with some felt priority
  - EmOC training has not yet been received except for the skills imparted in Medical College

- In last two years only 3 RKS meetings were conducted; although accounts person was maintaining the records (such as cash book, vouchers etc), he was not trained.

**Facility:** PHC, Sudhmadev, Udhampur

**Date:** 14/09/2011

**In-charge:** Dr. Mohit and Dr. Bhasin

- This PHCs has 1 MBBS doctor and 1 AYUSH doctor, 2 ANMs, lab tech and 2 pharmacists (1 allopathic, 1 ayurvedic). 16 ASHAs are attached to the facility. The PHC has good physical infrastructure.
- Labour room/OT:
  - Around 4-5 deliveries per month are conducted. Home deliveries were on the decline by almost 60% from 34 in 2009/10 to 15 in 2010/11. in the first half of 2011/12, there were 13 home deliveries, indicating that the downward trend might reverse again
  - Macintosh sheet was available
  - 80% of the emergency drugs were not available, some since July 2011. Orders had not been placed for re-stocking, the MO was not aware of the situation, neither was the supervising MO from Chenani aware, despite his recent visit to the facility in August, the only available drug was lignocaine
  - There was no tray with assembled emergency drugs
  - An assembled normal delivery kit was also not available, with some effort it was possible to find sterilized gauze. Syringes and needles, drip set and iv-infusions
  - Radiant warmer is not working
  - Oxygen concentrator and Bag and Mask not available
- Immunization:
  - Open vials of BCG and Measles (reconstituted) kept in ILR. The staff was not able to tell since how many days these vials have been kept here. Date and timing not mentioned.
- Waste management poor
- No IUD insertions carried out at the facility.
- In last camp (September 09, 2011) 3 lapro and 1 NSV cases were carried out. However, data for the same is not maintained at PHC level
- Daily consumption register of medicines is not maintained.
- Good numbers of RKS meetings are conducted.
- Facility in-charge is not aware of "how much" to keep as cash in hand.
- Since 2008, only 9 VHNDs were held
- Hand washing steps not known, soap not available

**Facility:** Health Sub Centre, Nagoulta, Udhampur

**Date:** 14/09/2011

**In-charge:** Ms. Chanchal Gupta (ANM)

- Population of SC area is 5994. The SC is staffed by 2 ANMs and a pharmacist.
- There are 2 villages and 4 ASHAs under SC area.
- 1-2 ECP and 4-5 OCPs are used every month.
- No IUD insertion are carried out at SC; considering the difficult terrain in which the SC and distance from nearest health facility it would be appropriate to train ANMs to conduct IUD insertion. .

**Facility:** Sub-Centre, Patnitop, Udhampur

**Date:** 15/09/2011

**In-charge:** Ms. Kurmila

- Population-2190; Villages-2 ANMs, 1 pharmacist and 1 sweeper. 2 ASHAs are attached to the SC.
- OPD: 15-20 per day; 27 deliveries conducted between April-August 2011 (5-6 deliveries per month), the first delivery of a women is referred to the higher level institution
- There was no Haemoglobinometer in the facility,
- Blood pressure was measured by standard: about 97% entries were "normal", indicating that even these skills were lacking. The pharmacist carried out this task instead of the ANM
- There was no stock of IFA tablets during the last 2 months of 2010/11
- Immunization: knowledge adequate for site, route and angle of vaccination
- MCTS: Though formats are regularly being filled, there was lack of understanding on the use of MCTS.
- No IUD insertions carried out at SC; further, ANMs are not even aware of any cases of sterilisation motivated in their area. Further, names of the cleinst for sterilisation are not mentioned at SC level.
- There is a VHND register available; however, it does not have any record of Eligible Couples and FP counselling services.

**Facility:** Village Health and Nutrition Day, Anganwadi Centre, Ramsu, Ramban District

**Date:** 15/09/2011

- Immunization:
  - DPT vial found frozen
  - Staff not trained in RI
  - Vaccine dept in direct contact in vaccine carrier
  - Orientation on RI and BF done
- No usage of FP services in the area. Husbands not allowing their wives to go for any type of FP methods considering it against religion.
- After discussion with some of the village members it was observed that there is a need for quality IPC services.
- There is a myth regarding IUD services that it creates various problems in the body.

**FACILITY WISE REPORT – BARAMULLA, JAMMU & KASHMIR**  
**JRM-8 VISIT: SEPTEMBER 12-16, 2011**

**Facility:** Sub centre Dachi Block Uri

**Date:** 13/09/2011 (DAY-2)

**In-charge:** Ms. Mumtaza (ANM), Nisar Ahmad (MMPHW)

- SC manned by 1 contractual ANM, 1 MPHWP, post of regular ANM vacant
- Residential facility for ANM is not available in the SC.
- 40 deliveries conducted in 10-11, 8 in 2011-12 till date.
- Pregnancy tracking register maintained at the SC
- All the 8 beneficiaries have received JSY benefit. However, JSY incentive is paid at Block office and not at the sub centre. The beneficiaries list is displayed.
- Well maintained labour room with labour table, etc
- ANM conducts deliveries, but is not SBA trained, Need for 2<sup>nd</sup> ANM
- Privacy curtains for patient examination but toilet facility was unavailable
- Immunization sessions are conducted on Wednesdays at the sub centre.
- IEC on JSY and Save the Girl Child along with citizen charter displayed at the facility.
- Eligible Couple register was maintained. Eligible couples in village: 217. The camp for family planning was held last year in URI. Out of these 217 couples, 15 women went for ligation. Cu T insertion was not taking place in SC. OCP (Mala N) and emergency contraceptive pills were also distributed at SC, the record of latter was not found there.
- VHSC: according to ANM, the VHSC meetings take place every Saturday. The participants of the meeting held are: lambardaar, sarpanch, AWW, ASHA and ANM. The record of minutes of meeting was seen and the last meeting took place on 6.9.11.
- Untied Funds were being used by ANM for purchasing table, chairs, fencing, and paint and for electricity fitting purpose.
- Calendar for Village Health & nutrition days was displayed at the SC. VHND was being conducted at AWC with the help of ASHA and AWW. 2<sup>nd</sup> Wednesday of every month, immunization is held (BCG, measles, DPT, OPV, Hepatitis B) and Thursday of every month, left out children were vaccinated and Inj TT is given to pregnant women and albendazole to children. According to ANM, health education to adolescents is also given at AWW Centre.
- Cash book is maintained since 2007/2008. Cash Book being closed monthly.
- Joint bank account for the SC : general medical officer & head of the village are signatories.
- Available funds: 10000 INR untied funds / 10000 INR maintenance funds (AMG)
- Expenditure based on the decisions taken during the meeting with village community and ASHAs. Report is being sent to their respective block.

**Facility:** CHC Uri

**Date:** 13/09/2011 (DAY-2)

**In-charge:** Dr. S. Farooq, BMO

- 40 bedded hospital, Gynaec. Anaesth., Surgeon, Paed. (Relieved two days later for the MC), 4 Assist. Surgeons
- Hard to reach area allowances not given to any Allopathic PHC in Baramulla district whereas it is given to all ISM clinics.
- Telemedicine facility started in 2005. However, the facility is not functional on account of server problem
- Stabilization unit available, with placement of 1 trained nurse.
- Quarters for staff were not available.
- Adequate stock of gloves, vaccines including measles, OCPs.
- JSY beneficiary list was displayed at the entrance and outside the labour room of CHC.
- Block Programme Manager was posted, however, Block Accounts Manager has not been recruited. Post of Data Evaluation & Monitoring Operator lying vacant.
- Referral transport through three Govt. ambulances is available for the patients. In case the patient hires private vehicle for referral from home to the facility an amount of maximum Rs. 1000 is paid by the Block MOIC.
- The data of the entire block is uploaded on HMIS portal. However, the data is not analyzed for planning and monitoring purposes.
- Routine Immunization micro plan was available and followed for immunization sessions. Wednesday and Saturday are fixed days for immunization services at CHC.
- AD syringes were being used for immunization. BMW management practices were being followed.
- USG machine in CHC-Uri is not registered under PC PNDDT
- A Family Planning camp was held last year in 2010 where 169 ligations took place. NSV: 5 last year. The motivation for NSV is lacking because of socio-religious beliefs.
- Female sterilization in terms of abdominal ligation/ minilap is being done at the health facility. Ligation: 44 in total, from April, 2010 to August 2011.
- Cash Book being closed twice a week. Cash book, ledger and statement of expenditures are certified by the BMO.
- Bank Reconciliation not carried out since April, 2011.
- E transfer facility introduced wef 1.4.2011.
- JSY payments being done through cheques and all the beneficiaries' records being maintained properly. Test checked by calling 4-5 recipients.
- Governing body meetings are very irregular and are held only when the funds are received. No proper minutes of the meetings, only attendance list.
- CHC Uri is monitoring 20 facilities present in Uri Block, receiving financial report as well as doing physical checks. Every 20th of each month, meeting is held at Block level, gather all 20 facilities representatives.

**Facility:** PHC Boniyar  
**Date:** 13/09/2011 (DAY-2)  
**In-charge:** Dr. S. Farooq, BMO

- Block Boniyar has 3 PHCs, 9 SCs, 2 ADs (allopathic dispensaries), 2 MAC.
- Average OPD of 150-200 per day and delivery load of 20-30 per month.
- Referral transport through four Govt. ambulances is available for the patients.
- 15 bedded PHC (24X7) having 2 Assist. Surgeons, 1 ISM and 1 Ayurveda doctor, 3 ANMs, 1SN, 2 LTs; 1 X-ray technician
- IEC on JSY, display of JSY beneficiaries names and Save the Girl Child displayed.
- No residential quarters for staff.
- Well managed drug store with display of name, batch no, expiry date etc of drugs.
- Routine Immunization micro plan was available and followed for immunization sessions. Wednesday and Saturday are fixed days for immunization services at PHC.
- No staff in Block Programme Management Unit.
- 1 ANM trained in SBA.
- Well maintained labour room, absence of quality protocol posters, toilet is not attached with labour room
- Family Planning: IUD was being inserted in the health facility. 4 IUD was inserted since April 2011. Oral Contraceptives (Mala N) - 327 cycles of OCs were distributed to 95 women since April 2011. Emergency pills were procured by the facility last month.
- Condoms were distributed. 1050 pieces to 105 persons since April 2011 were distributed.
- Cash Book being closed once a month.
- RKS earned a profit of Rs 3.50 lacks for the year ending 31.3.2011 and Rs 1,49,880/- between 1.4.11 to 31.8.11. The only PHC to have an exceptional achievement.
- Governing body RKS meetings are being held every 6 months, when the funds are received.
- The interaction with District Accounts Manager is once in 6 months.

**Facility:** PHC Dangri Waacha  
**Date:** 14/09/2011 (DAY-3)  
**In-charge:** Dr. Mohd. Maqbool (BMO)

- 10 bedded PHC with a population size of 37000
- 6 Doctors, 1 dentist, 4 LTs, An Anaesthetic has been posted at the PHC.
- In 2010-11, 383 deliveries were conducted. This year 86 deliveries have been conducted in the facility till August 2011.
- Micro plan for RI sessions was available. Wednesday and Saturday are fixed days for immunization services at PHC.
- 2 ambulances used for higher referrals and drop back home of pregnant women
- Pregnant women are given free medicines and diagnostics services. However; user charges for OPD are levied and diet is not provided to the pregnant women during their stay in the facility.

- Facility has a well display of user charges, services available, JSY entitlements for beneficiary and ASHA, JSY beneficiaries names and Save the Girl Child.
- Oral Contraceptives (Mala N) were distributed in facility. 110 cycles of OCs were distributed to 45 women since Jan, 2011 and 180 cycles to 76 women since April, 2011.
- Condoms were distributed but records were not maintained.
- No staff in Block Programme Management Unit.
- Cash Book being closed once a month.
- JSY payments being done through cheques and all the beneficiaries' records being maintained properly, also matching with the Delivery register. Test checked by calling 4-5 recipients.
- Incentive payment pending for 40 cases @ Rs 600/- under ASHA for the period April,2011 till August 2011 amounting to Rs 24,000/-.
- Governing body RKS meetings are being held with a long gap, when the funds are received. Last meeting was held on 12.10.2010.
- Procurement Guidelines are followed and documentation on procurement procedure is well maintained.
- No interaction with District Accounts Manager and no monitoring by him for utilization of funds

**Facility:** SC Watergam

**Date:** 14/09/2011 (DAY-3)

**In Charge :** Ms. Misra Banoo (Jr. Grade Nurse)

- Total Population catering : 5000
- Junior Nurse, 2ANMs, 1 Pharmacist posted. ANM was very competent and efficient worker of district.
- Facility has the required equipments and drugs for conducting deliveries.
- Running water, electricity, toilet available
- Cu T insertion since April 2011: 5
- OC and condoms were present but ECs were not being distributed.
- Eligible couple register was maintained and total eligible couples are: 800
- Supervisory visits by CMO and BMO had been made to the SC regularly.
- Available funds: 10000 INR untied funds / 10000 INR AMG
- Resolution of the last meeting dated 18/03/10 with members of the Village Health Committee was presented and is more like a simple attendance list.
- 

**Facility:** DH Baramulla

**Date:** 14/09/2011 (DAY-3)

**In-charge:** Dr. Nisar Ahmed Kanoongo, Med. Sup.

- 100 bedded hospital which is very old building
- Availability of all specialists, 3 Gynaec, 2 Physicians, 2 Surgeons, 1 Ortho, 3 Anaesthetist, Radiologist

- Average of 8-10 deliveries take place a day
- SNCU is under construction and is at the phase of completion; some equipment for SNCU has also procured.
- SBA training (ongoing) observed. A batch size of two ANMs was being trained. However, latest SBA training guidelines were not available and training material was not provided to trainees. Partographs not taught nor practiced in the labour room. Quality protocol posters not available
- Blood Bank functional with 1 MO and 1 LT who require training. No NACO supported LT (require coordination with SACS for 1 extra LT through NACO support)
- 4 OTs functional. 91 C-sections conducted this year and 4 and 2 C-sections were conducted in night in the months of August and July respectively.
- HMIS: District hospital uploads the data for institution in the urban areas. Data is fed online from block level upwards.
- An ARSH clinic is functional with a female counselor. Audio-visual privacy is maintained in the counseling room. Condoms, Contraceptive pills, sanitary napkins need to be provided through the ARSH clinic.
- DPMU is staffed with District Programme Manager and District Accounts Manager. DPMU is providing managerial support to the CMO and programme officers. There is a good coordination between the regular staff of Health department and DPMU. DPMU staff undertakes regular supervisory visits to the block and at sub centres.
- E-transfers have improved the flow of funds.
- JSY payments being done through [cheques](#) and all the beneficiaries' records being maintained properly. Delivery register matching with list and account of Beneficiaries and cash book. Until recently, the list was also published in the newspaper (prohibitive price so this practice was stopped). Test checked by calling 2 recipients.
- RKS: 15/11/2010: 5 lakhs. The DH sends the request for funds and within approximately 1 month, funds are transferred electronically.
- Minutes of the RKS meeting dated 09/03/11 shows approval of 537,883. INR for already purchased items / works: medicines, furniture for OT, various equipments. Procurement: random checks on procurement show that DH Baramulla follows Procurement Guidelines even in emergency context: call for tenders published in newspaper (with call for deposit of INR 5,000. for on-time delivery), 3 quotations signed by evaluation team, best economically advantageous offer selected (but no comparative evaluation statement), supply order.
- There is a Sick New Born Care Unit being constructed in the DH for 55 lakhs. 10 lakhs of civil works have already been committed through Executive engineer R & B division of the District.

**Facility:** ANMTC, Baramulla

**Date:** 14/09/2011 (DAY-3)

**In-charge:** Dr. Nisar Ahmed Kanoongo, Med. Sup.

- ANMTC, Baramulla is under Centrally Sponsored Scheme.
- Only 04 positions are filled against sanctioned staff strength of 16.
- The institute is having two batches of 18 students in 1<sup>st</sup> year and 33 students in 2<sup>nd</sup> year
- The institute is running with insufficient infrastructure and inadequate facilities. Basic training equipments were not available. Only one training hall with a capacity of 25-35 students. One 30-seater bus is available.

- Centre has an unspent balance of 3.82 lakhs out of 4.5 lakhs received in 2010-11.

**Facility:** GNM Nursing School, Baramulla

**Date:** 14/09/2011 (DAY-3)

**In-charge:** Dr. Shafat, Principal

- Newly constructed building with ample space for teaching, training, administration, hostel and mess facilities.
- The School is accredited with the Indian Nursing Council.
- Regular trainings were going on. Batch of final year is awaiting result.
- Faculty is not positioned as per the sanctioned staff strength.

**Facility:** CHC, Kreeri

**Date:** 14/09/2011 (DAY-3)

**In-charge:** Dr. Bilquees (BMO)

- A functional 30 bedded CHC FRU conducting sigmoidectomy, pyelolithotomy and thyroidectomy as well.
- Partographs are maintained in CHC.
- Since April 2011, ligation: 25m , Cu T insertion: 48
- 2 Gynaec, 2 Anaesthetist, 2 Surgeons, 1 ENT, 1 Ortho, 9 MBBS, 4 SNs, 5 ANMs
- No Paediatrician and no Eye specialist posted
- 15 C sections conducted last year and 44 C sections this year in last 5 months
- Blood storage centre being set up, LT trained, MO yet to be trained, construction for BB, garage, staff quarters going on
- A pain management clinic running
- Immunization on Wednesdays and Saturdays
- Good stock of vaccines, good record keeping and staff well oriented
- JSSK being implemented except for diet, user charges and assured referral transport
- Cash Book being closed twice a week. Cash book, ledger and statement of expenditures are certified by the BMO.
- Bank Reconciliation not carried out since April, 2011.
- E transfer facility introduced wef 1.4.2011.
- JSY payments being done through [cheques](#) and all the beneficiaries' records being maintained properly. Test checked by calling 4-5 recipients.
- Governing body meetings are very irregular and are held only when the funds are received. No proper minutes of the meetings, only attendance list.
- Post of Data Evaluation & Monitoring Operator lying vacant.
- CHC Uri is monitoring 20 facilities present in Uri Block, receiving financial report as well as doing physical checks. Every 20th of each month, meeting is held at Block level, gather all 20 facilities representatives.

**Facility:** PHC, Gulmarg  
**Date:** 15/09/2011 (DAY-4)  
**In-charge:** Dr. Bilal Ahmed, MO

- PHC functional since last 1 year,
- A tourist place and functional more for first aid and OPD services for tourists who may need medical care
- MO, LTs, etc; deliveries not conducted
- Case load is less.

**Facility:** CHC, Tangmarg  
**Date:** 15/09/2011 (DAY-4)  
**In-charge:** Dr. G.M Dar, BMO

- A well functioning CHC with availability of specialists except Paediatrician;
- Blood Storage Centre needs licensing and training of staff, record keeping in dire state
- Labour room very old but well maintained
- ANMs not SBA trained
- Focus group discussion was conducted with ANMs of nearby PHCs and CHCs about their work profile, relationship with ASHAs and AWWs, issues requiring attention in their areas etc. ANMs told the team that they share a healthy relationship with ASHAs and AWWs. ASHAs help them in their day to day activities like conducting VHND, mobilizing children and pregnant women for immunization, maintaining records and preparing due lists etc. NRHM funds in the form of untied grants have helped them a lot by equipping their Subcentre with all the required equipments. They talked about non-prevalence of sex determination test in their area. They discussed about equal education opportunities being provided to the girls. ANMs shared facts of low trend of permanent methods of family planning in the region because of socio-religious beliefs but spacing methods are commonly acceptable in the community. All of them were maintaining eligible couple registers and some of them are also conducting deliveries at their health facilities. One of the ANMs told about her health facility which is in a far flung area and home deliveries were common in that region because of less connectivity.
- Block Programme Manager is looking after accounts.
- Expenses are incurred after approval of the RKS committee whose chairman is the local MLA. The Governing body meets quarterly and the executive body meets monthly. Funds are disbursed in 2 tranches per year. Minutes and attendance list of RKS Committee are maintained.
- No AMG since all are in rented buildings.
- INR 10,000. untied funds are transferred to the sub-centers : and expenditure are decided at the village level committee.
- CHC Tangmarg does physical as well as financial checks (periodic statement, invoices are sent from Sub-centers to Block and report are then sent from Block to District).
- Frequency of visits of District to Block: thrice a year
- Monthly meeting at District level (every 26th of each month) with BPM, BMO, CMO, DPMU

**Facility:** VHND, Tariran (Ferozepura)

**Date:** 15/09/2011 (DAY-4)

**FMPHW:** Ms. Asmat

- Well organised VHND at Anganwadi centre.
- ASHA has mobilized pregnant women for ANC and children for immunization for VHND.
- ASHA diary and immunization cards were well maintained.
- Institutional deliveries have improved considerably in the Subcentre area.

**Facility:** Regional Institute of Health & FW, Baramulla

**Date:** 15/09/2011 (DAY-4)

**In-charge:** Dr. S.M. Kadri, Epidimiologist

- Very good infrastructure with halls, library, hostel facilities, guest house, lecture theatres, audio-visual facilities for training, simulation lab being started. However, the Institute is highly underutilized.
- Absence of faculty, which are drawn from the Medical Colleges, experts from the districts and other guest faculty
- Trainings on National Programmes, ASHA TOTs, pre-service training of medical and para-medical staff are being conducted.
- The institute is not utilized for RCH trainings.

**Facility:** State Health Society, J & K- Kashmir Srinagar Office

**Date:** 15/09/2011 (DAY-4)

- The SHS is not inviting any tender or quotations for its procurement of Office Equipments of as high as Rs 2 lacks. It simply procures from DGS &D where the rates seems to be higher by 10-15%.Cost of Dell Latitude Computer Note Book E 4310 for Rs 62,100/- is higher than the market rate.
- The remuneration of first 2 months of the contractual staff is being held as security which is forfeited in case they resign from the organization before completing 1 year. The practice is unethical.
- Bank has not been reconciled since April, 2011.
- Cash Book is being closed daily.

**STATE VISIT REPORT:**

**MADHYA PRADESH**

## STATE VISIT REPORT: MADHYA PRADESH, SEPTEMBER 12-16 2011

### INTRODUCTION

The Eighth Joint Review Mission (JRM-8) team to Madhya 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 **Jhabua and Mandasaur** from 12<sup>th</sup>-16<sup>th</sup> September 2011.

The team was led by Dr. P.K. Prabhakar, Deputy Commissioner (Child Health), Ministry of Health and Family Welfare (MoHFW), Government of India and comprised of consultants from MoHFW, Technical and Management Support Agency (TMSA) and Development Partners. (Annex-1).

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 visit started with a briefing session at Ujjain on 12<sup>th</sup> September, 2011 wherein Dr. Manohar Agnani, Mission Director, National Rural Health Mission, Government of Madhya Pradesh, briefed the JRM Team highlighting the progress, status of implementation of various RCH programs and new initiatives being taken by the state.

The Mission had a wrap-up debriefing session on 16<sup>th</sup> September, 2011 at Bhopal with the Mission Director, NRHM, MP at chair. All Key health officials including Director Health Services, Consultants and officers from State Health Society and representatives from Development Partners were present in this meeting where JRM Team Leader made a detailed presentation highlighting the achievements and the gaps observed in the two districts during the field visit; MD NRHM and the state officials responded to these in detail and assured early 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 JRM teams.

### BACKGROUND

There has been a substantial improvement in the demographic indicators in MP over the years, however in absolute values maternal and infant mortality rates still continue to be much higher as compared to national figures or even when compared to other states.

Annexure 2 outlines key RCH indicators for the state and the districts visited by the mission. A detailed analysis of the decline, current scenario and future projections for key demographic indicators i.e. IMR, MMR and TFR is also given in the annexure. Of interest is the observation that Orissa which had a much higher IMR in 2000 has a lower IMR than MP in 2009. The faster decline is attributed to a much higher rate of decline in neonatal mortality (NMR) in Orissa particularly from 2005 onwards. MP therefore needs to give focused universal attention to both neonatal and post neonatal) interventions.

Similarly the decline in MMR for MP has been quite good as reflected by the combined Sample Registration Survey (SRS) data for MMRs for MP and Chhattisgarh. The results of Annual Health Survey (AHS) 2010 which have given MMR for MP for the first time after division of the state show the MMR to be much higher at 310. This makes it imperative for the state to have a good look on the data as well as the need for new initiatives.

### **RCH expenditure**

The state reports progressive improvement in expenditure as regards allocation from 2005. Expenditure as a percent of allocation was 31.22% (05-06), 82.79% (06-07), 93.20% (07-08), 99.77% (08-09), 143.57% (09-10), 119.56% (10-11) and 125.30% (11-12). Annexure 5 provides the detailed financial report for the state.

## **KEY FINDINGS and ISSUES**

The team visited the districts of Jhabua (high focus district) and Mandasaur (non high focus district) during the review (Annexure 3).

### **Programme management and supervisory structures at various levels**

- The state has able leadership under the Principal Secretary (PS) and Mission Director (MD). The State Health Society (SHS) works in co-ordination with the Directorate of Health Services. The state is divided into 7 working divisions with each division being headed by Divisional Heads and supported by Divisional Programme Management Units. District Health Societies (DHS) are headed by District Magistrate (DM) and supported by the Chief Medical and Health Officer (CMHO).
- There is also good collaboration between the state and many Development Partners (DPs).
- State Institute of Health Management and Communication (SIHMC), Government of MP, Gwalior is conducting the Post Graduate Diploma in Public Health Management (PGDPHM) in association of Public Health Foundation of India (PHFI). First batch of in service doctors have completed the course and are awaiting posting in the capacity of DPMs. The team was informed that the trained doctors would be posted as DPMs.
- State Health System Resource Center (SHSRC) is non functional in the state. Two consultants appointed for SHSRC currently work in the SHS and the building is being used as the Information Education and Communication (IEC) bureau.
- While the District health Action Plans (DHAP) are being prepared, their use for implementation and monitoring of the programme has to be improved. While in Mandasaur the DHAP was available and was being followed, in Jhabua DHAP was not shared with the team.
- Mission Director has full delegation of administrative and financial powers. Financial powers have also been delegated up to the level of CMHO and Civil Surgeon (CS) for local procurement.
- Rogi Kalyan Samities (RKs) and Village Health and Sanitation Committees (VHSCs) have been constituted as per guidelines and are functional. However the involvement of VHSCs in preparation of village health plans is limited.

### **Human Resources**

- Large number of vacancies exists in the State Programme Management Unit (SPMU), Divisional PMU and DPMU and it is attributed to the need for following the "Roster system".
- Similarly posts of specialists, medical officers, staff nurses and paramedical staff in both the districts visited are vacant. In Jhabua the vacancy position for contract appointments exceeded 50% in most categories.

- At Mandsaur post of District Program Manager (DPM) and District Account Manager (DAM) is vacant since the last 3 years. In Jhabua the medical officer who has been given the charge of the DPM was not fully aware about his roles and responsibilities.
- The state has taken a decision to appoint doctors as DPMs after training them in Public Health Management from the SIHMC. This may not be desirable as filling up a contractual non medical post with a regular employee would accentuate the already existing acute shortage of medical officers.
- Rationale deployment of human resource is lacking. SHC Chapari and likewise SHC Dhekalwadi in Jhabua which were neither delivery points nor planned MCH centre had 2 ANMs in position. In Mandsaur LSAS trained doctor has been posted in DH which already has two anaesthetists while Civil Hospital Garoth which is a designated FRU has no anaesthetist.

#### ***Supportive Supervision (SS)***

- The state has initiated a system of allotting 4 districts to senior officials from the SHS for quarterly SS visits. However this process of making regular visits needs to be implemented effectively.
- Divisional and District level Consultants are also appointed for supportive supervision of FW & MCH services
- Though supervisory visits are being made in the districts at all levels record of observations were generally not available and feedback was found to be lacking. In such a situation the purpose of the SS visits is defeated.
- In Mandsaur, structured review meeting system in place and minutes of meetings available at some of the facilities visited

#### ***Training and ANMTC***

- No district plan for training was shared with the team in Jhabua; data base of trained personnel in the district was not readily available and needs to be updated.
- Good infrastructure with well-equipped clinical laboratory in ANMTC Jhabua. Latest Syllabus of Indian Nursing Council (INC) which includes IMNCI and SBA is being used. However the school is short of tutors and needs at least one more to conform to the recommendations of INC.
- The Principal and the tutors need to undergo in-service training programmes in various RCH interventions to bring them up to date with programme needs.

#### ***Information Education and Communication (IEC)***

- IEC was concentrated only at facilities, community level IEC activities is desirable
- Lack of Interpersonal Communication (IPC) materials and understanding at grass root level workers

#### ***Procurement***

- For drug procurement the state has a tie up with Tamil Nadu Medical Services Corporation (TNMSC). 80% procurement is through TNMSC and the rest 20% procurement can be done through local purchase. State drug MIS is functional and is used to monitor procurement though TNMSC, no MIS in place for local procurement
- Essential drugs with few exceptions such as cotrimoxazole and Zinc were available at all the facilities visited; stores in most of the facilities were in good working condition.
- State has not received RCH drug kits A & B since 2009. However the state has made some procurement of the kit items from their own budget though this wasn't enough for meeting the requirements.
- Frusemide tablets were found at one HSC. This drug is of specialized nature and as per regulations cannot be prescribed by ANMs. In one PHC 5400 small IFA, 1000 dicyclomine and

500 cold relief tablets were found with expiry in September 2011. Drugs with very short expiry are being pushed from the district stores to the field facilities. The district RCH officer should perhaps exercise more control on the logistics of drugs.

#### ***Specific issues in Programme Management***

- ✓ Performance appraisal mechanism under NRHM is weak, job responsibilities are not clearly defined and renewal of contract is not regular.
- ✓ Lack of coordination between regular and contractual staff was noted. A possible reason might be salary and other perks which the regular staff enjoys vis a vis the contractual staff.
- ✓ Medical officers and BMOs are required to perform multiple tasks for which they lack technical competencies and skills.

### **Quality of Services**

#### **Quality Assurance Systems**

- A number of initiatives for improving quality have been undertaken by the state. Directives for initiatives have been issued to the districts and the districts are in the process of implementing these initiatives:
  - State Quality Assurance Committee (QAC), divisional and district level Quality Assurance (QA) Committees have been reconstituted on 1.04.2011 in keeping with the revised Terms of References (ToRs) where in addition to FP the overall MCH component has been incorporated in the purview.
  - QA system in place in all 50 districts. State, divisional and district level quality assurance cells are established
  - Quality checklist have been formulated and detailed directives on quality have been issued by the state for mentoring visits to MCH centers, Services of Labour room, SNCUs, NRCs and VHND.
  - National Accreditation Board for Hospitals & Healthcare Providers (NABH) accreditation and International Organization for Standardization (ISO) Certification process of District Hospitals initiated
- Marked improvement in quality of services provided at labour rooms at health facilities; essential drugs, equipment and material to ensure quality of obstetric services including infection prevention are in place in the facilities visited. Initiatives towards maintaining privacy, clean toilets for women are encouraging.
- All health facilities visited in the two districts have their own buildings and were well maintained.
- Signage's were generally in place at all the facilities visited
- Citizen charter and Janani Shishu Suraksha Karyakram (JSSK) guidelines were displayed only in some facilities
- The reconstituted district quality committee is still to take effect in Jhabua as per new guidelines, quality checklists are not being used at the district level

### Specific issues in Quality

- ✓ A general lack of awareness towards quality issues was observed among staff across the board from district to PHC level. Primary reasons for this was: lack of Technical/operational Guidelines: While the district officers along with the Medical Officers in charge of facilities are required to operationalise the facilities – Technical/operational guidelines particularly for IMEP are not available in the district.
- ✓ Standard/treatment protocols were in evidence at all health facilities. However, the protocols are displayed on walls at height where these are not readable.
- ✓ Though DH Jhabua was ISO certified in 2009, several quality issues were observed. While the ISO certification mainly focused on signage, cleanliness, infection prevention and Biomedical waste management, there were gaps in staff norms, ICU facility, hand washing area in labour room, training and skills
- ✓ Health care waste management and infection prevention practices though partially in place, the knowledge of “what and how’ are extremely poor at all facilities with no/poor segregation of waste, poor storage and disposal of sharps and placenta etc
- ✓ Training is an important issue in quality management. No training plan for the supervisory staff responsible for providing supportive supervision or any other initiative in this direction was however shared with the team by the district officers.



**Protocols displayed at heights making them non readable**

### Intersectoral convergence

- At the state level different departments are being involved in implementation of various initiatives: RTI / STI services and HIV testing facilities for pregnant women with Madhya Pradesh State AIDS Control Society (MPSACS), referral of Severe Acute Malnourished (SAM/) children to Nutrition Rehabilitation Centers (NRCs) with Department of Women and Child Development (DoWCD) and implementation of the School Health Programme (SHP) with Department of Medical Education.
- Effective coordination was observed amongst the ANM, AWW and the ASHA during Village Health and Nutrition Days (VHNDs). Community mobilization by the ASHA was observed to be good and ASHAs were found to be very effective with good communication skills. Involvement of Panchayati Raj Institution (PRI) members at VHNDs was encouraging
- Computerized Tomography (CT) scan facility installed in the DH Mandsaur in partnership with private company with the support of Rogi Kalyan Samiti (RKS)

### Operationalisation of health facilities

- The state has undertaken steps to improve functional status of CEmOC and BEmOC facilities. This was evident during the field visits to the districts. In Jhabua it was heartening to note that 3 FRUs/CEmOC facilities including one at the DH are fully operational in the district. In contrast at Mandsaur only the DH was functioning as an FRU resulting in patient overload.

- 16 other facilities at Jhabua (5 CHCS and 11 sector PHCs) are providing 24x7 delivery and newborn care services in the district. Of the sixteen facilities, 5 CHCs and 5 sector PHCs have been designated as providing for BEmOC level facilities.
- None of the facilities visited in Mandsaur other than the DH had easy access for disabled and infirm at the entrance.
- CHC Petlawad a designated FRU in Jhabua has 30 beds with more than 400 deliveries conducted per month, a nutrition rehabilitation centre and large number of OPD cases besides other services requiring attention. The CHC however has only 4 doctors (3 specialists and one medical officer) besides an Ayurvedic doctor and only 4 staff nurses. They are doing an excellent job, however the need for providing more staff is obvious).
- Mandsaur district has two Civil Hospitals Garoth and Bhanpura. Though Garoth is designated as a FRU by the state it was non functional due to lack of a Blood Storage Unit (BSU), appropriate New Born Stabilisation Unit (NBSU) services and an anesthetist.
- 2 of the 3 PHCs visited (PHC Pipliyamandi and PHC Nahargarh) in Mandsaur were functioning as 24x7 facilities; whereas Bardiya Amra PHC in Garoth Block was not operational as a 24x7 PHC. Bardiya Amra PHC has been constructed on the highway away from the village and the PHC is situated a few hundred meters away from the old HSC which is now used as a residence by the ANM. The PHC did not have a medical officer posted and though designated as a PHC was functioning only as a HSC; normal deliveries were being conducted. Though the ANM was not SBA trained she had conducted 80 deliveries in the last one year out of the 215 deliveries conducted in the given area.
- Essential laboratory services were available at most of the facilities visited, but serum bilirubin which is essential for a unit providing phototherapy services was found to be lacking in Jhabua
- A well equipped and functional 20 bedded Sick New Born Care (SNBC) unit is operational at the DHs in both the districts with United Nations Children Fund (UNICEF) providing technical assistance.
- Blood bank in DH Mandsaur was observed to be functioning well and was equipped with standard equipments whereas blood bank at Garoth Civil Hospital was non functional.

- ✓ Major renovation is going on at DH and Civil Hospital in Mandsaur. Operation Theatre (OT) is being constructed in the DH while extensive renovation is underway at Civil Hospital Garoth. However the renovation at Garoth is not as desired since the existing structure is more than 100 years old and the same is being renovated instead of establishing a new hospital building. Instead of an integrated building, 8-10 small blocks are being constructed at different levels separated from each other all around the hospital premises which would lead to operational difficulties given the shortage of staff nurses and ANMs.
- ✓ No functional New Born Stabilization Unit (NBSU) was observed in any of the BEmOC facilities visited in Mandsaur or Jhabua.



### *Empty male ward at a facility SNCU at District Hospital Mandsaur*

#### **Referral transport system and 24 x 7 call center**

- The state has instituted an effective system of referral transport for pregnant women and newborns through the Janani Express (JE) Yojana. Under JSSK the facility for drop back has also been started. The referral transport is backed up by well functioning 24x7 call centers
- However the JE vehicles are not suitable for transporting obstetrical emergencies like bleeding and convulsing patients.
- In both the districts visited it was observed that regular ambulances though available at many facilities were not being used for transporting women, newborns and other patients even in serious situations requiring immediate referrals to higher facilities.



*Janani Express vehicle not suited for emergency referral*

#### **Maternal Health**

- There has been an increase in Ante Natal Care (ANC) coverage and Institutional Delivery rates over the last few years as is evident through survey data. The quality of services has also improved though gaps still remain.
- The state has initiated JSSK from 01/07/2011, however all entitlements like free services during ANC are not being implemented at all facilities.
- Partogarth was being maintained at all the delivery points visited. In all delivery cases, active management of third stage of labour was being done.
- Very few doctors have been trained in 10 day regular BEmOC training. Most of those trained in 2/3 day course were found lacking in skills for managing/ referring obstetrical complications in Jhabua.
- Janani Sahyogi Yojna is operational across 33 hospitals in 17 accredited districts through Public Private Partnership (PPP) mode
- The rate of caesarian sections in CEmOC facilities varies from 0.27% in District Hospital to 2.72% in the busiest facility at Petlawad. This is too low and needs to be looked into.
- Most of the staff nurses at BEmOC facilities visited in the two districts had undergone training as Skilled Birth Attendants (SBAs) at the district hospital and were aware of the SBA drugs. However, they were not very clear of the indications for use of the drugs particularly injection Oxytocin
- Use of new labour room registers with additional columns for date and amount of JSY incentive paid were in use in most of the facilities visited in Mandsaur, same was found to be lacking in Jhabua
- Essential newborn care facilities were found in all labour rooms and were generally well equipped and stocked. Nursing staff is aware of the need for newborn care, however Skills of

staffs are not adequate-and many staff attending to newborns has still to receive NSSK training. Many ANMs have been inappropriately trained in package meant for doctors/Nurses for managing sick newborns in SNCU

- ASHA were unable to stay with the mothers for 48 hours post delivery at DH due to lack of proper accommodation
- **Maternal Death Review (MDR)**
  - Though MDR has been initiated there is underreporting of deaths. While most reported deaths had been investigated, no detailed review is taking place. There is a lack of understanding of the concept of MDR and casual approach of the officials was observed.
  - Though Mandsaur had a District MDR Committee, meetings were not happening regularly hence none of the reported maternal deaths had been reviewed by the committee so far. In Jhabua the committee needs to be constituted.

### **Safe Abortion Services (SAS)**

- This is the weakest link in the spectrum of maternal health services and only four health facilities (DH. Civil Hospital Garoth, CHC Suwasara & PHC Nahargarh) at Mandsaur and CHC Petlawad in Jhabua are providing SAS. While a large number of MOs are reported to have been trained for conducting MTPs, very few facilities were actually providing the service.
- Very little involvement of private sector was seen in the districts. District Level Committees for SAS under the MTP Act have not been constituted in both the districts visited.
- There is a lack of perception on the need for instituting the service for reducing maternal deaths.
- Very poor IEC for SAS (availability of SAS in the health facilities, MTP Act etc) both in health facilities and community

### **Janani Suraksha Yojna (JSY)**

- JSY was observed to be well functioning in both the districts visited. Timely disbursements of incentives were being practiced and it was linked to 48 hour stay in the facility.
- There was no shortage of JSY fund in the delivery units. Incentive was being issued through cheques at the time of discharge
- Though 14 private hospitals are conducting deliveries in Mandsaur none of them had been accredited for JSY scheme
- In Jhabua the team came across a case where it was reported by beneficiary that PHC consistently delayed JSY payment, which appeared to have been caused by medical staff requesting “co-payment” by beneficiary before releasing the JSY cheque. (specific issues)
- Janani Express (JE) is serving about 50% of the beneficiaries for pick up. Effectiveness of JE is an issue during midnight and early morning hours.
- Though list of JSY beneficiaries is displayed in health facilities in Jhabua it was beyond public domain (displayed either at the remote corner of the hospital or inside the room of the accountant). In Mandsaur the list of beneficiaries were not displayed publically except at CHC Sitamau.
- Grievance Redressal mechanism as stipulated under JSY does not exist in the both the districts.

### **Child Health**

- **New Born Care**
  - Excellent progress has been made in operationalizing and maintaining SNCU at the DHs though there is a need to further strengthen NBSUs at CHC level

- In both districts visited by the teams, though equipment for newborn care was available knowledge and skills to use them were lacking and awareness about essential newborn care is low among most health professionals
- State has started implementing home visit programme by ASHA. However quality of counseling and skills need to be upgraded through appropriate training. Home visit coverage in terms of expected births is still very low.
- **Child Health**
  - Low Osmolarity Oral Rehydration Solution ORS was available at majority of facilities visited; dispersible zinc tablets so far have not reached in the facilities. Syrup Zinc is being procured through local procurement. Districts may be advised to procure only dispersible Zinc tablets as per national guidelines.
  - Skills for managing diarrhoea and Pneumonia were uniformly poor in all categories of personnel. Cotrimoxazole was not available in Jhabua though in Mandsaur it was generally available.
- **Nutrition**
  - The State has improved in terms of early initiation and exclusive breastfeeding rates. The State has developed breastfeeding promotional pamphlets which were seen in facilities visited. The state has developed innovation for improving early initiation of breastfeeding through Yashoda model in select districts. The same needs to be strengthened further.
  - The state has a well developed system of NRCs. 251 NRCs are operational in the state (till Aug. 2011) and the state aims to have 293 functional NRCs by 2012. Currently all children with MUAC less than 115 mm are being admitted though only those with failure of appetite test or with complications need to be admitted.
  - Management of SAM in facilities also needs to be supplemented with community management of SAM, so that children with SAM who pass the appetite test can be effectively managed at home. It was encouraging to note that Govt of MP has plans to pilot community management of SAM in a few districts
  - Coverage of Vitamin A supplementation and deworming during the last biannual round in June 2011 was 76% and 65% respectively
  - Although paediatric IFA was available at most places the staff was ignorant of its routine supplementation.
- **Integrated Management of Neonatal & Childhood Illnesses (IMNCI)**
  - IMNCI is being implemented in more than 30 districts, but saturation has been completed in only 7-8 districts. MP was one of the few States to start Pre Service IMNCI. The same needs to be expanded.
  - There is a need to ensure their optimal utilization and have role clarity between IMNCI trained Anganwadi worker and ASHA. There is also need to improve home visits in the district



*Medicine tray at NRC Adult size ambu bag used for newborns*

- **Routine Immunization**

- Routine Immunization (RI) in MP is provided as a part of the integrated package of VHND services.
- State has successfully conducted Measles Supplementary Immunization Activity (SIA) in 5 districts and undertaking same in 18 districts this year. Effective Vaccine Management (EVM) exercise for Cold Chain Management conducted and training of cold chain handlers completed in 10 districts
- Adequate availability of cold chain equipment's at the district, block and sub block level cold chain points; equipment's were properly installed as per guidelines with power back up available at the facilities visited
- Routine immunization micro plan with estimation of beneficiaries and logistics was not available at most of the facilities.
- Vaccine and logistics management and storing practices were poor, no proper indenting mechanism observed at facilities visited
- No proper recording and reporting of vaccines and logistics; no standardized formats for maintaining vaccine distribution and stock registers available
- OPV zero dose coverage poor in spite of increased institutional deliveries
- Time of opening the vial mentioned on BCG and Measles vials at session sites, date of opening observed on Vitamin A bottles.
- District vaccination coverage data, disaggregated by block, aren't very useful as it often goes way above 100 percent, apparently because denominators are provided by the State. A bottom-up approach, based on the household data generated by ASHAs and ANMs would evidently be more useful.



***Cold chain equipments placed as per guidelines Mixing of vaccine vials: incorrect storage***

### **Family Planning**

- While the achievements in sterilizations show an increasing trend since 2003, there is constant decline in the use of spacing methods in the state. Female sterilizations constitute 98% of the reported 6.43 lakh sterilizations done during 2010-11.
- Post partum family planning needs strengthening
- Family Planning counselors in place at District Hospital Mandsaur but in Jhabua none of the beneficiaries with whom the team interacted had been counseled for family planning. The 48 hrs stay after delivery should be utilized for counseling for FP by staff nurses in the hospital.
- In Jhabua Minilap Sterilization and NSV are conducted in DH & CHCs in camp mode. Fixed day services are not being provided for sterilizations. Minilap sterilizations are not done in the PHCs visited as none of the doctors are trained.

- There is lack of supportive supervision despite trained trainers available at Jhabua for IUCD insertion. In the facilities visited, ANMS trained in IUCD insertion and providing services were not able to demonstrate the correct loading technique of the device. Majority of the ANMs interacted were unaware of the 10 years duration of IUCD 380-A. It was observed especially at PHC Sarangi that the ANM who inserts IUCD as a routine demonstrated the loading of the device exactly in the opposite direction, thus, defeating the very purpose of IUCD insertion.
- In the state 687 sterilization failure cases have been registered so far over 50 districts. Of these for 492 cases compensation have been paid, 74 cases have been rejected while 121 cases are reported pending.

### **Village Health & Nutrition Days**

- Directives from state health society has been issued that no meetings / trainings to be scheduled on session days (Tuesday /Friday )
- Quality assessment mechanism for Village Health Nutrition Days has been attempted through standardized checklists. Inspection rosters with advance tour programmes has been created
- ANC, Eligible Couple Registers are in place for quality service delivery.
- Development Partners entrusted responsibility to train paramedics & MO, BMO for supervision.
- In both the districts VHNDs visited were being held as per microplan and were conducted in areas easily accessible to vulnerable sections of the community
- Though the state advocates for VHND Signage Boards for Anganwadi Centers (AWCs) the same were not found in any of the two districts

### **Adolescent & School Health**

- Specific components of the programme remain untouched
- Adolescent Friendly Health Services (AFHS) Clinic set up in District Hospital Jhabua, although state compilation does not reveal a single attendee. In Mandsaur ARSH component still remains to be initiated though the District is a 'B' category district under NACP III.
- School health programme is yet to have a comprehensive approach with convergence of departments of Health, Education, DWCD departments for a regular systemic approach rather than the adhoc approach currently adopted

### **Biomedical Waste Management**

- Waste segregation practices were in evidence in the facilities visited as separate receptacles were available. Segregation and further disposal are however not being carried out as per IMEP guidelines of RCH-2 programme. No other guidelines from state were available in the facilities
- Waste segregation at immunization session site level and waste management at facility level were found to be inappropriate. Though Auto Disable (AD) syringes and hub cutters were available at session sites recapping of needles were being practiced. The state needs to strengthen immunization waste management through dedicated training
- Bleaching Solution was available in Labor Rooms at the time of Visits. The staff however was not fully aware of its use. This solution should be available in the OT, Laboratory and Injection room/site also.

- Waste disposal at Mandsaur was outsourced but health workers unaware of final disposal processes undertaken by the agency



### ***Blocked Sharp Disposal Pit Incorrect waste disposal at a PHC***

## **Health Management Information System (HMIS) and Data Management**

- Availability of simplified formats and registers for data collection provided (translated in Hindi) up to the facility level. Additionally data dictionary containing definitions and meanings of all the terminologies/ key words which are used in the formats also made available.
- District & Block level health functionaries trained to report on HMIS formats. Block level officials (BPMs & DEOs) trained to operate online software & block-wise online data entry started.
- 90 % districts are uploading data on time (10th -15th of every month) in the HMIS
- Two districts - Sehore & Hoshangabad have been taken up on pilot basis for facility wise data entry
- **Maternal Child Tracking System**
  - Maternal Child Tracking System trainings of Divisional level Officials, District Level Officials, block & below block level health functionaries completed.
- HMIS data is used for monitoring of programme performance at state & district level. CNAA formats now replaced with facility-wise HMIS formats and HMIS is the only source of data compiled at State, District and Block level
- Eligible couple registers are being prepared in each SC but the rationale use of the data is a concern.
- State M&E unit analyzes the reported data and provides feedback to districts and to the program officers. Monitoring visits to validate data are also undertaken.
- The Health bulletin is published monthly and it includes district wise data analysis of the HMIs data on important indicators which is appreciable. The state has initiated a ranking system for all the districts based on the HMIS data. A set of 15 indicators (VHSC setup as GSSGTS in Qtr, ASHA Incentives, IUD (2), Family Welfare, Immunization (Measles, DPT, BCG), NRC, SNCU Level-2, Newborn Corner, deliveries, JEY, BEmOCs, CEmOCs and LSC) is reviewed by the Chief Minister with additional indicators reviewed by the Principal Secretary and the Mission Director.
- There is a shortage of data entry operators across the state which has resulted in multi-tasking by the PMU staff.
- Physical achievement against the financial expenditure is reported quarterly and analyzed in the state

### Key issues in HMIS and Data Management

- ✓ With no facility based data feeding below the block PHC level the exact data errors and feedback mechanism to personnel who are collecting and aggregating the data is not in place. The data gets rectified without an expected feedback to the front line workers who are collecting the data.
- ✓ Committed data levels were not reported at the block and district levels. CMHOs do not validate the district reports.
- ✓ The utilization of available data for monitoring and planning was not very evident and needs more orientation of Block and District officers in this area.
- ✓ The Regional office of Central Bureau of Health Intelligence information, MP has initiated training facility of ICT enabled HMIS for Maharashtra, MP, Chhattisgarh, Goa, Daman & Diu Dadra and Nagar Haveli. The facility is not being used by the state very effectively

### Gender

- The state is making conscious efforts to address gender issues at service delivery level, especially in relation to having separate toilets in maternity wards, in labour rooms and also ensuring privacy in labour rooms
- Confidentiality and privacy is maintained at district hospital for female clients accessing RTI/STI services
- Although there are no special training programs designed and organized to address gender issues, gender focus is given due weightage in Skilled Birth Attendant (SBA trainings) and in contraceptive update workshops
- For addressing harassment at work place, the state has circulated Vishakha guidelines; however, no conscious efforts have been made for dissemination of these guidelines right up to grass root level. The district committees to review cases of harassments are not functioning. In Jhabua Vishakha guidelines are shared with the district officials. There was an example, where ANMs were harassed by villagers, at night, and the local RKS/Panchayat intervened by posting a guard at the PHC. Vishakha guidelines issued upto District level in Mandsaur, district level Redressal committee not formulated, committee as per Vishakha guideline is still to be operationalised.
- For addressing gender based violence (GBV), no efforts have been made to orient staff members in the casualty to identify GBV cases, screening and counseling and further to have linkages to provide them support (through counseling centers functioning in police stations)
- As per district Annual health survey (2010) data infant mortality and 0-4 mortality among girls is more. Efforts to address gender disparity, improving health and treatment seeking behavior of parents towards girls are not being addressed through communication efforts

### PCPNDT

- Declining child sex ratio is a cause of concern in the state. Child Sex Ratio (CSR) in the state has come down from 932 in 2001 to 912 in 2011 with an overall fall of 29 points from 1991-2011; sex ratio at birth varies across districts. In response State Supervisory Board (SSB) has been constituted under the chairmanship Hon'ble Health Minister. A State Advisory Committee has also been constituted.
- A State Multi member Appropriate Authority has been appointed. District Collector appointed as appropriate authority by the State Government from 04/04/2007. Block Medical Officers appointed as Sub District Appropriate Authority.

- District and Sub District Advisory Committee have been constituted and Nodal Officers nominated for PCPNDT Act implementation in each district .DAA, Advisory Committee members and CMHO addressed by State Authorities through focused Video Conferences & review meetings.
- Support of Law Department is being sought for effective implementation of PC&PNDT Act in the State. Orientation of Judiciary (25 lawyers) done at National Law University with support from UNFPA. Second batch of 30 is under training.
- A dedicated PNDT cell has been established at Directorate. 1559 institutions in the State have been registered. Regular and surprise inspections of the registered clinics are being conducted in the districts. Record checking specially Form F
- Community initiatives:
  - Hon’ble CM is launching “**Beti Bachao Abhiyan**” in the state from 05/10/11 in the state to create awareness among the people and generate a respectful feeling towards girls, reducing gender ratio and controlling female feticide. Committee of “Group of Ministers” has been constituted.
  - Online PC & PNDT Act [www.hamaribitiya.nic.in](http://www.hamaribitiya.nic.in)– registration, monitoring and management of complaints is under testing, to be launched soon
  - **Bitiya clubs** (parents with only one or two daughters who have adopted terminal methods) have been formed in all districts. The members of the club will be honored, to spread the message of importance of girl child in the public, to prevent the elimination of girl child
  - Instructions for organizing group sensitization involving PRIs, ASHA, Anganwadi Workers, NGOs, Social Workers Lawyers, Media & Medical Personnel etc in districts where the child sex ratio as in 2011 census is above 1000, have been issued. Lessons learnt regarding gender non-discrimination, respecting and treating girl child equally- “the mindset of society” from these districts will be disseminated in other districts
  - Focused IEC activities have been initiated as sas bahu sammelan, Nukad natak, katputli shows etc to sensitize the community.
- In both the districts visited Advisory committee constituted but meetings are not organized regularly. Formal minutes of meetings, action taken report on minutes of meetings not available. Inspection team not constituted and regular monitoring of USG clinics is not done. CMHO has been made nodal officer by district collector but no formal authority letter issued
- The DH in Mandsaur has a registered USG clinic under public private partnership fully compliant with PCPNDT guidelines. One private USG clinic is present in Jhabua district and is accredited.

### Focus Group Discussions (FGDs)

- Over all ANMs have realized importance and contribution of ASHAs and AWWs have good coordination with them and are satisfied with their help.
- Major concerns brought out during group discussion were too many programs, too many records and reports to be maintained, large geographical area required to be covered by each sub center (7-8 thousands), continued pressure of higher authority last year for achieving sterilization targets at the cost of compromising other programs, lack of supportive supervision for hands on skills building, delayed release of sub center untied funds, irregular supply of sub center kits and other essential medicines and material (short supply of condoms, oral pills and IFA tablets), over burden of the staff posted in CHCs/PHCs because of too much delivery load and need to perform services under other national health programs.
- Over all perceptions of clients about doctors and nurses about their attitude was positive

- Almost all clients were aware about antenatal, intra natal and post natal services, emergency transport, entitlements under JSY and where to go for institutional deliveries.
- Medical officers and BMOs felt need for strengthening their technical and managerial skills.
- Salary and other perks and facilities are areas of major discontent and lack of coordination between regular and contractual staff adversely affects the functioning.



**FGD with community members FGD with ASHAs**

#### FMG report (Detailed report in Annexure 4)

- District-wise annual plans were prepared for FY 2011-12 and shared with the districts in the beginning of April 2011.
- Availability of funds at facility levels has improved, particularly for JSY and FP. JSY and ASHA payments were generally made on time. Electronic transfer is used for salary payment for staff at all levels and for payments to ASHA.
- Computerised accounting system (Tally) is functional in both districts. Improvement was observed in maintenance of records e.g., separate Registers for JSY/FP payments. The system of financial reporting has been strengthened at district/PHC level. The state office has started more comprehensive reporting from district level, including details of advances and aging of advances. Sample check showed regular monthly reporting from block to district level.
- RKS has become functional. Funds have been released to VHSCs.
- **Flow of Funds:** Frequent Diversion of funds from one pool to another pool at district level was observed. Irregular disbursement of funds e.g., for annual maintenance grant , untied funds, Rogi Kalyan Samiti Grant and VHSC funds, as funds were either partially disbursed or not disbursed. AMG was provided to Health Sub-Centers for non-government building in district Mandsaur. Bank accounts of all VHSCs were not opened (e.g., in CHC- Sitamau & Meghnagar in Mandsaur district).
- **Advances:** High unspent balances and large outstanding advances, particularly for RKS, Untied Funds, PWD, training etc. Delay In submission of UCs and weak monitoring of UCs at all levels. Low utilization of Immunization funds was observed.
- **Audit:** Non-Compliance of findings of Statutory Auditor. Concurrent Audit is not effective and system of compliance has not been put in place.
- **Staffing and Training:** Large number of vacancies have been persisting since many years. Low level of salary and lack of increments till this financial year has affected motivation of contractual staff. Shortage of staffing has affected FM performance and FM monitoring. Staff, particularly district and sub-district level need to be trained in financial management.

## Recommendations

1. There has been a substantial improvement in the RCH indicators including decline in IMR and MMR over the last few years. In MP, however, this has fallen short of the declines achieved by other EAG States like Orissa (in case of IMR). The state therefore needs to look at various options for accelerating the decline in mortality rates.
2. The State has put in place a good infrastructure in health facilities. Essential equipment and drugs were generally available in most designated facilities. The utilisation of health facilities has also gone up considerably not only for deliveries but also for other general ailments. However, leaving out a few facilities, there is a lack of ownership of the improved health facilities and of the programmes by the health staff at facility level. This stems from lack of knowledge and the absence of any systematic effort to orient them on the plans and programmes and their responsibilities.
3. While the State is doing an excellent job in putting up the infrastructure for both CEmOC and BEmOC facilities, the service delivery at most BEmOC facilities remains a cause of concern. For accelerating decline in MMR, it is essential that good quality and effective management and referral facilities for emergency obstetric and newborn cases are put in place. This is a gap needing urgent discussion and attention. Standard evidence based protocols for skilled attendance at birth and provision of essential and emergency obstetric care need to be ensured and monitored carefully. State needs to (i) strengthen training quality and follow up supervision as also (ii) look at the desirability of accelerating the implementation of 10 day training of MOs at BEmOC facilities (iii) strengthen referrals from lower to higher facilities for emergencies.
4. The state has taken a decision to post MOs as DPMs after completing a Public Health Management course at the SIHMC. The state has a huge vacancy position and use of MOs for DPM positions besides aggravating this situation is going to take away the trained public health resource from programme implementation and service delivery towards managing routine mundane general administration issues for which the DPMs were originally thought of.
5. At the district level no specific officer is designated to look after the RCH interventions. While different officers look after some aspects of the programme like immunisation, family planning and MH there was a visible gap into who is responsible for areas like gender, adolescent health etc. The responsible officers were also not clear/fully aware of the latest guidelines even in their areas of responsibility. A clear policy option is to have detailed guidelines and job responsibilities for each intervention in place and available with the district management.
6. The contractual DPMs and BPMs should be provided clear job descriptions, role clarity and reporting mechanisms should be made systematic. Induction training and follow up review meetings should help to sort out confusions in roles and responsibilities. This should be backed by an effective performance appraisal system and taking care of delays in renewal of contracts and issues of salary and other perks.
7. The State Government is seized of the rationalisation of posting right people at the right place for a job. Decisions to this effect have been taken at the highest level of state government and it is hoped that most CEmOC and BEmOC facilities will be fully functional in near future. The state however needs to have a well defined/clear HR policy in terms of the requirement (need), posting, training & deployment of staff particularly specialists and also on the need for multi tasking trainings of MOs and other staff.
8. The state has good pre-service training institutions for ANM training. It was observed that excellent work was being done in ANM training centres in both districts. However, the visit

did bring out the need for strengthening facilities such as Library, putting in place faculty and teaching aids and a good programme for hospital postings for robust skill development of trainees.

9. While the HMIS is substantially in place and improving, systematic analysis and understanding of data & feed back to facilities or its use for planning or effecting corrections was not visible. In addition Facility based data entry to be operationalised and committed data is to be entered at the district and state level. Also the data needs to be validated by the CMHO before forwarding it to the state
10. Monitoring and Supervision system though theoretically in place was not very visible during the district visits. A well defined and implementable system for monitoring and supervision is needed urgently.
11. The state need to be complemented for putting in place various Technical Protocols at most health facilities. The nursing staff and ANMs were doing the Partogarth also which is a significant achievement. Some observations which need to be taken note of in this regard are;
  - That the placement of the protocols on the walls needs to be made rational and more users friendly.
  - Protocols for other areas like waste disposal etc need to be put up
  - While nursing staff was aware, awareness among medical officers in most places need to be improved.
12. A general lack of awareness towards quality issues was observed among staff across the board from district to SHC level. Primary reasons for this were: lack of availability and knowledge Technical/operational Guidelines: While the district officers along with the Medical Officers in charge of facilities are required to operationalise the facilities – Technical/operational guidelines particularly for IMEP and some other issues are not available in the district.
13. Many services like disposal of bio-medical waste are being outsourced. Clear guidelines on monitoring these services need to be issued to district officials for strict enforcement of standards. Remote district like Jhabua may perhaps need state intervention in locating willing agencies. Besides this, the state urgently needs to provide training at all levels on infection prevention practices and waste management specially segregation practices.
14. Many maternal deaths remain unreported. It is recommended to evolve a system so that all maternal deaths are reported. MDR should be looked as an opportunity to identify gaps in management and to take urgent appropriate steps to avoid similar incidences in future. It is also suggested to include the demographic back ground characteristics and response delay analysis along with cause of death.
15. Good facilities for newborn care including resuscitation and providing warmth are now available at majority of facilities visited. However, the skills of the service providers in providing essential care at Birth need improvement. This can prove to be crucial input in accelerating decline of IMR in the state. Similar to the MDR a NMR and IMR review can be positioned.
16. State needs to ensure home visits rates for post natal care of mother and newborn as per HBNC guidelines. Capacity building of ASHAs for home visits through ASHA module 6&7 training to be initiated. Those ASHAs who have not received IMNCI training should be given preference for getting training in ASHA module 6&7.
17. Skills in managing diarrhoea and pneumonia cases needs significant strengthening at all levels. Continued low ORS use rates are a cause of alarm. State needs to urgently accelerate this by involving ASHA and accelerate procurement of zinc so as to accelerate ORS use rates. Regular supply of cotrimoxazole to be ensured for management of ARI.

18. Management of SAM at NRCs needs to be supplemented with community management of SAM, so that children with SAM who pass the appetite test can be effectively managed at home.
19. IMNCI: state needs to accelerate saturation of districts as training coverage in districts is low.
20. Vaccine and logistics management and recording and reporting practices in immunization to improve, state to improve OPV coverage rates.
21. In the districts visited the thrust visibly is on terminal methods of Family Planning. Spacing methods have not been given any attention by the state and where it is done retention/use rate beyond 6 months is very poor (refer DLHS-3 data). State needs to give focused attention to this area.
22. Post partum family planning needs strengthening. In view of encouraging response to institutional deliveries and stay of women for 48 hours after delivery, there is a good scope to institutionalize post partum counseling/sterilization/post placental IUD insertion.
23. Minilap services need to be promoted in PHCs through training of Medical officers.
24. VHNDs are mainly concentrating on immunization and folifer distribution. The state should take immediate steps to ensure that all essential investigations expected during antenatal period are carried out during VHNDs. For abdominal examination of pregnant women, minimum privacy (examination table, curtains, etc) should be provided.
25. Counseling for family planning, IYCF practices and home based newborn care should be done during VHND sessions as both provide a suitable platform for providing counseling services to ANC mothers.
26. The data collected by ASHAs for newly married couples can be used for increasing the age at first pregnancy and sequenced with post partum counseling would increase the spacing span.
27. In both districts, ARSH is a neglected area; there is an urgent need to establish and strengthen ARSH services and streamline the functioning of linkages with the School health programme.
28. State needs to ensure that screening of school students is comprehensive and covers all the children in the schools, with documented follow up of children with disease, disability and deficiency. Convergence with ARSH, AACP, NBCP and MH is anticipated as comprehensive package. Giving the large youth population State may need to reorient programme implementation, design and monitoring..
29. The state needs to review all ongoing training programs and material under RCH and integrate gender as an important component in to all ongoing training programs, rather than organizing separate gender training programs.
30. Vishakha guidelines for addressing harassment at work place should be circulated to all staff. District committees as per the guidelines should be constituted and made functional as a redressal mechanism. In addition medical officers and paramedical staff should be trained on priority at district hospitals on identification and proper management of Gender Based Violence (GBV) cases. Training/Sensitization workshops for all staff focussing on improving their communication skills with female clients can be initiated.
31. Provision of separate clean toilets for female clients, ensuring confidentiality and privacy to female clients (e.g. curtains) and clean labour rooms should be undertaken. Provision of separate duty room and separate toilets for female nursing staff of district hospitals is needed.
32. Provision of some dormitory staying arrangements for ASHAs or relatives accompanying the clients for institutional delivery is needed to ensure their stay for 48 hours along with the beneficiary
33. District and sub district advisory committees on PCPNDT need to meet regularly as per guidelines. Sensitization workshops for PRIs, ASHA, Anganwadi Workers, NGOs, Social Workers Lawyers, Media & Medical Personnel etc in districts to be held regularly.

34. The state needs to ensure that regular and surprise inspections of registered clinics are strengthened across all the districts and strict checking of form F to be done.

## Recommendations: FMG

- It is recommended that block-wise plans should be prepared and shared with the blocks, which will facilitate implementation of activities at sub-district level.
- Frequent Diversion of funds from one pool to another pool is to be avoided. The mission recommends that the state office should receive regular updates from district for bank accounts operating at all levels and ensure that three bank accounts are opened in all blocks with immediate effect.
- Advance Registers and Journal vouchers need to be maintained at district and block level.
- The system of Advance Monitoring needs to be considerably strengthened at all levels. The state should prescribe a time-bound plan for reduction of advances at all levels and monitor it closely, particularly for settlement of old advances.
- The system of reconciling flow of funds between all levels needs to be further strengthened, with monthly reconciliation between all levels.
- Bank Reconciliation Statement (BRS) is to be prepared regularly at district and sub district levels. The state office may consider receiving signed copies of monthly BRS from districts and district offices to receive the same from blocks.
- Internal Control of Bank Accounts: The mission recommends that monthly Financial report from district to include the following information for each level (block/PHC/Sub-Health Center/VHSCs): (a) number and name of bank accounts; (b) designation of signatories; (c) types of funds released by districts to blocks. State to monitor the information and follow-up with districts.
- The state may consider strictly enforcing more frequent reporting of expenditure e.g., quarterly reporting from RKS, for training activities at state/district level.
- A system of regular monitoring of financial management at all levels should be established.
- The mission recommends that SHS should closely monitor quality and timeliness of statutory and concurrent audit and implement system of regular compliance.
- It is recommended that RKS activities need to be monitored regularly at various levels and a system of regular financial reporting (e.g., monthly/quarterly) should be put in place.

**TEAM MEMBERS**

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## KEY RCH INDICATORS (MADHYA PRADESH)

The following is an analysis of the decline, current scenario and future projections for key demographic indicators:

<b>Infant Mortality Rate</b>	<b>India</b>	<b>MP</b>	<b>Orissa</b>
IMR 2000	68	87	95
IMR 2005	58	76	75
IMR 2009	50	67	65
Av Ann Decline (4 Yrs)	2.00	2.25	2.50
% Av Ann Decline	3.70	2.96	3.33
Year by which goal of 30/1000 will be achieved	2019	2026	2024

<b>Neonatal Mortality Rate</b>	<b>India</b>	<b>MP</b>	<b>Orissa</b>
NMR 2005	37	51	50
NMR 2009	34	47	44
Av Ann Decline (4 Yrs)	0.75	1.00	1.50
% Av Ann Decline	2.00	1.96	3.00

Orissa which had a much higher IMR in 2000 has lower than MP in 2009. The faster decline is attributed to a much higher rate of decline in neonatal mortality (NNMR) in Orissa particularly from 2005 onwards. MP therefore needs to give focused universal attention to both Neonatal and post Neonatal (Diarrhoea & ARI) interventions.

<b>Maternal Mortality Rate</b>	<b>2001-03 (SRS data)</b>	<b>2004-06 (SRS data)</b>	<b>2007-09 (SRS data)</b>	<b>Av Ann Decline</b>	<b>Years to reach target of 100/lakh</b>
India	301	254	212	12.7	09 (2017)
MP	379	335	269	15.7	11 (2019)
MP	379	335	310 (AHS 2010)	9.9	21 (2031)

\*SRS data up to 2007-09 is for MP and Chhattisgarh combined.

While the decline in MMR for MP has been quite good the previous SRS data for MMR was for MP and Chhattisgarh combined. The results of AHS 2010 which have given MMR for MP for the first time after division of the state show the MMR to be much higher at 310. This makes it imperative for the state to have a good look on the data as well as the need for new initiatives.

**Total Fertility Rate**

	<b>Year</b>							<b>Change in points</b>						
	2003	2004	2005	2006	2007	2008	2009	03-04	04-05	05-06	06-07	07-08	08-09	
India	3.0	2.9	2.9	2.8	2.7	2.6	2.6	-0.1	0.0	-0.1	-0.1	-0.1	0.0	
MP	3.8	3.7	3.6	3.5	3.4	3.3	3.3	-0.1	-0.1	-0.1	-0.1	-0.1	0.0	

Though there has been a steady decrease in the TFR of MP it remains much higher than that of India. The rate of decline for both India and MP has been the same, resulting in the difference in TFR to persist.

- TFR (SRS, 2009) for the State is 3.3. While the achievements in sterilizations show an increasing trend since 2003, there is constant decline in the use of spacing methods in the state. The TFR has shown decline by only 0.4 points over the period of 5 years (2003-2008). Female sterilizations constitute 98% of the reported 6.43 lakh sterilizations done during 2010-11. As birth order of 3 and above is 32.8% in the State and as high as 48.5% in Mandsaur and 54.8% in Jhabua districts (DLHS-3), the emphasis on sterilization methods is not yielding any results.
- However, while the sterilizations have shown an increasing trend over the years, achievement in IUCD insertions have decreased. In view of the increase in unmet need for spacing methods from 7.5 (DLHS-2) to 8.6 (DLHS- 3) and high percentage of births to women during 15-19 years in the state (as well as in the districts visited), there is urgent need to scale up spacing methods through IEC and training not only to prevent adolescent pregnancies but also to reduce complications, improve retention rates and thus increase the contraceptive usage

Select indicators for the state and the districts visited (DLHS and CES)

Indicator	Madhya Pradesh			Jhabua		Mandsaur	
	DLHS-2	DLHS-3	CES	DLHS-2	DLHS-3	DLHS-2	DLHS-3
<b>% eligible couples using any modern contraceptive method</b>			Not Part of CES				
Overall	46.9	53.1		36.2	42.0	53.1	56
Sch. Casts	39.6	47.7		NA	NA	NA	NA
Sch Tribes	28.4	37.6		NA	NA	NA	NA
Wealth Quintiles*							
Lowest	27.5	23.6		NA	NA	51.7	65.5
Highest	83.6	84.9		NA	NA	17.3	13.7
(for DLHS-2 it is standard of living)							
Permanent method (% of Overall)	81.6	86.4		76.5	94.8	76.8	86.6
Male sterilization(% of Permanent)	1.31	1.77		4.7	0.8	4.9	3.5
Spacing methods (% of Overall)	17.7	13.2		22.7	5.0	23.0	13.0
Pill ( % of spacing)	28.9	27.1		12.2	52.4	14.8	11.0
IUD ( % of spacing)	12.0	7.14		18.3	14.3	9.0	2.7
Condoms ( % of spacing)	59.0	65.7		69.5	38.1	76.2	86.3
Couples using spacing methods for more than 6 months	NA	5.0		NA	NA	NA	NA
<b>% of deliveries conducted by skilled providers</b>							
Overall	35.8	50.1	82.9	29.5	42.5	42.3	58.6
Sch. Casts	39.6	47.7		NA	NA	NA	NA
Sch Tribes	28.4	37.6		NA	NA	NA	NA
Wealth Quintiles*							
Lowest	27.4	23.6		NA	NA	NA	NA
Highest	83.6	84.9		NA	NA	NA	NA
(for DLHS-2 it is standard of living)							

Indicator	Madhya Pradesh			Jhabua		Mandsaur	
	DLHS-2	DLHS-3	CES	DLHS-2	DLHS-3	DLHS-2	DLHS-3
<b>% 12-23 months children fully immunised</b>							
Overall	30.4	36.2	42.9	14.6	20.9	25.5	38.0
Sch. Casts	41.9	41.3		NA	NA	NA	NA
Sch Tribes	36.5	36.6		NA	NA	NA	NA
Wealth Quintiles*							
Lowest	31.3	35.6		NA	NA	NA	NA
Highest (for DLHS-2 it is standard of living)	70.3	73.1		NA	NA	NA	NA
<b>% mothers and newborns visited within 2 weeks of delivery by a trained worker</b>	NA	32.7		NA	NA	NA	NA
<b>% Institutional deliveries</b>	28.7	47.1	81.0	26.2	40.6	30.2	52.4

Indicator	Madhya Pradesh			Jhabua		Mandsaur	
	DLHS-2	DLHS-3	CES	DLHS-2	DLHS-3	DLHS-2	DLHS-3
Mothers who received any(at least one) Antenatal check up	74.3	61.8	92.3	63.2	NA	91.8	NA
Mothers who had 3 or more Antenatal Check ups	32.3	34.2	60.0	23.5	23.5	49.4	57.5
Mothers who had full Antenatal Check up	6.0	7.9	11.1	4.9	2.8	8.3	12.5
Children 12-23 months who received measles vaccine	47.3	57.7	61.9	30.3	26.1	50.9	62.5
Children 12-23 months not received any vaccine	17.1	9.8	7.0	31.3	31.9	14.8	2.8
Early initiation of breast feeding children under 3 yrs of age	21.4	43.1	31.2	NA	50.0	NA	40.0
Children with diarrhoea in last 2 weeks who received ORS	26.4	29.9	45.1 *	9.2	32.2	27.9	24.7
Children with ARI or fever in last 2 weeks who were given advice or treatment.	59.7	62.6	75.8 #	NA	45.9	NA	86.7
Children (age 9 months and above) received at least one dose of Vit A supplement (%)	22.3	39.5	45.1	19.6	16.8	42.3	36.0

• The indicator in CES gives ORT use in children under 2 yrs rather than only ORS

# For children below 2 yrs of age

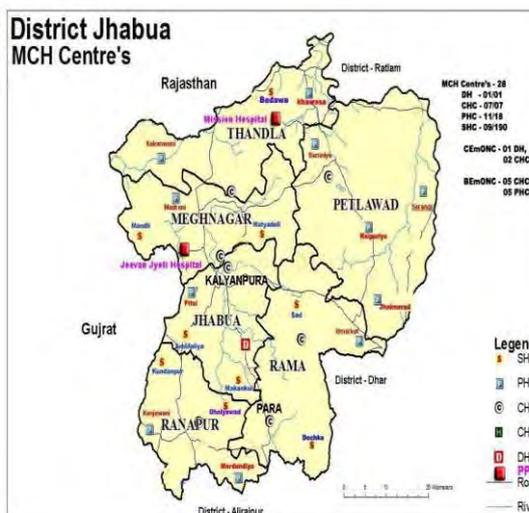
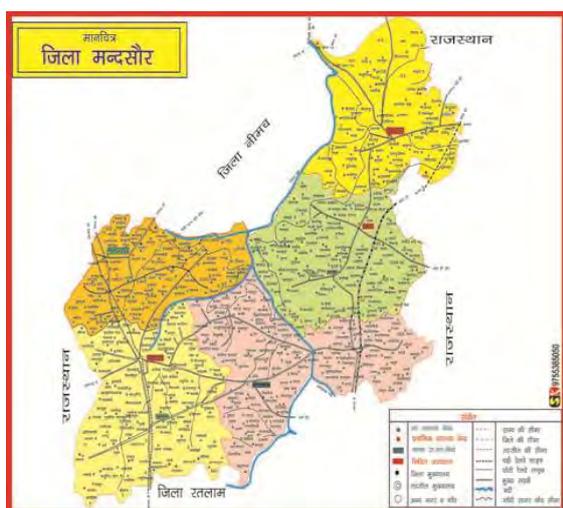
Other RCH Indicators	#	MP	Jhabua	Mandsaur
No of districts having specific activities to reach vulnerable groups		66%	100%	blocks NA
Number of district not having measles at least one month stock of critical inputs		26%	0%	for all items NA
at least one month stock of OCP		70%		at block level
Gloves		50%		
No of 24x7 PHCs conducting more than 10 deliveries per month		75%	73%	NA
% of district hospitals conducting 20 C sections in a quarter		66%	0%	NA
% of districts with at least one sub district level facility doing 10-C.sections per quarter		22%	100%	NA
% districts conducted SBA training in last quarter		38%	NA	NA
% districts conducted IMNCI Training in last quarter (it is for F-IMNCI against IMCI Required)		34%	NA	NA

# Data is from hand outs given by the state & districts

## DISTRICT PROFILE OF MANDSAUR AND JHABUA

## Key demographic indicators\*

INDICATORS	M.P.	Mandsaur	Jhabua
Population	72597565	1339832	10,24,091
SC population <sup>#</sup>	15.2%	17.9%	2.8%
ST population <sup>#</sup>	20.3%	3.2%	86.9%
Child Proportion to total population	14.5%	13.0%	20.3%
Growth Rate	20.3	13.2	30.6
Sex Ratio	930	966	989
Total literacy	70.6%	72.7%	44.5%
Male literacy	80.5%	86.8%	54.7%
Female literacy	60.0%	58.3%	34.3%

\*Census 2011, <sup>#</sup>Census 2001

## Health indicators\*

Indicators	MP	Mandsaur	Jhabua
Birth Rate	25	19	24
Infant Mortality Rate	67	64	68
Neonatal Mortality Rate	44	37	40
Maternal Mortality Rate	310	268 (Ujjain division)	278 (Indore division)
Under Five Mortality Rate	89	85	92
Sex Ratio at Birth	904	910	942
Sex Ratio 0- 4 Yrs	911	907	927

\* Annual Health Survey 2010

**Human Resources: District Mandsaur**

	Sanctioned posts	In position		Vacant (%)
		Regular	Contractual	
Specialists	71	17	-	54 (76%)
Medical officers	103	42	15	46 (45%)
Staff Nurses	276	54	9	213 (77%)
ANMs	286	218	41	27 (09%)
Laboratory Technicians	37	06	25	06 (16%)

**Human Resources: District Jhabua**

	Sanctioned posts	In position		Vacant
		Regular	Contractual	
Specialists	52	14	-	38 (73%)
Medical officers	64	39	2	23 (36%)
Staff Nurses	106	54	2	50 (47%)
ANMs	380	190	49	141 (37%)
Laboratory Technicians	27	22	1	04 (15%)

**District and Block Program Management Units: Mandsaur**

Post	Sanctioned	In position	Vacant
District Program Manager	1	0	1
District Accounts Manager	1	0	1
Monitoring & Evaluation Officer	1	1	0
Block Program Manager	5	4	1
Block Accounts Manager	5	3	2
BEMoC Accountant	9	3	6
Data Entry Operator	5	5	0

**District and Block Program Management Units: Jhabua**

Post	Sanctioned	In position	Vacant
District Program Manager	1	1	0
District Accounts Manager	1	1	0
Monitoring & Evaluation Officer	1	1	0
Block Program Manager	6	5	1
Block Accounts Manager	6	6	0
BEMoC Accountant	5	1	4
Data Entry Operator	6	3	3

## District Report: Mandsaur

The Joint Review Mission (JRM) team visited district Mandsaur from 12<sup>th</sup>-15<sup>th</sup> September 2011. The visit started with a briefing by the Chief Medical and Health Officer (CMHO) Dr. Mahesh Patni on the focus areas as outlined in the process manual of JRM. The facilities visited were Indira Gandhi District Hospital, Mandsaur (designated as First Referral Unit (FRU/CEmOC)), Civil Hospital, Garoth (designated as FRU), CHC Malhargarh, CHC Sitamau, CHC Suvasra (designated as BEmOC facilities), PHC Papiliyamandi, PHC Nahargarh (designated as BEmONC facilities), PHC Bardiya Amra, HSCs / AWCs Balaguda, Suthi, Titrod, Auxillary Nurse Midwife (ANM) Training Center (ANMTC) and the district cold chain store. During the visit the team covered facilities across 4 out of the 5 blocks in the district.

### Summary

- A large number of vacancies exist among specialists (54 posts vacant against 71 sanctioned); medical officers (46 vacant against 103 sanctioned); staff nurses (213 posts vacant against 276 sanctioned) and managerial staff (68 posts vacant against 211 sanctioned)
- Post of District Program Manager (DPM) and District Account Manager (DAM) is vacant since the last 3 years.
- Good review meeting system in place: sector level meetings on Saturdays, block level meetings on Mondays and district level review meetings on Wednesdays. In addition monthly meeting of ASHA held on third Wednesday of every month at the block level. Minutes of meetings available at some of the facilities visited
- The district has a weak supportive supervision structure
- District hospital (DH) is the only functional First Referral Unit (FRU) in the district leading to overcrowding especially in Maternity services. Inpatient number at sub district facilities was poor and most of the sub district facilities were functioning as maternity centers
- District Quality Assurance Committee (DQAC) is constituted and meetings are held regularly. Marked improvement in quality of services provided at labor rooms at institutions.
- Janani express yojna was operational in the district supplemented by efficiently working call center
- Maternal death review started in the district but health functionaries especially grass root and field workers need further orientation to streamline it
- The district had a well-functioning twenty bedded Special care New Born Unit (SCNU).
- Good coordination observed amongst ANM, AWW and ASHA in VHND sessions; ASHAs act as a effective coordinator between the ANM and the AWW
- ASHAs very found to be very effective with good communication skills and commanded the respect of the society.
- Drugs are being procured by the district against rate contracts finalized by Tamil Nadu Medical Services Corporation (TNMSC). However rational drug distribution is needed in the district
- HMIS data is being uploaded at the block level but data validation needs strengthening and a feedback system needs to be put in place. Use of data for action to be prioritized in the district
- District has initiated the Maternal and Child Tracking System (MCTS); needs streamlining
- Beti Bachao Abhiyaan to be initiated in the district from 5<sup>th</sup> October 2011 alongwith the other districts in the state. to create awareness among the people and generate a respectful feeling towards girls, reducing gender ratio and controlling female feticide. Formation of Bitiya Clubs (Parents with only daughters club) started in the district from 2010-11. Under the Bitiya Club parents who have one or two daughter and who accepted permanent family planning operation are registered and felicitated by the Government. 126 members were

registered in 2010-11 and 103 members have been registered in 2011-12 till date. District workshop for further strengthening of the Bitiya Clubs scheduled in December 2011.

- Din Dayal Antyodya Upachar Yojana for SC/ST/BPL population is in operation in the district. Under this scheme free treatment including investigations is provided to patients admitted to government hospitals. Another special scheme 'Atal Bihari Vajpayi Bal Arogya Mission' for providing thyroid testing, iodised salts and calcium tablets in addition to the routine supplies to pregnant mothers is also being implemented.

## **Key Findings**

### **Demographic Profile and Health Indices**

- Mandsaur district has a population of approximately 13.4 lacs with a sex ratio of 966 compared to 930 of the state and rural population constituting 79% of the total population. Key health indicators as IMR, MMR, NMR and Under 5 mortality rates are better as compared to state figures

### **Programme Management and Supervisory Structures**

- The DPMU is operational; however the post of DPM and DAM is vacant since the last 3 years.
- The Monitoring and Evaluation (M&E) officer has been given the additional charge of DPM around 15 days prior to the JRM visit.
- At the Block level out of 5 sanctioned posts of Block Program Manager (BPM) one is vacant, while 2 of the 5 posts of Block Account Manager (BAM) are vacant; 6 of the 9 posts of Block Accountants are vacant.
- The District Health Society (DHS) is in place and the district has a District Health Action Plan (DHAP)
- DHAP is a live document and the district uses it to monitor the performance of the block facilities as per identified targets
- Good review meeting system in place: sector level meetings on Saturdays, block level meetings on Mondays and district level review meetings on Wednesdays. In addition monthly meeting of ASHA held on third Wednesday of every month at the block level. Minutes of meetings available at some of the facilities visited
- The supportive supervision mechanism is weak in the district. Filled supportive supervision checklists were unavailable at any of the health facilities; blank formats were available only at the district hospital
- Reports of supportive supervision visits to the health facilities were unavailable at any of the health facilities
- RKS and VHSC
  - RKS in all places; constituted as per new guidelines. 49 of the 50 societies have been registered
  - Adequate financial delegation done
  - 123 meetings held in 2010-11. Fund generated in 2010-11 was Rs 208.36 lacs while fund utilization was Rs 197.73 lacs (95%). 32 meetings have been conducted in 2011-12 upto August; fund received is Rs 172.85 lacs and utilization is Rs 67.48 lacs (39%). In both the years about 90% of the fund has been generated through user charges the rest contributed by NRHM
  - User charges being collected from APL patients
  - VHSCs in place with regular meetings
  - Good coordination between VHSC and ANM

## Quality of services

- **Quality Assurance**

- District Quality Assurance Committee (DQAC) has been constituted; meetings are organized regularly
- Initial terms of references of working of QACs were review of sterilization deaths and failures. Scope enhanced in 2010 and maternal health issues including review of maternal deaths included as an integral component of QACs.
- However, DQACs are not viewed and functioning as a committee to review quality issues related to important components of RCH program.
- Quality assessment teams are not constituted and did not receive any orientation (might be because of lack of manpower).
- Quality assessment and quality improvement initiatives based on observations of quality assessment has not started.
- Although some monitoring checklists are available, standardized quality assessment tools are not developed and strategy to visit health institutions with the help of these tools has not been initiated.
- Essential drugs, equipment and material to ensure quality of obstetric services including infection prevention are in place.
- Protocols for management of obstetric emergencies, neonatal, pediatric emergency are in place at appropriate sites
- Marked improvement in quality of services provided at labor rooms at institutions.
- Initiatives towards maintaining privacy, clean toilets for women are encouraging.
- Entitlement under Janani Shishu Suraksha Yojana (JSSK) is in place – rights of clients.
- Lack of manpower at district level and at block level was brought out as the major constraint for regular QA and quality improvement initiatives

- **Operationalisation of facilities**

- Operationalisation of FRUs/CEmOC

- All health facilities visited had their own buildings
- The DH is the only functional First Referral Unit (FRU/CEmOC) in the district against the requirement of three. Due to this patients from Garoth and Bhanpura blocks situated at a distance of more than 100 kms from the district headquarters are referred to the DH for treatment. The district needs to operationalise two FRUs at Civil Hospital Garoth and Civil Hospital Bhanpura to improve service delivery.
- Civil Hospital Garoth though designated as an FRU/CEmOC, is not functional as it lacks a Blood Storage Unit (BSU), appropriate New Born Stabilisation Unit (NBSU) services and an anesthetist. The CMHO has nominated one medical officer of the hospital for LSAS. The District is advised to revive the existing Blood Storage Unit at the earliest to make it functional as FRU
- None of the FRUs visited except the DH had easy access for disabled and infirm at the entrance
- Other than the district hospital the inpatient and outpatient strengths were found to be poor at the FRUs visited. At Civil Hospital Garoth a 30 bedded male ward was vacant and closed. Very few patients were observed at CHC Mallhargarh and PHC Nahargarh. Most of the sub district health facilities catered to only maternity patients and no male patient or children were found to be admitted
- At Civil Hospital Garoth it was observed that the Operation Theatre (OT) had the scrub room within the main OT and access to the scrub room could be gained only after entering the main OT. The team advised for a separate scrub room

- Renovation is ongoing in the district. Operation Theatre (OT) is being constructed in the DH while extensive renovation is underway at Civil Hospital Garoth. However the renovation at Garoth is not as desired since the existing structure is more than 100 years old and the same is being renovated instead of establishing a new hospital building. Instead of an integrated building 8-10 small blocks are constructed at different levels and separated from each other all around the hospital premises which would lead to operational difficulties given the shortage of staff nurses and ANMs.
  - The building at CHC Mallhargarh had been renovated in the recent past. However the team observed that the labour room door opened in the open corridor of the hospital towards the road entrance, the team advised for the entrance to be rerouted through the maternity ward
  - A well equipped and functional 20 bedded Sick New Born Care (SNBC) unit is operational at the DH, with United Nations Children Fund (UNICEF) providing technical assistance.
  - No functional New Born Stabilization Unit (NBSU) was observed in any of the BEmOC or CEmOC facilities visited. A 3 bedded SNCU Level 1 / NBSU is present at Civil Hospital Garoth but is situated in a block away from the labour room and was unoccupied and unused during the team's visit to the facility
  - Computerized Tomography (CT) scan facility installed in the DH in Public Private Partnership (PPP) with the support of Rogi Kalyan Samiti (RKS)
  - Labour room, Suvasra needs attention as it was lacking hand washing facility, privacy and standard labour table. The radiant warmer was lying out of order. The staff was still using the old labour room register which was lacking many important information.
  - Essential laboratory investigation facility was available at most of the facilities visited except CHC Mallhargarh.
- **Operationalisation of BEmOC / 24x7 PHCs**
    - 2 of the 3 PHCs visited (PHC Pipliyamandi and PHC Nahargarh) were functioning as 24x7 facilities
    - The team visited Bardiya Amra PHC in Garoth Block situated on the highway away from the village. The PHC is situated a few hundred meters away from the old HSC which is now used as a residence by the ANM. The PHC did not have a medical officer posted and though designated as a PHC was functioning only as a HSC; normal deliveries were being conducted. Though the ANM was not SBA trained she had conducted 80 deliveries in the last one year out of the 215 deliveries conducted in the given area.
    - Assisted deliveries were limited to the district hospital but only in rare cases and that too forcep delivery. BEmOC trained medical officers at 24 x 7 facilities were hardly using skill to manage delivery complication. There was a practice to refer cases with complications to tertiary level resulting in high delivery load at district hospital.
    - Signage's generally in place at all the facilities visited
    - Citizen charter and Janani Shishu Suraksha Karyakram (JSSK) guidelines displayed only in some facilities
    - **Referral transport system and 24 x 7 call center:**
      - The district had a well-functioning 24 x 7 call center located in the district hospital with four operators working on shift basis. The center was coordinating the fleet of 17 Janani Express vehicles located at different delivery points. The number of call center has been widely publicized in the community and any pregnant women or sick child can be transported from community to health facility by calling the call center. Total 10,674 pregnant women were transported in 2010-11 using this service with most of the beneficiaries from SC and OBC

category. The service is being provided free of charge. The running cost of the center is Rs. 30,000 per month which is being met through RCH funds.

- The call center uses simple software developed by UNICEF which can generate periodic reports on different parameters like response time, distance travelled to reach health facilities, call conversion rate etc. The data was well managed and displayed in the center
- The ASHA and Anganwadi workers in the district were aware of the call center facility and using it to transport pregnant women for institutional delivery. Large number of women at health facilities were using the call center facility to get vehicle for reaching the health center for institutional delivery. However, in order to handle the current load, 7-10 extra vehicles were required
- The drop back home facility to mothers was also found available at most of the facilities and the service was made available for delivered mothers during afternoon hours (12-3pm)
- Though functional the current vehicles being utilized for transporting the beneficiaries were unequipped and not suited to manage obstetric emergencies like eclampsia, ante partum hemorrhage (APH) and post partum hemorrhage (PPH)
- However the ambulance services in the facilities was underutilized and vehicles at facilities were in a bad shape because of lack of appropriate maintenance. At Civil Hospital Garoth the ambulance was used on a regular basis
- Wherever used the ambulances were utilized mainly for administrative purposes

- **Maternal Health**

- 24 x 7 deliveries facility was available at two of the three HSCs (HSC Balaguda & HSC Titrod) visited by the team
- The labour rooms were in good working conditions with protocols adequately displayed. However, these to be displayed at the readable height
- Partographs (revised) were being prepared at all the health facilities visited with delivery services
- Active management of third stage of labour (AMTSL) was being followed at most of the health facilities
- There is a need of refresher training on SBA of labour room staff to update their skills
- Use of new labour room recording register initiated at most of the places (except CHC Suvasra)
- All the delivery patients were made to stay at the facilities for 48 hours
- Free diet provision made at facilities to indoor women in the maternity wards
- The state has initiated the JSK since 01/07/2011. However user charges for ANC care (eg ultrasound) were being levied at certain facilities in the district. The district needs to issue guidelines to the health facilities regarding the same
- Abdominal palpation was not being done at some places due to lack of privacy (especially at HSCs)
- Uristix being supplied by sources other than the Government were being utilized in the field which might affect the sustainability in the future
- ASHA were unable to stay with the mothers for 48 hours post delivery at DH due to lack of proper accommodation
- **Maternal Death Review (MDR)**
  - The District MDR committee under the chairmanship of CMO has been constituted.

- The meetings of District MDR Committee were not happening very regularly (once monthly) and this was the reason that none of the reported maternal death had been reviewed by the committee so far.
  - The blocks have started reporting the maternal deaths to the district. Three maternal deaths had been reported to district committee so far.
  - Line list for “Nil” reporting was not being forwarded to district committee.
  - Minutes of each meeting to be kept to take corrective action.
  - The paramedical and field staff to be oriented on MDR during monthly meeting as less than one third of expected maternal deaths had been reported so far.
  - The women from the farthest blocks (Bhanpur, Garoth) were going to Rajasthan (district Kota, Jhalawar etc) for delivery. The maternal deaths among these cases might be happening in Rajasthan. Therefore, a system for interstate notification for maternal deaths to be established.
- **Janani Suraksha Yojana:**
- JSY disbursements to the beneficiaries and ASHAs were on time.
  - Adequate fund available in the district to accommodate increased demand with smooth fund flow to the peripheral health facilities.
  - Payment of JSY benefits to the beneficiaries was done at the time of discharge and only after ensuring 48 hours stay in the facilities after delivery. The beneficiaries were paid JSY incentive by cheque. There was a practice of providing birth certificate and discharge ticket along with JSY cheque.
  - Cases of home delivery from BPL families were being paid JSY benefit (Rs 500/- by cheque) only after getting the required documents.
  - The lists of JSY beneficiaries were not displayed publically except at CHC Sitamau
  - The beneficiaries from CHC Sitamau who are going to adjoining districts of Rajasthan to get better services were not getting JSY payment from the concerned districts of Rajasthan.
  - Though 14 private hospitals were functional in the district none of them had been accredited for JSY scheme
- **Child health**
- IMR and NMR of district is below the State average ( 64 and 37 respectively as per AHS 2010)
  - IMNCI and FIMNCI training underway in the district. The State had invested significantly from 2007 to 2010 in scaling up of IMNCI with more than 25,000 workers trained in IMNCI. There is a need to ensure their optimal utilization and have role clarity between IMNCI trained Anganwadi worker and ASHA trained in module 6 and 7. In addition those ASHAs who are trained in IMNCI (State Decision) and will be trained in module 6 and 7 would need to be given clear guidelines for home visits. There is also need to improve home visits in the district
  - ORS available at all the health facilities
  - Zinc syrup procured through the district available at the health facilities, the district needs to use dispersible zinc tablets instead of the syrup
  - Staff needs to be oriented on correct pneumonia and diarrhea management techniques as the same was found to be lacking amongst the service providers
  - Home visits initiated by health workers; quality and timing of home visits needs to be addressed
  - The still birth rate at most of the BEmOC centers visited was high ranging from 30 to 40 per thousand. This was also contributed by the fact that most of the indications for which pregnant women was being referred to CEmOC were Maternal indications while

- fetal indications for referral were not seen at the facilities visited. There is need to improve intra partum care to address this.
- There is need for Capacity building and mentoring of staff at peripheral delivery points to provide quality essential new born care and ensuring adequate utilization of New born corners.
  - **Special Care New Born Unit:**
    - o The district had a well-functioning twenty bedded Special care New Born Unit (SCNU). The unit has been developed with technical support of UNICEF and operational cost being met from RCH funds.
    - o The unit has a dedicated team of three pediatricians (sanctioned: 4) and 10 staff nurses (sanctioned 12) who are providing quality care to the admitted new born. The different services like Breast feeding room follow up OPD, staff duty room and ward to keep mothers of the baby admitted in SCNU are all a part of the unit.
    - o The data of every baby is recorded in specified software and the case recording formats and monitoring sheets developed by the State with support from UNICEF were being used. Total 1034 new born were admitted this year from 1<sup>st</sup> April till 31<sup>st</sup> August with a mortality of 10.4%.
    - o The staff of SCNU has been trained in the FBNC module developed by NNF and also undergoing further two weeks training at PGI Chandigarh.
    - o NBSUs should be established at CHC / BEMONC facilities
    - o NBCs at place in delivery points, adequate utilization of new born corners needed, skill up gradation of the health workers necessary along with optimal utilization of available equipments like suction machines and radiant warmers.
  - **Nutrition Rehabilitation Centre:**
    - o Nutrition Rehabilitation Centers (NRCs) operational at the district and block facilities.
    - o Only one Feeding Demonstrator (FD) and sweeper posted at the NRC in the DH, post of cooks and nurses vacant. The FD had received just one day orientation training with no formal induction training
    - o Occupancy at block NRCs to be improved
    - o Need to look into cure rate and relapse rate and compare it with global norms
    - o Need to link NRCs with community based model for treatment of malnutrition
  - **Routine Immunization (RI)**
    - Adequate availability of cold chain equipment's at the district, block and sub block level cold chain points
    - Cold Chain equipment's properly installed as per guidelines
    - Power Back up available at all cold chain points
    - Auto Disable (AD) syringes in use, hub cutters available at immunization session sites
    - Routine immunization microplan with estimation of beneficiaries and logistics unavailable at most of the facilities
    - Tracking bags were in use at most of the HSCs
    - Vaccine and logistics management poor, no proper indenting mechanism
    - No proper recording and reporting of vaccines and logistics; no standardized formats for maintaining vaccine distribution and stock registers available
    - Waste segregation at the session site level and waste management at the facility level inappropriate; red disposal bags unavailable, unutilized
    - Alternate Vaccine Delivery (AVD) and need further strengthening
    - IEC measures to be undertaken to facilitate community involvement

- **Village Health and Nutrition Days (VHNDs)**
  - VHNDs held as per microplan, accessible to the vulnerable population group
  - Effective coordination observed amongst the ANM, AWW and the ASHA. Community mobilization by the ASHA observed to be good
  - ASHAs very found to be very effective with good communication skills and commanded the respect of the society. They act as a coordinator between the ANM and the AWW
  - Both RI and Ante Natal Care (ANC) services provided during VHNDs
  - Due list of the beneficiaries available at the session site
  - New Maternal and Child Protection Cards (MCP) cards noticed at VHND sessions
  - All vaccines available at the session site, time of reconstitution written on opened BCG vial, date of opening written on Vitamin A phial.
  - Hub cutter available at the session site, waste segregation done but not as per guidelines
  - Functional sphygmomanometer and haemoglobinometer available; the ANMs are trained in using them
  - Essential drugs available at the session site
  - Involvement of Panchayati Raj Institution (PRI) members at VHNDs encouraging
  
- **Family planning**
  - District Quality Assurance Committees (DQACs) to review sterilization deaths, complications, failure is in place. Failure/complication/death cases reviewed by the committee and cases being send to ICICI Lombard GIC, Bhopal.
  - Family Planning counselors in place at District Hospital Mandsaur
  - In view of the unmet need for family planning in the district being as high as 17.3%,(state is 18.1%), percentage of births to women during 15-19 years being 14 %, and the percentage of birth order of 3 and above nearly 50% (as high as 48.5%) the achievements and focus solely on limiting methods will not yield any significant changes in the reduction of unmet need for Family Planning. There is need for focused promotion of spacing methods through IEC and training of staff.
  - Post partum family planning needs strengthening
  - The 48 hrs stay after delivery should be utilized for counseling for FP by staff nurses in the hospital. Counseling for family planning in VHND is not done although VHND is a good platform for providing counseling for FP services to ANC mothers.
  - **Safe Abortion Services (SAS)**
    - Only four health facilities (District hospital. Civil Hospital Garoth, CHC Suwasara & PHC Nahargarh) had been providing SAS. Among these, only district hospital was providing MTP more than 12 weeks but in rare cases.
    - Under reporting of MTP especially MTP below 7 weeks by medical pills
    - District Level Committee for SAS had not been constituted. There is a need for constitution of District Level Committee so that private health facilities are accredited for MTP services to expand the service delivery.
    - Underutilization of trained medical officers as they hesitate to perform MTP due to lack of confidence. Up scaling of MTP training of medical officers needed with rational deployment of trained doctors
    - Very poor Information Education and Communication (IEC) for SAS (availability in the health facilities, MTP Act etc) both in health facilities and community
  
- **Adolescent and school health**
  - Remains a neglected area; follow up of children needed
  - School health programme is operational till the middle schools in the district. In 2009-10 all 1736 schools were covered under the school health programme. Total 117,222

children (57,888 of 6-9 years of age and 59,334 of 10-14 years of age) were screened out of the total school children 134,415 (67,255 of 6-9 years of age and 67,160 of 10-14 years of age). While 26,758 received immediate attention 339 children were referred to health facilities. 296 students required instrument support. However follow up of children is a neglected area.

- In 2010-11, of total 1624 schools, 1211 were covered. Of total students – 130744 (61,029 of 6-9 years of age and 69,715 of 10-14 years of age), 110744 (58,929 of 6-9 years of age and 51,815 of 10-14 years of age) were screened. Of the students screened, 3,556 received immediate attention, 47 were referred.

- **Drugs and equipments**

- Rate contract with TNMSC in place. District administration has procurement powers of upto 20% of the budget for need based local purchase
- Essential drugs available at all health facilities
- RCH Drug Kit A and B not received by the district since 2009
- Patients do not have to procure drugs from external sources at the facilities
- Oral Contraceptive Pills (OCPs) and condoms made available in the district last month after being unavailable for the last one year
- Shortage of gloves being met through RKS procurement
- Rationalization of drugs required eg Frusemide available at one HSC visited; the ANM did not know it's use, short expiry medicines (expiry date in 09/11) observed in many health facilities eg in one PHC 5400 small IFA, 1000 dicyclomine, 500 cold relief tablets found
- Equipments especially for labour room, NBCC, SNCU and Bio medical waste in place
- No Annual Maintenance Contract (AMC) in place; repair work of equipments hampered
- 6 generators lying unused at the DH; installation not done for the last 6 months

- **Bio Medical Waste management**

- Bins for waste management observed at all the facilities visited
- Awareness and practices of segregation and disinfection lacking
- Waste dispersal outsourced, health workers unaware of final dispersal processes undertaken

### **Health Management Information System (HMIS)**

- HMIS is functional in the district; PHC based online data entry has started 3-4 months back; facility based entry to be operationalised.
- HMIS dictionary in hindi has been circulated and followed.
- District Management Information System (MIS) officer reported on time data feeding in the HMIS.
- Block level data operators to be trained on HMIS.
- Committed data levels were not reported at the block and district levels.
- The data gets validated at the state level and the checked data and field report is being communicated by the SPMU to the district who in turn notify the block level PHC MIS data operator. However with no facility based data feeding below the block PHC level the exact data errors and feedback mechanism is not in place. The data gets rectified without an expected feedback to the front line workers who are collecting the data.
- Block based data commitment and monthly follow up mechanism in same line of the state based district monitoring and ranking can be positioned easily. Following this quarterly financial expenditure review can be positioned.
- Block PHC based MIS officer should be instructed to conduct 10 % back check of filled formats at PHC and HSC level with reports send to district and complied report to divisions. This would further strengthen the on job HMIS supportive supervision mechanism.

- District has initiated the Maternal and Child Tracking System (MCTS); needs streamlining

#### **Gender**

- Visakha guidelines issued upto District level in Mandsaur, district level Redressal committee not formulated
- Most of the facilities visited had separate toilets in the labour room with supply of running water. However separate male and female toilets in the hospital were either unavailable or if available were not being used. Separate toilets for male and female staff were unavailable
- Beti Bachao Abhiyaan to be initiated in the district from 5<sup>th</sup> October 2011 alongwith the other districts in the state to create awareness among the people and generate a respectful feeling towards girls, reducing gender ratio and controlling female feticide.
- Formation of Bitiya Clubs (Parents with only daughters club) started in the district from 2010-11. Under the Bitiya Club parents who have one or two daughter and who accepted permanent family planning operation are registered and felicitated by the Government. 126 members were registered in 2010-11 and 103 members have been registered in 2011-12 till date. District workshop for further strengthening of the Bitiya Clubs scheduled in December 2011.

#### **PCPNDT**

- CMHO has been made nodal officer by district collector but no formal authority letter issued.
- District Advisory committee constituted but meetings are not organized regularly. Formal minutes of meetings, action taken report on minutes of meetings not available. Inspection team not constituted and regular monitoring of USG clinics is not done.
- The district hospital has registered USG clinic under public private partnership. This clinic is fully PCPNDT Act compliant clinic, Form F and other documents are very well maintained
- District level sensitization workshops conducted in collaboration with United Nations Fund for Population Activities (UNFPA)

#### **Training**

- Since 2005 the district has trained a medical officers and paramedical staff. 20 MOs have been trained on BEMONC (of which 4 have been transferred or have resigned), 1 MO trained in EMONC and LSAS, 8 in IMNCI, 10 in FIMNCI, 32 in NSSK and 6 in general administration
- 22 staff nurses (SNs) and 70 ANMs / LHVs (Lady Health Visitors) have been trained in SBA, 58 in SBA refresher training while 896 paramedical staff have been trained in IMNCI, 167 in immunization and 129 under NSSK
- 874 of the 886 ASHAs selected in the district have received module 1 training, 792 are trained on module 2, 3 and 4 while 680 have received module 5 training. 858 ASHAs have received refresher trainings. The district plans to roll out Module 6 and 7 training from November 2011

#### **ANMTC**

- A 60 seat ANMTC is available in the district which serves for three districts, Mandsaur, Neemuch and Ratlam with equal seats reserved for the three districts.
- The facility has one class room, seminar rooms, and faculty rooms.
- There are 2 sister tutors and 2 public health tutors. Position of principal, 1 sister tutor and 2 public health tutors are vacant.

- The facility is supported by a 45 room hostel facility. The position of house keeper, LDC, driver and 4 domestic servants are vacant. Hostel building needs repair and renovation.
- The 18 month training of ANM is mostly through role plays pedagogy. During training the students are positioned for field training at the CHC Malhargarh and post training they are positioned at District Hospital Mandsaur.

#### **Financial Management**

- AMG funds were given to Sub Centre of Non –Govt. buildings and under construction.
- High cash balance at DHS(Mandsour): Rs.108,180.00( as on 12/9/2011)
- RKS were functional however the funds were utilised for Civil Construction.
- No monitoring on high Unspent Balance and Advances given to the peripheries.
- Concurrent Audit: Substantial delay and irregular audit defeats the purpose of audit.
- Six months audit report issued and signed on a single day (28/5/2011) with same observations which defeats the purpose of concurrent audit.

The field visit concluded with a meeting with the Distirct Magistrate Shri Gyani wherein his inputs on challenges faced by the administration in health care delivery was sought and the findings and observations of the JRM team communicated to him.

## District Report: Jhabua

The team (Annex1) visited Jhabua from 13<sup>th</sup> to 15<sup>th</sup> September 2011. The team visited the District Hospital Jhabua, CHC Petlawad, designated as FRU (CEmonc facility), CHC Meghnagar and Sector PHC Kakanwani (designated as BEmonc facility), Sector PHC Sarangi , VHND at Anganwadi centres at village Barakhara and village Narayanpura, Sub Health centers, Chapri and Harinagar and ANM Training centre at Jhabua. Focus Group Discussions were held with women and Panchayat representatives at VHNDs, The team also talked to group of ANMs, a number of ASHA workers and a few Anganwadi Workers at the facilities visited.

### Summary

- DPMU was in place and is headed by a medical doctor. The DPM had been trained at Bhopal. At block level while PMUs have been established at all blocks with positions of Block Programme Managers, Accountant and Data entry operators. All posts at the block PMUs are filled except for one Block Program Manager (BPM) and one Data Entry Operator.
- The district and block Programme Management officers have been oriented for their responsibilities, however the DPMO and BPMOs lacked full understanding of their roles and require training/orientation and written TORs.
- At the district level the RCH interventions seems to be the responsibility of a number of officers like MCH Officer/DIO/CMO with roles not very clearly defined. Clearly defined roles for various officers with CMO as the Coordinating officers would be desirable.
- A Din Dayal Antyodya Upachar Yojana for SC/ST/BPL population is in operation in the district. Under this scheme free treatment including investigations is provided to patients admitted to government hospitals. Another special scheme 'Atal Bihari Vajpayi Bal Arigya Mission' for providing thyroid testing, iodised salts and calcium tablets in addition to the routine supplies to pregnant mothers is also being implemented.
- Drugs are being procured by the district against rate contracts finalized by Tamil Nadu Medical Services Corporation (TNMSC) for the state. Adequate financial delegation is available to the district administration.
- Drug Kits A&B have not been received in the district this year. While drugs like IFA were available due to districts own procurement, drugs like zinc and cotrimoxazole pediatric tablets were not available.
- Rogi Kalyan Samities exist in all facilities and the funds are generally being used for emergency drugs and for improving health facilities. Annual grants under NRHM are being received regularly. User Fees are not being levied on BPL families.
- The teams could see a large number of beneficiaries at health facilities indicating an upsurge in demand/utilization of services particularly for institutional deliveries. A significant increase has also occurred in OPD attendance due to increasing awareness and availability of services; though lack of manpower particularly doctors and nurses is a major problem.
- A large number of vacancies exist among specialists (38 against 52 sanctioned); medical officers (23 against 41 sanctioned); staff nurses (59 against 106 sanctioned) and ANMs (141 against 380 sanctioned). Perhaps inability of district management to recruit contractual staff due to 'Roster for SC/ST is a contributory factor.
- 839 ASHAs have been selected by the district for 786 villages. There is a problem of high turnover of Training of ASHAs is progressing well though due to high turnover and new ASHAs being recruited there could be some ASHAS who have undergone training in Module-3 or Module-4 without having undergone training in Module-1.
- ASHAs were available at most of the health facilities. They seem to be doing very well and it was refreshing to see them responding to the queries from the team members. Drug kits are available with them. They escort the women to the facilities for delivery and there was not much

of a problem in their getting the JSY benefits. Regular monthly meetings are held with ASHAs at block level.

- Generally, community involvement in planning and monitoring of health services needs further strengthening. Involvement of traditional village leaders, community leaders might be a way to ensure stronger community engagement.

## **Key Findings**

### **Demographic Profile and Health Indices**

- Jhabua is primarily a tribal district. District has population of a little more than 10 lakhs with 87% population belonging to scheduled tribes. More than 54% households are BPL. Health indices like CBR, IMR, MMR, TFR and growth rate compare favorably with the state. Roads are the major means of transport and are in bad condition.

### **Programme management and supervisory structures at various levels**

- Though the District Health Society (DHS) is in place, the meetings are not held regularly
- The medical officer who has been given the charge of the DPM was not fully aware about his roles and responsibilities
- The Programme Management Unit Staff lacks motivation since there is no system of appraisal and career progression in place.
- The Block Programme Management Unit (BPMU) in all the 6 blocks has adequate staff other than Ranapur Block where the BPM position is vacant and Kakanpura wherein position of Data Entry Operator (DEO) is vacant.
- BPMs have been given induction trainings and orientation about the programme and their roles and responsibilities as well.
- Decentralized Planning – The districts have been given formats for Village health plans to assess the needs of the community. In Jhabua in the previous year these were filled and available. But the participation of the VHSC members in the same was found to be missing.
- Feedback mechanism to be instituted for supervisory visits; concerned district officials and the service providers at the facility to receive timely feedback for improving clinical as well as managerial skills.
- Rational deployment of human resource is lacking. For example in SHC Chapari and SHC Dhekalwadi which were neither delivery points nor planned MCH centres; had 2 ANMs each, in position.

### **Quality of services**

- **Quality Assurance**
  - Quality control committee has been constituted at the district level. It was constituted for the first time in May this year according to the old constitution/ rules under Family Planning set up. The Government of India recommendation for expanding role of QA committee is still to be implemented.
  - District hospital was ISO certified in 2009, however there were several quality issues observed. While the ISO certification mainly focused on signage, cleanliness, infection prevention and Biomedical waste management, there were gaps in staff norms, ICU facility, hand washing area in labour room, training and skills.
  - A general lack of awareness towards quality issues was observed among staff across the board from district to PHC level. Primary reasons for this were
    - Lack of Technical/operational Guidelines: While the district officers along with the Medical Officers in charge of facilities are required to operationalise the facilities – Technical/operational guidelines particularly for IMEP are not available in the district.

- Standard/treatment protocols were in evidence at all health facilities. However,
    - o The protocols are displayed on walls at height where these are not readable. To make them user friendly it is essential that brief important points are printed in bold and are displayed at eye level.
    - o Protocols need to be put up in areas as per the need for those protocols i.e. in the labour room protocols for PPH rather than APH.
  - The rate of caesarian sections in CEmonc facilities varies from 0.27% in District Hospital to 2.72% in the busiest facility at Petlawad. This is too low and needs to be looked into.
  - Health care waste management and infection prevention practices though partially in place, the knowledge of “what and how’ are extremely poor at all facilities with no/poor segregation of waste, poor storage and disposal of sharps and placenta etc
  - Training is an important issue in quality management. No training plan for the supervisory staff responsible for providing supportive supervision or any other initiative in this direction was however shared with the team by the district officers.
- **Operationalisation of FRU / 24X7 facilities and Maternal Health**
    - Efforts in operationalising FRUs/CEmOC facilities) and 24x7 Primary Health centers (BEmOC facilities) are visible. It was heartening to note that 3 FRUs/ CEmOC facilities including one at the district hospital are fully operational in the district. The team visited the district hospital and the FRU at Petlawad. The 3 critical elements of functionality are in place. At the district hospital a SNCU is in place and functioning well with a pediatrician and other dedicated facilities in place. Some observations requiring attention of administration are
      - o At CHC Petlawad FRU there are 30 beds, more than 400 deliveries per month, a nutrition rehabilitation centre and large number of OPD cases besides other services requiring attention. The CHC however has only 4 doctors (3 specialists and one medical officer), an Ayurvedic doctor and only 4 staff nurses. They are doing an excellent job, however the need for providing more staff is obvious.
      - o All essential laboratory investigations are available. However serum bilirubin which is essential for a unit providing phototherapy was not available.
      - o At the district hospital, the blood gas analyzer has been out of commission for quite some time and needs attention perhaps through an Annual Maintenance Contract (AMC) which could be operated by the hospital.
    - 16 other facilities (5 CHCS and 11 sector PHCs are providing 24x7 delivery and newborn care services in the district. Of the sixteen facilities, 5 CHCs and 5 sector PHCs have been designated as providing for BEmOC level facilities. The team visited 2 BEmOC facilities at Meghnagar and Kakanwani. At both places
      - o Large number of deliveries are taking place, new born corners are in place and the staff understands the essentials of newborn care
      - o Emergency drugs and other essential equipment were found in the labour rooms and were in working condition.
      - o BEmonc facilities are required to provide for Normal deliveries, assisted deliveries, newborn care and referral management for obstetric emergencies. None of the BEmOC facilities visited provides for assisted deliveries or referral for obstetric emergencies.
      - o At CHC Kakanpura labour room does not have running water supply. Essential laboratory investigations were available.
      - o At Meghnagar the medical officers has undergone training in 2/3 days BEmOC training course while at Kakanpura the MO has not received any training in either newborn care or in delivery care.

- The staff nurses at both facilities had undergone training as Skilled Birth Attendants (SBAs) at the district hospital and were aware of the SBA drugs. However, they were not very clear of the indications for use of the drugs particularly inj. Oxytocin
- Partogarp was being maintained. In all delivery cases, active management of third stage of labour was being done.
- No doctor trained in 10 day regular BEmOC training. Most of those trained in 2/3 day course lack skills for managing/ referring obstetrical complications. A woman who reported with PPH (BP 60/...) at 10.30 AM was kept till 12 PM and when the BP became un-recordable and patient started gasping the patient was referred to district hospital. During the stay of the patient, the patient was not administered any of the specific drugs needed to manage PPH and even though a regular Ambulance was available at Meghnagar the same was not used for referral.
- The team also visited the Sector PHC at Sarangi which though not designated as a BEmOC facility is providing 24x7 delivery facilities. At this place also about 60 deliveries are being done per month. The labor room is manned by 2 ANMs, only one of them I strained as SBA. As in other BEmOC facilities dugs were in place and Partogarp was being maintained. Newborn corner was equipped and working. Only IUD insertions were being undertaken but by ANMs. Essential laboratory investigations were available. There is only one medical officer who is new and is not aware of his responsibilities as PHC MO. There is a need for orienting the new incumbents at induction stage.
- All mothers are being kept at the health facilities for 48 hrs and food and drugs provided.
- Essential newborn care facilities were found in all labour rooms and were generally well equipped and stocked. Nursing staff is aware of the need for newborn care, however Skills of staffs are not adequate-and many staff attending to newborns has still to receive raining.
- Safe abortion services are being provided at the CEmOC facility at Petlawad using mostly medical methods. Otherwise this has been found to be the weakest link in the maternal health interventions.
- **Maternal Death Audit**
  - Maternal Death Audit has been initiated in the district. A line list of 24 cases was shared with the team. A large number of these have been investigated by ANM, MPW or both. General observations of the team are
    - Review of maternal deaths is not done properly as per the protocols, importance of the review not understood by the district officials
    - Generally cases of maternal deaths are grossly underreported and efforts to train MOs and other staff at facilities to report all deaths should be undertaken.
- **Referral transport**
  - There are 14 private vehicles under Janani Express(JE) scheme spread in 6 blocks of Jhabua district. Transportation of pregnant women to health facility is being provided through Janani Express for about 50 % of the JSY beneficiaries. Effectiveness of JE is an issue during midnight and early morning hours.
  - Of the JSY beneficiaries interviewed in the health facilities and in the VHNDs all JSY beneficiaries acknowledge being dropped back home by JE.
  - JE vehicles are mostly privately owned. In some cases JE vehicles are not provided despite the patient requesting the call centers due to reasons like “No Diesel”

- JE is operated through call centers located at health facilities. At the district hospital, the team made a call to the centre and found that the centre was functioning efficiently.
- The JE vehicles are not suitable for transporting obstetrical emergencies. It was observed that regular ambulances though available at many facilities were not being used for transporting patients. This needs to be taken note and some arrangements made for emergency cases in rural areas.
- **Janani Suraksha Yojana (JSY)**
  - Considerable numbers of institutional deliveries are taking place in the district. Beneficiaries at the health facility are provided with free food and medicine
  - Fund flow for JSY was timely and regular. There was no shortage of JSY fund in the delivery units.
  - Payment of JSY benefits has been linked with 48 hr stay. JSY benefit is routinely paid through cheque at the time of discharge. Team came across a case where it was reported by beneficiary that one PHC consistently delayed JSY payment, which appeared to have been caused by medical staff requesting “co-payment” by beneficiary before releasing the JSY check.
  - JSY payment registers are well maintained and are up to date in all delivery units.
  - Though new registers for labor room have been received by all delivery units which has additional column of date and amount of JSY payment, they have not been utilized. At PHC Sarangi date and time of discharge is not recorded for any case of delivery.
  - Eligible BPL home delivery beneficiaries are paid JSY incentive through cheque and necessary documents are also maintained for record.
  - List of JSY beneficiaries is being displayed at all health facilities but placed at the remote corner of the hospital or inside the room of the accountant.
  - None of the delivery units has grievance Redressal mechanism in place.

**Case Study:**

Nanduri w/o Maan Singh a resident of Katjipara village in Jhabua district reached PHC Sarangi for the delivery of her second child. Nanduri had been registered for ANC during the first trimester and had received all services. While inquiring about the mode of transport to reach the health facility, it was learnt that she has travel by a bullock cart to reach the hospital. Her mother narrated that at about 2.00 a.m. Nanduri experienced labor pain. Janani Express was called up but they were informed that due to lack of fuel the vehicle could not transport her to the facility. Nanduri had to travel by a bullock cart and reached the hospital at around 3.00 am; she delivered at 3.15 am. Concerned ASHA could not accompany her as she was not informed. However she was informed in the morning and was on way to the hospital. Nanduri is aware about JSY incentive and will stay in the health facility for the next two days.

The above case study clearly depicts that, PHC Sarangi is providing round the clock delivery services and in the community ASHA's service is appreciable. However district authorities need to monitor Janani Express' effectiveness in the night and early morning hours as it is a crucial time, resulting in majority of the home deliveries due to non availability of transport facility.

- **Child Health**

- Though ORS is available at all health facilities visited, regular supply of Zinc has not started
- Skills in managing diarrhoea and pneumonia (ARI) cases needs significant strengthening at all levels
- Pediatric cotrimoxazole was not available in any of the facilities visited.
- Universal availability of irrational drugs such as furazolidine through state supply is a matter of concern.

- Nutrition Rehabilitation Centers were functional with drugs and logistics available. Community level linkage is a weak area.
- **New born/post natal care**
  - o Essential newborn care facilities were found in all labour rooms and were generally well equipped and stocked.
  - o Newborn Corners at all labour rooms and SNCU at district hospital were functional. Stabilizing units have not been put up in any facility.
  - o Nursing staff is aware of the need for newborn care, however skills of staffs are not adequate-and many staff attending to newborns have still to receive training.
  - o Early initiation of breast feeding practiced at health facilities, prevention and management of hypothermia undertaken.
  - o Overcrowding observed in post natal wards, general cleanliness and hand washing measures poor.
  - o Post natal counseling on family planning and nutrition was weak in most of the hospitals
  - o Post Natal visits being made by ASHAs however quality of care and timeliness of visits as per schedule were found to be areas of concern.
- **Routine Immunization**
  - Focus on improving immunization coverage not visible despite low full immunisation rates.
  - AD syringes and hub cutters available and in use during VHND sessions
  - Hand Generated list of beneficiaries being used
  - Polio-HepB vaccines not available resulting in inadequate coverage
  - IEC visibility needs strengthening
- **Village Health Nutrition Days(VHNDs)**
  - VHNDs are held in the district on all Tuesdays and Fridays. The team visited 2 VHNDs which were held at the Anganwadi centers. The important observations are
    - o VHND was being conducted in the AWC in places visited and was easily accessible to vulnerable sections of the community.
    - o Integrated services are provided by the AWW, ANM and ASHAs in close co-ordination. However there was a need to improve skills and confidence of ANMs for BP and Hb measurements
    - o Alternate Vaccine Delivery system in place.
    - o No examination table to conduct abdominal examination of pregnant women.
    - o ANC reporting was not done on the site
    - o Contraceptive services are not provided in the VHND.
    - o Supplies inadequate in some places in VHNDs. IFA and Vit A available. Pediatric IFA, Co- trimaxazole, OCP and EC not available.
  - New Mother and Child Protection (MCP) card not yet implemented.
  - Data on the number of VHNDs held, regularity and evidence of supportive vision during VHNDs was not shared with the team. Cold Chain was adequate
- **Family Planning**
  - Trained manpower is available for laparoscopic sterilizations.
  - Minilap Sterilization and NSV are conducted in DH & CHCs in camp mode. Fixed day services are not being provided for sterilizations.
  - Minilap sterilizations are not provided in the PHCs visited as none of the doctors are trained.

- In the facilities visited, ANMS trained in IUCD insertion and providing services were not able to demonstrate the correct loading technique of the device. Majority of the ANMs interacted were unaware of the 10 years duration of IUCD 380-A.
  - IUCD removal rate reported is as high as 25% for the district with highest removal in Kalyanpura block (57%) which is unacceptable. Causes of removals are generally not recorded in IUCD insertion registers by ANMs and hence not captured in HMIS.
  - There is urgent need for adequate counseling of beneficiaries and skill training of ANMs/MOs for IUCD insertions, removals, and infection prevention/management practices.
  - Supply of OC Pills and Condoms is erratic in the district. EC pills were available in the District warehouse but they were not available in any of the health facilities visited.
  - None of the beneficiaries with whom the team interacted had been counseled for family planning. The 48 hrs stay after delivery should be utilized for counseling for FP by staff nurses in the hospital.
  - Counseling for family planning in VHND is not done although VHND is a good platform for providing counseling for FP services to ANC mothers.
  - The percentage of girls getting married below 18 years is 36%. Besides this, the unmet need for family planning in the district is also high. There is thus a need for focused promotion of spacing methods through IEC and training of staff.
  - There is Lack of supportive supervision despite trained trainers available at district level for IUCD insertion. District trainers urgently need to initiate block level trainings for correct technique of IUCD insertion removal and infection prevention/management practices and correct recording and reporting .It was observed especially at PHC Sarangi that the ANM who inserts IUCD as a routine demonstrated the loading of the device exactly in the opposite direction, thus, defeating the very purpose of IUCD insertion.
  - Discrepancy was observed in reporting failures. Failure rate of sterilization is reported as nil but 3 cases have been so far discussed in QAC meetings.
- **Bio- Medical Waste Management**
    - Bleaching Solution was available in Labor Rooms at the time of Visits. The staff however was not fully aware of its use. This solution should be available in the OT, Laboratory and Injection room/site also.
    - For Waste segregation, separate receptacles are available. Segregation and further disposal are however not carried out as per IMEP guidelines of RCH-2 programme. No other guidelines from state were available in the facilities
- **Adolescent Health**
    - Adolescent Friendly Health Services (AFHS) Clinic set up in District Hospital.
    - Adolescents are also provided services during VHND for de- worming and IFA tablets.
    - An Adolescent Health and Development Project is to be initiated in Jhabua and Dindori Districts of MP. As part of this intervention (with support of UNFPA) clubs of adolescent boys and girls will be established in through adolescent peer educators and peer educators.

### **Health Management Information System (HMIS) and Data Management**

- CHCs and PHCs are using the latest formats and reporting is on time. Computers for HMIS are available at most CHCs/PHCs. Since the district lacks good internet connectivity transmission of data depends on routine channels.
- Data operation at sub centers and some PHCs continues to be manual since computers are not available.
- The utilization of available data for monitoring and planning was not very evident; district and block managers need to be better oriented.
- Mother Child Tracking System has been initiated in the district; needs to be streamlined

### **Gender and PC-PNDT**

- Vishakha guidelines are shared with the district officials. There was an example, where ANMs were harassed by villagers, at night, and the local RKS/Panchayat intervened by posting a guard at the PHC.
- Bitiya club has been set up (includes parents with only daughters); meeting planned from October 2011. A plan for awareness activities in schools and colleges is available – not yet implemented
- Gender disaggregated data is available with the health workers and facilities.
- Separate male and female toilets available in facilities visited.
- Female sweepers are employed in the labor room.
- Jhabua district was amongst the early districts to achieve their ELA for NSV in 2010-11
- District Advisory Committee for PC PNDT is formed but their meeting is not held regularly.
- One private USG clinic is present in the district and is accredited.

### **Training**

- No district training plan was shared with the team. It would perhaps be useful to have one in view of the large number of trainings held under the RCH Programme.
- It was intimated that the FRU facility at Petlawad has been accredited as training centre for SBA training. While this is a good step and otherwise a good step, it may not be appropriate to overstretch the already short staff of 4 doctors and 4 nurses in interest of patient care and quality of training.
- It was noted that ANMs are being trained in 14 days SNCU training which is otherwise meant for doctors and staff nurses who are either working/are to be posted in SNU. The team met 2 ANMs who have been trained for 14 days but are working in their sub health centers with no possibility of their utilizing whatever they have learnt during this training. The rationality of this need to be re-examined.
- A system of monitoring needs to be put in place urgently to ensure quality of training (technical as well as managerial skills) being imparted in the district.
- The database of trained personnel available in the district needs to be constantly updated.

### **ANM Training School**

- Good infrastructure with well-equipped clinical laboratory. Latest Syllabus of Indian Nursing Council (INC) which includes IMNCI and SBA is being used.
- The Principal was trained in IUCD 380 A and was suggested to use Zoe's Model available at the in-service training site for giving hands on training to the students. There is a need for providing a Zoe's model to the school itself.
- The students were posted in labor room and other clinical training site for practical work but it needs to be ensured that they are provided sufficient opportunities to practice the clinical and counseling skills in order to avoid the disconnect between service requirements and pre-service training.

- The school is short of tutors and needs at least one more to confirm to the recommendations of INC.
- The Principal and the tutors need to undergo in-service training programmes in various RCH interventions to bring them up to date with programme needs.

### **Financial management**

- Untied Funds for VHSC and Sub-Centre are not disbursed regularly.
- Corpus Grants for RKS not disbursed regularly
- AMG not disbursed to all Sub centre
- High Unspent balance at both district as well as block level
- Immunization funds is diverted for RCH activity leads to low utilization of funds
- Concurrent Audit system not effective in the district as Concurrent Audit not conducted in the year 2009-10. Delay appointed in the year 2010-11 (Appointed in May, 2011). Not appointed for the year 2011-12.

## State Financial Report

**Financial Status of Madhya Pradesh:** An amount of Rs.1364.87 crore was released by Govt of India since inception of the NRHM i.e. from 2005-06 to 2011-12 against which the State has reported expenditure of Rs.1578.71crore (up to June, 2011) which 112% of funds released. While under Mission Flexi pool total amount of Rs.896.28crore has been released to the State during this period against which the State has incurred reported expenditure of Rs.657.28 crore (up to June, 2011) which is 73% of the funds released. The State has reported expenditure of Rs.75.41 crore under Immunization against release of Rs.60.04 crore which is 130% of release.

Financial Status (Rs. in Crore)								
Particulars	2005-6	2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	Total
<b>RCH FLEXIBLE POOL</b>								
Opening Balance		39.91	45.22	-52.06	-85.79	-182.47	-287.02	0
Allocation	95.31	117.11	264.25	183	194.07	220.34	242.84	1537.26
RELEASE	66.20	114.35	230.65	316.84	244.07	271.34	121.42	1364.87
Available funds	66.20	154.26	275.87	264.78	158.28	88.87	-165.60	1364.87
EXPENDITURE	26.29	109.04	327.93	350.57	340.74	375.89	48.25	1578.71
Unspent Bal	39.91	45.22	-52.06	-85.79	-182.46	-287.02	-213.85	0.00
<b>MISSION FLEXIBLE POOL</b>								
Opening Balance	0	81.55	171.11	220.52	268.49	266.70	250.42	
Allocation	0	106.82	186.73	157.51	207.59	244.36	298.98	1446.35
RELEASE	82.23	136.62	152.24	157.51	147.82	219.86	0.00	896.28
Available funds	82.23	218.17	323.35	378.03	416.31	486.56	250.42	2155.07
EXPENDITURE	0.68	47.06	102.83	109.54	149.61	236.14	11.42	657.28
Unspent Bal	81.55	171.11	220.52	268.49	266.70	250.42	239.00	0
<b>ROUTINE IMMUNIZATION</b>								
Opening Balance	0	8.08	10.21	7.73	-0.86	-8.08	-11.16	
Allocation	12.59	9.77	7.00	8.00	14.75	12.34	12.32	89.11
RELEASE	8.56	5.70	7.4	4.60	9.10	12.34	0.00	60.04
Available funds	8.56	13.78	17.61	12.33	8.24	4.26	-11.16	57.88
EXPENDITURE	0.48	3.57	9.88	13.19	16.32	15.42	1.13	75.41
Unspent Bal	8.08	10.21	7.73	-0.86	-8.08	-11.16	-12.29	0

- 1) Vacancies Position:** There are large numbers of vacancies of District Accounts Managers in the State (currently 26 out of 50 positions are vacant), while at block level, 109 out of 313 positions of Block Accountants are vacant. At Divisional level, 3 out of 7 positions of Divisional Accounts Managers are vacant. The State has appointed a Finance Officer recently. However a Director Finance or DD Finance is required under Ministry's Guidelines. Adequate Finance Officers and staff have not been engaged and deputed at District and Block levels for more than a year.
- 2) Status of Advances:** The State had substantial Advances of Rs. 355. 63 crore (Rs.54.35 crore under RCH , Rs.196.87 crore under Mission Flexi Pool and Rs.4.41 crore under Routine Immunization as on 31.03.2011 which increased to Rs.378.98 crore (Rs94.70 crore under

RCH, Rs.277.89 crore under Mission Flexi Pool and Rs.6.39 crore under Routine Immunization) as on 31.08.2011. The State has not able to provide advance details as on 31.08.2011. The total advance at State Health Society are as on 30.06.2011 is Rs.72.26 crore out of which Rs.12.26 (17%) is shown as advance from district year of which is not available. The Year wise details are as under:

Year	Amount (In Rs.)	(Percentage)
2004-05	14132143	1.96%
2005-06	2371274	0.33%
2006-07	164769271	22.80%
2007-08	29958682	4.15%
2008-09	27792283	3.85%
2009-10	46613152	6.45%
2010-11	260478277	36.04%
2011-12	53847334	7.45%
Advance from Districts	122689513	16.98%
<b>Total</b>	<b>722651929</b>	

- 3) **15% State Contribution:** The state has contributed Rs. 127.09 crore as against Rs. 138.43 crore outstanding up to f .y 2010-11. The State of MP has Rs. 196.69 crore outstanding for the period 2007-08 to 2011-12. The break up of State Contribution are as under:

Year	Amounts required on basis of releases (Rs. in Crores)	Amount Credited in SHS Bank A/C (Rs. in Crores)	Short/ (Excess) (Rs. In Crores)
2007-08	108.90	0.00	108.90
2008-09	124.92	90.00	34.92
2009-10	106.73	133.00	-26.27
2010-11	138.43	127.09	11.34
2011-12	153.80*	86.00	67.80
<b>Total</b>	<b>632.78</b>	<b>436.09</b>	<b>196.69</b>

\*State Share for 2011-12 as per ROP

- 4) **RCH-I Unspent Balance:** The State has total unspent advance of Rs.12.27 crore under RCH-I in the district which need to be refunded by the State.
- 5) **Mixing of Funds:** State is keeping funds received from other programme like UNICEF in the same bank account in which funds for Mission is also kept by the state.
- 6) **Diversion of funds:** Diversion of funds was observed in State from one pool to other i.e RCH to NRHM and also NRHM to RCH and also NRHM to RNTCP in the year 2011-12. Details of the same are as under

Diversion of Funds	
<b>From RCH Flexi Pool to Mission Flexi Pool</b>	
Date	Amount
05-07-2011	10,00,00,000
<b>From Mission Flexi Pool to RCH Flexi Pool</b>	
18-05-2011	2,00,00,000
<b>From Mission Flexi Pool to Immunization</b>	
08-06-2011	5,00,00,000
<b>From Mission Flexi Pool to RNTCP</b>	
01.04.2011	2,00,00,000

02.05.2011

2,00,00,000

- 7) **Procurements:** In the year 2010-11 State has reported total Procurement amounting to Rs.19.71 crore against approved PIP of Rs.11.72 crore. Out total procurement of Rs.19.71 crore an amount of RS.10.00 crore was booked against the payment made to M/s Karnataka Antibiotics and Pharmaceutical limited after judgement of Jabalpur High court against the State Government pertaining to the year 2007-08. This is against purchase made in the year 2007-08 of Rs.31.15 crore and amount of Rs.8.99 crore paid and balance amount of Rs.22.16 crore was to be paid and State has paid Rs.10.00 crore against after court case but what it is not clear about the balance amount.

It reflects that State has not incurred the other procurement planned in the year 2010-11. Further State needs to take approval for re-appropriation/ excess expenditure under procurements head from the Government of India. In the State the procurement has been done from the Madhya Pradesh Laghu Udyog Nigam. MLUN is selecting party on behalf of the state and supplier billed directly to the Sate directly.

- 8) **Civil Works:** At the State for better progress Infrastructure and Civil works under NRHM a Civil Engineering Cell has been created. On the basis of information made available to the team the composition of the cell was as follows:

**State level:** One Executive Engineer and Asst. Engineer was deputed at SHS level. In addition there were two consultants one as Civil Works Consultant and another retired from the rank of Chief Engineer of Govt. Civil Engineering Department.

**District level:** 7 Divisional Asst. Engineer deputed from Civil Engineering Department of the State to monitor the civil works in 7 Divisions. In addition, in few districts sub engineers has been selected on contractual basis.

The main implementing agency for civil works was State PWD. At District levels for construction of Health Sub Centres were done through Rural Development and **Madhya Pradesh Laghu Uddyog Nigam** (State Govt. Agencies). In addition to above, recently the State Civil Engineering wing has assigned work contacts to the agencies registered with PWD through open tender system for civil works in SNCU for all 50 districts, Maternity wards, Paediatric wards, 18 PHC Buildings, Nutrition Rehabilitation Centre and other small civil works at State level. For agencies other than PWD the rates of civil works has been approved as per the scheduled rates of PWD and agreements had taken as per the prescribed format of PWD. Payments made to these agencies (other than PWD) were done through on the basis of running bills.

**Areas where Internal Controls require strengthening:**

- **Poor Monitoring of Civil Works:** While the State had created an Engineering Cell to monitor Civil Engineering Works under NRHM. No mechanism to monitor the works periodically had been developed. No Inspection report on monitoring done was available with the state. There was no indication from the records made available that any such report had been sought by the state.

**The State must roll out a process for monitoring whereby a co-relation between the funds paid to Implementing Agencies and the progress of work (including the specific details of facilities remaining incomplete on time and cost overruns) is available for better focus on end results and targets.** No monitoring of the quality of work was available with the State level officials. For district and sub district level works, it was stated that monitoring was to be done by the engineers posted at Divisional levels. However, no monitoring and feedback on action taken reports had been sought from District level by the State.

- **Milestones for Civil Works Construction not fixed:** No stipulated time frame schedule had been fixed for completion of the works at the time of awarding contract. There was no

monitoring of the progress of work between completion, subsequent delay, if any & handover of the facility.

- **High unspent balance with PWD:** A substantial amount of fund Rs.4.68 crore crore remained unutilised with State PWD. The State should monitor the progress of civil works and install a robust mechanism to expedite the utilisation of fund.

#### 9) Emergency Medical Response Services:

- The State Govt. has entered an MOU with GVK Emergency Management and Research Institute, for operationalization of GVK EMRI 108 Operation in MP on 25<sup>th</sup> November, 2007 which became operational from 16<sup>th</sup> July, 2009.
- 100 Ambulances under this scheme has been procured which were operational in only 9 districts viz. Bhopal, Gwalior, Indore, Jabalpur, Rewa, Sagar, Datia, Damoh and Sehore.
- The fund track sheet maintained by GVK –EMRI comprises of Fund received, operational and capital expenditure is enclosed for ready reference.

#### GVK Emergency Management & Research Institute ,MP Funds track sheet

Sr. No	Year	Letter no	Cheque No	Date	Amount (Rupees)	Opex (Rupees)	Capex (Rupees)
1	2007-08	SPMU/RCH/07-08/1984	250075	19.12.2007	4,00,00,000.00	1,00,80,628.00	2,78,95,856.00
2	2008-09	RCH-II/SPMU/083172	592270	28.06.2008	1,00,00,000.00	3,14,58,544.20	4,36,71,197.00
3	2008-09	SPMU/RCH/4152	855450	31.03.2009	2,53,00,000.00		
4	2008-09	RCH/NRHM/08/4362	874497	17.11.2008	9,07,00,000.00		
5	2009-10	RCH-II/SPMU/09/7612	530232	15.12.2009	50,00,000.00	5,72,30,313.16	1,82,00,358.72
6	2009-10	RCH-II/SPMU/10/8095	845349	04.02.2010	1,62,00,000.00		
7	2009-10	RCH-II/SPMU/10/8504	845379	19.03.2010	2,50,00,000.00		
8	2010-11	RCH-II/SPMU/10	845440	26.04.2010	3,00,00,000.00	10,63,54,981.66	4,58,00,738.28
9	2010-11	RCH-II/SPMU/10/9786	845503	28.07.2010	75,00,000.00		
10	2010-11	RCH-II/SPMU/10/20006	845520	12..08.2010	4,56,00,000.00		
11	2010-11	RCH-II/SPMU/10/10532	845590	06.10.2010	75,00,000.00		
12	2010-11		203648	04.01.2011	2,25,00,000.00		
13	2010-11	RCH-II/SPMU/10/11924	203719	21.01.2011	75,00,000.00		
14	2010-11	RCH-II/SPMU/10/12407	203790	10.03.2011	2,12,50,000.00		
15	2011-12		204241	30.04.2011	1,50,00,000.00	5,05,85,703.65	1,47,540.46
16	2011-12		204519	12.07.2011	4,70,80,000.00		
			<b>Total</b>		<b>41,61,30,000.00</b>	<b>25,57,10,170.67</b>	<b>13,57,15,690.46</b>
					A	B	C
					<b>Balance Grant</b>		
					D=(A-B-C)	<b>2,47,04,138.87</b>	
					<b>Interest &amp; Other Income (E)</b>		
					07-08	5,750.00	
					08-09	1,15,160.00	
					09-10	1,49,080.00	
					10-11	8,60,628.90	
					11-12	4,18,143.68	

**Total Funds in Hand (D+E) 2,62,52,901.45**

- For the year 2011-12, further 50 ambulances under this scheme was sanctioned, however the process has not been initiated by the State. The State should initiate the process at earliest.

**10) Multiplicity of Bank Accounts:** In the State Health Society there is six numbers of Bank Accounts.

**DETAILS OF BANK ACCOUNT OPENED BY THE STATE HEALTH SOCIETY MADHYA PRADESH**

Group	Name of Account	Account No.	NAME OF BANK
A	RCH Flexi pool	30212828612	STATE BANK OF INDIA
B	Additional ties Under NRHM	30213511954	STATE BANK OF INDIA
C	Immunization	30213511965	STATE BANK OF INDIA
D	Common Bank Account	1230100010208	BANK OF BARODA
E	State Office Expenses (SPMU)	10637865333	STATE BANK OF INDIA
F	NIPPI funds		ICCI Bank Account

Apart from above bank there are two banks account Bank of India and UTI which already closed but there is still credit balance available in the books of State Health Society.

**11) Concurrent Audit:**

**a) For year 2010-11:** There is substantial delay in the appointment of Concurrent Auditor for the year 2010-11 in the state. Details of appointment of the concurrent Auditor are as under:

Quarter	No of Districts
First Quarter of 2010-11	2
Second Quarter of 2010-11	23
Third Quarter of 2010-11	19
Fourth Quarter of 2010-11	5
After 2010-11	2

Concurrent Auditor for State Health Society has been appointed only in third quarter of 2010-11. Concurrent Audit report of 16 districts has not yet been submitted.

Concurrent Audit report for the State Health Society has been received on 16th September, 2011. The main observation is as under:

- While checking the opening balance we noticed that cash balance was understated by Rs. 3683.84 s on 1 April 2010 and it still continued
- The department spent fund on installation of TALLY in May 2010. NRHM is still maintaining accounts on manual basis during financial year 2011 -12 as well.
- In the following cases VAT is not deposited within in the prescribed time limit : -

Deductee Name	Due date of depositing	Date of deposited	Amount
M/S Govind Fabrication	15-01-2011	19-01-2011	Rs.4748
M/S Plexus Consultancy Services	15-01-2011	19-01-2011	Rs.14669/-

- In the following Cases TDS is not deposited within the prescribed time limit : -

Deductee Name	Due date of Depositing	Deposited on	Deduction on	Delay	Amount
Yash Construction	07-12-2010	08-12-2010	29-11-2010	01	Rs.30587/-
M/s Maharaja Associate	07-01-2011	12-01-2011	14-12-2010	05	Rs.9380/-
Vasundhara Travels	07-01-2011	12-01-2011	31-12-2010	05	Rs.1183/-
Jansampark Sanchar	07-01-2011	13-01-2011	31-12-2010	06	Rs.1585/-
R.K Travels	07-01-2011	19-01-2011	28-12-2010	12	Rs.2229/-

- It has been observed that the following cheques were issued but not presented for payment S.B.I. NRHM A/c. The Following cheques are time barred , is pending for reversal in the books.

S.No.	Cheque No	Date	Amount (Rs.)
1	414620	04-04-2007	5000/-
2	530264	04-01-2010	466720/-
3	530265	04-01-2010	501720/-
4	530292	11-01-2010	650/-

- f) Bank Reconciliation of SBI shows following credits received in the bank but the effects thereof are not found in the books.

S.No	Date	Amount
1	18-12-2008	Rs.10746
2	12-02-2008	Rs.1
3	05-06-2008	Rs.162608
4	28-06-2008	Rs.356
5	No record of date	Rs.54

- g) Similar the following debits were found in NRHM, SBI statement, but not responded in the books of society.

Sino.	Date	Cheque No.	Amount
1		124192	1353
2	24-05-2007	-	5000
3	31-12-2008	-	2040
4	27-03-2008	-	400
5	07-04-2008	35652	25770
6	06-05-2008	35712	12238
7	06-05-2008	-	355
8	06-06-2008	35810	5243
9	06-06-2008	35784	590
10	02-07-2008	340191	2651
11	12-12-2008	844944	3475
12	12-08-2008	844939	1525

- h) The Society purchased medical kits for a total amount Rs. 31125000/- against which Rs.62251200/- was paid in the 2007-08. There was a dispute with the supplier regarding medical kits. The matter went to the honourable Jabalpur High Court. The society has to pay Rs. 10000000/- under the order of the court. Since much detail of the order and the matter is not available on the records, the proper treatment of the whole transaction cannot be decided. The justification for the payment of Rs. 10000000/- , which is shown as the expenditure needs to be looked into.
- i) The royalty amount deducted the bills of the contractor is liable to be deposited with the conserved authority. It is advice able to keep such royalty amount in the separate bank account so that the society does not face any payment crises at the time of actual payment
- j) Under the scheme the society purchased ambulance Rs. 76844626/ for EMRI 108. The amount has been treated as expenditure. From the nature of the transaction there is no clarity regarding the ownership of such ambulances. Therefore, the matter needs further elaboration.
- k) Advances adjusted to against Rs.2266957 of flexi pool are not bifurcate by the society in the proper head which has not been defined by the society.
- l) Payment made to Tops security services amount to Rs. 21959/- TDS deducted net of service tax amount. Otherwise TDS should be deducted on the gross amount which is including service tax amount
- m) The royalty amount deducted the bills of the contractor is liable to be deposited with the conserved authority. It is advice able to keep such royalty amount in the separate bank account sot that the society does not face any payment crises at the time of actual payment.
- n) Under the scheme the society purchased ambulance Rs. 76844626/ for EMRI 108. The amount has been treated as expenditure. From the nature of the transaction there is no clarity regarding the ownership of such ambulances. Therefore, the matter needs further elaboration.

- o) Advances adjusted to against Rs.2266957 of flexi pool are not bifurcate by the society in the proper head which has not been defined by the society.
- p) Payment made to Tops security services amount to Rs. 21959/- TDS deducted net of service tax amount. Otherwise TDS should be deducted on the gross amount which is including service tax amount.
- q) In case of voucher No. 510 dated 17-11-2010, cheque no. 3078033 payment made to M/s Plexus Consultancy Services amounting to Rs. 751968/- In this respect tender process papers not made available to us for verification.
- r) Payment made to the Dynamic Garage and Carries Bhopal, voucher no. 514, date 02-12-2010, amounting to Rs.212186/- T.D.S. deducted net of service tax amount. Otherwise TDS should be deducted on the gross amount which is including service tax amount.
- s) Payment made to DSS security on 04-12-2010 amounting to Rs.211667/-. TDS deducted net of service tax amount. Otherwise, TDS should be deducted on the gross amount which is including service tax amount.
- t) On 06-12-2010 payment made to M/s Palak Enterprises amount of Rs.269918/- TDS not deducted on such payment and in this respect tender process papers were not available to us for our verification.
- u) TDS return for the quarter (October-December) filed after the due date on 21-01-2011.
- v) No satisfactory explanation was given to us for the credit balance of Rs.78211/- in the name of Mr Nema and Rs.11817/- in the name of Atul Kulshreshtha outstanding for more than 9 months.
- w) Under the scheme the society purchased Laptops and Computers for Rs.6648057. The amount has been treated as expenditure. From the nature of the transaction there is no clarity regarding the ownership of such Laptops and computer. Therefore the matter needs further elaboration.
- x) Bank of India and UTI showing credit balance of Rs.24131/- and 950116, respectively, NRHM already closed these accounts but it is still showing credit balance in the bank books.
- y) Advances given to the staff which has been pending from long-time showing in following :-

1. Basant Shailke	Rs.159705 Dr.
2. S.L. Rawat	Rs.85000 Dr.
3. Rajesh Sharma	Rs.20000 Dr.
4. M.J. Chawala	Rs.72200 Dr.
5. Savita Jain	Rs. 26800 Dr.
6. Sanjay Nema	Rs. 15665 Dr.
7. Ashwin Bhagwat	Rs. 85000 Dr.
8. Ram Milan Sahu	Rs. 13735 Dr.

- z) Huge Outstanding advances pending at state , Districts and Sub District Level and out of which some of the amounts are pending for the more than 9 months which needs to be settled at the earliest .The total Advance as on 31.03.2011 was Rs.64.93 crore.

**b) For the year 2011-12 :**The State has appointed Concurrent Auditor for the year but Audit for the year 2011-12 not yet started at the state level.

**12) Statutory Audit Report for the year 2009-10:** State had submitted incomplete Audit Report (without NDCPs) for the year 2009-10 on 9<sup>th</sup> September, 2010 which was not accepted and returned to the state on 20<sup>th</sup> September, 2010 along with some prime-facie observations. State had submitted a revised Audit report on 4<sup>th</sup> January, 2011. FMG has reviewed that audit report and an analysis report has been sent to the state on 10<sup>th</sup> February, 2011. In response the state has sent a compliance report which was further analyzed and comments, sent to the state on 29/04/2011. Reply to the same is awaited. Some of the major observations are as under:

- a) The state is required to furnish the details of adjustment of Rs. Rs. 74.02 Lakhs which is shown as "Difference in Opening Balance/Books".
- b) The state must pass all rectification entries for all old outstanding cheques issued for more than six months but not paid by bank and for pending credit entries shown by bank but not entered in the books of the SHS.
- c) The state is again advised to follow up with Auditor regarding details of advances and send the same to the Ministry at an early date.
- d) The state is requested to check details as given in Annexure B of the state's reply and pass necessary entries giving effect to these bank drafts of Rs. 67.06 lakhs shown as outstanding as on 31.03.2005.(Refer audited balance sheet of year 2004-05 ) which has been cleared in the next financial year.
- e) In the reply the details of other Current Assets have been given in Annexure 'C', where in under the head Intensive Pulse Polio Immunization (IPPI) following items needs further clarification.

Difference in Opening Cash & Bank Balance = Rs.4.23 lakhs

Suspense A/C 2004 Fund in Transit = Rs.12.79 lakhs

Difference in Opening Capital Fund = Rs.22.99 lakhs

- f) The state is advised to follow up with the Statutory Auditor regarding adjustment of Rs.315.70 lakhs being difference of "**Additions/adjustments**" and "**Expenditure/Transfer** " as shown in Schedule IX of Audited Balance Sheet as on 31.03.2010 under Reserve and Surplus funds and send details of the same to FMG.
- g) As per the Balance sheet as on 31.03.2010 unspent grant shown is Rs.21.40 crore whereas as per the various programme wise schedules (I-B to I-K) the total unspent balances comes to Rs.166.60 crore. This is not clear and the state is required to clarify the same, as to why schedule wise unspent balances have not been provided.
- h) The state is required to furnish the details of adjustment of Rs. Rs. 5.31 Lakhs which shown as difference in Opening Balance in Receipt & Payment Account
- i) The state is advised to conduct regular follow up so that all RCH –I advances are settled during current year and are reported to FMG.
- j) **Statutory Audit Report for the year 2010-11:**The Statutory Audit for the year 2010-11 is completed in the State report is yet to be received by Govt of India.

### 13) E-BANKING:

During the conclusion meeting of 8th JRM, on discussion with high unspent balance the State MD stated he would like to go ahead with E-banking developed by NRHM-Finance division as the details of funds balance, advances and other reports were not available with CPSMS. He instructed the State Finance Division to send letters the Ministry for implementation of E-banking (NRHM-Financial Management System).

## Financial Management (District Mandsaur)

### Critical Internal Control Issues:

On analysis of books of accounts at DHS –Mandsour, following anomalies has been noticed that needs immediate intervention.

- I. Frequent diversion of fund from one pool to another pool under NRHM:** Frequent fund diversion from one pool to another pool under NRHM has taken place during the year 2010-11 and 2011-12.

Few of which were as follows:

Date- 7/2/2011: Rs. 50,00,000.00 from NRHM Additionalities to RCH Flexible Pool .  
 Date-18/4/2011: Rs.25, 00,000.00 from RCH Flexible Pool to NHRM Additionalities.  
 Date -23/6/2011: Rs.700,000.00 from RKS account to Civil Surgeon cum Hospital Supdt. ( JSY)  
 Date- 10/5/2011: Rs.100,000.00 from Civil Surgeon Account to RKS account.

**Recommendation: The diversion of funds from one pool to another is not allowed under NRHM.**

- II. High Cash Balance:** For better payment mechanism the district has opened an account at Axis bank for payment to JSY beneficiaries and Incentives under Family Planning, in the name of Civil Surgeon cum Hospital Superintendent (Janani Suraksha Yojhana). It was noted that for the purpose of compensation payment to the beneficiaries of Family Planning substantial amounts of cash withdrawn [such as 16/3/2011 Rs.100,000 (self) , 25/3/2011 Rs.100,000.00 (self)], without assessing the average number of beneficiaries that would avail the benefit and a substantial amount of cash balance was lying under this account during the period of visit. **A high amount of cash balance amounting to Rs. 108,180.00 was lying on 11/9/2011 at District Head Quarter under this account head during the visit.**

**Recommendation: The District should avoid maintaining high amount of cash balance.**

- III. Delay in distribution of funds:** Delay in distribution of funds has been noticed At Head Quarter.

**As on 31.08.2011, high amount of bank balance amounting to Rs. 1.32 Crore and total unspent balance of Rs.2.93 crore under NRHM Additionalities has been noticed.**

(Rs. in lakhs)

Programme	Closing Balance at the end of 31.08.2011			
	Cash	Bank	Pending Advances	Total
<b>RCH II</b>	<b>0.00</b>	<b>26.62</b>	<b>223.01</b>	<b>249.63</b>
<b>NRHM Additionalities</b>	<b>0.00</b>	<b>132.34</b>	<b>161.12</b>	<b>293.46</b>
<b>Immunization</b>	<b>0.00</b>	<b>6.62</b>	<b>11.07</b>	<b>17.70</b>
<b>Total</b>	<b>0.00</b>	<b>165.58</b>	<b>395.20</b>	<b>560.78</b>

**Reasons for high unspent bank balance at DHS it was explained that the funds received from SHS in the month of June, 2011 was distributed in the month of September, 2011.**

**Delay in distribution of the fund defeats the purpose of the programme.**

**IV. Mixing of funds of Donor Agencies with the NRHM Account:** It has been noted that funds received from the Donor agencies has also been included. Such as funds received from UNICEF and other agencies were mixed up under NRHM fund account.

**V. Ineffective Concurrent Audit Mechanism:**

- (a) For better internal control the District has initiated the concurrent audit mechanism on monthly basis. However, it was noticed that the concurrent auditor has signed the reports from November, 2010 to March, 2011 on a single day dated 28/5/2011. The purpose of concurrent audit gets defeated if it is not carried out on regular basis. As the reports were signed on a single day obviously the observations will be similar one. To get similar observation for different months reflects irregular mechanism of concurrent audit mechanism.
- (b) Stale cheques not rectified: Due to the absence of robust concurrent audit system, the stale cheques not presented for payment for more than two years remained unclear in the books of accounts and appeared in the Bank Reconciliation Statement as on 31.03.2011. Few of which were

Date	Cheque No.	Amount
29/3/2008 (RCH)	775295	15209.00
03/07/2008(RCH)	91406	5000.00
09/7/2010(RCH)	52129	400.00
12/4/2010(MFP)	28435	10000.00
20/12/2007(MFP)	794311	34216.00

**Recommendation:** The DHS should regularise the concurrent audit mechanism for better internal control. Rectification entries for stale cheques need to be passed.

**VI. High Amount of Unspent Balance at DHS level:**

A high amount of advance amounting to Rs.1,84,51,177.00 at DHS level was noticed as on 31.03.2011 inclusive of advances for more than 2 years , on which no action has been taken.

**Advances remained unsettled for more than two years Rs. 685,499.00. Few of which were**

Particulars	Amount
Advances to BMO Dhundarka	200,000.00
Advances to BMO Melkheda	10,400.00
Advances to CS Office Mandsour	400,150.00
<b>Amount of Rs.46,68,620.00 remained as advances for more than 1 year but less than 2 years. Few of which were as follows:</b>	

Particulars	Amount
Advance to RKS Nimbod	2,28,832.00
Advances to RKS Nagri	100,000.00
Advances to RKS Bhavgarh	1,30,524.00
Advances to DTO	11,15,337.00
Advances to PWD	10,26,836.00
Advances to SHC-Maintenance	496947.00
<b>In addition to above, it was noted a high amount of advances amounting to Rs. 12,87,674.00 towards advances to various RKS functional under the District.</b>	

**DHS- Mandasaur**  
**RCH/NRHM/Immunization**  
**Details of Pending Advance as on 31.08.2011**

S.NO	Name of Persons/ Institute	Opening Balance of Advances As on 01-04-2011	Advance Given After 01.04.2011	Total Advances	Exp. Received Against Advance	Pending Advance
1	Block Dhundarka	2903558	5565000	8468558	1044769	7423789
2	Block Malhargarh	2561429	4930576	7492005	2120190	5371805
3	Block Melkhera	2020254	7300000	9320254	2379738	6940516
4	Block Sandhara	3413690	3470000	6883690	2126333	4757357
5	Block Sitamau	1814033	7795000	9609033	3069044	6539989
6	District Hospital	1895021	8100000	9995021	4537754	5457267
7	Others Inst/Person	3843192	578387	4421579	1000823	3029733
	<b>Grant Total</b>	<b>18451177</b>	<b>37738963</b>	<b>56190140</b>	<b>16278651</b>	<b>39520456</b>

**High amount of advances to the peripheries of DHS amounting to Rs. 3.95 Crore needs to be liquidated at the earliest.**

**Recommendation: Robust monitoring mechanism to settle the high advances.**

**VII. No Budget Receipt & Control registers were maintained:** No Budget Receipt & Control registers were maintained. The funds were distributed from the SHS in various pools under NRHM as per the approved DHAP; however the district didn't make the allocation of funds received as per the approved budget. As a result it was noted that utilisation of funds had not taken place uniformly. It is also not known under which activity how much amount has been received.

**VIII. Utilisation of Interest funds:** Utilisation against Interest earned had taken place in the pool under which that was earned; however the approval for utilisation had not been taken up in DHS.

**IX. Mismatch in JSY Payment Register and Delivery Register Serial No:** Few instances of mismatch had been noticed. It should be rectified.

**Other Issues:**

**HR:** The position of District Programme Manager and District Accounts was vacant in the District for a long period of time. One of the Block Accounts Manager was deputed in the District to look after Accounts. Divisional accounts manager was posted at there that looked after four to five districts.

**Key Recommendations:** To improve the Financial Management System the vacant positions needs to be filled in at the earliest.

**CPSMS:** In the District the pilot run of the CPSMS was going on. On discussion with the deputed District Accounts Manager the following observations has been noted.

- (i) Time Consuming
- (ii) Reports, MIS, FMR etc, were not generated.

(iii) Information and bifurcation of accounts does not show this software.

#### **Financial Management (CHC-Sitamau)**

- I. Diversion of funds from one pool to another pool.** Frequent fund diversion from one pool to another pool under NRHM has taken place during the year 2010-11 and 2011-12. Such as on dated 13.07.2011, fund transferred from NRHM Additionalities to RCH Flexible Pool of Rs.300,000.00
- II. No proper books of Accounts were maintained :**
  - No bank book was maintained, hence there was no bank reconciliation.
  - There was only cash book and no ledger, although proper cash book was maintained. Daily closing of transactions had not been taken place.
  - No Advance register to monitor details of advances and funds remained unspent.
- III. AMG Funds were distributed to HSCs for non government buildings:**

It was noted that during the year Annual Maintenance Grant @Rs.10000/= per Health Sub Centre (HSC) had been given to sub centres which were in Non – government buildings. In that block out of 38 HSCs there were 31 in Govt. buildings and 7 were in rented premises. However the funds were distributed to all the 38 HSCs. No instruction was communicated by the DHS to Blocks.

**The District office didn't aware that the AMG funds were meant for only Govt. buildings. The same may happened with other blocks also those coming under that district.**
- IV. No post facto approval of funds utilised under RKS of PHC Sitamau:**

Substantial portion of the RKS fund was utilised for major civil construction work, although there was no post facto approval of the expenditure. The RKS decisions taken for civil works was also not specific.
- V. All VHSCs accounts were opened up:** It was told that in Sitamau there were 231 revenue villages, however only 132 no. of VHSCs has been formed till date.
- VI. Funds were distributed to blocks pool wise except UF, AMG and RKS funds however, the block was not aware of their approved plan. As a result frequent fund diversion has not been taken place.**

### Financial Management (District Jhabua)

- 1) **Financial Status of Jhabua:** It was observed that since 2007-08 to 2011-12 Rs.31.40 crore was released under RCH and total expenditure reported for the period is Rs.35.84 crore while under Mission Flexi pool total release is Rs.17.74 crore and reported expenditure is Rs.9.69 crore for this period. while under Immunization total Rs.1.02 crore was released to the district and expenditure reported is Rs.0.70 crore .Details are as under

Financial Status of District Jhabua			
RCH Flexi Pool			Expenditure (Rs. in lakh)
Financial Year	Approved PIP	Releases	
2007-08	969.15	810.00	1068.37
2008-09	1215.35	970.00	1120.47
2009-10	590.66	492.00	452.17
2010-11	664.22	558.00	737.79
2011-12	713.76	310.74	204.84
Mission Flexi Pool			Expenditure
Financial Year	Approved PIP	Releases	
2007-08	362.35	355.00	217.29
2008-09	513.62	420.00	224.96
2009-10	332.47	270.00	206.26
2010-11	538.48	295.34	271.15
2011-12	474.37	335.15	49.06
Immunization			Expenditure
Financial Year	Approved PIP	Releases	
2007-08	44.89	10.00	11.83
2008-09	52.96	26.43	17.02
2009-10	30.48	15.00	19.21
2010-11	32.8	29.00	18.72
2011-12	29.35	21.80	3.66
<b>Source of data- District presentation of Jhabua (for expenditure) and Release Collected from State level</b>			

- 2) **Release of Funds:** Funds from the State to district level is transfer pool wise not activity-wise. District Health Action Plan is not being use at state level. In the beginning of the year approved PIP is being sent to district. From the district to block level funds is being transferred pool wise. In the year 2010-11 Jhabua district Untied funds to VHSC and sub centre are released from the block as well as from district i.e. first one installment from the block and other from the district level.

**Recommendation: Funds should be released from one entity for better internal control**

- 3) **Books of Accounts:** Books of Account is prepared in Tally Erp9.0 at district level but it was update up to 31<sup>st</sup> August, 2011as same was provided to the team up to 31<sup>st</sup> August, 2011. Books of accounts in block levels are maintained manually.
- 4) **High Unspent Balance:** It was observed that there is high unspent balance at District level total Rs.2.34 crore is outstanding advance as on 31.08.2011 out .Details of advance outstanding since 01.04.2010 are as under:

Sl no.	Particulars	Balance as on	
		01.04.2010	31.08.2011
1	RKS Pitol PHC	1,00,000	1,82,500
2	RKS Madrani	2,00,000	2,00,000
3	RKS Rambhapur	1,00,000	1,00,000
4	BMO Bettawad	12,33,591	23,40,856
5	Para CHC MO	92,264	1,54,834
6	Rama BMO	14,42,540	18,54,253
7	RKS Rama CHC	1,53,590	5,35,490
8	Umarkot PCH MO	76,001	1,51,000
9	Ranapur BMO	1,19,165	8,20,879
10	RKS Kakanwani PHC	1,00,000	1,00,000
11	Thandla BMO	19,62,259	29,47,594
12	Misc Advance	14,22,353	14,22,353

Further district has high bank balance as on 31.08.2011 which Rs.2.80 crore it reveals that district has not made funds to the sub-district level during the year 2011-12.

**Recommendation: District should do robust monitoring for settlement of advance. District should disbursed the funds to sub-district level as soon as they receive funds from the state level**

- 5) **Bank Reconciliation Statement:** Bank Reconciliation Statement not prepared on monthly basis at District Health Society. It is prepared up to 31<sup>st</sup> March, 2011 only. It was observed in BRS of RCH bank Account there is an amount of Rs.275637 shown as un-reconciled balance pertaining to the period of 2008-09 which need to be looked into. Further there are some Stale cheque amount of Rs.21000 which need to be reversed. Further in CHC - Petlabad no Bank Reconciliation Statement was prepared after 31<sup>st</sup> March, 2011. It was also noticed that in CHC – Petlabad no Bank Reconciliation Statement was prepared for JSY Bank Account since inception.

**Recommendation: District should prepare Bank Reconciliation Statement on monthly basis.**

- 6) **Irregular disbursement of funds:** It was observed that in the district of Jhabua funds for Untied funds for Sub centre, VHSC, AMG and Corpus Grants for RKS not disbursed regularly. Untied funds not received by Barkheda sub centre in the year 2010-11 only Rs.5000 received in the year 2011-12. Same in case of Sub centre Unnai funds for 2009-10 received in the month April, 2011 i.e. in 2011-12. RKS Funds not received by CHC Meghnagar in 2010-11 which was received in the year 2009-10, further in case of Petlabad RKS funds for 2010-11 received in the month of March, 2011. Annual Maintenance grants were not disbursed to Sub centre under CHC Petlabad in last three years 2008-09 to 2010-11. Further partial VHSC fund disbursed under CHC Petlabad.

**Recommendation: District should disbursed funds as per Block action plan and in regular for all activities.**

- 7) **Diversion of funds:** Frequent diversion of funds was observed in the district from one funds i.e. RCH to NRHM and also NRHM to RCH. Details of the same areas under

<b>Diversion of Funds</b>	
<b>From RCH Flexi Pool to Mission Flexi Pool</b>	
<b>Date</b>	<b>Amount</b>
<b>05-08-2010</b>	10,00,000
<b>From Mission Flexi Pool to RCH Flexi Pool</b>	
<b>10-06-2010</b>	30,00,000
<b>02-11-2010</b>	5,00,000
<b>16-11-2010</b>	20,00,000
<b>28-02-2011</b>	2,00,000
<b>07-03-2011</b>	50,00,000
<b>16-03-2011</b>	2,00,000

**Recommendation: Diversion of funds should be avoided as it is not allowed under Mission.**

- 8) **TDS:** District has not deposited TDS on time as total TDS payable as on 31.08.2011 is Rs.310883 out which Rs.73120 pertaining to year 2010-11.

**Recommendation: Statutory due should be deposited on time to avoid any penalty for delay payment.**

- 9) **Concurrent Audit :** Concurrent Audit system is not effectively implemented in the district of Jhabua as it was not appointed for the year 2009-10. There is substantial delay in the appointment of Concurrent auditor for the year 2010-11 which was appointed in the month of May, 2011 after completion of the financial year. Although Audit was completed *but* report was not received till date of the visit. Further Concurrent Auditor was not appointed for the year 2011-12.

**Recommendation: The DHS should regularize the concurrent audit for better internal control. Timely appointment of concurrent auditor leads should give better financial monitoring.**

- 10) **Statutory Audit:** Statutory Audit for the year 2010-11 is completed in the district. Statutory Auditor has not visited block in the district. Further district has not sent compliance of the audit for the year 2009-10. Some of the major observation for the year 2009-10 are as under:

- Advances: There are outstanding advances of Rs.144.20 crore as on 31.03.2010 which are pending for adjustment. There is time gap between the date of advance & its adjustment due to ineffective monitoring.
- TDS has been not deducted from the payment made to M/S Seva Bharti for running Mobile Medical Units total payment during the year 2009-10 is Rs.67.20 lakh
- In the balance sheet for the year 2009-10 there is old outstanding amounting to Rs.66.23 lakhs under the head IPPF FUND (As per Last Report). It is clarified to us that this fund was disbursed to Pulse Polio team of the district who already furnished UCs for the same to the State and there is no physical funds available in the district.
- There is no compliance available for the Statutory Audit report in the district.

**Recommendation:** District must send compliance report on Statutory Audit report to the State.

#### **11) Low utilization of Immunization Funds:**

**A)** It was observed that in the District Jhabua 57% of funds were utilised under Immunization head. Moreover most of the expenditure is under ASHA incentive head which is 43% of the total budget of immunization but expenditure under this head is 63% of total expenditure. It was also observed that in one of CHC—Patel bad there is frequent diversion of from Immunization to RCH. Details are as under:

Year	Funds Received	Date of receipt of funds	Amount transferred	Date of transfer	Remark
2009-10	4,00,000	05.11.2009	82050	19.11.2009	RCH
			150000	05.12.2009	RCH
2010-11	100000	06.07.2010	1,00,000	08.10.2010	JSY
	200000	31.01.2011	150000	31.01.2011	JSY
2011-12	200000	20.07.2011	100000	25.07.2011	JSY
			80000	25.08.2011	JSY

B) In the year 2010-11 district of Jhabua has received an amount of Rs.55.71lakh from the State health Society for Immunization activity and Rs.7.14 lakh was unspent balance as on 01.04.2010 under this activity, out of which Rs.10.00 lakh transferred to the block level , Rs. 300000 was diverted to RCH and Unspent balance as on 31.03.2011was Rs.44.74lakh.Further in the year 2011-12 no funds received from the State and Rs.12.00 lakh was released to the district and Rs.32.68 lakh was unspent balance as on 31.08.2011.

#### 12 Other Issues:

- a) **Mobile Medical Unit** : In the district Medical Mobile Unit which is running as **Pt. Deen Dayal Chalit Aspatal** which is not operational in the district Jhabua since February,2011.Total 6 MMU was running in the district out of which 5 is not operational since February,2011 and 1 is not operational since June,2011.This may be looked into.
- b) **Referral Transport:** Janani Express which is used as referral transport in the district is hired vehicle. While checking records pertain to the Janani express it is observed hat insurance of some of the vehicle was expired and renewal of the same was not available.
- c) **Civil Constructions:** In the district Jhabua major civil works is undertaken by PWD and PHED.As explained to us that advance released to agencies and same is adjusted after receipt of UCs.The outstanding advance as on 31.08.2011 is as under  
**EE PWD, Jhabua- Rs.16.32 lakh**  
**PHE Jhabua- Rs. 5.45 lakh**
- d) **Human Resources:** In the district Jhabua post of District Programme Manager is looked after by Dr. Rahul who is medical officer in district hospital holding additional charge of District Programme Manager. Out of 6 posts of Block Programme Manager one post is vacant. Further 3 out of 6 post of Block Data Entry Operator is vacant.
- e) **JSY Payment:** In the district Jhabua most of the JSY payments are regular but in few cases there were delay observed in two CHC ,Petlabad and Meghnagar instances are as under

#### Details of Delay in Payment - JSY

CHC-Petlabad	Date of Delivery	Date of Payment
S. N	Date of Delivery	Date of Payment
1	08.04.2011	18-06-2011
2	14.03.2011	21.06.201
3	03.08.2011	24.08.2011
4	07.08.2011	24.08.2011
5	28.07.2011	27.08.2011
6	11.07.2011	09.09.2011
<b>CHC-Meghnagar</b>		
7	01.02.2011	02.05.2011
8	17.02.2011	02.05.2011

## **STATE VISIT REPORT:**

### **MAGHALAYA**

## **RCH II: JOINT REVIEW MISSION VIII: STATE VISIT REPORT MAGHALAYA (SEPTEMBER 12-17, 2011)**

### **Introduction**

A joint Review Mission led by Ministry of Health and Family Welfare, Government of India and development partners visited Meghalaya during September 13-17, 2011 to review the implementation of the Reproductive and Child Health II program (RCH II).

The details of Mission members are mentioned in Annex 1.

The eighth JRM has focused on the following aspects: Progress since inception, Programme Management and Supervisory Structures at Various Levels, Quality of Services, Health Management Information System (HMIS) and data management and Gender including PCPNDT.

As a part of the JRM, Sh. D. P. Wahlang, Mission Director (NRHM), and Commissioner (Health), Department of Health and Family Welfare, Government of Meghalaya, chaired a briefing meeting on 12<sup>th</sup> September 2011 in Shillong which was attended by the senior officers of the department.

Mission Director of the Meghalaya presented progress made by states in RCH and NRHM during the Briefing JRM team interacted with state officials and program officials for clarification on programmatic issues for planning for district visit.

The mission visited two districts, Jaintia Hills and West Khasi Hills (both districts are RCH high focus districts). The details of the facilities visited are provided in the Annex 2. Further, two district sub group were constituted and thematic areas had been assigned to each of the team members. Team were accompanied by the state official for facilitation of the field visit. At the district level, the JRM team were briefed in meeting under the chairpersonship of the Deputy Commissioner (District Collector of the districts). A detailed presentation was made by the District Medical and Health Officers of the district. District field visit plans were finalized after the discussion with the district health officials.

Both the district team have visited District Hospitals, Community Health Centre, Primary Health Centre, Sub Centre, Village Health and Nutrition Day proceedings and interacted with health officials, health workers, Village Health Sanitation Committee members and beneficiaries at all levels. Team members Interacted with District health official and NRHM program officials during visits for programmatic issues.

On the last day of the field visit, respective district team made a debriefing presentation at the District Head quarter under the chairpersonship of the Deputy Commissioner of the districts.

The Mission had a debriefing meeting on the key findings of the JRM state visit on September 16, 2011 with Sh. D. P. Wahlang, Mission Director (NRHM), and Commissioner (Health), and Additional Secretaries of the Department of Health and Family Welfare. Individual program officers clarify on the issues raised in the debriefing presentation. The Mission Director commented on the findings and assured the team leader of JRM to call a review meeting of the district officers of both the districts to disseminate the finding of the JRM visit.

The team would like to acknowledge the efforts made by Government of Meghalaya for facilitating the review and appropriately responding to various issues raised by the JRM members.

### State Profile:

Meghalaya has come a long way in improving the health facilities and improving health status of the people in this hilly state during the last 38 years of its creation. While the coverage and the reach to the people have also increased over these years, the state still has many challenges to counter and has to go a long way to achieve the desired results of health for all.

The Public health system of Meghalaya, through the ASHAs, the Auxiliary Nurse Midwifery (ANMs), Anganwadi Workers (AWWs), General Nurse Midwifery (GNMs) and Doctors reach out to the people living in about 6250 villages. 39 Block of Seven Districts of states are now functional unit for implementation of the NRHM activities. Five out of the total seven districts of Meghalaya are RCH high focus districts i.e. East Garo Hills, Jaintia Hills, South Garo Hills, West Garo Hills and West Khasi Hills.

Map of Meghalaya



Demographic/ Socioeconomic Indicators of Meghalaya

Indicator	Meghalaya (2011)	India (2011)
State Population – Total (in lakhs)	29.65	1210.19
Population density (persons/ sq. km)	132	382
Decennial Growth Rate (%) 2001-11	27.82	17.64
Sex ratio (females/ 1000 males)	986	940
Area in sq km	22,429	3,287,263
State Population – Total (in lakhs)	29.65	1210.19
Population density (persons/ sq. km)	132	382
Literacy rate (in %)		
Total	75.48	74.04
Male	77.17	82.14
Female	73.78	65.46

#### i) Outcome indicators

Indicators	Meghalaya	India
Maternal Mortality Rates	343(HMIS 2010-11)	212 (SRS 2009)
Infant Mortality Rates	59 (SRS 2009)	50 (SRS 2009)
Total Fertility Rates	3.1 (SRS 2007)	2.6 (2009)

## ii) Health Infrastructure

Centres	Jaintia Hills	West Khasi Hills	Meghalaya
AWW centre	565	616	5115
Sub Centre	76	61	405
Primary Health Centre	18	19	109
Community Health Centre	5	5	29
Sub Division Hospital	-	1	1
District / Civil Hospital	1	1	7
Medical College	-	-	-
FRU DH	1	-	5
FRU CHC	-	-	0
24 X 7 PHC	2	2	14

## Profile of Visited Districts

### West Khasi Hills

West Khasi Hills lies in the central part of the State of Meghalaya and is situated between approximately 25 degrees 10' and 25 degrees 51' N latitude, and between 90 degrees 44' and 91 degrees 49' E longitude. It is bounded on the north-west by Kamrup district of Assam, on the north-east by RiBhoi district, on the east by East Khasi Hills district, on the south by Bangladesh, on the west by East Garo and South Garo Hills districts. The district comprises an area of about 5,247 sq. kms which is 23 percent of the total area of the state. Nongstoin, covering an area of about 76.00 Sq. Kms, is the Headquarter of the District. The District has 1136 villages. Administratively West Khasi Hills has 2 Sub-Divisions namely Mairang Sub-Division & Mawkyrwat Sub-Division and 5 C & D Blocks – Mairang, Mawkyrwat, Mawshynrut, Mawthadraishan, Ranikor & Nongstoin.

### Jaintia Hills

The Jaintia Hills District lies between Latitude 24° 58' and 26° 6' N and Longitudes 91° 59' and 92° 51' E. The Jaintia Hills District is the easternmost district of Meghalaya. It is bounded with the Karbi-Anglong district of Assam in the north, North Cachar Hills and Cachar Districts of Assam in the east, Bangladesh in the south and East Khasi Hills District in the West. District Head Quarter of the Jaintia Hills is Jowai. Geographically it covers an area of 3819 sq.kms. District has two sub divisions Khliehiat and Amlarem and 5 Community Development blocks-Amlarem, laskein, Thadlaskein, Khliehiatn & Saipung, Jaintia hills district is also well known for coal mines in the area. Coal mining has improved the socioeconomic status of the population in the area.

### Socio-economic indicators of visited districts

Indicators	West Khasi Hills	Jaintia Hills
Total Population (Enumeration, 2011-2012)	381099	4,44,252
Sex ratio	980	1018
No. of villages	1136	
Literacy rate (in %)		
Total	79.30%	53.03%
Males	80.29%	50.52%

Females

78.30%

55.54%

### **Progress on RCH II Goals and Outcomes**

The state has reported the following progress on RCH II interventions:

Maternal Health: including JSY, Number of JSY beneficiaries in the state increased from 4257 in 2006-07 to 8600 in 2008-09, and 12699 in 2010-11 (till Dec 2010). State has operationalized 6 FRUs and 26 PHCs as 24X7 (targets for 2011-12 are 5 and 18 respectively). The state shows unpromising progress in all key trainings (LSAS-5, EmOC- 7, and SBA-224). Institutional delivery is very low in the state. The institutional delivery has declined from 31 percent in DLHS -2 to 25 percent in DLHS -3.

Child Health: Meghalaya has proposed to operationalize 4 SNCUs and 17 NBSUs during the period 2005-12. However, as of now not a single such facility is operationalizing in the state. Stabilization units have been established in 14 CHCs/BPHCs as of 2010-11 and 123 have been proposed to be added during the year 2011-12. The coverage of full immunization is considerably low in the state. However, it shows a marginal increase of 19.4 percentage point from 13.7 percent in DLHS-2 to 33.1percent in DLHS-3. The state has also reported 23 percent drop out from BCG to measles in 2010-11.

Family Planning: DLHS-3 report reveals that the proportion of currently married women who ever used any modern method is only 20 percent in Meghalaya. The state has proposed various family planning training during the year 2011-12 and budget has been approved for the same. However, it is observed from the quarterly progress report that nil expenditure is made for Laparoscopic Sterilization training and NSV training. The target set in the year 2011-12 for male sterilization, female sterilization and IUD insertion are 1000, 5000, and 10,000 respectively. However, achievement during the 1st quarter is very poor.

Adolescent Reproductive and Sexual Health: ARSH programme in the state is at the initial point. Few batches of MOs are being trained under ARSH during the past three years till then there was no follow up activity was conducted and strengthening of PHCs for AFHS clinics is nearly zero. However 9 (nine) adolescents counsellors are in position at all districts hospitals to cater to the need teenage clients basically through their field visits, school visits, and referrals by MO's of the hospitals.

### **Salient findings of the JRM visits**

Districts have functional District and Block Program Management Units and good coordination between the Health department official and managers. Various committees under NRHM are constituted, however meetings are irregular at CHC & PHC.

The infrastructure at District, CHC, and PHC level is in good condition. It is also observed that all most all health facilities are very neat and clean, but few facilities needs repair and renovations.

There is no Independent Officer for RCH & no coordination between RCH services and Hospital Services. The team found shortage of Specialists all level (West Khasi civil hospital don't have any specialist) however ANM are present in majority of SCs, and adequate Staff Nurses in CHC and District hospitals. Staff Nurses are trained in SBA / NSSK (60-70%) in visited districts.

Very less number of facilities are providing 24 hour delivery services (only 8 in West Khasi). 108 Ambulance services are functional and 30% of Referrals are pregnancy related. Record maintenance is good at all level.

Convergence at district, sub centre & village level was observed. Effective VHNDs planning but no fix roster is followed due to traditional Rotating Market days and VHNDs are planned on the same rotational days.

Women are usually staying for 24 hours after the delivery in most of the health facilities. Institutional deliveries are low and also lower rates of conversion of the First ANC to full ANC. No Safe abortion and RTI-STD management services in the visited districts. Irregular supply of IFA and state has not procured Magnesium Sulphate. Maternal deaths are reported in the state but Maternal Death Review is yet to take off.

ASHA are conducting first home visit, but irregular follow up. Neonatal deaths are reported but causes of death are not recorded. Radiant Warmers and Phototherapy Machine are available but not functional (TSMH, Civil Hospital) and at some facilities Radiant Warmer are supplied but no delivery is conducted in that facility. There is a weak referral system for sick child to the higher facilities in both the districts. There is no provision of the management of Sever Acute Malnutrition. Awareness of new guidelines of Vitamin A is not universal. It is observed during the visit that Vitamin A is not available at some of facilities.

## **Key Findings**

### **Programme management and supervisory structures at various levels**

#### **Functioning of SHS, DHS, RKS and VHSC**

State has functional SHS with good coordination with other vertical programs like RNTCP, NLEP, NPCB etc. Regular Meetings have been held in presence of Health and Family Welfare officials.

District health Societies in both of the districts are functional and meeting regularly. Deputy Commissioner of the districts is the chairperson of the meetings. District level convergence with other important departments is visible. Elected representatives are not the members of the societies.

RKS are constituted at the all level including PHCs. RKS is functioning well at the district hospital and sub division hospitals but not effective at the PHC level because of lack of community participation in the RKS. No elected representatives are the members of the RKS. 6 District Hospitals, 29 CHCs and 99 PHCs have constituted for RKS but detail on the functionality is not made available to the team.

Village Health and Sanitation committee are constituted in the 5568 villages. Display of the VHSC information is prominently in all the visited villages. Meeting are not held regularly in this financial year as no funds have been received since the last October in visited districts.

#### **Human Resource**

936 ANMs are working in state against the position of 407 Sub Centre in the state. Very few sub centres are without ANMs and some centres are also having more than ANM. 752 Regular ANMs and 211 contractual ANMs are posted in state.

All PHCs are having at least one medical officer and CHCs and district hospital have more than one medical officer. 51 Dentist are also providing services in the PHCs and CHCs. All CHCs are having required number of SNs (649 SNs) and other paramedical staffs i.e. Pharmacists, Lab technicians, Radiographer etc.

DPMs and BPMs are in place along with the support staff (Data and Account staff) in visited districts and blocks. 24 X 7 PHCs are provided with NRHM contractual PHC accountant for managing day to day accounting and managing the RKS funds as well the other NRHM financial issues.

There is shortage of Specialists in state; only 14 Obstetricians, 10 Paediatricians and 10 Anaesthetics are working in state. In district West Khasi only one Obstetrician & Paediatrician is available. Only one LSAS trained doctor is available in state.

### **Supportive supervision**

Shortage of Medical Officers and Senior officer is affecting supervision of health services. No standard norms for supportive supervision are available in the state for visit of district by state officers. State program management unit staff is visiting districts as and when need arises. District level officers are often visiting peripheral health facilities on random basis as there is not standard norms are available for the visits. Monthly monitoring and review meeting at district level are held at district HQs and reports are shared with the Medical Officer for follow up of the decision taken in the meetings. PHC and Block PHC officers are not conducting supervisory visit to the SC and PHCs. Availability of transport is also constraint at the level of PHC and Block PHC for visits. Although the Block Program Managers are often visiting the facilities where NRHM activities. No ASHA meeting at the PHCs and Block PHCs. ASHAs are usually informally meeting at the SCs mainly at the VHND.

### **Planning**

DPM seems to be having good understanding of the programme; however, it is observed that most of the activities are carried out under clear directions from state with limited flexibility At the district level, a few people are responsible for preparation of the plan and the others remain totally aloof of the process. The involvement of the block is also limited. Monitoring visits are irregular without objectives and reports are not compiled after visit. Record keeping and reporting is not monitored and not been utilized for program planning or hospital management, except for Nartiang PHC in Jaintia Hills.

Poor understanding of decentralized planning at block level and certain formats for planning are developed at block level, but it is confined only to physical targets. Poor utilization of data for planning purposes as no data analysis is carried out at block level to understand the block level situation.

### **Financial Management**

Consultant from Financial Management Group- NRHM visited state along with JRM team for review of financial matter at state and district. Observation and analysis of financial management of state has been discussed with finance manager-NRHM and Account officers of state. Records have been reviewed with all details.

State Health Society has posted impressive financial performance since 2005-06 till 2011-12 (till 30-06.2011) under RCH-II, Mission Flexi-pool and Routine Immunization programs. Details are annexed.

### **State Health Society:**

The SHS is maintaining ten bank accounts at State Head Quarter comprising of three accounts for AYUSH and one each for NRHM Flexi-pool, RCH-II, UIP, IPPI, IDD, Security deposit and State health

Society respectively. The SHS is preparing bank reconciliation statements for each of the bank account on monthly basis which were examined with bank passbooks.

The SHS has failed to implement Tally ERP 9.0 version which was recommended by FMG. The accounts of SHS and DHS are being maintained manually or on unofficial version of Tally 7.2. The concurrent audit report for 2010-11 has been submitted by the auditors on 26-07-2011 but SHS is yet to forward the same to FMG and prepare a compliance report on the observations contained therein.

The auditor has remarked that there is scope to make unwarranted changes in the accounts at subsequent periods thus rendering the entire exercise of internal control and audit futile. The Advances amounting to Rs. 86.33 lakhs are outstanding under NRHM Flexi-pool and Rs. 1305.52 lakhs under RCH-II account as per audit report as on 31.03.2011 but the SHS is yet to implement Advance Monitoring system at SHS and DHS levels.

The integration of vertical programs with SHS has not started yet and SHS is maintaining accounts of IDD, IPP, AYUSH, NRHM other than RCH-II and reporting the same in quarterly FMR. All other NDCPs have appointed their separate statutory auditors and reporting FMRs separately. The funds released to NDCPs are also not routed through SHS and no integrated database of all NDCPs is being maintained at SHS.

The procurement guidelines are not being followed at SHS and DHS and lower levels, thus, leading to unwarranted procurement and audit remarks. SHS is not deducting TDS/ VAT from the various payments made to contractors/vendors. Under RCH-II, an amount of Rs. 2.70 lakhs was paid to Dr G T Passah in cash on 31-03-2010 which has not been settled till date. The physical verification of cash and fixed assets needs to be undertaken periodically. The bank books are being maintained by SHS on Tally 7.2 and closing not done on daily basis.

SHS is yet to respond to the letter dated : 26-4-2011 on audit compliance for FY 2009-10. The proposal of RNTCP to setup a DOTPLUS centre with additional funding of Rs. 16.00 lakhs from SHS/ State Govt is pending with SHS since final site for DOTPLUS centre is yet to be selected.

#### **District Health Society:**

The DPMU is not preparing few books like vouchers, Journal register, advance register, register of NGO/PPPs, trail balance and fixed assets register. The bank reconciliation statement is being prepared by the concurrent auditors on quarterly basis instead of monthly basis and the concurrent auditor is doing year end closing of accounts. The timeline for submission of FMR to SPMU is often delayed due to delayed receipt of SOE from BPMU and CHC/PHC. The delegations of powers circulated by SHS are still under consideration of Chairman, DHS.

The release of funds to BPMU/ CHC/PHC/SC is made by issuing cheques instead of by way of e-transfer which results in delay of 30 -45 days in funds release and accumulation of committed liabilities. The Tally ERP 9.0 not implemented at DPMU and BPMU leading to inefficiency. The cash/ bank book are being kept manually and closed on monthly basis.

The concurrent audit for 2010-11 completed but report not available at DPMU. The concurrent auditors for 2011-12 have not appointed by DHS so far. The Utilization certificates for FY 2010-11 not submitted in prescribed format.

## Quality of services

### Quality Assurance systems

**State Level:** State Meghalaya has piloted Facility based quality assurance mechanism through a state level District Quality Assurance Grading. On the quarterly basis this group visit the health facility in the two pilot districts (East Khasi and West Garo) and gave grading to the facility based on the their performances. Monitoring of performance is reviewed on quarterly basis and encouraging results are observed. Red, Blue and Green grading is given to facility (Green-functioning optimally, blue-need of improvement and Blue-not performing as per norms) and it was observed that grading of the facility is shared with facility to facilitate them in addressing the gap for improvements. This initiative is newer initiatives and only visits are made by team in both of the districts and results have shown improvement in red graded facilities are observed. None of the visited districts have this system in place.

**District Level:** No mechanism of quality assurance is in place, district is completely depends on the state directives. District Health and Medical Office has constituted the District Quality assurance committee but regular meeting were not held at districts. West Khasi District does not have sterilization and IUCD services so no reports of sterilization failures and complaints are reported and investigated. Although District officers are visiting facilities for monitoring but not supervisory norms are available and reports are not shared with the facilities. Quality issues observed in the field visits are discussed during the monthly meeting of Medical Officers in the DMHO office.

### Quality of services (RCH)

Service deliveries at facilities including convergence with other services and PPPs were observed and salient findings are as under:

#### Maternal Health

Hilly states and peculiar matrilineal community is giving a unique status to the state profile. Although very low % of institutional deliveries are reported in state but gender ratio is one of the highest in country. Religious and traditional beliefs are also affecting maternal health care in community and facilities. It was observed that usual lithotomic position is not commonly practices in community. Health department should take details study of the practices in community and their implications in maternal health status.

The state has a very low percentage of institutional deliveries (24.4). It has decreased from 30.9 (DLHS-2) to 24.5 (DLHS-3).

Moreover there were only 8 (4 CHCs, 2 PHCs, 1SDH, 1 Civil Hospital) delivery points, no FRU is functional in the district. Out of 8 facilities, 2 delivery points were having the case load of 1-2 deliveries per month. Labour rooms were generally clean and maintained and provided privacy. Protocols were displayed in all the facilities. C-Section services were not available in the district West Khasi Hills. FA tablets, Mag sulphate were not available in any of the health facilities. Partographs were not being maintained.

On exit interviews with the pregnant woman, it was found in civil hospital that she had spent money on transport, medicines and tests. Mothers having full ANCs are quite low (14.4 %). However the quality of ANC being given is also questionable. No Hb estimation, urine examination for sugar and

proteins during ANC being done. Conversion rate of ANC registration to full ANC is low. It was found that community has a mindset to deliver at home conducted by untrained dais and no sub-centre deliveries were reported in West Khasi hills.

A large number of home deliveries are reported. Post natal stay is 24 hrs.1 CHC & 1 DH providing ANC services from old building (3-7 km far) however lab investigation for ANC are in New building. It is observed that there is lack of coordination and service delivery in the two facilities.

The joint MCP Card was being implemented for ANC, PNC and for Immunization of children. Outreach activities for ANC, PNC and Immunization are conducted via VHNDs at the Anganwadi centres at the village level. The new MCTS register was introduced without training and staffs are not clear how to use it. The MCTS register- too bulky and huge to carry. Uniform register is not in place. Referral in/out registers are not being maintained.

**Janani Sishu Surakhsha Karayakaram (JSSK):** Although the state has launched the programme on 1st July, a lot needs to be done for rolling out the programme.

At the state level MoU is being signed between Women Taxi Driver Association and State for transportation of pregnant mother and sick new born children. The state has issues necessary instruction to all the districts for such arrangements. Pregnant women spending out of pocket on drugs and diagnostics. Referral transport seen in some of the facilities in the West Khasi Hills. No drop back facility. Free diet was being given in Mairang only. No display of entitlements at health facilities.

**Maternal Death Review:** 14 MOs in the district West Khasi have been trained in MDR, however only 2 facilities were reporting the maternal deaths in the format. Other facilities did not have MDR formats. Community reporting of maternal deaths was almost nil.

**RTI/STI Services:** Colour coded drug kits for RTI/STI management was not present in any of health facilities.

**Safe abortion services:** No Safe abortion services present in the district. However 4 to5 cases of incomplete abortions in the last month were being referred to Ganesh Das Hospital, Shillong.

**Gender:** The state has matriarchal society. Women's participation in socio-economic sphere is quite normal. Therefore, sense of security among women is good and they are not discriminated. State has not any specific issues regarding gender but during field visits few observation are made. There is need of sensitization of the health workers in this regards. At few places Male and female patients are kept in one ward. There are no separate toilets for male and female, not even for staff, however, the toilets were clean with stored / running water. Screens / partition in the examination rooms found to respect the privacy. The separate toilets and water for female staff observed. No grievance redress mechanism displayed at District Hospital, CHCs & PHCs with name of contact for complaint delivery. Strong matrilineal system is in practice in community and gender discrimination is socially not acceptable. Male parents are observed in taking care of their child while mothers are working in community. State level planning does not have gender specific initiatives. No institutional mechanism is in place in health system for gender equity but socially gender equity is practiced due to strong matrilineal system.

**PCPNDT:** Implementation of PC&PNDT Act is been done accordingly. Funds have been released to all Districts for inspection and other related activities. Big hoardings are displayed in CHC campus and district health office campus but not in cities and elsewhere. In District West Khasi no ultrasound

machine is registered and in Jaintia hills district few machine are registered but no case has been investigated.

Further, District Advisory Committee has been formed at Jantia Hills has been constituted. Additional DM&HO has been appointed as nodal officer. Out of 4 three USG machines have been registered. However, the report is not sent regularly in the prescribed format.

**JSY:** This scheme is welcomes by the communities in state. ASHA are accompanying pregnant women up to hospital. JSY payment (to beneficiary and ASHA) is through cash. Post Natal Stay for 24 Hours. Registers for JSY are maintained. Payments for home deliveries are delayed in District West Khasi Hills. JSY beneficiaries are paid through cash in Jaintia Hills Districts due to difficulty in opening a bank account. The list of JSY beneficiaries are displayed at some of the facilities, for e.g. Ummulong CHC, Nartiang PHC, and Shangpung (24X7) PHC. In most of the places, a delay in JSY payment to beneficiaries is observed which varies from 15 to 20 days. JSY forms are filled up for payment of incentives to beneficiaries; however, MCH card is not in use. It is found that ASHAs have not received their JSY incentives for the last six months. There is an increase in number of beneficiaries receiving JSY incentives for institutional deliveries (public institutions) is observed in the 1st quarter of 2011-12 compared to 1st quarter of 2010-11.

#### **Child Health:**

Child health as intervention in Public health service has been unaddressed in the state. Non availability of paediatrician in districts, trend of home deliveries, in accessibility of the services due to hilly terrain, high fertility rates, malnutrition in children due to more dependence rice based food during complimentary feeding etc are major reasons for higher morbidity and mortality in children. Specialized care for sick neonates and other children are only available at state head quarter is affecting outcome of referred cases. Irregular supply of IFA and Vitamin-A is also affecting management of malnutrition. Salient Observation.

Incentives to ASHA for Home based new born care guidelines have received at state Head Quarter, planning to roll out the scheme is final phases. Dissemination for the guidelines is not yet planned. Funds have been approved by GOI and Communication is received at State.

Only Navjat Shishu Suraksha Karyakram had been rolled out in state and Staff nurses are trained for providing emergency new born care at facilities. Ironically very few facilities are having deliveries in the districts (only 8 in West Khasi out of 25 facilities and only four are actual delivery points as per Maternal Health norms). Radiant Warmers and Phototherapy machine are provided to CHC and PHCs but unutilized because of lesser delivery load and poor referral of newborn from community. Out of visited 5 facilities with Radiant warmers only one is working in district West Khasi.

State have shortages of paediatrician and not scaled up the Facility IMNCI, in this situation child health care services are not available across the health facilities in the state. In district West Khasi only one paediatrician is posted in sub division hospital Mairang (No Paediatricians in District Hospital) and 2 paediatricians are posted in District Jaintia Hills (2 in district Hospital). No peripheral health facilities (PHCs and CHCs) are having any paediatrician and not even FIMNCI trained. None of the sub centers in both the districts have delivery services so new born have been referred from SCs. All Sub centre have ANMs in District West Khasi and few of them are also trained in NSSK. None of visited districts have Sick New Born Care Units (SNCU) and New born stabilization units (NBSU) but New born Care Corner (NBCC) are established and NSSK trained SNs are handling these NBCC.

Neonatal Deaths are reported in facilities and records are kept with details. Neonatal deaths from communities are also reported to block PHCs but no verification or Infant Death Audit conducted.

Health Facilities does not have provision of counselling for infant and Young Child Feeding practices, SNs and Doctors are counselling the pregnant mothers for the same. In West Khasi Hills District it was observed that all admitted mothers have initiated breast feeding within one hours and nothing is given along the first breast feeding.

Medical officers and Official are aware about the malnutrition but no provision of management of severe malnourished children (SAM) at facilities. Facilities are also not tracking and keeping records for the reported SAM children in the facilities for their follow up in community.

Small IFA tablets are available in some of the facilities but no special activities are planned for screening of the anaemic children and their management. Vitamin A Supply is irregular and not found in some of the facilities. Information on the newer guidelines for the Vitamin A supplementation (five years and nine doses) are not percolated to the Sub centers. Vitamin A deficiency is common in area because of Rice based weaning food.

State does not have specific program to address the diarrheal and Acute Respiratory Infections management. Low osmolar ORS is available in stores of Facilities, Oral and Inject able antibiotics are available at PHCs and CHCs. Antibiotics like Ciprofloxacin, second generation cephalosporin are available at SC level.

Very few sick new born are referred by the 108 ambulances whereas community referral is on foot and public transport. Referral from communities usually addressed to shillong as there are no paediatricians in District Hospital of West Khasi.

TOT for IMNCI has been completed at the state level. No training in IMNCI and FIMNCI has initiated in district.

### **Immunization**

Immunization activities are usually streamlined in state and there is no shortage of vaccines in states. Availability of cold chain equipments were satisfactory and found to be functional in visited facilities except one place. CES coverage evaluation (2009) reports 60% immunization coverage in state. Salient Observation of the Visit to various facilities and interaction with ANMs and health staff are as under.

There was no fixed immunization day in the State. The vaccination is been carried out through both outreach session site and fixed centre. The immunization days varies from center to center. The VHNDs days are not fixed because of rotational market days in each village. The villages are avoided for VHNDs during the market days. Facility decided VHNDs according to the markets days. Sub-center were also having a floating weeks days to vaccinate children in the market as per the rotational plan of the market days. Hence there was no microplan been prepared by the sub-center indicating detail of number of beneficiaries per session, required number of doses is not available at any of the visited facilities. The sub-center ANM has a monthly date wise advance tour plan for the month. At least 5-10% of these advance tour plan gets cancelled because of the fact that the monthly meeting at block, weekly meeting at sub-center are not factored in these advance tour plan resulting in cancellation of the plan session.

ASHA incentives for mobilization, Alternate Vaccine Delivery & Mobility Support funds are not available in West Khasi Hill district but available in Jaintia Hill district. Non availability of funds for these activities is having negative impact on the immunization coverage in West Khasi Hills.

In two facilities in West Khasi Hill the vaccination to children and ANC checkup was still being provided from the old building but other services shifted to new building which is about 3 to 7 Kms. Thus there is missed opportunity for birth doses in these centers. The laboratory investigation are in new building resulting in many pregnant women missed laboratory service as they do not commute this distance for the investigation.

All vaccines are available. AD syringe 0.1ml is out of stock for about one month in both districts. Birth dose is not provided at the institutional delivery. MCT – The new MCT register introduced without training and staff are not clear how to use it. The existing registers are still used resulting in duplication of entry.

LR – In one of the center not working for more than 2 weeks (Ranikor). This is a remote CHC and it takes about 5-6 hours from district HQ to reach the center. District has taken note and promised to replace it in two days. Wastage disposal – Pit?, Separation of waste at places is questionable. Tickler box use is not universal for tracking children. Session site monitoring to oversee conduct an immunization session.

The wrong practices of ANM for providing immunization services noted are as under. a) Recapping, b) Measles reconstitution timing not recorded, c) Cleaning of top of the vaccine vial after opening, d) Shaking of reconstitution vial between the hand e) Opening of multiple vial and f) After immunisation, children were not observed for adverse effect for 1/2 hours.

## **ARSH**

In district West Khasi, no ARSH activities are observed at any of the facilities. District Medical and Health Office also don't have any program planning for the same.

ARSH activities are observed in Jaintia Hill districts.

Primary Health Center, population of PHC is 23,423 and 10-18 yrs is 4681 (20%), which has been rendering emergency & indoor services 24x7 since April 2008.

Youth Friendly Corner – an Innovation under ARSH program a clinic dedicated to young people's health – at Nartiang PHC was inaugurated on the 31st March 2011.

The objective to establish this Youth Friendly Corner at Nartiang PHC clinic was to improve access to Youth Friendly Health Services and increase knowledge on Youth Sexual & Reproductive Health Rights (YSRHR) of all doctors, nurses, and paramedics of Nartiang PHC.

A three day orientation training of service providers of Nartiang PHC on Youth Sexual & Reproductive Health Rights (YSRHR) was organized on the 17th through 19th March 2011 at Nartiang PHC. The objective of the training is to improve knowledge of staffs of Nartiang PHC on Youth Sexual and Reproductive Health Rights (YSRHR) so that a technically competent team is available to serve the sensitive needs of young people.

The Friends' Corner is nicely built, which has convenient location & comfortable environment. Privacy and confidentiality of the clients and their problems is being ensured as only MO I/C has access to documents of a client.

IEC material has been developed in local language. The contents of the IEC pamphlets range from adolescent growth & teenage pregnancy, contraceptive information, RTI / STI, and, drugs & alcoholism.

Other activities undertaken:

Plan for Outreach services: A session on young people's health during the monthly village health & nutrition day (VHNDs). As an initial step, youth friendly day will be dedicated once a month in each of 6 health sub centers of Nartiang PHC.

Plan for comprehensive services: A roster of laboratory technicians will be maintained in order to ensure laboratory services for young clients during the clinic timing. Also, a roster for doctors & nursing staffs will be maintained & displayed in the reception room of Friends' Corner.

Plan for community monitoring & young people's participation: A quarterly meeting with members of 4 youth NGOs of Nartiang, teachers of both high schools will be held at the facility.

#### **School Health Programme:**

State is planning to launch an ambitious state supported school health program. No uniformity of school health program in both districts. West Khasi Hills don't have any school health activities as no funds have been released by district to PHC and CHCs. Below given information is based on observation made in Jaintia Hills.

School Health Cards are in use in the visited blocks. Weak implementation of School Health Programme in the district of Jaintia Hills as coverage and activities under the programme are very minimal. In some of the facilities MOs are visiting the schools for screening of school children. However, information on their visit and activities carried out during their visit are not available. The activities conducted under SHP are organizing health talks (mostly on Adolescent issues, sanitation, personal hygiene, drugs abuse, and nutrition) in schools, supply of IFA tablets, de-worming and screening of school children for dental problems, problems in eye, and to some extent for anaemia. No system of referral to higher health facilities for major problems.

In West Khasi district Dentist had visited schools for dental check up only. No information on health talks and other activities of school health program is available with the Block PHCs. State officers have told that no funds for school health have been released this year.

#### **Family Planning:**

State has peculiar constraints in promotion of family planning program in the community because of resistance by the religious leaders and tribal heads. Churches have great influence on the community for their family planning issues, health staff had narrated recent incident of the boycott of Population week celebration in one of the villages. State with high fertility rates needs extensive assessment of community behaviour and region specific strategy. State official have understanding of the high TFR of the state. However, state has not yet planned additional initiatives for addressing the issue.

Newer schemes for distribution of the contraceptive by the ASHA (Social Marketing) are not rolled out in districts. State informed that they have not received the kits for the scheme.

State is performing poorly on the family planning indicators. Only 0.9 % of IUCD targets, .05 % of Female Sterilization and 0.0032 % of Male Sterilization targets have been achieved in 2010-11. HMIS reports have shown improvement since the last year 2009-10.

In Jantia Hills district, female sterilization and NSV services is available at district hospital. There is one MO trained in NSV, providing NSV services at Nartiang PHC. During 2011-12 there were 7 NSV conducted and during current year, up to July 2011 3 NSV conducted at the Nartiang PHC. IUD service is available at all the CHCs and PHCs.

Non availability of family planning services at peripheral facilities is major constraints. Community response to Family Planning methods remains elusive and religious & traditional beliefs are major hurdles.

In visited districts West Khasi no facilities is providing sterilization services and only sub district hospital Mairang is providing IUCD insertion facilities. Supply of Oral pills is also irregular and use of condom is not monitored and recorded effectively. Emergency contraceptive pills are never supplied to the facilities in West Khasi District and Jaintia hills. Maintenance of Eligible Couple Registry needs strengthening.

IEC /BCC for family planning issues are not effectively able to address the core issues of the community in the Meghalaya. A technical and community based study is required for identifying the gaps. Culture sensitive and region specific approach for addressing the identified issues should be developed. Availability of the Emergency Contraceptive pills may also be able to address to control unwanted pregnancies among eligible couples.

#### **Drugs and Consumables:**

Essential drugs list are universally displayed in almost all facility (PHC and CHCs). Majority of OPD drugs are available but supply of drugs like adrenalin and Anti Snake Venom is not supplied regularly. Stores are maintained well by pharmacists.

The AYUSH doctor is not practicing their system of medicine. This is mainly because of lack of drugs (Jowai District Hospitals). It was also observed that some of the drugs are fungus affected and cannot be used.

None of the facility estimates the consumption of drugs for indenting taking into consideration what is Vital, Essential, or Desirable which ends up in procuring large quantity of unwanted supply of drugs. Short expiry medicines are found in some of the facilities (e.g. Baroto PHC, PPP model).

Drugs are not dispensed according to actual requirements or performance of the facility but by the supplies available. Overall the maintenance of stock register is poor in most of the facilities, for .e.g. there is no information on batch no and date of expiry of medicines.

Drugs like Nimusulide are being supplied to the SCs whereas this drug is banned for use in country. Antibiotics like Ciprofloxacin and Second Generation cephalosporin are available at SCs. ANMs are not trained enough to use the drugs like these. Drug inventory are maintained well in visited facilities and supplied are sufficient and no shortage is reported from any facilities.

### **Public Private Partnership:**

Missionary based charitable hospitals are often providing services. In West Khasi district 3 PHCs are functional in PPP model. Interestingly all three are providing delivery services to community.

In district West Khasi Hills, a missionary hospital HOLY CROSS hospital in Mairang providing quality services to the community. This hospital is not being accredited for the deliveries and other services. Families with middle class and higher income are getting benefits from the hospitals. Quality of services are good and public health facilities are referring case to this facilities as there is no government hospital providing emergency obstetric care and neonatal care.

PHC Barato (PPP Model) was visited by team. This is a 24X7 facility with one Medical officer and 3 Staff nurses are posted. Pharmacist, Lab technician and administrative staffs are available in the facility.

All Staffs are paid by Jaintia Hills Development Society. Staff salaries are paid by cash. Ambulance is outsourced, mainly used for transport of patient and to bring medicines for state HQ.

Only OCPs & Nirodh are available at the PHC, no IUCD insertion is conducted at this facility. Further the distribution of Condom is also very less. MOs, ANMs & staff nurses are not trained on IUCD insertion. Eligible couple register is not in use; however some information on eligible couples is recorded in a notebook which is incomplete as most of the relevant information was missing. Number of deliveries conducted at this facility is very low.

The record keeping is poor for immunisation, micro plans are not prepared. Record keeping and reporting is not monitored by the Program Officer appointed by Jaintia Hills Development Society and not been utilized for hospital management.

Drugs are not dispensed according to actual requirements or performance of the facility but by the supplies available. The maintenance of stock register is poor, for .e.g. there is no information on batch no and date of expiry of medicines. Short expiry medicines are found and no record was maintained for such medicines.

### **Village Health and Nutrition Day (VHND):**

Most of the VHNDs are found to be organized at the AWC, which is a place nearer to most of the villagers. In few cases it is conducted in school. The program to be conducted during the VHND is decided by the ANM, ASHA and AWW in advance. Due to the local conditions, VHND is not a fixed day in the district. It is held with respect to the market days of the village. Some of the major issues/activities held during the VHND include; immunization/vaccination of infant/children, ANC, PNC, discussion on nutrition, Family Planning etc.

It was found that ANM, ASHA, AWW and AW Helper were found to be actively involved in VHND. PHN, Health Educator, Basic health Worker was also there during some of the (30%) VHND. However, the participation of Headman (PRI) was found as well as informed to be almost absent.

There were no specific cases of malnutrition in any of the site/SCs visited, though the detail of all the children was maintained in the children register. The background of all the households was STs.

Proper maintenance of records by ASHA as well as ANM was observed. The record maintained in relation to VHND includes; updated list of pregnant woman, women who has delivered, updated list of infants and children, TB and Malaria cases etc. Cases of drop outs (children) were also found to be recorded.

Record maintained by ANM in the SC include records such as; ANC register, JSY register/delivery register, children register, maternal & infant death registers provided through , overall death register, pregnancy test register, stock register (medicine & others), VHND register etc. However, records related to Post Natal Services provided through home visit were not observed

All the ASHA interacted ( 6 ASHAs) were found to have trained up to 1st round of Module 6 & 7 training. They all were having weighing Salter scale, digital thermometer, and digital watch which were provided during the training.

**Information on Ongoing VHND:** During the VHND which was observed in both the districts, it was found that, ASHA, AWW, AW helper and ANM were found to be actively involved during the VHND. It was found that PHN of nearby health facility (PHC/CHC) was also present for supportive supervision; she too was actively involved during the VHND.

**The major observations and findings of the VHNDs include:** The session planned for the day (VHND) include; immunization, ANM and nutrition. However, the session planned was not found to be displayed in the AWC during the VHND observed in Jaintia Hills. However, in West Khasi Hills, it was found to be displayed, though time of the VHND was not displayed.

Vaccination was done for all the infants. The vaccines were brought in Vaccine carrier with ice pack by ANM to the AWC/VHND Site. AD syringes was also brought by the ANM from SC. After using, it is carried away by the ANM, and disposed it in the SC (as informed).

Other materials such as ORS, Cotrimoxizole, Chloroquine, Condoms, OCP, gloves, kit for urine test, nischay kit, hemoglobin meters were available. However, IFA Tablet and Vitamin A was found to be unavailable as it was out of stock. Vitamin A was available in VHND in District West Khasi. However, in case of Jaintia Hills, DMNHO, informed that these (IFA tab and Vit-A) has reached the district in Sept. 2011, and it will be dispatched soon. Equipments such as stethoscope, BP instrument, foetoscope, nischay kit were available (all were brought by ANM from SC).

Adult weighing scale was available, but not for children. Adult weighing scale was not available in AWC; rather it was brought by the ANM from the SC for VHND.

There were needs for privacy in AWC for conducting ANC. Examination table for ANC was available, however, it need replacement as it was very small as well and old (yet to break), and also need to have a curtain for privacy during ANC.

In Jaintia Hills district all the mother and pregnant woman (clients) were found to be satisfied with the services. Out of the 15 children, it was learnt that 12 was delivered at home. All these 12 were assisted by TBA (Local). They have never prepared any birth preparedness plan (with ASHAs). Another 2 pregnant woman in their 1st trimester, have not yet decided the place for their delivery and also have not yet prepared any micro-planning for delivery (birth preparedness). SC are not providing delivery services hence pregnant women prefer for home delivery then going to the PHCs / CHCs.

No due list for the ANC/immunization was prepared in case of West Khasi Hills. The demand generation activities in relation to VHND is done by ASHA through household visits, and informed the beneficiaries such as pregnant women, mother and family members about the VHND in advance. However, no IEC materials were available during the VHND. IEC material is displayed in VHND held in West Khasi hills.

ASHAs in both the districts has received training on interpersonal communication as part of ASHA Module 5 training, and also some part in 1st round- Module 6 & 7 training.

**ASHA incentive:** ASHA never receive any incentive for mobilizing the beneficiaries for VHND. However, during the interaction with ASHAs of other area, it was informed by one ASHA (out of six ASHAs) that she receive Rs.100 for every VHND from the VHSC fund for mobilizing the community though rest of the other ASHA informed, they also never receive any incentive for the purpose. The major activities in which ASHA received incentive includes; incentive for immunization and JSY. However, none of the ASHA has received any incentive for blood slide (for malaria test) though they are involved in the activity.

**Coordination with AWW and Headman (PRI):** Active coordination between AWW and ASHA was observed in all the places visited and also informed by all the ASHAs interacted with. Active involvement of Headman/PRI was informed by only 2 ASHAs. More than 50% ASHAs (4 out of 6) as well as AWW informed about coordination with Headman as a challenge, as he never attends VHND, and is hardly ready to give time to VHSC. In the VHND site which was observed by the team, it was found that, the Headman was not present during the VHND, and it was also informed that, he never attend any VHND.

#### **Village Health and Sanitation Committee (VHSC):**

According to most of the VHSC members their roles and responsibilities include; work for better health and hygienic situation of their village by doing cleanliness drive, preparation of Village Health Plan, organizing health awareness campaign, utilization of untied fund in these mention activities and also buying furniture, small construction work like urinal site etc.

**The key findings include:** VHSC members were Headman, ASHA/ANM, AWW, School teacher and 3 - 4 other women of SHG/community. ASHA and Headman is the joint signatory of VHSC account. Meetings of VHSCs are irregular in both the districts. VHSC meetings are held irregularly as most of the VHSCs have conducted 1-2 meetings in last six months. VHSCs so far have not identified any household for construction of latrine. However, they have constructed one public toilet in the village. Construction of (pukka/cemented) disposal of household refuse has been done by VHSC. A common disposal bin (cemented) has been constructed for villagers.

Spraying DDT and also limestone has been done to deal with mosquito breeding in and around the village. Activities on which VHSC fund have been utilized includes; construction of urinal site/latrine for village, cleanliness drive, buying furniture, hoardings, road repairing etc. However, the discussion on disease prevalence/burden and action on it remains absent in activities conducted so far by all the VHSCs. VHSC also assisting in repairing the water supply pipes in village in West Khasi.

**Convergence:** Above information related to VHND and VHSC clearly indicate the presence of inter-sectoral coordination (convergence) at village level. However, it still needs improvement as there is almost absence of participation of Headman during VHND and VHSC related activities except for the meeting which is held irregularly (instead of monthly, it happens once in quarter or half year).

The same is in case of facility level as well as District level. RKS meetings are held, however, the presence of all the members from different background/dept. is still a challenge.

#### **Health management information system (HMIS) and data management:**

Status of the current information system: The state has started facility based reporting system on the revised HMIS format introduced by Statistics Division, MoHFW, GoI from January 2009 and the District Consolidated Report uploading was started from the same month. Facility level i.e. Sub Centre, PHC, CHC, District Hospital data uploading in the HMIS Web Portal has been started in the entire state from April'2011.

Facility wise data are being entered at Block level in offline mode and the same is being uploaded either at District or State Head Quarter. It is also observed during the visit that the District & Block Data Managers are in place and are notified as District Nodal Officer & Block Nodal Officer for HMIS respectively. But it is noticed that the notification of the HMIS Nodal Officer at facility level and sensitization thereof is yet to be done. The area of concern is the delay in entering 'committed' data into the web-based HMIS

Computer with Printer is available at District as well as Block Programme Management Support Units. Internet facility is available only at District HQ with poor connectivity. No telecommunication is available at most of the health facilities as well as in some of the blocks. Irregular power supply hinders in compiling and uploading HMIS report and all others sorts of computer work.

The DPMSU and BPMSU personnel are trained in Revised HMIS Formats and using of the HMIS Web Portal. The State has also conducted the training regarding analysis of the collected data for getting meaningful information and usages thereof. The service providers at SC level like ANMs were also trained on the different data elements of the HMIS Reporting Format. But during the field visit it was observed that further reorientation is required as they are not clear with few of the data elements. The same may also be taken up as part of CME during the monthly review meeting at the facility. Inconsistencies in Physical and financial data in HMIS for certain indicators (family planning) is observed.

Activity wise multiple registers are in place. ANMs are maintaining multiple registers for the same activity which make inconvenient to her. e.g separate Family Planning registers are being maintained for each of the methods.

It's a matter of appreciation that the State has taken initiatives for providing printed uniform MCTS register and also separate Immunization register / ANC register. However some of the information like the basic information of the beneficiaries could have been used as an extension of the existing Immunization /ANC register, making it more user friendly. Further, MCTS registers for the child and mother have been supplied to the periphery without any prior training to the field workers. Existing Labour Room Register should have also cover some additional requisite information, eg, Time of delivery, Time of breast feeding initiation and whether ASHA has accompanied the PW, etc..

Most of the ANMs are not able to comprehend the basic idea of facility based reporting. They are still reporting on the basis of performance of the area, which also includes the performances of the facility. Though this reporting is not uniform for all the services, e.g. Institutional delivery conducted in other facilities is not reported but Hb% estimation done outside being reported as performance of the facility. This may lead to duplication of the data. It is also observed that the service provided to the beneficiaries from other area is in record but not included in HMIS report. This may also lead to loss of information. e.g. One IUCD inserted at the Mairang CHC but was not reported. Jekrem SC does not have the facility for Hb estimation but had reported in the HMIS reporting format as the pregnant mother belonged to her area of jurisdiction and was tested outside.

Use of HMIS / Information System in Planning &Monitoring: The State has extensively used the analyzed information from Health Management Information System while preparing the State & District Health Action Plan in addition to the use of different survey data.

All the facilities have analyzed the data & displayed information on various indicators like Immunization, Institutional Delivery, Population covered by the Block, facility & village wise. The analyzed performance report helps at various levels to monitor the existing functioning status of the health facilities and improvement thereof.

**Use of CNA & Eligible Couple Register:** Eligible Couple Register is being maintained at all facility. The ANMs are conducting surveys at the beginning of the year to set the targets for pregnant women & infants but unable to use these data to make a proper action plan for implementation. Proper detailed Micro plan for Immunization could not be seen in many of the facilities, visited.

**Any parallel System:** All the facilities are using revised HMIS reporting format available in the HMIS Web Portal. Sufficient number of copies of the revised reporting format is available at the different facilities. Few of the state specific data elements are collected through their own reporting system on different time which is not available in the HMIS format.

**MCTS Issues:** State is not yet prepared for MCTS. At very few facilities the MCTS register is in use. At present only they have uploaded some information i.e. ASHA's and ANM's contact number, no other information are uploaded. The MCTS registers are too big to handle. The state could have printed MCTS formats in user friendly manner. Otherwise there is chance of tearing of forms in the register. As reported by state official, the offline mode of uploading MCTS reports in the MCTS web portal is presently not working. Login from one district can still view/edit the other district's performances (no restriction on the user's level). It is also reported that junk data gets populated into their user's ID which is not their data. Internet connectivity at the Block Level is a major obstacle for the rolling out of MCTS in the state.

#### **Monitoring of HMIS:**

A non-functional HMIS Core Team has been established at District Head Quarter. The monitoring activity at the facility level is without structured advance tour plan. The visits should be made as a team, not as an individual, and also lack of proper guidance, monitoring mechanism & monitoring tool.

Data validation at state & district level is going on only based on validation rule available at the HMIS Web Portal but the validation at facility level with the different registers are yet to be started. Based on facility level data validation process the necessary correction may be done at the monthly review meeting instead of waiting for conducting full day training.

It is found that there are discrepancies between uploaded data and the actual recorded performance in the register for a given period in many of the facilities visited, eg. As per the available record, number of IUCD insertions at Mairang CHC is higher than what was actually uploaded in the web portal.

Some data are being uploaded in the web portal, source of which become doubtful as no records were made available at the facilities, eg. Number of complicated pregnancies treated with IV antibiotics, IV antihypertensive, IV Oxytocins, blood transfusion, etc.

#### **IEC/BCC:**

Wall writings on JSY, ANC, Immunization, DOTs in local language are available only at the Hospital premises. Citizen Charter and availability of the drugs are displayed at the patients waiting area. Performance details of the Hospital are available either at the Block Programme Management Office or at the Immunization room.

Street Play, Healthy Baby show, Focus Group discussion are organised by the BPMSU. The District has high Unmet need regarding family planning but no systematic effort to make proper IEC / BCC plan on this issue.

## **KEY ISSUES**

### **Facilities**

FRUs / CHCs: Non availability of Obstetrician and Paediatricians are major constraints. Effective referral transport from community to facilities and from facility to higher facilities needs strengthening.

Community resistance to family planning practices and non availability of Family planning services in facilities dual constraints.

RTI management and safe abortion services are not available in the facilities, which is also a constraint for community faith on the facilities.

Dissociation between the MCH services (ANC and Immunization) and maternity wing of hospital is one of major issue of lower conversion of ANC and lesser delivery load in hospital. (in Mairang and District civil Hospital in West Khasi).

24X7 PHCs / PHCs: Functional well in majority of places with sufficient number of medical officer and Staff nurses but delivery load is not as per the population served. Issue of accessibility, community faith on facilities and traditional beliefs are often major constraints. Family planning services are not provided at majority of facilities as community resistance to FP practices is prevalent in regions due to religious and traditional beliefs.

SC: Community have not accepted SC as effective place for deliveries, reasons may be the non availability of ANMs for 24 hours, irregular power supply, 24 hour running water and provision of sufficient place for stay and heating of the Labor room and waiting room.

Accessibility of SCs is also a concern, transporting pregnant women in hilly terrains is difficult task. It is preferable to ANMs and community to call ANM at home for home delivery then going to SCs.

VHNDs: AWW, ASHA and ANMs are available in all VHND but participation of other stake holder is negligible including PRI members. Platform is not been used for promotion of family planning services.

District Hospital: District West Khasi Civil Hospital is located about 6 KM from the town population and markets hence are underutilized. ANC and Immunization services are not available in civil hospital but available in MCH centre about 6 KM from the hospital. During ANC check up no medical officer and Staff nurses are available. Despite of Medical Officer of Urban health centre is placed beside the MCH centre but his services are not utilized. No laboratory facilities are available at MCH centre, pregnant women are asked to go to Civil Hospital and majority does not turn up for investigation and drop out.

District Health and Medical Office: No independent RCH officer, CDHO is in-charge of RCH services. Monitoring of the Program is affected by his or her busy schedule as district officer.

Planning based on regional data and regional issues is not undertaken in both the districts. No district level initiatives have been observed. Official are accepting the facts like higher home deliveries, resistance to Family planning services, no delivery at SCs. No involvement of Elected members in the district health societies also a concern.

District PMU: Young and energetic staff but working under the direct control of the SPMU. No regional analysis of data for actionable planning. Young but with lesser experiences in the health and social issues affects their understanding of the critical social cultural implication of the health program i.e. resistance to Family planning etc.

SPMU: Office is effectively functional under the leadership of Commissioner & Mission Director-NRHM. SPMU team is directly working under the guidance of Mission Director. A team of RCH consultant is not available, only single consultant (senior retired MOHFW GOI official) is working. State needs an extended RCH consultant team at state level to address RCH issues in the states. Especially for Maternal health, Family Planning and Child health, experts in community health with experience of working in relevant subject need to be recruited.

Health & Family Welfare office: Only two senior directors with only 2-3 joint directors are working in the office. During the de-briefing session, the Commissioner & Mission Director-NRHM informed that many officers in State have been promoted and by end of September there six Director to support the directorate work.

## **Recommendations**

### **Program Management and supervisory Structure at various levels**

#### **Program management structure**

- Elected members are not represented in state and district health societies, need to be included for fairer representation as committed in NRHM policy framework
- Similarly no elected members, PRI members are represented in RKS of health facilities
- Regular meetings of RKS with wide dissemination of the meeting minutes to community.
- VHSC are not meeting regularly, periodical meeting are required and to be monitored by State as well district health society
- Services of SC and ANM posted are underutilized as no SC is providing delivery services. Some centres are having more than one ANM need rationalization of the services of ANMs.
- Dentists are underutilized due to lesser case load in facilities; need to be included in school health program with additional trainings to these cadres.
- State is facing severe shortage of the specialist cadre, state should plan for extensive training of available medical officer in short term specialist training like EMOC, LSAS, F-IMNCI.
- NRHM contractual staff attrition is concern for holding experience workers with department. State may plan some rewards in terms of incentives, increments and career progression opportunity for the contractual workers
- States should have an exclusive nodal person for RCH and programme officers for maternal health; child health & immunization; ARSH & school health and family planning at the state level for effective running of the programmes.

#### **Supportive Supervisory**

- State does not have supervisory norm at any level. State may need establish a supportive supervisory mechanism at state, district and block level. Although NRHM staff is performing supervisory visits but not standard reporting mechanism in place.
- Facility based monitoring and rating system has been scaled up in two districts; results are shared with the districts. To be scaled up in all districts.
- ASHA meeting at PHC should be initiated for better interaction among PHC staff and ASHA

#### **Planning and monitoring**

- Lack of decentralized planning at District level, district officer is often dependent on State officer and NRHM official for guidance and directives. District should be empowered for decision making for their regional issues
- Involvement of Block Level official in district level planning is lacking. Block level NRHM official and Block Medical Officer should be consulted for planning and implementation of newer schemes and district specific initiatives.
- Data management requires strengthening
- Record-keeping needs to be updated with reference to HMIS indicators and to ensure analysis and feedback on uploaded data
- Data validation with different registers at facility level needs to be in place so that accurate data can be uploaded in the HMIS web portal
- Regular monitoring visits with structured tour plan and monitoring tools, and sharing of report within time is required for corrective actions.

### **Financial management**

- Initiate steps for electronic transfer of funds from District to Blocks/ CHC/ PHC/SC/VHSC to avoid delay in funds availability.
- Initiate process of integration of NDCPs with State Health Society by passing a resolution in the Governing body meeting of SHS and holding joint meetings with all stakeholders.
- Expedite appointment of Director (Finance) at SPMU for enhanced supervision and more visits by SPM /SAM/DPM/DAM/ Internal Audit Manager and monthly review meetings.
- Ensure timely appointment of auditors (covering NDCPs) and obtain compliance with the audit observations given by statutory and concurrent auditors.
- Implement Tally ERP customized accounting software at DHS/ Block levels.
- Strict adherence to NRHM Financial guidelines especially about cash withdrawals and cash retention in hand at DHS/ Block/CHC/ PHC /SC / VHSC levels.
- Timelines for submission of SOE/ FMR / U.C. to be strictly followed at all levels.
- Ensure regular meetings, recording of minutes and audit of the accounts of all RKS registered in the state.
- Procurement Guidelines to be distributed at District and Sub-district levels and training to be imparted in procurement procedures.
- Implement age-wise advance monitoring system as detailed in the Model accounting handbooks
- Ensure that cash/ bank books are closed on daily basis and signed by the concerned Accountants and MOIC.
- Physical verification of cash and fixed assets must be carried out every year.
- Ensure that correct information is uploaded on HMIS portal within prescribed timelines.

### **Quality of Services**

- District quality assurance committee are in place, need to be effective in monitoring of RCH service delivery. Meeting of committee need to regular.
- Facility based Quality Assurance mechanism are initiated in states in two districts, results are encouraging and state proposed to scale up in all districts.
- Visit reports of district officer should be disseminated to facilities for corrective action and follow up of suggestion should be ensured

### **Quality of Services (RCH)**

#### **Maternal Health**

- For increasing institutional delivery, JSSK should be effectively implemented, so there is a need to:

- a. Widely publicise the initiative.
  - b. Providing free services to the Pregnant Woman
  - c. Building a robust drugs and logistic mechanism
  - d. Strengthening the referral transport to build a robust system
  - e. Establishing Grievance redressal mechanism
- For provision of better MCH services a coordination between MCH centers and Hospital is required. Extensive IEC /BCC for comprehensive range of services for MH, CH, FP, ARSH
  - Training of MOs in EMOC, LSAS, MDR, NSSK and FIMNCI need to be undertaken.
  - Improvement in Quality of ANC ( Hb, urine examination, BP monitoring and recording on the MCP card) needs to be taken on priority basis.
  - For Monitoring Severe Anaemia:
    - At sub centers ANM should have line listing of all the severely anaemic cases.
    - Doctors at PHCs to have a list of severely anaemic cases of their area for intensive monitoring.
  - Standard technical protocols (Partographs etc) needs to be followed during deliveries.
  - C section services needs to be started at Mairang, WK on highest priority.
  - Indiscriminate referral of all PW especially to GDH Shillong therefore there is a need to track the referral cases to avoid unnecessary referral. For tracking Referral in/out registers as formulated by GOI needs to be implemented.
  - Renovation / maintenance for Infrastructure (Ranikor-WK)
  - For addressing the high percentage of home deliveries and ensuring skilled attendance at birth, ANMs need to be trained in SBA, as there is a need to strengthen sub centres as delivery points
  - Maternal Death Review of each Maternal Death should be undertaken for both community and facility based deaths..
  - MTP service provision needs to be strengthened and monitored. District MTP committees need to be constituted and made functional.

### **Child health**

- Dissemination of Child Health Guideline in details i.e. Neonatal Care Services, vitamin A guidelines, home based new born care incentives to ASHAs and ARI, diarrhea management protocols and scaling up of the module 6 and 7.
- Monitor the supply of neonatal equipments and their use by facilities, supply to non functioning facilities should be reviewed.
- State should undertake assessment or study for status of malnourished children in community.
- Efficient logistic management for un-interrupted supply of Vitamin-A, IFA tablets etc.
- Scale up FIMNCI training to bridge the gap of paediatrics
- IMNCI implementation through ASHA (or 6 & 7 training module) and Improved community referral for neonates and children
- Strengthen NBCC at all delivery points and functional NBSU at higher facility
- Review the proposed SNCU in view of delivery load at proposed facilities and availability of paediatrician.

### **Family Planning**

Extensive BCC campaign for promotion of Family Planning practices

- Details Study on the practices in the Community and reason for resistance for family Planning practices
- Ensure supply of Emergency contraceptive pills
- Regular Supply of OCP and condoms

- Promotion of IUCD in community in view of resistance to the permanent methods of sterilization
- New scheme for family planning need revision in light of wide spread resistance to the family planning practices
- Training of doctors in Minilap and Laparoscopy

#### **JSY**

- Payment through cheque and account transfer is not suggestive due to difficulty in accessing bank by ASHA in inaccessible areas of state.
- ASHA are not accompanying pregnant women often due to higher fertility rates and beyond second child no JSY benefit to ASHA and beneficiaries. Policy decision is needed for supporting mothers for their deliveries beyond second child.

#### **School Health Program**

- School health activities need thrust and require campaign approach.
- Dentists and Ayush doctors may be given additional responsibility of school health activities
- State has many church and private schools in area and need to be covered under program
- School health activities should also includes family planning issues for adolescent age group (beyond class eighth)

#### **VHSC, VHND and ASHA**

- There is need for uninterrupted supply of medicines required during VHND.
- Weighing Machine as well as examination table for ANC could be purchased/arranged utilizing VHSC untied fund. And also ASHA may be paid incentive up to Rs.100 for mobilizing community for VHND. Though it is up to the VHSC to decide the areas/activities for which the untied amount/money will be utilized, however, they may be sensitized/ informed that, VHSC utilized for the mentioned activities/purposes.
- There is need for promoting participation of teachers, Headman, male participation, eligible couple, husband and mother in-law etc. during VHND. This issue may be addressed during the VHSC meeting as well as VHND meeting.
- IEC materials need to be provided and used during VHND. The flip book provided to ASHAs by State during 1st round training of Module 6 & 7 may be used during VHND; however, there is need for other IEC materials such as posters/hoardings.
- VHSC meeting needs to be held regularly (monthly) instead of once or twice in six months or a year. The agenda/issues of discussion during VHSC meeting should also include discussion on disease prevalence/burden, disease out-break if any, ad necessary action in addition to the present agenda such as procurement.

### **Team members**

- Dr Pradeep Haldar DC (Immunization), MOHFW, Team Leader
- Dr Ravinder. Consultant (MH), MOHFW
- Dr Naresh, Consultant (CH), MOHFW
- Mr Utpal Kapur, Financial Controller, (NRHM)
- Mr. Sanjay Valsangkar, DFID, (DPs Representative)
- Mr. Bhaswat Kr. Das, Consultant –RRC Guwhati
- Mr. Karunakar Consultant, (Donor Coordination-RCH), MOHFW
- Dr. Abhishek Gupta. Consultant, NRHM
- Ms. Soumya Mohanty, Consultant (RCH-Monitoring), MOHFW
- Mr Euan Lindsay Smith, European Commission (DPs Representative)
- Mr. Nongyai, Consultant (RRC), Guwahati

## **List of Facilities visited**

### West Khasi Hills District

- TSMH-Mairang
- Civil Hospital Nongaistan - (District Hospital)
- MCH Centre (Urban Health Centre) Nongaistan
- SC-Jakhram
- CHC-Ranikor
- CHC- Mawkyrwat
- PHC- Mawthwad
- SC-Mawkyrwat
- VHND and SC- Mawleih
- PHC -Rambri

### Jaintia Hills District

- Jowai Civil Hospital
- Ummulong CHC
- Nartiang PHC
- Wahiajer SC
- Laskein CHC
- Wapung Pamra PHC
- Shangpung PHC
- Raliang SC
- Barato PHC (PPP)
- Shiliang Myntang SC (PPP)
- Mynsgat SC

# **STATE VISIT REPORT:**

## **MAHARASHTRA**

**RCH II: JOINT REVIEW MISSION VIII: STATE VISIT REPORT MAHARASHTRA  
(SEPTEMBER 12-16, 2011)**

The visit to Maharashtra for 8<sup>th</sup> Joint Review Mission comprised of field visits to Gondia and Kolhapur followed by a debriefing session at the State Headquarter at Mumbai. The details of team members and facilities visited are placed at annexure I. Facility wise reports for both the districts are placed at annexure II.

As per the 2001 Census, Maharashtra is second largest State in India with population of 9.67 Crores after Uttar Pradesh having 9.42% population of the nation. With an area of 3.08 lakh Sq. Km, the State also ranks second in area after Uttar Pradesh. The State has the highest percentage of urban population i.e. 43.3%.

Following is an analysis of some of the key performance indicators with regards to reproductive and child health as compared from the launch of NRHM:

**I. Key Performance Indicators for the State of Maharashtra**

<b>A</b>	<b>Infrastructure</b>	<b>As on 01.04.2005</b>	<b>As on 31.03.2011</b>	
1	Blood Storage Units	23	132	
2	Blood Banks	26	37	
3	SNCUs	28	33	
4	NBSU	0	146	
5	NBCC	23	904	
<b>B</b>	<b>Operational Facilities</b>	<b>As on 01.04.2005</b>	<b>As on 31.03.2011</b>	
1	No. of District Hospital conducting C-Section	26	18	
2	No. of CHCs conducting C-Section	NA	64	
3	No. of PHCs conducting more than 10 deliveries	NA	289	
4	No. of Sub Centres conducting more than 3 deliveries	NA	1575	
<b>C</b>	<b>Human Resource</b>	<b>In position as on 01.04.2005</b>	<b>In position as on 31.03.2011</b>	
		<b>Regular</b>	<b>Regular</b>	<b>Contractual</b>
1	Anesthetics	Data NA	118	84
2	Obstetrics & Gynecologists	Data NA	184	70
3	Pediatricians	Data NA	151	72
4	Staff Nurses	Data NA	3972	1380
5	ANM / MPHW(F)	Data NA	3318	2585
6	Laboratory Technicians	Data NA	748	522
7	ASHA Recruited	0	-	59880

<b>D</b>	<b>Maternal Health</b>	<b>As on 01.04.2005</b>	<b>As on 31.03.2011</b>	
1	Institutional Deliveries (%)	62(HMIS)	92 (HMIS)	
2	Mothers registered in the first trimester (%)	51.7*	61.6*	
3	Mothers who had at least full ANC checkups (%)	22.5*	33.9*	
5	Sex Ratio at Birth	873	883	
6	Number of pregnant women having severe anaemia (Hb<7) (treated at institution)	Data NA	18751 (2010-11- HMIS)	
<b>E</b>	<b>Child Health</b>	<b>As on 01.04.2005</b>	<b>As on 31.03.2011</b>	
1	Children under 3 years breastfed within one hour of birth	44.3*	53.3*	
2	Children (age 6 months above) exclusively breastfed	14.0*	33.6*	
3	Children with Diarrhoea in the last two weeks who received ORS (%)	42.0*	44.2*	
4	Children who received full immunization	19,99,010 (HMIS)	18,42,706 (HMIS)	
<b>F</b>	<b>Family Welfare</b>	<b>As on 01.04.2005</b>	<b>As on 31.03.2011</b>	
1	Any modern method for family planning	60.8*	62.6*	
2	Female Sterilization (No. of Tubectomy)	6,48,406 (HMIS)	4,68,083 (HMIS)	
3	Female sterilization (No. of Minilap)	4,65,193 (HMIS)	3,09,538 (HMIS)	
4	Male sterilization (NSV)	NA	23,967 (HMIS)	
5	Male sterilization (Vasectomy)	41,341 (HMIS)	24,395 (HMIS)	
<b>G</b>	<b>Number of Facilities functioning as per IPHS</b>	<b>As on 01.04.2005</b>	<b>As on 31.03.2011</b>	
		<b>Total Number of Facilities</b>	<b>Total Number of Facilities</b>	<b>No. of Infrastructure created as per IPHS</b>
1	DH	26	23	23
2	CHC	443	387	117
3	PHC	1800	1816	1090
4	Sub centre	9761	10,579	3542

\* Figures are taken from DLHS2 & DLHS3

### Maternal Health

Maharashtra has achieved the Millennium Development Goal (MDG) and is on the verge of achieving NRHM goals for reduction in MMR with a MMR of 104/lakh live births (SRS 2009). There has been substantial infrastructure development under NRHM in the State. In 23 District Hospitals, 117 CHCs,

1090 PHCs and 3542 Sub Centres, infrastructure has been created as per IPHS standards. The number of Blood Banks has increased from 26 to 37 and Blood Storage Units has increased from 23 to 132 between the years 2005 to 2011.

However, the facilities are underutilized and it needs adequate information and confidence building in the public for utilization of government health facility. Out of the above facilities where infrastructure upgradation has been invested in, there are only 1575 subcentres conducting more than three deliveries per month and only 289 PHCs conducting more than 10 deliveries per month. As regards provision of Emergency Obstetric Care there are 64 CHCs conducting C- Sections and 18 District Hospitals conducting C- Sections. The number of DH conducting C- Sections has reduced from 26 to 18 as the DHs have been converted to Medical Colleges. Thus, every district has at least one facility providing Emergency Obstetric Care. However, considering the fact that Maharashtra is the second most populous State in the country today, there is a need to improve in service delivery and its utilization as also confirmed during field visits.

	<b>Three or More than 3 ANC (%)</b>	<b>Mothers who consumed 100 IFA tablets (%)</b>	<b>Full ANC (%)</b>
<b>DLHS 2</b>	69.2	27.7	22.5
<b>DLHS 3</b>	74.5	45.7	33.9
<b>CES (2009)</b>	82.6	29.2	27.0

During field visits, it was observed that the ANC registers have columns for 5 ANCs which are being filled. Majority mothers receive 3 or more than 3 ANCs. However, as seen in the above table, as per DLHS III, 33.9 % had received full ANC and as per CES only 27 % women had received full ANC. This indicates that technical protocols for conducting ANCs are not being followed. Another reason for such low percentages of full ANC appears to be lack of consumption of 100 IFA tablets. Recent initiative by State for strengthening supply of drugs will ensure that supply is maintained. However, State needs to ensure that women are advised and motivated to consume the IFA tablets for reducing the number of anemic women. Implementation of Mother and Child Protection Card will help in ensuring rendering services during ANC/ PNC as per defined protocols.

As per DLHS 3, there are 63.6 % institutional deliveries. As per the CES 2009, there are 82 % institutional deliveries in the State but 42 % of these deliveries are in the private sector. Interactions with beneficiaries revealed that out of pocket expenditure (OOP) for private deliveries ranged from Rs. 3000-5000 for normal deliveries to Rs. 15000 for C- Sections in Kolhapur. This further points to the need for increasing service delivery in government hospitals if OOP expenditure has to be reduced.

#### **Availability of Key Human Resources for delivering EmOC and Neonatal Care Services**

There are 181 regular Anesthetists, 184 regular Gynecologists and 151 regular Pediatricians employed by the State apart from 84 Anesthetists, 70 Gynecologists and 72 Pediatricians employed on contractual basis. Also, 94 MOs have been trained in CEmOC and 153 MOs have been trained in anesthesia. Since there are only 82 facilities providing EmOC services, it can be said that if rationally deployed, there is no shortage of key human resources for delivering emergency obstetric care in the State and State could have achieved the NRHM goal earlier than the targeted year.

#### **Child Health and Immunization**

While the IMR of Maharashtra is 31/1000 live births (SRS 2009) and is very close to the NRHM goal, the NMR is 24/ 1000 live births (SRS 2009) and requires great focus if further decline in IMR has to be achieved.

The number of SNCUs in the State have increased from 28 to 33, NBSUs have increased from 0 to 146 and NBCCs have increased from 23 to 904 between the years 2005 to 2011, it has still not reached all the 289 PHCs conducting more than 10 deliveries and all the 1575 sub centres conducting more than 3 deliveries per month. Thus, the pace of provision of new born care needs to be increased substantially. State also needs to rationalize creation of infrastructure and link with service delivery. The delivery points need to be prioritized for creation of SNCU, NBSU and NBCCs. The State has 151 regular pediatricians and 72 pediatricians on contractual basis besides those trained in FIMNCI and only 82 facilities providing EmOC services as stated earlier.

As per DLHS 2, the percentage of children fully immunized was 70.9% but in DLHS 3 it has reduced to 69.1%. As per CES 2009, the percentage of fully immunized children is 78.6%. Immunization activities were observed to be conducted well even during field visits. Due lists were maintained by all ANMs and VHNDs were popularly known as '*Lasikaran Diwas*' or immunization days on field. The immunization registers and records of the infants indicate good coverage upto measles. During field visits, it was observed that all vaccines were available except Hepatitis B.

State has initiated *Hirkani Kaksha*, a designated space for breastfeeding in the PHCs. During field visits, it was observed that most of the women had initiated breast feeding within half an hour of birth. As per DLHS 3, 53.3% Children under 3 years are breastfed within one hour of birth, 33.6% Children (age 6 months above) are exclusively breastfed and 44.2 % Children with Diarrhea in the last two weeks received ORS. As per CES 2009, 51.2% women had showed early initiation of breastfeeding, ORT or increased fluids for diarrhea were used by 58.1% children. While compared to the national average, these percentages are good; Maharashtra being a progressive State should aim at improving these parameters and should try to reach the levels of Kerala.

### **Family Planning**

During field visits, it was observed that contraceptives were generally available, nurses were proficient in IUCD insertion, ANMs were trained and FP services were available at all designated facilities. As per DLHS II, 60.8% of the population was using any modern method for family planning and as per DLHS III, 62.6% of the population used any modern method for family planning. In 2011, the State has achieved 85.35 % of its ELA and the TFR of the State has decreased from 2.2 in 2005 to 1.9 in 2009 (SRS).

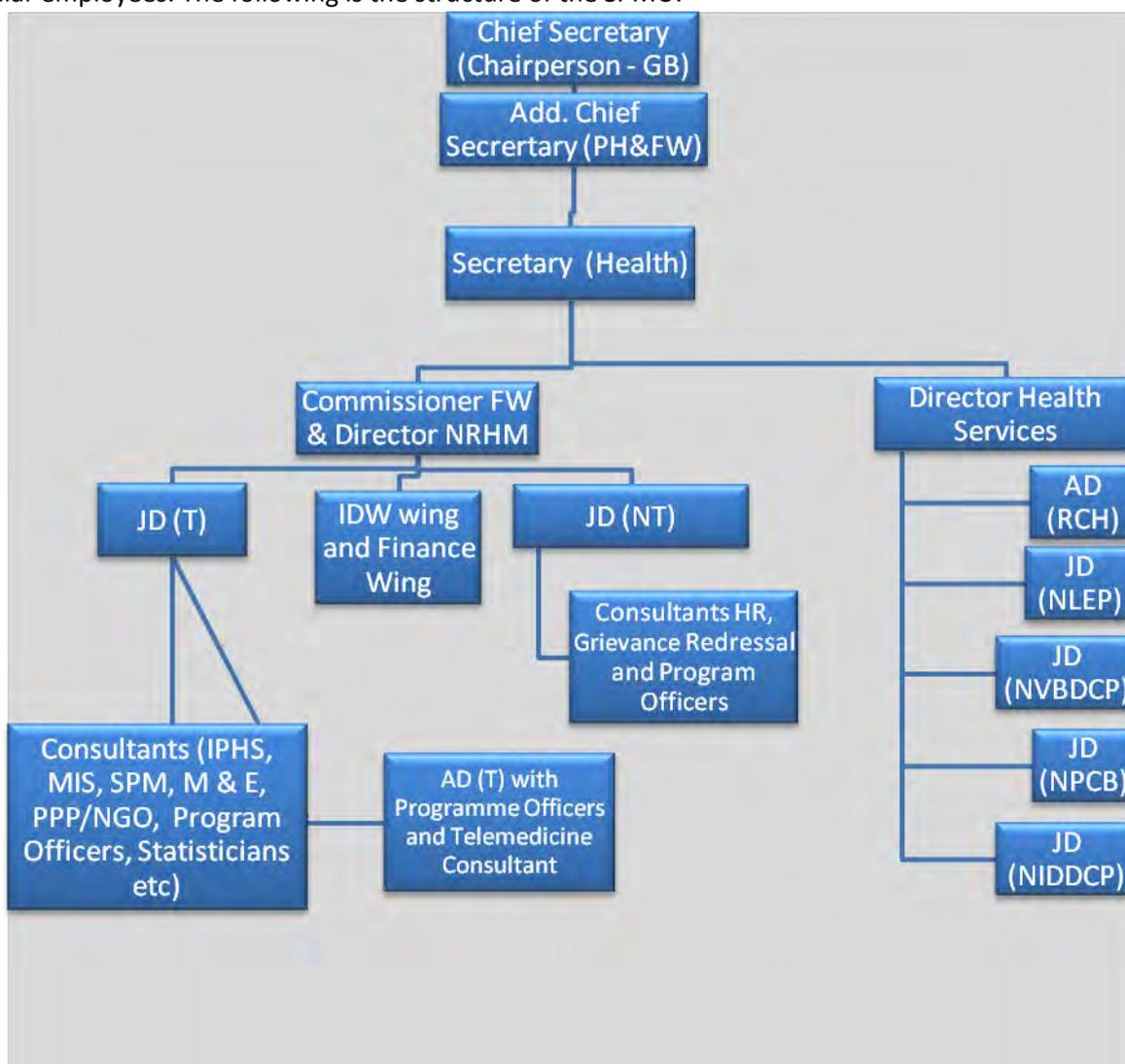
However, as per DLHS 2 the total unmet need was 12.6 % and as per DLHS 3 it is 14.2 %. Performance of Female/Male sterilizations declined since 2005 in absolute numbers. The reasons for increased gap on unmet need and decline in absolute numbers of male/ female sterilizations need to be analyzed by the State. The State should also look into district wise data reporting on FP activities including achievement of its ELA.

**gramme Management**

Under the NRHM, State, District and Block Programme Management Units have been set up to ensure smooth implementation of the Programme.

**A. State Programme Management Units:**

In Maharashtra the SPMU is set up involving both regular and contractual staff. All contractual staff have been deployed under a regular employee and they provide technical and managerial support to the regular employees. The following is the structure of the SPMU:



Various consultants/programme managers specializing in different areas have been employed in the SPMU under the Mission as per the felt need of the State. A list of some of the categories of consultants/managers employed by the State under the Mission is annexed (Annexure III). In Maharashtra, RCH activities are overlooked and monitored by the designated technical officer under the Family Welfare Bureau. The structure of the Family Welfare Bureau is as follows:

- 1 Additional Director (Program)
- 11 Joint Directors (All Vacant)

14 Deputy Directors (9 vacant)

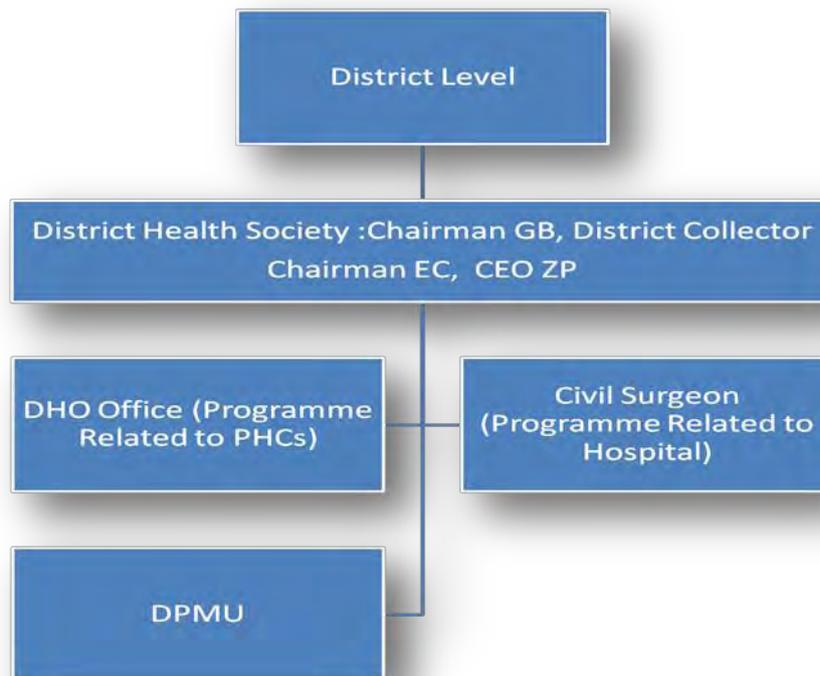
8 Assistant Directors (1 vacant)

1 State Demographer and (10-12 Supervision Staff and other staff)

Over all, under NRHM office, the State has 8 regular and 197 contractual staff and under the Family Welfare Bureau, the State has 111 regular and 51 contractual staff. Out of the regular posts at the Family Welfare Bureau, 23 key positions are vacant and need to be filled on a priority basis. Deputy Directors are incharge of the individual programmes but the contractual support structure under them is quite weak as against the structure under the NRHM office. Thus, there is a definite need to reorganize and strengthen these structures. However, this is clear that no additional manpower is required, a definite ToR, job responsibility and close performance monitoring of each supervisory staff is needed for a comprehensive outcome particularly for establishing technical protocol and services.

## B. District Programme Management Units

At the district level, the DPMUs have been set up and the following is the position of the DPMU in Maharashtra. The DPMU reports directly to the CEO, ZP who is the Chairman of the Executive Committee of the District Health Society and also via the DHO and CS. However, the reporting through CS is weak and instead of reporting directly to CEO, they should report via DHO and CS.



The District Health Officer has under him/her RCH officers, Additional DHO, Assistant DHO and contractual staff such as the DPM, DAM, M&E Officer, ASHA Coordinator, RKS Coordinator, IPHS Coordinator, Public Health Specialist, Sickle Cell Coordinator, School Health Coordinator, ARSH Coordinator, AYUSH Coordinator, Junior Engineer etc. Some of the above contractual employees also report to the Civil Surgeon. Almost all contractual positions are completely filled.

Despite such a good structure Monitoring and Supervision of different programme especially MH, CH and FP is quite weak for implementation of technical protocols and guidelines.

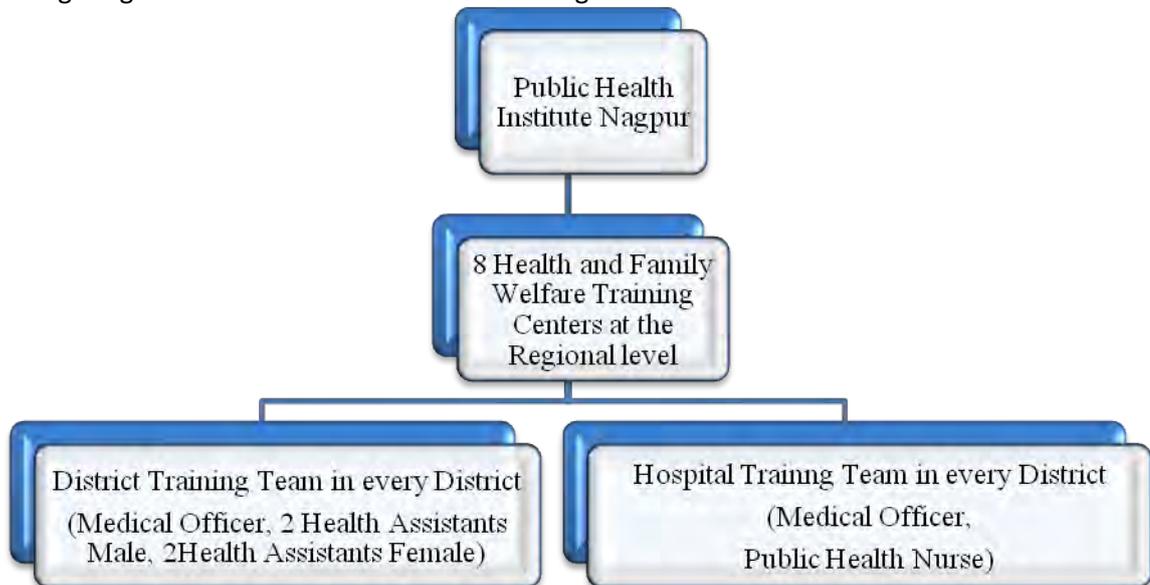
## C. Management Structures at the Block level

Maharashtra has locally adapted a management structure at the Block level under NRHM with active involvement of PRI members. The BPMU consists of the Block Medical officer, Data Officer, Block Nursing officer (MCH), Block Finance officer and other supervisory staff. In the BPMU, there is 1 regular post and 2 contractual posts of a DEO and an accountant. The total number of people employed under the BPMU across the state is 1,042. Besides this, the positive feature is a very good support and active involvement of PRI members in different functional committees. From block to village level some of these committees are

- **Taluka Monitoring and Advisory Committee** - Chairman (Hon. MLA/MLC)
- **Taluka Mission** - Chairman (Hon. Chairman Panchayat Samitee)
- **Block Project Management Unit** Headed By - Taluka Health Officer
- **RH/SDH RKS** - GB Chairman : Dy. Collector and EC Chairman : MS Of Hospital
- **PHC RKS** - GB Chairman: Local ZP Member and EC Chairman : THO
- **Sub-Center Advisory Committee** - Chairman : Sarpanch of HQ Village, Member Sec. : ANM
- **Village Health Nutrition Sanitation And Water Supply Committee** - Chairman : Local Influential Person, Member Secretary : AWW

#### D. State Training Program Unit

State Training Program Unit is structured in the following manner:



Visit to the District Training Centre and the Health and Family Welfare Training Centre revealed that:

- There were no guidelines, no training plan, staff did not know the details of the training and technical and operational understanding is particularly weak. Poor knowledge of the training component.
- Staff needs strengthening, orientation and practicing of the skills before they conduct the training.
- There is no supervision and monitoring of training from any levels state/regional/district
- There is weak support to the technical personnel at state level and also district level for supervision and monitoring
- Training Infrastructure including building and hostels needs improvement eg. At Gondia it is running in a rented building.

- Supervision by the apex training institute i.e. Public Health Institute, Nagpur is very weak. Their field monitoring is poor and completely lacks the role of a mentor.
- Similarly, the regional training centres also lack in supervision, monitoring and mentoring of the trainings particularly the RCH trainings.
- Convergence between training units located at Nagpur and Regional Centres with the technical programme management unit is weak and certainly needs close monitoring under senior State level official.

#### **Strengths of Programme Management**

- Implementation of RCH activities is the responsibility of technical persons
- SPMU and DPMU are fully functional and have no vacancies
- The attrition rate is low
- Commendable support and Supervision by PRI members
- Commendable administrative support from the administration and CEO and no delay in file clearance
- Contractual staff is working under the support and supervision of regular staff which helps in continuity of programme implementation
- Some officer for District Health Societies are recruited directly through SHS, Mumbai and deputed to Districts (like: DPM, DAM, M& E Officer etc.) In case of other posts to be filled with the salary less than Rs.21600/- pm is filled by the District Societies
- Performance appraisal conducted at the end of each year and renewals are based on performance. The appraisal is done by the DHO or the Civil Surgeon as per their reporting structures

#### **Weaknesses of Programme Management**

- There is complete lack of monitoring and supervision at the field level. None of the programme officers either regular or contractual undertake regular field visits. The Family Welfare Bureau who is supposed to monitor the implementation of RCH has 23 positions vacant.
- All of the contractual staff at the DPMU at Kolhapur had been given a specific TOR and job responsibilities. However, a substantial amount of their time was spent in providing support for office file works and other administrative works at the DPMU for various activities, leaving less time for their core functions
- Very few of them received orientation training on NRHM before starting the job leading to difficulty in implementation of their tasks initially and all learning about the programme happens while performing their duties. This is an issue that requires great attention. In Maharashtra, since the qualification for the DPM is MBA-HR (with relevant experience), it is important that an orientation of such key staff on NRHM is arranged before posting the staff at the district level.
- The training structures are particularly weak and require great attention and improvement.
- The District training cell needs strengthening with more technical faculty of doctors, public health specialists etc

### **III. Quality of Services**

#### **Quality Assurance (QA) Systems**

##### **State Level**

A State QA consultant (Nodal Officer) has been appointed in Maharashtra to focus on Quality Assurance issues. An orientation workshop for QA was organized at the State Level for State Officials. With the support of UNFPA, the programme has been implemented in 12 districts with further plans for scaling up in the remaining districts.

##### **District Level**

District QA committees are set up in all 33 districts. The District Reproductive and Child Health Officer has been appointed as the District Nodal Officer for QA. 12 districts have been specifically selected for monitoring by the UNFPA and presently 12 QA coordinators are working in these districts. In these 12 districts, a QA cell and District QA Group (DQAG) under the chairpersonship of Civil Surgeon/DHO have been set up. Districts identified members for the DQAG from amongst district Officers, Clinical specialists, Public Health personnel, PHN and MO-DTT and HTT. Each district identified 20-24 officials to be members of the DQAG. The districts were requested to identify on an average 50 health institutions for QA in the first phase. However, their active involvement in QA activities was not visible in the health facilities visited, since adherence to the technical protocols during service delivery was weak. Wherever available it was due to good pre service knowledge and training of staff rather than training by the QA team.

##### **Activities Undertaken:**

- A comprehensive checklist for monitoring of QA activities at Sub centre, PHC and FRU has been developed. There are 10 sections in the checklist which cover provider availability, infrastructure, essential protocols and guidelines, infection prevention practices, availability of equipment, supplies and drugs, Family Planning, Maternal Health, Child Immunization, Output indicators and Initiatives under NRHM and State schemes. The checklist is designed in a different colour for different levels of facilities. It is quite comprehensive. However, it needs some technical additions.
- Orientation workshop on QA for District Officials in all 33 districts
- Medical Officer Sensitization at District Headquarter in all 33 districts
- Health facilities selected for QA in the 12 UNFPA districts. Work initiated in 6 districts since 2009-10 and in remaining 6 in 2010-11.
- QA is done at Sub Centre, PHC, RH and at Outreach session and sterilization camps. DQAG committees conduct visits to selected facilities and grade the facilities into A, B, C & D based on QA checklists. Four such visits are conducted every year to ensure improvement in QA.

##### **Observation of QA activities in Kolhapur District**

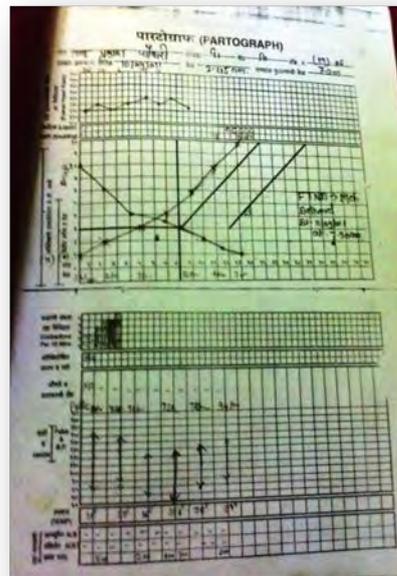
- A District QA coordinator has been appointed and has initiated the work of QA.
- QA committees formed at the district level and orientation of QA committees has been conducted at Nagpur.
- Currently, DQAG cell has been created in each of project district. This cell is chaired by Civil Surgeon/DHO of the respective district. District QA Nodal Officer is member Secretary. DQAG has defined ToR.

- Interaction with Quality Assurance Officer
  - In 2009, fifty IPHS facilities (14 PHCs, 8 RHs and 28 sub-centres) were covered by the QA cell and the planned 4 visits to each of these have been completed. This year, an additional 25 facilities have been selected this year and the first round of QA visit to these has been completed.
  - QA committee consists of 22 members and this is divided in 4-5 sub committees.
  - Detailed checklist has been used. In a year, each facility has been covered at least thrice.
  - Facilities have been graded on a scale of A to D. All the records are maintained at the facility level and adequate follow up has been conducted with active engagement of the facility staff.
- Observations during field visit
  - QAC has conducted facility follow up visits and files are available for action taken report based on these checklists at the facility level.
  - The facilities such as PHC Ispurli and RH Gadgorti have improved in certain aspects over 4 visits conducted over one and half year and the facility is performing well.
  - However, the activities conducted are individual driven like QAC co-ordinator of the district. Many supervisors did not know the purpose and outcome of this activity.
  - A system of QA needs to be in place.

## Quality of Services

### Maternal Health

- Focused efforts towards early registration and ANC services are available at the facilities.
- Labor room
  - Well maintained with all requisite equipments and functional new born care corner
  - Drug tray, instrument tray, oxygen, ambu bag, suction apparatus all in place and functional



- Training of service providers in maintaining partographs missing. However, Partograph is being maintained due to local initiatives, dedicated and motivated staff in facilities along with good quality pre-service nursing training. Nevertheless, knowledge on technical protocols like AMTSL, PPH not adequate.

- Necessary facilities and practices to maintain aseptic conditions were observed, and necessary drugs were available in the labor room and OT.

**Post Natal Care:** 48 hours stay post delivery being complied in Kolhapur but in SDH at Gondia and BGW hospital, mothers are discharged within 24 hours.

- Post-natal wards in facilities were neat and clean including toilets; provision of meals for mothers during the post-natal stay in most places in Kolhapur.
- Clients spoken to expressed satisfaction at the quality of services they received
- Maternal deaths are being tracked and MDR is conducted regularly. All ANMs are aware of the deaths that have taken place in their area.
- Free diet is made available to all pregnant women in facilities

### Issues

- Standard treatment guidelines and protocols were neither available nor adhered to.
- Very few numbers of staff nurses and ANMs have been trained as SBA. Those trained have poor knowledge and skills reflecting poor quality training.
- No supervision and monitoring (both service delivery and training) from any level i.e. State, regional and district.
- Oxytocin is not used as per guidelines.
- Most PHCs are handling normal deliveries but complications are being referred.
- Referral transport arrangements are in place. The centralized call centre and universally available toll free number is operationalized in Gondia but the facility is not available in Kolhapur.
- In some facilities, three ultrasounds as part of routine ANC is done.
- RTI services are not offered at most facilities as per guidelines.
- Drug kits for RTI/STI were not available in most facilities except DH.
- Other MH training not visible, those trained have poor knowledge and skills

### Child Health

- Facilities for basic newborn care and resuscitation are available at most of the facilities. New born corners have been set up at most places. However, knowledge on resuscitation is not adequate among the service providers. NSSK trained providers were present but those who are actually involved in delivery care have not been trained.



- Children are being treated for diarrhea, ARI and other illnesses. . However, provision of Zinc tablets during diarrhea not practiced; there were stock-outs across facilities in Kolhapur and knowledge of protocol was poor.
- There is good Immunization coverage and children are being tracked for full immunization upto measles in Kolhapur and Gondia.
- NBSU and SNCU are not established as per guidelines.
- Focus on early initiation of breast feeding and counseling on exclusive breast feeding for six months
- Very few service providers were trained in IMNCI and FIMNCI.

### Immunization

- Cold Chain is well maintained.
- Stock of all vaccines available except Hepatitis B.
- Microplans were available in Kolhapur. However, in Gondia, it was available only in some facilities.
- Record of all fully immunized children maintained well
- However, reporting of used vials could not be seen.

### Village Health and Nutrition Day (VHND)

- VHND sessions are held regularly. However, VHND micro plans were not available in all facilities.
- ASHAs, AWWs, ANM and MO present at VHND. Good participation from PRI representatives
- Growth monitoring charts are being filled by the AWW and children are screened for SAM and MAM but growth monitoring charts are not being analyzed by either AWW or their supervisors. Children with growth faltering and declining nutrition status, unless they fall into SAM and MAM are not being tracked and no corrective action is taken. Besides treatment of SAM and MAM children, there needs to be a focus on prevention of malnutrition.



- AWC is performing designated job, cooked food is given to children.
- Adolescent girls between 15-19 years are getting dry ration in pilot block at Kolhapur but IFA tablets are not being provided.
- Some facilities have created NRC recently e.g. NRC has been started in BGW on 15 August, 2011.
- Due list is for immunization is prepared by the ANMs and ASHAs call beneficiaries as per due list.
- Pediatric IFA coverage is poor.
- Beneficiaries were satisfied with services offered. Women value the knowledge imparted at the VHND. However, more support and counseling for exclusive breast feeding for six months is required.
- There was role clarity in some areas like Take Home Ration distribution, weighing of children, plotting of growth charts, implementation of SABLA scheme for adolescent girls being done by AWW, immunization being done by the ANM, and ensuring institutional deliveries by ASHA.
- There was lack of role clarity between the ASHA and the AWW in several areas, such as home visits – its purpose and content, registration of pregnant women within 12 weeks, iron supplementation for adolescent girls. The relationship seemed collegial and collaborative. The ANMs are being respected by the community and also by AWW and ASHA. The coordination between them is very good.

### **Family Planning**

- In Kolhapur, Sterilization operations for family planning 100% achievement of ELA, only four deaths in last year due to sepsis.
- Counselling on breast feeding, family planning happening proactively. Doctors are actively involved in family planning counselling.
- The TFR of the State has decreased from 2.2 in 2005 to 1.9 in 2009 (SRS) but the performance of Female/Male sterilizations declined since 2005 in absolute numbers. State may need to analyze the reasons thereof.
- FP training in Minilap and NSV is inadequate.
- Fixed day FP services are not implemented as planned in all facilities.
- FP programme has inadequate focus on spacing particularly post partum IUCD.
- Availability of Emergency Contraceptives was poor.
- Sterilization facilities are available at PHC/RH and DH Level
- Minilap is common method but GoI standards are not followed. Minilaps are conducted using traditional method and women are admitted for seven days.
- NSV is popular but services are not available at all PHCs and RH.

### **Strengths**

- Impressive improvement in infrastructure at all levels from SC to DH Level
- General cleanliness and Ambience has improved at most facilities and is excellent at facilities visited in Kolhapur & Gondia.
- It was also observed that in Gondia rural institutions are better maintained than urban institutes
- Citizen Charter, Grievance Redressal, JSY Beneficiary List and other public utility information displayed prominently at all facilities

- Drugs and equipment are available in most facilities. Drug dispensing counter and drug stores meticulously maintained. Inventories are computerized and short expiry list and register is maintained at all facilities. Storage of drugs well organized and is an example for other states for getting oriented on store management



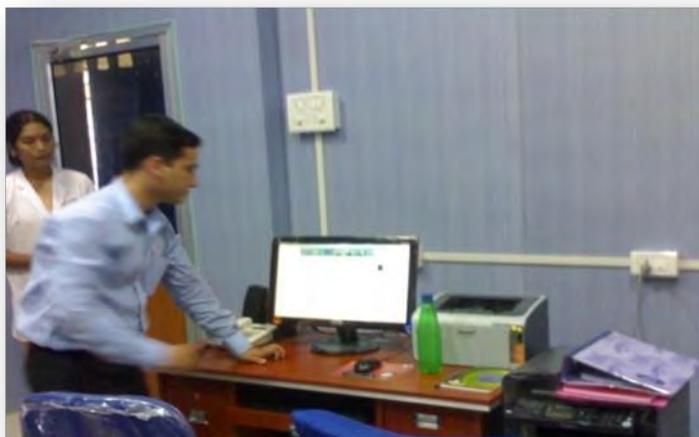
- Well equipped laboratory facilities for blood, sputum, and HIV testing available at PHCs, RHs.



## IV. Health Management Information System (HMIS) and Data Management

### Status of Information Systems

- A system of data management existed in Maharashtra on 'phd.nic.in.'
- The State is shifting to DHIS 2 for facility wise reporting from April 2011.
- Reporting is done for RCH, Health Facility Services, stock management and mortality.



- All the PHCs, RH, SDH, DH, Municipal Councils and Municipal corporations are uploading data online.
- The district uploads the consolidated report from DHIS-2 on Central Government Portal.
- Quality of the training and availability of electricity and internet at the reporting units is still an issue which hampers the data flow and analysis.

### Status of Data Upload

2011	Apr	May	June	July	Aug	Sep
State committed (level 4)	0	0	0	0	0	0
To be committed by State (level 3)	20	20	22	13	4	0
To be committed by district (level 2)	14	14	12	21	6	0
District Not uploaded (level 1)	0	0	0	0	24	34
Gondiya	level 3	level 1				
Kolhapur	level 2	level 3	level 3	level 3	level 2	level 1

- The State has not committed data for any district in financial year 2011-12 till the month of August.
- The State has committed data for only 22 districts out of 34 in June, 2011. Moreover, the number of districts data committed is lower than 22 in all the other months from April to August.
- Kolhapur District has not committed data for the months of April and August and data for both the districts is yet to be committed by the State.

### Use of HMIS in Planning and Monitoring

- It is planned to replace 'phd.nic.in' with DHIS-2 in a phase wise manner till December, 2011.
- Facility wise data reporting is yet to be initiated on Government of India Web Portal.
- The State pointed out that the outliers are identified and communicated to the concerned districts.
- It was presented that the weaker areas are identified on the basis of data from HMIS. These poor performing areas are visited regularly for monitoring.
- However, utilisation of data for programme planning, implementation and taking mid course corrections needs to be improved at all levels.

### Mother and Child Tracking System (MCTS)

- All the health institutions have been mapped in MCTS health master.
- Data base generation is complete till July, 2011. Data entry drive was taken up in August, 2011 to clear the backlog data entry. Entry for the month of August is being done.
- User ID and passwords have been created for all the PHCs and monitoring health officers.
- **Pregnancy Tracking:** A total of 21,90,000 pregnancies are expected in Maharashtra. In 173 days till 20.09.2011, it was expected to register 10,38,000 pregnant women. However, as on 20.09.2011, data for 4,89,930 pregnant women has been entered. It is **47%** of the expected level on this date. It is expected to register 6000 pregnant women every day to meet the target of 21, 90, 000 registrations.
- **Child Tracking:** A total of 19,29,000 children are expected to be registered in Maharashtra. In 173 days till 20.09.2011, it was expected to register 9,14,305 children. However, as on 20.09.2011, data for 2,42,525 children has been entered. It is **26%** of the expected level on this date. It is expected to register 5285 children every day to meet the target of 19,29,000 registrations.
- Follow up for service delivery on entered data is not being done.
- In Kolhapur few pregnant women were called on the given mobile number which ultimately was traced to AWW.
- 100 % entry of date and follow up needs to be strengthened.

## **V. Gender and PNDT Implementation**

### **Mainstreaming of Gender in the Health Sector**

- Good progress has been made in initiating women's participation in the community based structures in the Health Institution. Kolhapur Zila Parishad president is a woman and most of the Panchayats visited by the team were headed by female Sarpanchs with good participation in the decision making.
- Clean and separate bathrooms for women patient and screens/ partitions are properly used in the examination and labour room to maintain privacy.
- Safety and security of women staff has been taken into consideration. In all sub centres visited by the team, ANM quarter was available adjacent to the sub-centre.
- Deputation of female staff especially lady doctors had improved the cases load in the facilities. Good numbers of female doctors have been deputed in PHCs and Sub centres. All visited facilities have adequate number of female staff nurses and ANMs bringing confidence in the beneficiaries visiting health facilities.

### **Concerns**

- No Gender person designated for mainstreaming gender in health programs
- Sexual Harassment committee to address sexual harassment at work place has neither been constituted nor are there any redressal mechanisms for addressing such cases.
- Male participation in the family planning is showing decline over the years. In 2010-11, only 44% of the estimated target was achieved in Vasectomy as compared to 108% achievement in 2004-05. Condom users have also reduced from 525346 in 2004-05 to 327846 in 2010-11.
- Sex disaggregated data for access of services e.g RTI/STI, Immunization, Child Health Care services is not being collected with the result there is no gender perspective in terms of services being delivered. For example, as per the year wise performance report of SNCU of SKNP General hospital, Satara in 2009-2010, 362 boys compared to 182 girls and in 2010-2011, 390 boys compared to 122 girls were admitted in the SNCU. This clearly shows that there is gender disparity in service delivery. Such desegregated data can be very crucial and useful in ensuring health services for girl child and thus minimizing the gender gap in infant mortality and likewise in other health indicators in the State.

### **PC& PNDT Implementation**

- State Supervisory Board has been constituted and met five times. Last meeting was held in 2011.
- State appropriate Authorities and advisory committee have been constituted and notified.
- District Collector for rural areas and Medical Officer for urban areas (Municipal Corporation level) have been appointed as District Appropriate authority in the District in 2009.
- Advisory Committees at District and Municipal Corporation level have been constituted.
- State Inspection and Monitoring Committee is functional and carrying periodic inspections. Special cell has been created for guidance especially in legal cases at the state level and there are further plans to have a functional PNDT cell, legal advisor and investigation Cell at State and district levels.
- 7939 centers are registered and 244 cases have been filed under PC & PNDT Act in the State. Total 34 sting operation has been carried out and 17 doctors have been convicted (3 imprisonment and 14 penalized) but Doctors names have not been communicated to State Medical Council for further suspension/ cancellation from the State council.

- Sting operations and provision for witness support participation has been included in the State PNDT program plan. Award to informers has also been planned to be included in the program.
- A dedicated website has been launched for registering complaints under the PC&PNDT Act and addressing other related issues also a toll free No. 18002334475 has been started.
- The State is planning to initiate the online filling of Form F at the level of clinics. Program Managers and clinic operators have been trained to rollout this initiative.
- Presently State is holding orientation program for appropriate authorities and planning to constitute inspection and monitoring committees at the district level to ensure consistent and localized monitoring of the Sonography centers.
- Online reporting of Sonography and MTPs by the concerned clinic to the District Appropriate Authorities and tracking of ultrasound scans and MTPs of migrated beneficiary has been proposed.

### PNDT Implementation in Kolhapur

- District Collector is the District Appropriate Authority for the rural area and medical officer is in urban area (Municipal Corporation) in the district and Advisory Committees in place are meeting regularly.
- Appropriate authorities have been also appointed at the block level with respective advisory committees.
- 121 clinics are registered in rural areas and 123 clinics in urban areas. 7 and 8 cases have been filed in rural and urban jurisdiction respectively.
- Online portal has been launched for online submission of maternity scans and MTPs record.
- Silent observer initiative has been initiated in the district. Under which a device is installed in the ultrasound machines to record all the scans so that information of form F can be crosschecked for under reporting and false reporting on the part of Ultrasound centers.



- *Lakshmi Ali Ghari* Scheme launched for welcoming birth of female child in the rural areas under which every female child in rural area is felicitated by giving thermal set and baby kit and parents by giving sari, certificate and five Teakwood plants. Under the scheme, Grampanchayats deposits Rs. 5000/- in the fixed deposit in the name of new born female child.
- Sex *ratio* at birth score boards have been displayed in all health facilities conducting deliveries. Monthly Sex Ratio at birth of the facility is displayed regularly to assess the situation.

## Concerns

- Sex ratio at birth recorded till the village level but the data is not used in planning areas specific strategies or programs.
- Lakshmi Ali Ghari Scheme is helping lower economic class and whereas the problem is seen more in upper economic class
- Systematic and regular monitoring of clinics are not done.
- MTP tracking can lead to violation of reproductive rights of the women.
- MTP and PNDT Act needs to be implemented separately. Effective implementation of PC&PNDT will lead to a lesser number of Sex Selective Abortions
- Conviction rates are low and convicted doctors are not suspended from the State Medical Council

## VI. Strengths in other Areas

1. AYUSH doctors performing very well at most of the facilities in Kolhapur and Gondia such as Kavaranbandh PHC, RH Gargoti and SDH Kodoli such as:
  - Ayush doctors both Ayurveda and Homeopathy have maintained their records of performance and data analysis for treatment and recovery meticulously. Cure rate is 70%
  - Ayurveda doctor Dr. Sulekha has also published a small booklet on the treatment for common ailments by Ayurvedic medicines.
2. Dedicated and motivated Staff at the health facilities and their willingness to take responsibility is a big strength. However, they need adequate supervision and monitoring.
3. **ASHA:** ASHAs are well versed with their roles not only in Reproductive and Child Health issues but also in TB, Malaria and Leprosy related work. Their good knowledge indicates good quality training. They work closely both with the community and the health system. State has also initiated the online ASHA monitoring software.
4. IEC/ BCC Bureau is active and every facility showed good display of IEC material in local language. However, coverage of IEC outside the facilities in forms of posters or banners was not adequate.



5. Mobile Medical Units have been established with the help of NGOs
6. Community Monitoring is also actively taken up in many districts
7. Sickle Cell anaemia programme is running extremely well in tribal areas

8. While State has operationalized Village Child Development Centres (VCDCs) and Child Treatment Centres (CTCs) in many districts, NRCs have also been started in some selected Districts. VCDCs have admitted 128776 children till date and 27494 children have been admitted in CTCs till date.
9. State has also focused on following innovative activities:
  - a. Book your bed scheme in selected Rural Hospitals for pregnant women to encourage pregnant women to deliver in government institutes
  - b. Expected Date of Delivery Monitoring and Expected Place of Delivery monitoring
  - c. Solar power system in selected tribal PHCs



- d. NRC in selected districts
- e. Hirkani Kaksha for promotion of breast feeding
- f. Maher scheme for promotion of institutional delivery
- g. Lek Ladki Abhiyan under PCPNDT
- h. Telemedicine facility in selected districts connected with Medical Colleges and tertiary care centres
- i. School Health Programme
  - i. Examination of 16.50 Lakhs students in 2011-12
  - ii. 539- Heart surgeries & 190 other surgeries conducted.

## VII. Finance

The state has net unspent balance of Rs. 212/- crore in RCH, Rs. 177/- crore in NRHM and Rs. 9/- crore in RI from Financial year 2005-06 to 2011-12. Expenditure increased from 2005-06 (25%) to 2010-11 (80%) under RCH and from 2005-06 (0%) to 2010-11(173%) under NRHM. Expenditure reported during the first quarter of financial year 2011-12 is very low. A detailed year –wise status of funds release and expenditure of the State is placed at annexure IV.

State has Rs. 311.74 Crore outstanding advance as on 30-06-2011. These advances need to be settled and the period wise details of advances needs to be maintained. The Bank Balance of Rs. 257.73 crore available with bank needs to be transferred to district for timely implementation of the activities of RCH/NRHM. The advance and bank position as on 30-06-2011 is placed at annexure IV. This was discussed during the debriefing meeting at Mumbai and the State assured that corrective action on the issue had already been initiated.

**State Share:** State has not contributed Rs.26 crore State share in 2011-12 and overall Rs 292.69 Crore is outstanding against the State from 2007-08 to 2011-12. The year wise details of State share are placed at annexure IV. The State is thus required to contribute the outstanding State share of Rs.292.69 crore and to send the Bank Statement copy for credit of state share of Rs. 26 crore for financial year 2011-12.

### **Best practices followed by the Maharashtra at State and District Health level Society**

- Information regarding DHO and District Health Society members are well displayed at Gondia DHS
- Tally ERP9 software has implemented at State Health Society (Pune) and District level (Gondia and Pune).
- State is transferring the funds to District Health Societies through e-transfer from ICICI Bank.
- Every cheque is signed by Joint Signatories at State and District level.
- Taluka Accountant appointed at Taluka level for strengthening the Taluka level financial Management.
- Concurrent Audit system is implemented at Districts (Gondia, Pune) and State level in 2010-11.
- RKS funds were fully utilized at PHC Mulla
- ANMs and Assistants maintained Cash Book at Surtoli SHC/Mulla PHC respectively in proper format
- State has completed Statutory Audit for the year 2009-10.
- State has issued the Government order for Delegation on Financial power.
- JSY records are well displayed on the wall of the surtoli sub centre

### **Observation from Concurrent Audit Report (Gondia)**

As per the audit reports of M/S JLN & CO Chartered Accountants, Mumbai for the year 2009-10 and 2010-11, the main observations are as under:-

- Required books of accounts and fixed assets register should be maintained as per NRHM guidelines.

- No tender process followed for procurement of equipments from M/S Raajdeep Trader, Gondia. Open tender process must be followed if purchase of amount is more than Rs. 50000/-
- All payment over Rs.1000/- must be discharged through cheques.
- Quotations should be obtained from proper sources / suppliers and proper procurement procedure should be followed in each and every procurement as per State government financial rules.
- All BRS must be maintained in files.
- Proper authorization should be taken for all expenditure so that it known to concerned authorities.
- Advance must be settled within 30 days.
- 

#### **Observation from the Statutory Audit Report (Gondia)**

As per the Statutory audit report of Gondia, DHS of M/S. Malani Somani Chandak & Associates CA, Pune the following are the observation of the auditor:

- Auditor reported that receipts for security deposits in respect of construction work for the year 2007-08 to 2009-10 amount received in cash is Rs.2716529/- but as per bank details, amount deposited in bank till date was Rs.2337720/- .Reconciliation is required for the security deposited by the contractor.
- General Ledgers were not prepared.
- Details of expenses for advances given to officers have not been maintained.
- Most of the payments for expenditure are made in cash rather than by cheque.
- District Health society have no action taken reports of the Statutory Audit report (2009-10) /Concurrent audit report for the year 2009-10 and 2010-11.

#### **Key Observations for State Level**

- Full e-banking system is not properly implemented in Maharashtra.
- Tally ERP9 is implemented at State Level.
- Summary of Concurrent Audit Report for the financial year 2010-11 and 2011-12 was not being sent to GOI, on quarterly basis.
- MIS report for July 2011 has not been submitted.
- RCH –I unspent balance of RS.64.54 lacs is still pending for refund to GOI.
- Books of accounts-(RCH) State Health Society (Pune) are not kept in proper format. Ledger is used as cash book. One Cash book is continuing for the accounts of two years. One Bank book is used for RCH, RI and PPI activities.
- Lag of 73 days in funds transfer of RCH from State Health Society Pune to DHS. The file was initiated for funds release on 17-05-2010 and the final sanction given on 26/07/2010 and funds transferred to District Health Societies on 27-07-2010.
- Lag of 24 days in funds transfer of RI from State Health Society, Pune to District Health Societies. The file was initiated for funds release on 23-05-2010 and the final sanction given on 14/06/2010 and funds transferred to District Health Society on 16-06-2010.
- RCH accounts are being maintained in the Pune office and all files relating to funds release are sent to Mumbai office. There is double reporting system in Maharashtra. District Health Society sends reports to Pune office and Mumbai office. Consolidated FMR is prepared at the Mumbai office.
- As per the table below, JSY beneficiaries increased in 2007-08 (369.85%) whereas the expenditure is increased only (154%). During the year 2009-10, JSY beneficiaries increased by 55% whereas the expenditure increase only 14%. Year –wise physical and financial progress of JSY in Maharashtra is placed at annexure IV.

- As per JSY guideline For urban area, the beneficiary after delivery in the institution is to be paid Rs.600 within 7 days and in rural area, the beneficiary will be paid Rs.700/-within 7 days. The expenditure booked under JSY for the year 2006-07, and 2008-09 is more than the average expenditure.
- State is not reporting the expenditure as the physical progress. There is following difference in JSY expenditure as per FMR and Physical Finance statement:

JSY expenditure			
Year	As per FMR	As per Phy.Fin. Statement	Difference
2005-06	146.53	146.52	0.01
2006-07	605.43	640.58	-35.15
2007-08	1880.19	1628.96	251.23
2008-09	2259.42	2414.48	-155.06
2009-10	2681.16	2740.60	-59.40
2010-11	3141.46	3181.86	-40.40

#### Key Observations for District Health Society (Pune and Gondia)

- **Books of Accounts:-** Books of accounts are maintained at Pune district level on manual basis and TallyERP9 software basis. There is difference of Rs. 9, 08,808/- between the Bank Book balance and Tally ERP9 software Bank balance. As per the Bank book shown the Bank balance of Rs.5,98,599/- (77407+314055+207137).As per the Tally ERP9 software shown the bank balance of Rs.1507407/-. Expenditure reported by the DHS for particular quarter is differing from the state FMR figure.
- **Accounts Training:** Accounts Training is not provided to CHC/PHC Accountant at Gondia and Pune.
- **E-banking:-** E-banking system is not implemented at District level. District Society transferred the funds to Cooperative bank accounts and Nationalised Banks through Cheque/DD/RTGS to Taluka level.
- **Financial Monitoring:** No proper period wise advance control and monitoring system exists in District level. Districts Accounts Manager is not frequently visiting the Taluka and CHC/PHC. Civil Surgeon, Pune has not reported the expenditure for the year 2011-12.
- **Integration of NDCPs:** No integration of NDCPs programme under NRHM. NDCPs at district level are directly submitting their reports from district to their programme manager at state level.
- **Funds Transfer:** District Health Society transferred the funds to CHC/PHC/Rural Hospital after June 2011 for implementing the activity of RCH /NRHM /RI.
- **Cheque Issue Register:** Most of expenditure is incurred in the month of March .About 200 cheques issued in the month of March 2011 at Gondia and Pune DHS. Cheque register is not signed by the authorized signatory at Gondia DHS.
- **Procurement of mobility support (Vehicles):** Vehicles are purchased by District Health Society on special PIP approval from Mumbai and also administrative approval of Zila Parishad, Gondia. Total sanctioned of 11 Vehicles for Rs.83.75 for Taluka Health Office, District Health Officer, DPMU-office and Civil Surgeon office.11 Ambulances for Mobile Unit (Primary Health Units) and Rural Hospital /Sub District Hospital.
- **Vehicles are purchased from Gondia DHS from District level on DGS&D rate.** Districts Health Society given advance to M/S Tata Motors Rs.61, 72,754/- and M/S Jayaka Motors Rs. 10, 09,826/- on the basis of Performa Invoice. Vehicle has given to 8 Taluka Medical Officers and 1 vehicle each to District Health Officer, Additional District Health Officer, Civil Surgeon, and DPM. No signature of DAM is recorded on the note sheet of vehicle purchase.

- **Construction:** Construction work has been allotted on the basis of lottery. Unemployed Educated engineers are registered with Zila parisad and work contracts have been allotted to them on the basis of lottery.
- Construction of Laboratory Room in PHC Campus at Gothangaon in Tah Tirora works have been allotted to Kumari Vaishali who is registered contractors in Zila parisad .Financial documents do not show her certificate of engineer and system of work allotment to her at Gondia.
- Construction and Procurement work allotment at many facilities and committees did not follow the tendering process. Local contractors are being allocated the work and competitive rates may be lacking.
- **Bank and Advances:** Advance outstanding and bank balances are not properly monitored at District Level. The Details of Bank and Advances of Gondia and Pune DHS are placed at annexure IV.
- **Key observations** of BG Women’s Hospital, Gondia, Gondia District Hospital Gondia and RH Deori are also placed at annexure IV

## VIII. Recommendations

### Programme Management

- Vacancies of regular posts in the State Family Welfare Bureaus to be filled on priority and emergency basis.
- Posts for MH and FP consultants, Paediatrician, Gynaecologist and Medical Officer that have been sanctioned at the State Family Welfare Bureau, Pune, should be filled on priority basis.
- Although performance appraisal systems are in place, State needs to reassess the need for employing such a large contractual workforce and their productivity especially at the State level. Such productivity should also be linked with operationalization and utilization of different health facilities.
- All key staff should receive an orientation on NRHM & RCH before posting them at the district level.
- Monitoring and supervision needs to be strengthened and field visits need to be undertaken by officers from State, District and Block levels with a specified checklist. The follow up visits should assess the progress made viz a viz the last visit. SPM, DPM must undertake field visits.
- The District Training Teams need strengthening by hiring professionals since the quality of training cannot be maintained by only faculties comprising of male and female Health Workers as observed during the visit. The State is thus advised to merge the Hospital Training Teams and the District Training Teams and the new merged structure should be responsible for quality of training under supervision and guidance of HFWTC and also the State Programme Officers.
- RKS coordinator and Program Assistants job chart needs to be widened since they are underutilized.

### Quality of Services

- Quality Assurance Cell
  - The State QA cell should be headed by a regular staff of the rank of Additional Director or Joint Director.
  - The QA checklists are largely input-focussed. A comprehensive QA system with a defined TOR needs to be prepared, which should include assessment of quality of training and also service delivery besides infrastructure improvement.
  - Strengthening of QA cells is suggested by putting up professionals at state level. The present TOR's need to be relooked into. This can be discussed with GoI officials while planning. There is a need for restructuring of QA cell for defined outcomes.
  - There is lack of co-ordination between QA cell and IPHS co-ordinators at District level. IPHS coordinator should not work in isolation and should be a part of the quality assurance for ensuring comprehensive infrastructural and service delivery protocols.
  - Huge sum Rs.35.63 lakhs has been sanctioned by the State for ISO/NABH accreditation. Since state has their own QA cell at all levels, the certification may be by their own cell. Accreditation by external agency should be deferred till internal mechanisms of ensuring quality of services are in place and are being adhered to. Once internal audit through QA cell is complete as per protocol then if the State desires, it can invite third party audit for QA.

- Service providers should be trained on standard treatment protocols and monitors and supervisors should be responsible for ensuring its adherence. A G.O may be issued in this regard.
- Staff working in labour rooms of all functional delivery points should be trained and oriented first on first on technical protocols.
- Infection prevention protocols are in place but adherence to the protocols needs improvement
- Bio Medical Waste Management needs attention for systemic implementation as also observed in the previous CRM. Clarity on which kind of waste will go in which coloured bin is missing. Orientation of staff on infection prevention required. Contract for biomedical waste collection and disposal not in place.
- An urgent review meeting for training and supervision under PHS is suggested. Persons under training institute should be made incharge of different skill based trainings. They should be made responsible for following the training protocols and ensuring quality.
- The training institute should work in close co-ordination with State technical programme officer. Quarterly Joint Review should be done on progress of training and its quality.
- The training institutes need to be reoriented in skill based training since protocols were not known to them.
- High level of supervisory vacancy affecting Quality of Care

#### **HMIS**

- Monitoring and review of the HMIS is poor at the district level. There is a lack of data verification and review at the district and facility in charge level.
- Utilisation of data for programme planning, implementation and taking mid course corrections needs to be improved at all levels.
- Uploading of data needs regular review and validation at every level i.e. from facility to State.
- State and District Data Manager should analyse programme wise data every month and share with respective program officers. A G.O on this may be issued.
- Programme Officer should do monthly review on quality of data upload.
- Only 47 % of estimated pregnancy has been uploaded under MCTS.
- Block data operators should be given target for daily average entry on MCTS. Non performers should be weeded out.
- MCTS is not being utilised for sending messages in due dates of ANCs, PNCs and immunization to the beneficiaries and also ANMs.
- Due list prepared by ANM and MCTS tracking should ultimately match. There is no such system in place for correlating both. Such mechanism should be evolved so that ANMs have a ready list of the due beneficiaries and she can concentrate more on service provision.
- The problem of electricity is being tackled with the use of solar energy. If it is a successful model, same can be done at other places where non availability of electricity is hampering the data upload.

#### **Finance**

- Proper book of accounts should be maintained at all levels based on double entry system. Standardization of financial books of account should be done.
- State is required to contribute the outstanding state share of Rs.292.69 crore and to send the Bank Statement copy for credit of state share of Rs,26 crore for financial year 2011-12.
- Flexi pool Funds to be transferred for implementing the programme activities instead of activity wise funds transfer.
- Accounts Training should be imparted to the accounts personnel working at CHC/PHC.

- Concurrent audit should be implemented on time and summary report should be sent to GoI on quarterly basis.
- Period wise advance analysis should be done at all levels.
- Statutory audit report should be submitted before 31<sup>st</sup> July every year.
- E-banking system should be properly introduced with support from banks.
- State and District Finance Manager / Accounts manager and Budget and Finance officers should visit the field for strengthening of Financial Management.
- Proper procurement procedure should be followed for procurement of medicine and equipments as per state government financial rules.
- Construction work should be given after following proper guidelines on the process of tendering and work allocation.
- Printed JSY payment register to be introduced at all levels for monitoring the payment of JSY beneficiaries.
- District Health society should comply the action taken reports of the Statutory Audit report (2009-10) /Concurrent audit report for the year 2009-10 and 2010-11.
- RKS funds should be audited by Chartered Accountant at District Hospital and sub District Hospitals.
- Taluka Accountants should visit the field for strengthening of financial management.

#### **Other Recommendations**

- State should consider investing in Drug Warehouses at district levels as they are running in rented buildings
- JSY audit in terms of whether all those beneficiaries entitled to JSY are actually receiving payments should be considered at a policy level
- Rational planning for upgradation of facilities as per IPHS and strict monitoring of IPHS funds to ensure that they are not being used for activities such as purchase of Xerox machines. Up gradation needs to be linked with delivery of services as per technical protocols and its utilization by clients
- Government can take decision in line of Government of Karnataka for 'No more creation of new infrastructure till existing is strengthened in terms of improving service delivery and technical protocols'.
- RTI services are not offered at most facilities as per guideline and should be strengthened.
- Quality of training and performance of trained personnel needs close monitoring
- All doctors trained in multiskilling should be immediately posted to a functional CHC/FRU and their performance monitored.
- Till trained doctors are not posted at designated FRU, a G.O. can be issued for their posting at district hospital/functional SDH. This power of temporary attachment can be delegated to district authorities
- All performing delivery points should first be strengthened in terms of HR, equipments, infrastructure, adherence to technical protocols and their performance should be monitored every month.
- Adequate IEC/BCC needs to be done for utilization of IPHS complied infrastructure.
- Performance of all IPHS facilities and delivery points needs to be monitored every month.
- A quick operational research should be done to understand non-utilization of government Health facilities in districts like Kolhapur. Any further creation of infrastructure should be linked with its utilization. State should arrange trainings for engineers in development of hospital infrastructure and architecture as per latest standards.
- Medical Superintendent Dr. Ms. Deshmukh, Ayurvedic doctor Dr. Sulekha and Homoeopathic doctor at RH Gargoti, Staff nurse Mrs. M.P. Janka, ANM Mrs. P.P. Dohe, Lab Technician Mr. Satish and such staff and doctors with outstanding performances need special felicitation and certificates of appreciation. Such steps will motivate other staff.

- Directives to be sent to all the health facilities for not storing any medicine except vaccines for immunization in the ILR of Deep Freezer.
- Irrational procurement of equipment should be stopped. Purchase to be done only on the requisition for equipment by the health facility.
- Incentives to ASHA should be linked with objective outcome and payment to be done after ensuring the activities as per MCP card and other performances.
- Efforts should be made for better implementation of Vishakha Guidelines.

## Annexure I

### Team Members

Kolhapur Team	Gondia Team
<p><b>Government of India Representatives</b></p> <ul style="list-style-type: none"> <li>• Dr. Himanshu Bhushan (Team Leader)- , DC (MH), MOHFW</li> <li>• Ms. Ashi Kathuria, World Bank</li> <li>• Ms. Shweta Verma, USAID</li> <li>• Mr Sanjiv Gupta, NRHM Finance, MOHFW</li> <li>• Ms. Ifat Hamid , RCH Consultant, MOHFW</li> <li>• Dr. Salima Bhatia, NRHM Consultant, MOHFW</li> </ul> <p><b>State Representatives</b></p> <ul style="list-style-type: none"> <li>• Dr. S.B. Nadoni</li> <li>• Dr. Madhusudan Karnataki</li> <li>• Dr. V. K. Rokade</li> <li>• Dr. Mukund Agrawal</li> <li>• Mr. Dhruvas Kode</li> </ul>	<p><b>Government of India Representatives</b></p> <ul style="list-style-type: none"> <li>• Dr D.K. Mangal, UNFPA</li> <li>• Ms. Raji Nair, UNICEF</li> <li>• Dr. Deepti Agarwal, RCH Consultant, MOHFW</li> <li>• Dr. Raghunath Saini, RCH Consultant, MOHFW</li> <li>• Mr Sanjiv Gupta, NRHM Finance, MOHFW</li> <li>• Mr. Vaibhao Ambhore, NRHM Consultant, MOHFW</li> </ul> <p><b>State Representatives</b></p> <ul style="list-style-type: none"> <li>• Dr. M. S. Pawar</li> <li>• Dr. Chandrakala Jaiswal</li> <li>• Dr. O.P. Tripathi</li> <li>• Dr. Anil Nandode</li> <li>• Mr. Jaideep Shere</li> </ul>

### Facilities Visited

Kolhapur	Gondia
<ul style="list-style-type: none"> <li>• Civil/General Hospital, Satara</li> <li>• Sub District Hospital-Kodoli</li> <li>• Rural hospital-Gargoti</li> <li>• PHC Kher Shivpur</li> <li>• PHC Umbraj</li> <li>• PHC, Kulachi, Shirol</li> <li>• PHC-Bambawade</li> <li>• PHC, Hupari</li> <li>• PHC - Ispurli</li> <li>• Sub Center-Buvachivathar</li> <li>• Zila Parishad dispensary &amp; sub-center Jyotibagh (Wadli Ratnagiri)</li> <li>• Sub Center-Kerli</li> <li>• Subcenter-Rendaal</li> <li>• Sub-center, Shengaon</li> <li>• AWC Sakharwari</li> <li>• AWC-Haveli</li> <li>• VHND at Kalamwadi Village, Rangoli PHC</li> <li>• VHND-Daryache Wadgaon</li> <li>• VHND at Gargoti Shindewadi</li> <li>• Bhudargarh- School Health Program-Khanapur</li> <li>• District Training Center and HFWTC</li> </ul>	<ul style="list-style-type: none"> <li>• General Hospital Gondia</li> <li>• BGW Hospital, Gondia</li> <li>• SDH, Tiroda</li> <li>• RH, Devri</li> <li>• PHC, Kavrabandh</li> <li>• PHC Chopra</li> <li>• PHC Mulla</li> <li>• PHC, Ekodi</li> <li>• SC, Zaliya</li> <li>• SC Surtoli</li> <li>• SC Dandegaon</li> <li>• VCDC Zaliya</li> <li>• District Training Center, Gondia</li> </ul>

### Facilities Visited By Finance Consultant

S.NO	Place Visited
1	State office Pune (RCH)
2	DHS, Pune and Gondia
3	Ganga Bai Women District Hospital ,Gondia
4	PHC –Mulla
5	SHC ,Surtoli
6	Rural Hospital Deori

## 8th Joint Review Mission Facility –Wise Report – Maharashtra

**District Kolhapur- Maharashtra****Interaction with District CEO, public leaders and health officials****Background Information**

- The district is divided into 12 blocks with sex ratio of 845, birth rate 14.1, MMR-, IMR-19.1, NIMR-62% and male female ratio of 953
- 82% literacy with 74% female literacy
- 1 medical college, 2 SDH and 2 FRU's

**Progress Made**

- 100% full immunization with 1 percent adverse effect
- Flow through e-transfer upto block level, plan to reach upto village level
- First and second referral free by government ambulances
- Tally implemented upto PHC level all financial reporting from different level to district head quarter reaches latest by 10<sup>th</sup> of every month
- Sterilization operations- for family planning 100% achievement of ELA, only four deaths in last year due to sepsis
- Institutional delivery 96%, a new initiative i.e. expected place of delivery at expected date of delivery are being monitored for every pregnancy
- Every month Maternal Death Review being taken by CEO and actionable points being sent upto PHC level within a week
- Continuous increase in OPD and IPD from year to year
- ARSH
  - A pilot on creating peer educator by the name '*Maitri*' being conducted in one block and 360 groups have been created
  - Community training on ARSH in various phases of implementation
- Three blocks and 41 villages covered by MMU
- ASHA training upto three modules completed
- All sub centres having VHSC's committees formed under Sarpanch
- Other regulatory committees like RKS registered and functional
- 8 RH, 40 PHC, 125 sub centre upgraded as IPHS with availability of all specialists and requisite manpower
- Dedicated team of School health, visiting each and every government and government aided institutions for routine screening

**Areas of improvement**

- Only 39% SBA training against target
- Lack of drop back facility for pregnant women and neonates
- Community monitoring initiated in 30 villages since April 2011. This will also include social audit.

**I. Interaction with President Zila Parishad**

- President Zila Parishad welcomed Gol team and requested for fixed remuneration for ASHA's.
- Vice President Zila Parishad requested for
  - Provision of more MMU vans
  - New PHC's for flood prone area

- Smooth mechanism for payment of different entitlements and cash incentives for the personnel residing in border areas of MH-KN states
- GPS fitted ambulances
- Computer operator/data entry operator for all PHC's since computers have been sanctioned but no operators
- He also suggested that the PCPNDT committee at central level should consider declaration of the sex of the foetus before 12 weeks and stringent provision of law for any attempt to killing.
- Villages selected for Nirmal Gram Abhiyan
- Bank online transaction till PHC level
- In Village Health and Nutrition Day (VHND) there is nutrition demonstration, due list is available with AWW and ASHA.
- Mobile Medical Units have been operational for hard to reach hilly areas and they follow fixed route plan.
- Full ANC coverage is at 93 percent.
- Breastfeeding corner initiative- Hirakani Kaksha
- Save the baby girl campaign
- There is no separate gender training but gender is part of other training modules. Committee for sexual harassment exists in the district and periodic meetings are held.
- Zilla Parishad members acknowledged that training needs to be strengthened as the numbers are low.

#### **Feedback from Zila Parishad, Vice Chairman and NGO representatives**

- Infrastructure is improving
- Community monitoring is a good initiative.
- Additional MMU is required for hard to reach areas
- More PHC's are required for flood prone areas.
- There is a need for a tracking system in rural areas
- Computer operators are not available at the facility.
- 25 PHC's have been approved but not functional.
- There is a need to increase ASHA incentives to keep them motivated.

## **II. NRHM-District Health Society Office- Kolhapur**

### **Discussion on Programme Implementation Plan of the District**

- Activity wise allotment received from the state however, the targets against the activities are not indicated.
- ARSH
  - Under the ARSH program Rs.2000 per block has been allotted for the estimation of Hb, however there is no clarity in the program for its implementation/utilization of funds in the field.
  - There is a need for redesigning the program, as one time estimation of adolescent girls will not help unless subsequent estimations are also being done. The Hb estimation is available at all the health facility and does not require to be conducted during the school health check up.
  - Weekly IFA supplementation should be considered and funds can be utilized for this instead.
- PCPNDT
  - Against target of 484 PCPNDT visits to the scanning centers, 324 visits were undertaken which is a good progress.
  - However, only 2 awareness camps were held till now.
  - Checking of F form by NGO and school students has not yet been initiated.

- Rupees 48 lakhs were drawn from the last year's NRHM fund for installing silent observer machine in the approved USG clinics. This was not approved in the state PIP by GoI.
- RKS coordinator and Program Assistants job chart needs to be widened since they are underutilized.
- Incentive of Rs.550 for reporting of maternal deaths to ASHA is not in line with the MDR guidelines.
- Quality Assurance
  - Huge sum Rs.35.63 lakhs has been given for ISO/NABH accreditation. Since state has their own QA cell at all levels, the certification should be by their own cell.
  - Strengthening is suggested by putting up professionals at state level and drawing adequate TOR's.
  - At present the cell is functioning with only one checklist which cannot be implemented properly in the absence of technical guidelines, protocols and orientation training to the service providers. Thus, there is a need for restructuring of QA cell for defined outcomes.
- ASHA is paid an incentive of Rs.1000 for ensuring full immunization in a village. Such indicators cannot be monitored adequately, unless every individual child is tracked for full immunization. So, state can consider paying incentive to ASHA against each child fully immunized.

#### **Interaction with the DPMU staff at Kolhapur**

Interaction with the DPMU staff at Kolhapur revealed that:

- Some officer for District Health Societies are recruited directly through SHS, Mumbai and deputed to Districts (like: DPM, DAM, M& E Officer etc.)
- In case of other posts to be filled with the salary less than Rs.21600/- pm ,post is filled by the District Societies
- All of them had been given a specific TOR and job responsibilities. However, a substantial amount of their time was spent in providing administrative support at the DPMU for various activities, leaving less time for their core functions
- Performance appraisal was conducted at the end of each year and renewals are based on their performance. The performance appraisal was done by the DHO or the Civil Surgeon as per their reporting structures
- Very few of them received orientation training on NRHM before starting the job leading to difficulty in implementation of their tasks initially and all learning about the programme happens while performing their duties. This is an issue that requires great attention. In Maharashtra, since the qualification for the DPM is MBA – HR (with relevant experience), it is important that an orientation of such key staff on NRHM is arranged before posting the staff at the district level.
- The feedback system for HMIS is extremely weak. There is only verbal conveying of the facility –wise progress on certain components during meetings of the district authorities with the MOs. The feedback system needs to be more streamlined and systematized and usage of the data collected from HMIS for monitoring and planning purposes needs to be strengthened.

### **III. Visit to District Hospitals and First Referral Units**

#### **Civil/General Hospital, Satara**

- OBG 5, Anesthetist-2, Paediatrician-5, LT-6, Staff Nurse- 133
- 235 functional beds, OPD 250-260 per day, major surgery 200 per month, minor surgery 50 per month, delivery 250 per month, C-section 60 per month, tubectomy 25 per month
- Underutilized for delivery

- Immunization
  - ILR 3, DF3, all stocks of vaccines available, alternate vaccine delivery plan and record for return of used vaccines not available, program officers of immunization needs orientation on monitoring, supervision and tracking
- Blood Bank
  - One blood transport vehicle with four blood transportation carriers available
  - Seventy five blood donation camps held and 2916 blood bags collected in one year
  - Four blood storage centres are in the process of establishment in the district
  - Monthly utilization of blood bags- 180 at district hospital and 120 at private hospital
- Updated HMIS reporting with information on MTP
- No user charges being taken for first pregnancy
- Functional telemedicine center with 12 telemedicine advise per month
- 20 cases of nutritional counseling in the nutrition clinic per day
- Drug store
  - 200 types of medicines available as per EDL, web based software for inventory management just installed. Inventory updated and maintained, expiry register maintained, 3 months advance notice of expiry drugs circulated to MO's, drugs kept on FIFO basis, no display of drug list for the public.
- ICU
  - Six bedded ICU with one MO incharge and six staff nurses and round the clock duty of one additional MO
  - Four admitted cases, two of coma, one myocardial infarction and one hypertension with laprotomy being treated rationally
  - Infection prevention protocol needs improvement
  - Ten bedded trauma and emergency unit
- Labor room
  - Well maintained with all requisite equipments and functional new born care corner
  - Drug tray, instrument tray, oxygen, ambu bag, suction apparatus all in place and functional
  - 8 staff nurses but only one having pediatric specialization is proficient in SBA skills without inservice SBA training (Mrs. MP Jankar)
  - None of the other SN's are trained in SBA skills, no display of technical protocols
  - Partograph not maintained
- SNCU
  - 10 bedded unit with six functional beds and only four admitted cases
- Sterilization amount paid in cash while JSY payment done by cheque.
- For JSY cheque payments are done, client signatures have been missing on some vouchers.
- Sterilization incentive and motivator money being paid to doctor
- Appointment of urban ANM's has resulted in improved JSY cases
- Counseling on breast feeding, family planning happening proactively.
- Form F duly filled and maintained for USG, Vishakha guidelines not followed
- No women participation in community process
- 33 maternal deaths last year. Out of which 10 due to PPH.
- ARSH clinic set up with 430 peer group members
- School Health Program also in place, 2 colleges and 2 schools reached out every month
- Segregation of waste in colour coded bins and disposal of waste contracted out
- RKS
  - RKS committee active with names of Governing body and executive committee displayed.
  - GB approves the proposed expenditures for RKS, IPHS and AMG and facility wise PIP is created.

- Under IPHS, the total funds received were Rs. 59.9 lakhs (with a prior unspent balance of about Rs. 3.06 lakhs). There was 100 % expenditure of the funds. The largest expenditure heads were instruments and equipments and cleaning services and office expenditure.
- HMIS
  - Information is available through the HMIS system on a regular basis.
  - More than 100 % achievement of targets was explained by the concerned District HMIS officer due to a glitch in the software. Corrective action of the individuals records between January and March 2011 is underway.

#### **Sub District Hospital-Kodoli**

- OBG-3, Paediatric-1, Anesthesia-1, GM-1, Dental and AYUSH doctor-1 each, SN's-15, LT-2
- No of beds- 50
- Delivery 40 per month, C-section-6 per month, major surgery 20 per month
- Underutilized for delivery and C. Section
- Labor room
  - Well maintained with new born care corner and latest labor table
  - Neither any women for delivery nor waiting at the time of visit
  - Drug tray, equipments, oxygen, ambu bag, suction apparatus all in place and meticulously arranged
  - Partograph being managed, knowledge on technical protocols like AMTSL, PPH not adequate
- OT- fully equipped and well maintained but not even one surgery is being conducted per day.
- Only 3 staff nurses out of 15 have been trained in OT.
- ANC clinic being conducted regularly.
- IPHS funds being utilized for salary of data operator, SN, Dentist, buying a Xerox machine, laptop, water purifier besides technical equipment and activities.
- Adolescent Reproductive and Sexual Health Services:
  - One Pediatrician, one Gynecologist, ICTC Counselor and a staff nurse are running ARSH Clinic
  - ICTC Counselor conducts the outreach programs in schools and colleges.
  - Good attendance of boys in the ARSH clinic.
- STI and RTI drugs out of stock
- The **two outstanding performances** of the facility are-
  - Ayush doctors both Ayurveda and Homeopathy have maintained their records of performance and data analysis for treatment and recovery meticulously. Cure rate is 70%
  - The Ayurveda doctor Dr. Sulekha has also published a small booklet on the treatment for common ailments by Ayurvedic medicines
  - Similarly lab technician Mr. Satish is doing 150 investigations per day. All routine and other investigations are being done except culture and sensitivity. His maintenance of lab and lab equipments are exemplary.
  - State need to consider giving certificates of merit/award to such outstanding personnel.
  - MS, Dr.Deshmukh is providing good leadership and this is the only facility where every department has kept a profile of their disease burden, services rendered and cure rate. Yearly, monthly analysis in numbers and by bars have been shown.
- Similar to other facilities in the district, drug store, maintenance of records/registers, display of IEC materials, grievance redressal, citizen charters and cleanliness of the facility are excellent.

### **Rural Hospital-Gargoti**

- 3 MOs and 1 Superintendent, 4 specialists (one gynecologist, 1 pediatrician, 1 General Surgeon, and 1 Orthopedic surgeon), there is no anesthetist. The facility has a total of 26 staff.
- Last year 300-400 sterilizations and 5 C-Sections had been conducted. The hospital has an average OPD of 80-100 patients per day.
- Lack of an Anesthetist
  - 72 C- Sections conducted in 2009-10 but only 5 conducted in 2010-11 and three till date in the current year
  - Lack of regular anesthetists leading to decline in number of C. Sections. Anesthetists on call basis from Kolhapur (over 50 kms away) available but due to lack of regular anesthetist only elective C- Sections can be conducted. Emergency surgery patients are referred to Kolhapur
  - Transportation facilities (RH ambulance) are available for referring out.
  - AYUSH clinics are running extremely well with the help of dedicated and motivated Ayurvedic and Homeopathic Doctors.
- Quality Assurance
  - This facility is under the QA committee mandate.
  - The IPHS coordinator is working in isolation. There is lack of coordination between the QA committee and IPHS coordinator.
  - There should be arrangements that the issues identified by the QA cell should be addressed on priority basis by underutilizing the IPHS funds and IPHS upgradation activities should not be independent of the QA mandates.
- PNC ward clean and well maintained. SNCU well maintained.
- Family Planning
  - Doctors are actively involved in family planning counseling.
  - In the ward there were 3 female sterilization cases.
  - In family planning there is no birth spacing focus. Limiting method is focused upon.
  - Sterilization payments are made in cash. Records and vouchers are well maintained.
- All the women in the maternity ward are provided with food.
- JSY records are well maintained. All vouchers are available. Last year 42 JSY beneficiaries.
- IPHS:
  - IPHS funds released last year has been Rs. 29 lakhs for the facility.
  - All the approvals are happening through RKS.
  - RKS capacity is limited to manage such huge volumes of funds and it also lacks the planning capacity for proper utilization of these funds.
  - The funds are used on ad hoc basis rather than strategic planning; there is no involvement from the district level.
  - RKS capacity building is required along with involvement of the Civil surgeon from the district level.
  - RKS, IPHS and AMG records are well maintained along with relevant vouchers and meeting proceedings are available.
- Patient Friendly Facilities and display
  - Citizen's charter, list of services, list of user charges for services, list of specialists, list of staff on duty are displayed prominently in the waiting area.
  - The waiting area had good ambience with good seating facilities, newspapers are kept, a suggestion box is provided and good amount of IEC material is displayed.
  - There is provision of safe and cold drinking water and separate toilets for men and women.
  - Walls and flooring are good – the facility is very clean and well maintained.

- Labor Room and OT:
  - A well equipped labor room (for normal and assisted deliveries) and Operation Theatre
  - Facilities for basic newborn care and resuscitation are available at the facility.
  - Necessary facilities and practices to maintain aseptic conditions were observed, and necessary drugs were available in the labor room and OT
  - Protocols for newborn resuscitation, PPH etc. were displayed in the labor room.
- Laboratory:
  - The laboratory offers facilities for sputum, blood (Hb, TLC, DLC, ESR, sugar, urea) Vidal, HIV, Malaria and waste for microbial testing.
  - The unit was clean, well maintained, had the necessary equipment, reagents, kits, syringes, gloves, prickers etc.
  - Staff included a Laboratory Technician and one ICTC technician.
  - During 2010-11, 5138 blood, 6335 urine, 684 sputum, 13350 HIV and 1137 water samples were tested.
- Blood Storage Units
  - A blood storage facility has been recently established.
  - The FDA certification was obtained only last week and the facility is expected to be made operational soon.
  - The Laboratory technical will also manage this facility.
- Drug Store
  - The drug store and dispensary were well stocked and maintained.
  - Stock registers, expiry register to track drug expiry were up to date.
  - There were adequate stocks available in the store except for 2 drugs (Ciprofloxacin tablets and Atropine injection), which were available at the dispensary and the IPD.
- Bio-medical waste segregation and disposal
  - Bio-medical waste was being segregated and disposed off in a burial pit in the RH premises after being kept in hypochlorite solution for 24 hours.
  - Sharps were being cut and disposed in the pit as well.

#### **IV. Visit to Primary Health Centres**

##### **Kher Shivpur PHC**

- MO-1, Ayush-1, SN-3, ANM-2, LT-2
- Six functional beds, OPD 2000 per month, IPD 50 per month, delivery 8 per month
- Well maintained infrastructure, good display of IEC including citizen charters
- Excellent coordination between public representatives, administration and health officials. Good public participation
- Exit interviews indicated no out of pocket expenses on drugs, JSSK not yet implemented so user charges on diagnostics being collected
- Inadequate utilization of available services, no ongoing/waiting delivery at the time of visit
- Drug store
  - 200 types of medicines available as per EDL, web based software for inventory management just installed. Inventory updated and maintained, expiry register maintained, 3 months advance notice of expiry drugs circulated to MO's, drugs kept on FIFO basis, no display of drug list for the public.
- Grievance redressal
  - Display board for grievances and complaint box available, complaints received are put up to the RKS meeting for redressal
- Functional dental clinic with BDS doctor
- Ophthalmic clinic being run by ophthalmic assistant, 17 cataract cases detected in the last month

- All routine lab investigations about 70 cases per day being done
- Labor room
  - Functional labor room with all equipments along with NBCC, one staff nurse and one LHV trained as SBA, proficiency and knowledge on technical protocols inadequate
- Records and registers
  - PCPNDT register for tracking pregnancy, ANC register with HB, BP and urine tests entered, weekly ANC clinic run by OBG high risk pregnancy being identified and referred, 3 USG being done for every pregnancy, technical protocols for care during pregnancy and child birth needs improvement. Form F register duly maintained.
  - Full immunization register with almost every children with measles vaccines entered and completed as per the age schedule, well maintained cold chain
- Fixed day family planning clinics being run
- JSSK toll free number displayed
- Good rapport with AWW
- Part time radiologist available twice per day
- Essential drug list available but not displayed.
- From Jan-Sept, 2011 45 children born out of which only 14 were girls
- ARSH sanitary napkins purchased from RKS funds manufactured by local SHG, brand name Mukta, pack of 5 for 15 rupees, pack of 10 for rupees 60
- RKS members listed on the wall, IEC material regarding JSY, TB, HIV AIDS, Chikungunya and booklets displayed in waiting area including one on PCPNDT Act.
- ASHA's money is transferred to account directly. Three trainings attended by ASHA's.

#### **PHC Umbraj**

- MO 2, LHV 2, SN 1, LT 2, delivery 25 per month
- Monitoring of infant deaths being done which has declined
- Similarly maternal deaths also being monitored, birth rate static, 48 hour stay linked to free diet and baby kit for female child
- OPD 24118 last year and 30 sterilizations done per month
- CTC program for 21 days for malnourished referred kids conducted at the PHC
- Lab in place with 2 pharmacists, HB, urine, malaria tests conducted. Average 25 routine tests and 7 other tests conducted per day
- Drug list displayed
- Information on waste management needs improvement.
- Shramdan by employees for peripheral improvement.
- Doctors duty chart displayed, service delivery chart displayed
- IEC materials are available.
- No patients in wards.
- PHC arranges for referral transport.
- Maternal deaths 2008-09 (3), 2009-10 (4), 2010-11 (1)
- Free diet provided for all maternity clients.
- New born care corner functional. Last year 44 children treated and current year 22 children till September, 2011.
- JSY records maintained. Total JSY deliveries last year 166.
- RKS proceedings available. GB 6 meetings and EC 6 meetings.
- Sterilization payment vouchers are missing.
- Dilatation chart displayed with misinformation; mentions check up every 2 hours instead of 4 hours.
- IUD displays are available in almost all facilities

#### **24x7 PHC, Kulachi, Shirol**

- LMO 2, SN 3, ANM1, LT 1, 6 sanctioned but 16 functional beds
- OPD 150 per day, deliveries 25-30 per month. The incharge LMO is very active, partographs are being maintained for all the deliveries however, but some improvement required in knowledge of technical protocols and plotting of partograph.
- Infrastructure, record maintenance including cash books, maintenance of drug store etc. does not need repetition since it is excellent at all the facilities.
- Interaction with RKS members
  - Similar to observations in previous facilities, all members actively engaged and had no complaints
  - Baby kits being given out of RKS funds
- Discharge slip and referral slip not available

#### **24x7 PHC-Bambawade**

- MO-2, SN-3,ANM-1, LT-1
- OPD-75 per day
- IPD-2 to 3 per day
- Delivery -23 per month
- Trauma cases-25 per month (situated on \_Kolhapur to Ratnagiri sub highway)
- PHC observations
  - The observations in terms of cleanliness, infrastructure maintenance, labor room, minor OT, equipments, ambu bag, oxygen cylinder, suction apparatus, drug stores, display of IEC materials, citizen charter, grievance redressal, cold chain maintenance, family planning fixed day clinics and achievements of targets are similar to those of other facilities visited
- Interaction with ASHA
  - Vibrant, knowledgeable and willing to perform. Requested for fixed remuneration.
- Interaction with RKS members
  - President of panchayat samiti, members of panchayat samiti, RKS members, BDO and other community members were present for interactions. They had no complaints, however they requested administration for following-
    - Conversion of PHC to CHC
    - Provision of x-ray machine
    - ALS ambulance for referral of trauma cases.
    - More doctors and C-section facility

#### **24x7 PHC, Hupari**

- Annual OPD load of 10,000, Total institutional delivery last year has been 226. Currently the average monthly delivery is 20.
- Staff - 2 MOs, 1 LHV, 4 GNMs, 1 Pharmacist, 1 PH nurse, a lab technician and an SI.
- The ANC coverage is good with 104% full ANC and the monthly average is 80.
- Total sterilization last year- 378. Total IUD insertion last year-350 and average monthly IUD insertion is 10-15.
- There is good screening of haemoglobin level and appropriate follow up with low Hb women.
- Well maintained (even though old) and clean. A help desk for ease of patients was also provided during OPD hours.
- The payment for sterilization is through bearer cheque.
- There are quarters for one MO, the second one is under construction
- Labor room
  - The staff nurses were proficient in their work.
  - In the labor room, partographs were being maintained.

- Oxygen cylinders were in working conditions and emergency tray contained most medicines except for Mag Sulph.
  - In-patient case records were also well maintained.
  - New born care corner including phototherapy unit was available.
- There has been no training for the entire staff including SBA, JSSK, IUD insertion, BeMOC. The training needs to be prioritized.
- Local Initiative:
  - The PHC had informally made arrangements with a local private pediatrician for referral of low income group neonates in case of emergencies such as meconium aspiration.
  - In such cases the pediatrician examined the neonate and stabilized the neonate at his set up and referred them back to the facility with complete instructions for further management. The neonate was then managed at the institute by the GNM's.
  - However, the patient had to pay the pediatrician for the examination where RKS funds could have been utilized.
- Patient Friendly Services
  - Citizen's charter and list of services provided were displayed.
  - Facilities for out-patients were limited, and the environment was not very gender friendly – there was no separate toilet for women out-patients, the common toilet was approachable either through the dressing room or through a back entry round the corner.
  - Information about the number of births by sex was displayed, and IEC material on various topics was displayed at the PHC
  - An ORT corner was displayed and a breast feeding corner had been created, although the staff could not provide a clear explanation of how these were used.
- Drug Stores
  - Drug list was displayed.
  - All essential drugs were in stock except Ampicillin, Amox. and Septran (on the epidemic list) which were out of stock.
  - Zinc tablets were also unavailable.
- Laboratory Services
  - The Laboratory is performing blood, sputum, urine and HIV tests (until last year only sputum and malaria slides were tested).
  - Equipment, supplies, personnel (one Lab technician) were satisfactory.
  - This year from January to August about 900 tests have been done while last year 460 sputum+112 follow-up cases and 7,837 malaria smears were done.
- Referral Services
  - The referral link is with the Civil hospital, Kolhapur and ambulance is available for transport of emergency cases. However, there were discrepancies in the records for use of ambulance. The number of patients transferred by the ambulance were higher than the number of patients referred by the facility showing need for supervision of the utilization of ambulances
- Biomedical waste management:
  - Waste is segregated – sharps, human parts/placenta/infected/blood stained material, and plastic/paper waste in color coded bins.
  - Sharps (after cutting) and placenta/human parts are buried in pits and covered with earth; dressings, blood stained gauze/cotton etc are burnt, and the normal waste is disposed off separately.
  - The pit had been recently created, the sharps kit had been received 2 days back and the bin with normal waste had some half-burnt gauze and cotton in it.
- Data entry for DHIS and MCTS was being done at the facility level.

- Maternal deaths-2 at the referral hospital and Infant deaths-6 in the PHC area.
- Untied Grants
  - Total flexi funds received last year-RKS 1 lakh, IPHS-5 lakh, AMG-50000, Untied funds-5000.
  - RKS functional and has had 4 meetings last year.
  - All the proceedings and records have been maintained.
- The JSY beneficiaries' records are not available as they are maintained at the sub center level.
- Interactions with Beneficiaries in the female ward
  - Interactions with a beneficiary who had delivered in the institute revealed that she had received free diet and medications at the PHC but not the JSY cash incentive. Since the beneficiary was not a resident of that area (she had come back to her maternal home which was in the vicinity of the PHC for delivery but was originally residing in Karnataka for most of her pregnancy), the functioning of ASHA and ANC could not be verified.
  - Interactions with family planning beneficiaries revealed that all of them had delivered in a private hospital and had incurred an expenditure of Rs. 5000 for their normal deliveries. However they replied that it was a regular practice for all to deliver in private facilities. They too had received free diet at the facility and had received compensation for family planning.

#### **24x7 PHC - Ispurli**

- On an average 20-22 delivery per month, 18-22 deliveries conducted per month
- There are 2 MOs, but there is lack of contractual GNMs. All deliveries managed by 2 ANMs
- Quality Assurance Cell
  - QAC has done a good job with facility follow up and file available for action taken report.
  - The facility has improved over 4 visits conducted over one and half year and the facility is performing well.
- Training of staff on BeMOC, IMNCI, MVA, MTP has been conducted. Doctors trained in BeMOC and proficient in protocols. ANMs not trained in SBA or NSSK but trained in maintaining partographs by the doctor.
- Family Planning Services
  - All PNC clients counseled on contraceptives both spacing and limiting.
  - Doctors are playing an important role in FP counseling.
  - Fixed day sterilization services available and Cu T insertions also available.
  - Had 4 cases of NSV in the previous year. Contraceptives are available including EC pills, IUD's, condoms and pills.
- Calendar developed and displayed with EDD and place of delivery with information on private sector delivery also
- Essential drug list is available and drug store maintained extremely well. All prescriptions have been honored.
- IEC with help of audio visuals on essentials of breast feeding and family planning practices displayed in the PNC ward. Other IEC material also displayed. TV available in the ward for infotainment.
- Referral to Rural Hospital and CPR hospital, Kolhapur
- Doctors are doing outreach with VHND.
- Last year 80 JSY deliveries conducted. JSY records are maintained, all vouchers are available. List of JSY beneficiaries displayed
- Active involvement of PRI members. 2 meetings of the Governing body of the RKS held every year and minutes well maintained, record keeping is good.

## **V. Visit to Sub Centres**

### **Sub Center-Buvachivathar**

- ANM 1, MPW 1,
- Well maintained, neat and clean infrastructure with labor room being constructed with attached bathroom
- No training for ANM since last 5 years, MHW received one training on malaria
- IEC display board particularly on maternal and child health, citizen charter displayed, complaint box available
- Sub center is having computer donated by MLA fund
- Records and Registers
  - Eligible couple register updated every year in April
  - ANC/MCH register updated and maintained, all children as per their due age were fully immunized
  - Register for JSY and untied funds well maintained
  - Funds utilized for purchase ofambu bag, height scale and maintenance of the infrastructure
- Smt. Done PP, ANM of the sub center is very active and has taken lots of initiative for improving the functioning of sub center. Although not trained as SBA but has adequate knowledge of SBA and ENBC skills.
- Interaction with VHSC members
  - Meetings are held as per schedule, meeting notice with agenda issued to members through ASHA's
  - There is no complaint on the functioning of health center, ANM's are staying round the clock, inverter has been provided out of VHSC fund
- Innovations
  - Hirkani Kaksha
  - Breeding of a special variety of fish, which eats mosquito larva are bred and distributed to the villagers
  - ANM distributes first pair of clothes to new born by self stitching.

### **Zila Parishad dispensary and sub-center Jyotibagh (Wadli Ratnagiri)**

- Ayush doc-1, Pharmacist-1, ANM-3
- Conducted only 1 delivery since April, 2011
- Lack of Training
  - None of ANM's are SBA trained
  - Technical protocols not known
  - Injection oxytocin given for augmenting labor and methargin being used post delivery
- All maternal deaths being tracked, one death took place in 2010-11, AYUSH doctor has good knowledge for management of PPH, RL, oxytocin was given prior to referral.
- All records/registers including cash book for untied funds being maintained meticulously.
- Excellent infrastructure, beautiful display of IEC materials including entitlements
- Interaction with VHSC members, indicated no grievances and were happy with the services being rendered

### **Sub Center-Kerli**

- ANM-1, MPW-1- none of them have received any skill based trainings
- All records/registers and infrastructure maintained except register for place of delivery and EDD. Here again community is fully involved. VHSC members are holding regular meetings, utilizing funds properly and guiding the sub-center activities.

- Community satisfied and no complaints.

#### **Sub Center-Satve**

- ANM-2, MPW-1
- 3 deliveries per month
- Infrastructure of the sub center has a delivery room, NBCC. All meticulously maintained but no training to any of the worker.
- Good relation between Anganwadi workers and health workers.
- Convergence between Sabla, ICDS and VHSC.
- Village Child development centers working in harmony with ICDS
- Here again the community is satisfied with the functioning of sub center.

#### **Subcenter-Rendaal**

- The sub-center covers a population of 19,000 population, the center has only two ANMs – one regular and one contractual.
- Last year (2010-2011) the subcenter conducted 65 deliveries. Last month (August 2011) 9 deliveries conducted at the sub center and IUD insertions are 7-8 units.
- Identified as an IPHS subcentre this year onwards. However, the important point was that in spite of the dedication of the ANM to deliver services, the supportive structure for ensuring quality service delivery was visibly missing. For example
  - The ANMs (neither contractual nor regular) had received any training in either SBA, NSSK, IUCD insertions etc
  - There was an ambu bag and mask, however it had been recently purchased (from IPHS funds) and had been unavailable for the entire previous year, wherein almost 65 deliveries were conducted.
  - Lack of newborn care corner
- Sub centre kits had not been received since 2009. Zinc tablets were not available at the subcentre. Most other medications and supplies were adequately stocked.
- All JSY payments are being made within 7 days through cheques; vouchers with signatures are available in the records.
- Immunization records are well maintained. Zero Polio and BCG were given to all children at birth. However, hepatitis vaccine was not available for past four months.
- Citizen's charter, rights for ante-natal care, and list of services provided by the sub-center was displayed. Also displayed was the month number of births of boys and girls – to create sensitivity about the low sex ratio and discuss about the PCPNDT.
- Untied funds and AMG funds are merged while utilization. Separate guidelines needs to be followed.
- Two points of concern are:
  - Because of the norm that one sub-center cannot have more than one contractual ANM, there is constraint in appointing another ANM. Given the spirit of decentralization and being responsive to local context of NRHM, provision to approve rational and justifiable exceptions, such as in this case could be considered.
  - The issue of multiple registers at the subcentre level remains. The team could identify 11 distinct registers such as ANC checkup, ANC referral, ANC tracking, 2 registers for JSY, 2 registers for immunization, register for Cu T insertion, OPD register, subcentre delivery register, eligible couple register etc. This was apart from the registers for accounts of AMG, untied funds and IPHS.

#### **Sub-center, Shengaon**

- The sub-center, since the last 2 years is an identified IPHS facility. 2 ANMs (one regular and one contractual), provides 24x7 services (normal delivery) and water, electricity are available 24X7.
- 17 deliveries last year and 11 deliveries have been conducted this year.
- 71% of the target for registration of pregnancy before 12 weeks for the year has been achieved.
- Transportation for high risk cases, referrals is arranged through pre-identified sources.
- The ANMs had not received SBA, NSSK training and IMNCI training.
- Labor Room
  - The labor room was equipped to conduct normal deliveries, necessary and emergency drugs, autoclave, gloves etc. were available
  - An infant warmer and one bed were available. Equipment for suction and Ambu bag was available.
- IEC and Display
  - Very prominently displayed information on valuing the girl child and month wise gender disaggregated birth statistics.
  - Lots of IEC material on other themes, such as maternal and child care, immunization are also displayed.
  - Inside the premises, information on maternal deaths, JSY beneficiaries etc. are displayed.
- Drugs, contraceptives, ORS, gloves etc. were in stock (there was a stock-out of zinc tablets).
- A sub-center strengthening committee was functional and a record of their proceedings to approve the IPHS and AMG funds were available. Over the past 2 years Rs. 20,000 had been received and had been expended – vouchers to support the expenditures were available.
- Bio-medical waste was segregated and disposed off through burial in a pit in the premises.
- The community appeared satisfied with the services provided by the centre and the staff.

## **VI. Visit to Aanganwadi Centres and Village Health and Nutrition Days AWC Sakharwari**

Vice President, Zila Parishad, Member-Zila Parishad and some other community leaders accompanied the team for the field visits and took active and supportive interest in showcasing the activities being carried out at the health facilities.

- Well maintained, clean and very good infrastructure.
- IEC material particularly on maternal and child health well displayed
- VHND session was in progress, pregnant women and children were there as per the due list, immunization and growth monitoring being done and WHO chart being maintained for every children
- Cold chain properly maintained
- Special scheme by the name Village Child Development Center being run at all VHND sites for detection of SAM and MAM children
- Once a group of 10 children are detected special nutritional drive for 21 days is undertaken and if not improved or on detection of any clinical problem by the medical officer is being referred to CDC.
- Cooked food as per ICDS provision and packed high nutritious dry food to pregnant women are being distributed
- 2 ANM and one LHV present on the session site. None of the ANM's trained on SBA, the LHV was trained but are not aware of the protocols.
- The LHV is also trained in IUD but her confidence level for IUD insertion was not adequate
- AWW and AWC are proactive and have adequate knowledge of their assigned job and protocols

- Services to pregnant women are limited to their registration, HB and urine estimation, BP measuring, height and weight are also being checked
- Although ANM was not trained as SBA but was doing HB, urine estimation, BP measurement with fair adequacy

#### **Interaction with ASHA**

- A cross sectional interview with the ASHA revealed they are vibrant with good knowledge of their job responsibilities on MH, CH, TB, Malaria, Leprosy and other assigned programs. They were knowing danger signs of complications during ANC, PNC and neonates.
- Reveals good quality ASHA training by the district

#### **Interaction with Public and VHSC members**

- President VHSC is a female sarpanch who is very proactive and briefed on the activities of VHSC. Regular meetings are being held and the fund being utilized on drugs, supplementary foods, equipments e.g. height scale etc. Despite our probing they confidently acknowledge rendering of good quality services by the AWC and sub center. The members conveyed that Panchayat has helped in building the AWC and requested administration for provision of its boundary wall.

#### **AWC-Haveli**

- VHND session
  - Pregnant women and children are present as per the due list. Cooked food is being given to children, the team members tasted the food which was very good.
  - Adolescent girls 15-19 years are given six packets of dry ration for two months.
  - MO in charge of the PHC has implemented innovative idea of giving case records of ANC and treatment given to the pregnant women. She carries it home and brings the file every time she comes for check up.
- Records/register and infrastructure are again maintained meticulously as seen in previous VHND
- Interaction with VHSC and GP members
  - Meeting held every month, funds being utilized for stationary, drugs, emergency referral, spray of insecticides etc.
  - Registers and cash books well maintained.
  - Committee members are very happy with the functioning of AWC and SC. No complaints.

#### **VHND at Kalamwadi Village, Rangoli PHC**

- Around 18 children, 3-6 years old were present at the anganwadi and about 10 pregnant women and mothers of children under 3 were attending the VHND.
- Nine ASHAs, aanganwadi workers, 2 ANMs, the ICDS supervisor and the MO were also present.
- Interactions with beneficiaries:
  - Interactions with beneficiaries revealed that VHNDs were conducted regularly
  - ANC and immunization services with IEC on nutrition were the primary focus of the VHNDs.
  - Take Home Rations are not provided at the VHND, but were distributed once in 2 months as soon as stocks are received by the AWW.
  - All the 15 women present had opted for delivery in private hospital and had paid Rs 5,000- 10,000 for each normal delivery and about Rs. 15000 for C- Sections.
    - The reason given was that the PHC was a little far.
    - However good roads and transport facilities are available thus this cannot be the only reason for the choice of private facilities.

- Most mothers had parallel ANC checkups at the private facilities even though they belonged to mostly to the lower income group.
  - However they attended VHNDs since they valued the health and nutrition knowledge imparted at the sessions.
- Due lists were available, and children had been immunized prior to team's arrival. There was adequate maintenance of cold chain and immunization records.
- Lack of VCDC at the Aanganwadi
  - All children had been weighed by the AWW, growth charts for the last few months had been plotted, and children had been screened for SAM and MAM for an ongoing VCDC at another AWC in the village.
  - However, the two children with MAM from this AWC were not participating in the VCDC.
  - Of the total 17 SAM/MAM children screened from all the five AWCs in the village, only 11 were participating in the VCDC reportedly because the VCDC AWC, while in the village, was far away for these children and norms prescribe that only one AWC in a village could conduct the VCDC.
  - Thus there is a need to provide flexibility in the application of norms/ guidelines to respond to local needs and encourage local problem-solving by functionaries.
- Lots of IEC material was available and AWW was using IEC materials (NRHM) for ANC session with pregnant women.
- IFA supplementation being provided to women and women are also being provided FP counseling. Pediatric iron supplementation was not happening,
- Zinc supplements were not available and there was a lack of knowledge about zinc supplementation.
- Records of beneficiaries were maintained by ASHAs.
- VHSNC functioning
  - The VHSNC had nine aanganwadi's under its jurisdiction.
  - Majority of the funds of the VHSNC were utilized for strengthening the aanganwadi and nutrition related activities such as purchasing of height measuring tapes, food such as fruits for children attending the aanganwadi.
  - Other expenditures included payment to ASHAs for immunization.
  - The meetings of the VHSNC had PRI representation and meeting proceedings are maintained.
  - Funds for the current year had been received in the previous week and only 50 % of the funds in the previous year had been utilized.
- There were no activities for adolescent health in the VHND.
- A gender sensitization and "valuing and saving the girl child" play was organized by one of the ASHAs, indicating that there are efforts to create social change around the issue.
- Beneficiaries seemed satisfied with the services offered by the AWC and the ASHA.
- While there was some role distribution in clear cut demarcated areas such as THR distribution, weighing of children, plotting of growth charts, implementation of SABLA scheme for adolescent girls by AWW, immunization by the ANM, and ensuring institutional deliveries by ASHA, there was a lack of role clarity between the ASHA and the AWW in several areas, such as home visits – its purpose and content, registration of pregnant women, iron supplementation for adolescent girls. However, the relationship seemed collegial and collaborative. However, there was visible hierarchy wherein ANM was considered the head, with the AWW working under her and the ASHA at a lower level.
- All ASHAs made a collective plea for a small fixed monthly remuneration in addition to the incentives and that they should be given incentives for all institutional deliveries irrespective of their BPL/APL status.

### **VHND-Daryache Wadgaon**

The VHND was being conducted in the gram panchayat building. As observed in other VHNDs, ANC and immunization were the main focus. There were around 20 children in the aanganwadi. The due list and cold chain were adequately maintained.

Interaction with beneficiaries

- Out of the beneficiaries, 50 % choose private facilities for their delivery and also get a few ANC checkups in the private facility. USG is also done at the private facility
- VHNDs are regularly conducted and ASHAs inform patients about the VHNDs

Interaction with ASHA's

- On an average ASHA's are earning around 2000 rupees per month.
- ASHA's have completed three rounds of training (7 days-4 days -4 days)
- ASHA supervisor in place and covers 43 ASHA's in 17 villages.
- Vaccination is the primary focus in VHND's with very little focus on other issues such as family planning or ANC.

Interaction with AWW, supervisor and CDPO

- Growth chart is maintained but workers are not able to interpret the chart and thus are not able to take corrective action.
- Three MAM cases identified in August and VCDC planned for the month of September. Till date there had been no VCTC in the aanganwadi.
- The quality of food served is good.
- Training of AWW was conducted 1 month back for 7 days, training of supervisor was conducted 2 years back, 1 supervisor covers 30 AWW
- Birth and immunization registers are well maintained

Interaction with VHSNC members

- VHSNC funds used for strengthening aanganwadi services. Aanganwadi stationary, food for malnourished children, sanitation of villages are common items on which the funds were spent. Incentives for VHND are also paid to ASHA from the VHSNC funds
- Regular meetings and good PRI involvement.

### **VHND at Gargoti Shindewadi**

- This was a surprise visit. The VHND was being conducted at the Panchayats Ghar
- Present at the VHND were: from the Health department – MO, 2 ANMs, ASHA; from ICDS – Anganwadi Helper, the AWW was on approved leave, the Lady Supervisor and the CDPO; the village Sarpanch.
- Immunization
  - The due list for immunization had been prepared by the ASHA, by the AWW and the children on the list for immunization and the pregnant women for ANC were present.
  - Required vaccines were available, the vaccine carrier had ice packs; all vaccine VVMs indicated stage 1, except for one vial in stage 2 (stage 2 is usable per the VVM guidance/protocol).
- IEC
  - A display board at the entrance provided information on the VHND schedule for every second/third Wednesday for the month. However, there was no display of the services provided at the VHND.
  - IEC material regarding maternal care, immunization, HIV/AIDS was displayed inside the room.
- ANC

- BP instrument, Hemoglobinometer were available with the ANM, the ANM and ASHA drug kits had sufficient drugs. However, no Hb testing is done at the VHND; the pregnant women are sent to the PHC/Rural hospital for blood profile and Hb levels are recorded from there.
- Recent registrations (well into the second trimester) did not have Hb records, since they had not yet had the blood profile done at the PHC. They had been provided the prophylactic dose of IFA.
- There were no zinc tablets; AD syringes
- Some knowledge gaps were observed. For example, the ASHA was not aware of how to use pediatric IFA tablets and the use of zinc tablets; one of the ANMs did not know Zinc tablets purpose or dosage.
- Nutrition
  - THR is not distributed at the VHND. These are distributed once in two months immediately upon receipt of stocks.
  - Although weights are being recorded at the VHND, there is little attention to inadequate growth (weight gain), and we noted several instances of children, whose growth charts reflected poor and faltering growth for even prolonged periods (6 – 10 months), it received no attention, and no corrective action in terms of counseling of mother, deworming, IFA supplementation, close follow-up by the health team.
  - This is despite the fact that all underweight children had been screened by a team of AWW, ANM and the Medical Officer to identify children with SAM/MAM using height for weight for the VCDC.
  - The focus is only to identify children for treatment of SAM/MAM but the prevention of undernutrition remains a neglected area at the VHND which aims to provide comprehensive health and nutrition services by the departments of health and the ICDS.
  - Similarly pediatric iron tablets, although available with the ANM and ASHA were not being distributed.
- **Recommendations**
  - Overall, it was found that much of the focus of the VHND was on immunization; the event is also known locally as immunization day. The maternal health and nutrition related components at the VHND need strengthening, including Growth Monitoring and Promotion, Infant and Young Child Feeding counseling.
  - Further, adolescent girls are left out of the VHND fold. Even though 38 adolescent girls had been enrolled by the AWC for the ICDS SABLA program, the VHND can play an important role in their nutrition and health and life skills counseling and in improving their nutritional status.
  - Along with the focus on treatment of SAM and MAM, prevention of malnutrition by strengthening the promotion part of GMP is strongly suggested. For this the ICDS and Health staff needs to be oriented appropriately.

#### **VII. Interaction with Quality Assurance Officer**

- Fifty facilities are covered by the QA cell.
- QA committee consists of 22 member and this is divided in 4-5 sub-committees.
- Detailed checklist has been used. In a year each facility has been covered at least thrice.
- Facilities have been graded on a scale of A to D. All the records are maintained at the facility level and adequate follow up has been conducted with active engagement of the facility staff.

#### **VIII. Visit to District Training Center and HFWTC**

- Interacted with DTT and hospital training team.
- HFWTC staff –Principal 1, Lecturer Medical-1, Para medical -2

- Staff DTT- MO-1, 2 Male Health Worker, 2 Female Health Worker
- Staff HTT- MO-1, Statistical Assistant-1, DEO-1, PHN-1
- Observation
  - No training plan, no guidelines, does not know the details of the training in particular technical and operational understanding is weak. Poor knowledge of the training component.
  - Training Protocols not known including HFWTC who are mentors for the training.
  - Needs strengthening, orientation and practicing of the skills before they conduct the training.
  - No supervision and monitoring of training from any levels state/regional/district
  - Weak support to the technical personnel at state level and also district level for supervision and monitoring
  - Training structure, supervision and even motivation is poor. This is clearly reflected in filed visits. It needs urgent priority attention by District and State Authority. Since there is no point in conducting such poor quality trainings where even trainer and supervisor do not know the protocols.
  - The recommendation is to merge HTT and DTT which should inturn be supervised by HFWTC.

#### **IX. Meeting with District Collector, Kolhapur on the PCPNDT Innovation**

- The district has installed active tracker device for capturing the running images of sonography in a device which is attached to the sonography machines. These trackers cost 25,000 to 28,000 rupees and are installed in the private sector. This initiative is on since April 2009.
- The district has also launched a website [www.savethebabygirl.com](http://www.savethebabygirl.com) which allows online filling of form F and analysis is possible
- There is a need for feasibility analysis whether this has served as a deterrent in sex determination or not. The device is expensive. As per the district collector 99.9% doctors are following the online system.

#### **X. Visit to Bhudargarh- School health program-Khanapur**

- Once yearly checkup for all students since 2008.
- All the 35 essential medicines are available at the school site.
- IFA supplementation is being provided by both SSA and School Health Program.
- Referral for heart anomalies, eye checkup, slow learner and other conditions are done.

#### **District Gondia- Maharashtra**

#### **XI. Visit to District Hospitals and First Referral Units**

##### **BG Women's Hospital, Gondia**

- Human resource is inadequate given the case load. (SNs 28/60, specialists: physicians 2/4; gynaecologists 4/4; MOs 6/7; Paediatric 1/2; anaesthetists 2/4; General surgeon 2/6)
- With limited resources, BGW hospital is handling high case load and providing tertiary level care to mothers and children in the district.
- Newly constructed blood bank unit awaiting FDA clearance (recruitment of specialist to be expedited for this purpose)
- Infrastructure falls short of the requirement both in terms of size, space and quality. There are 120 sanctioned beds. However, the number of patients admitted at any time is in the range of 150 to 180. The district is situated on Madhya Pradesh Border. Hence the facility also serves to the patients from Madhya Pradesh.
- One primary reason for high case load is non functional FRUs. This is the only facility offering Caesarean Section and managing complicated cases in the district on a regular basis.

- Bed strength for Neonatal services is inadequate. The upgradation to SNCU is yet to start. Due to inadequacy, more than one baby is sometimes kept in a warmer.
- Labour Room was clean, well equipped and recently renovated.
- Partograph is used. GoI guidelines followed for SBA training.
- Neonatal Corners are functional in Labour room and OT. Nurses and ANMs are trained in NSSK and Essential Newborn Care.
- 50 KVA Power backup & 24 hour water supply is available.
- Delay in payment of JSY benefit to ASHA and the beneficiaries.
- There is no pathologist in the Blood bank. The facility has collection of about 7,000 units per year and utilisation of 600 to 700 units /month. Workload is too high for one single doctor , affects its functionality 24x7
- Lab facilities are critical to a tertiary care centre. However, there is no designated specialist for the lab. Results are entirely dependent on the lab technician.
- Referral system is in place. Tie ups with private transport providers and call centre functional.
- RTI/STI treatment kits available at DH, 1 MO and 1 SN trained in management of RTI/STI.
- Nutrition Rehabilitation Centre has been established recently and is working as per protocols.
- Sonography service is available. F-forms is maintained.
- Maternal Death Review carried out on 30<sup>th</sup> of each month.
- After interviewing the beneficiaries, it was found that feedback on the services is satisfactory. However, overcrowding of the facility was an issue.
- Food is made available to all women.
- JSY payments are not made promptly and cases remain pending for months.

#### **District Hospital Gondia**

- District headquarter of Gondia has two hospitals. One is a women's hospital catering to institutional deliveries, newborn care and immunization. The other one, District General Hospital, caters to general patients.
- A new female medicine wing has been constructed. The ward visited in the wing did not have water facility. Water cooler has been given for repair for one and half month. The ward is situated on the 4<sup>th</sup> floor and patients have to go to ground floor for water.
- The telemedicine facility is functional at the hospital connected to B J Medical College Pune, Government Medical College Nagpur and similar medical college institutions. The referring doctor is given Rs. 100 and the doctor giving consultation is given Rs. 300. Even Ayurveda and Unani patients are consulted using telemedicine.
- ICTC counselling is done at the centres. However, there is need to enhance privacy at the counselling clinic.
- The laboratory records are not maintained in prescribed format. The lab results are recorded on a register meant for medicine stocks.
- The biomedical waste management protocols are not followed at the lab and hub cutter was found to be non functional.
- There are no staff quarters at the district hospital premises. Hence, round the clock availability of the doctor becomes a concern.
- The sonography service was present at the facility. However, the forms were not signed by the facility in charge.
- Around 20 thousand school students were checked every year under School health Program. 76 students have been operated for heart surgery under school health program.

#### **SDH Tiroda**

- The hospital has 5 Medical Officers, 6 Staff Nurses, 2 ANMs and 2 LTs. Posts of 2 Medical Officers and 6 Staff Nurses are vacant.
- There was newborn baby corner in the labour room.

- The ICTC counsellor was aware of the details of the programme implementation and was counselling pregnant women and adolescents.
- It has telemedicine facility. The hospital is connected to tertiary care hospitals to consult specialists in complicated cases.
- Variety of dentistry services are provided at the facility with some user charges.
- Bed nets are provided to all the patients in the wards.
- The colour coded buckets for biomedical waste segregation were being used in the hospital.
- The medical officer has taken initiative to provide a saree and sanitary pads for mother and clothes for baby in case of institutional delivery.
- The IEC material was displayed at strategic locations in the institutions.
- The drinking water facility was available in the facility.
- The medical officer is trained in CeMONC recently. However, only 2 C sections have been conducted at the facility.
- The two C Sections were conducted with team of specialist from other institution and not independently at the facility.
- The facility has blood storage unit. However, only 1 unit per blood group is available at the facility. Moreover, the blood has been used only twice in the facility.
- Two important services of Comprehensive obstetric care and blood transfusion are not regularly done at the facility and hence its operational FRU status is under question.

#### **RH Deori**

- This is Non functional FRU. This facility is only handling normal deliveries.
- Equipments for Caesarean section are available, but they are not in use.
- out of total 25 posts sanctioned at the Rural Hospital, 19 posts lie vacant hampering the service delivery
- The RH has a Trauma Centre sanctioned. It has been sanctioned with 15 staff positions including 2 specialist and 3 MOs. None of these posts have been filled.
- Most of the staff members posted at RH reside at campus.
- All the essential Drugs were present in stock except Emergency Contraceptive Pills
- The facility has Generator backup.
- *Maitri* clinic for adolescent health is functional at the facility.
- For Referral transport, only one ambulance is present and there is no alternative arrangement.
- Payments for JSY beneficiaries were found to be pending.
- Partograph not being maintained.
- There is no privacy in labour room.
- Though the doctor has been trained one year ago, MTP services have not been started yet.
- Waste Management needs to be improved.
- Toilets not up to the mark: overall cleanliness needs to be improved (may be because of old infrastructure)
- IEC component is weak
- Citizen Charter was in place
- It is an overall observation that the standard of the facilities for RH and above facilities is lower than the facilities at PHC and SC level.

## **XII. Visit to Primary Health Centres**

### **PHC Ekodi**

- It is 24X7 IPHS PHC.
- The PHC has 1 medical officer, 2 SNs, 3 ANMs, a Lab Technician and 2 support staff.
- The medical officer has been trained in BEmOC, IMNCI, RTI/STI, DOMS, and NSSK.

- The staff Nurse has been trained in RTI/STI, IUCD and NSSK. The ANMs have been trained in RTI/STI and IUCD.
- Labour room was well maintained with protocols for resuscitation of the baby clearly displayed. However, protocols for active management of third stage of labour were not displayed.
- Partograph was being maintained by the Staff Nurse and ANMs of the PHC.
- The attached toilet for the labour room and women toilet for IPD patients was relatively clean.
- New born care corner was well maintained in the labour room.
- The postnatal ward had *Hirkaani Kaksha* for promotion of breastfeeding.
- Tracking bag was being used for immunization. Staff Nurse and ANMs were well oriented about the use of the bag.
- The OPD utilisation of the facility has increased significantly from 12,346 in 2005 to 26,801 in 2010.
- The facility has separate safe drinking water arrangement for OPD and different wards.
- The drug stock management was computerized and well maintained. However, the stock position cannot be viewed offline without the use of the internet.
- TV set has been provided in the OPD waiting area for the patients which plays IEC messages.
- Dust bins were used at various places in the hospital.
- The facility has solar system for availability of warm water for the patients.
- There is a burial pit for disposal of bio medical waste.
- Citizen charter was prominently displayed with Medical Officer's phone number.
- Labour table in the labour room was rusted which may be replaced or properly painted.
- Labour register was not being maintained in prescribed printed format.
- The shadowless light of the OT was non functional and bulbs were being used in the OT. The floor of the OT was unclean. The OT does not have ante room.
- The medical officer has been trained in the NSV for only 1 day as against prescribed 5 days.

#### **PHC Chopa, Kawrabandh & Mulha**

- The infrastructure of the facilities is well furnished.
- IEC is displayed prominently on various issues at PHCs.
- 24 hour water supply is present. Solar backed generators are used for electricity in PHCs.
- Basic laboratory facilities available.
- Labour rooms are clean but no woman was present in labour room in any of the facilities visited.
- Separate toilets for men and women in all the facilities.
- Special corners for ORT and breastfeeding (*Hirakani Kaksha*).
- Waiting area is present with the labour rooms
- Display of Citizen's charter and Services available is present at the facility.
- Partographs maintained
- Drugs and vaccines available in stock (except for IFA, Zn tablets and ECPs)

#### **Innovations**

- Sickle Cell Anaemia Programme
- Designated space for ASHAs at the facility for their meetings and overnight stay in Kavarabandh PHC.
- *Hirkaani Kaksha* : a designated space for breastfeeding in the PHCs.
- *Maher* –a birth waiting home is present for deliveries in inaccessible areas is present
- ORT Corners present
- Referral transport system functional, call centre in place at PHC Kavarabandh.
- Temperature chart maintained for Deep freezers. However, other drugs (insulin, pancuronium, rabies vaccine, antibiotics) were also found in ILR in two out of three PHCs.
- Equipments have provided to the PHCs which are not required at PHC level.

- Integration of Safe Motherhood and HIV services is commendable. But integration of HIV with STI services and FP needs to be taken up.
- RTI/STI services should be included as an important component along with critical services, especially since ICTC facilities are available.
- Focus on FP is limited to Sterilisation
- Postpartum sterilisation and IUCD insertion very low
- Though NSV and Minilap is given high priority, non availability of trained doctors is an issue.
- Newborn corners established essential neonatal care to be strengthened.
- Equipments such as incubators which are not required at PHC level sent at PHCs. These equipments lie unused at these facilities.
- Waste management system put in place, but protocols to be adhered to diligently.
- MTP services: not available across all PHCs
- Women after deliveries are satisfied with services (inference after Interview)
- food is free for the mother and attendant
- free referral transport made available or the cost of transport is reimbursed. However, no drop back facility.
- hot water facility available

### **XIII. Visit to Sub Centres**

#### **Sub Centre Dandegaon**

- Newborn care corner was present in the labour room.
- Resuscitation kit was available though there was no oxygen facility at the facility.
- Thermometer was present in the labour room for measuring the room temperature and to take appropriate measures to keep the newborn warm.
- A clean attached toilet was present for the labour room.
- Protocols for child resuscitation were displayed in the labour room. However, protocols for active management of third stage of labor were not displayed.
- Labour register was not being maintained in prescribed printed format.
- The ANM is conducting deliveries regularly. However, she has not been trained in SBA. Hence, partograph is not being maintained. While interacting, ANM said that she is confident to deal with complication in baby. However, she is scared of dealing with complications in case of mother after delivery.

#### **Sub Centres Jhaliya and Surtoli**

- Overall the infrastructure is good and providing quality services
- Delivery room is fully functional.
- Electric supply is irregular. However, present power backup is not functional since 1 and half months.
- IEC is displayed on important MCH and other components.
- Micro birth preparedness plan is in place.
- Expected Date of Delivery and Expected Place of Delivery (EDD & EPD) displayed and accordingly tracking is done.
- Names of all JSY beneficiaries displayed
- Records were well maintained. At one sub-centre, requisite formats were not being used. However, desired information was being recorded in different format.
- Display of Services available in the facility
- JSY payments on time.
- Clean Labour rooms but no woman in labour room in any of the facilities visited
- ANM knowledgeable, motivated and providing quality services
- Partograph maintained

- Neonatal corners established essential neonatal care to be strengthened.
- Waste management system put in place but protocols to be adhered to diligently.
- Basic lab. facilities available (Hb, Urine)
- Timely referral of high risk cases

## Annexure III

### List of some of the Consultants employed under NRHM and RCH

- |   |  |
|---|--|
| <b>1. State Programme Manager</b>                         | <b>1. State Accounts Manager</b>       |
| <b>2. Telemedicine Consultant</b>                         | 2. Financial Consultant                |
| <b>3. IPHS consultant</b>                                 | 3. Accountant                          |
| <b>4. MIS consultant</b>                                  | 4. Budget and Financial Officer        |
| <b>5. Hospital Consultant</b>                             | 5. Procurement Assistants and Officers |
| <b>6. Computer Specialist</b>                             | 6. State Audit Manager                 |
| <b>7. M &amp; E Consultant</b>                            | 7. Coordinator Maternal Health         |
| <b>8. Sr. Consultant PPP/NGO</b>                          | 8. Child Health Co-ordinator           |
| <b>9. HR Consultant</b>                                   | 9. Coordinator - FP                    |
| <b>10. Grievance Redressal Officer</b>                    | 10. Consultant Adolescent Health       |
| <b>11. Superintendent, Executive and Deputy Engineers</b> | 11. Coordinator Menstrual Hygiene      |
| <b>12. Jr. Engineer</b>                                   | 12. Paediatrician                      |
| <b>13. Statistical Consultant</b>                         | 13. Gynaecologist                      |
| <b>14. NGO Facilitator</b>                                | 14. Medical Officer                    |

## Financial Details

## 1. Status of Funds release and Expenditure of State :

Sl. No.	Programme	2005-06		2006-07		2007-08		2008-09		2009-10		2010-11		2011-12		Total (Rs.in Crore)	
		Re.	Exp.	Re.	Exp.	Re.	Exp.	Re.	Exp.	Re.	Exp.	Re.	Exp.	Re.	Exp.	Re.	Exp.
		1	RCH-II	52	13	119	41	186	99	83	170	236	160	235	189	0	28
2	Add. under NRHM	65	0	113	9	178	130	194	352	307	485	316	547	184	13	1359	1536
3	R.I	10	1	1	2	2	6	7	11	15	15	15	15	10	2	62	53

## 2. Advance and Bank position as on 30-06-2011

Particulars	Advance Amount (Rs. in Crore)	Bank Balance (Rs. in Crore)
RCH Flexible Pool	77.66	154.37
Mission Flexible Pool	189.15	28.58
Routine Immunisation	6.32	-2.82
Pulse Polio Initiative	22.26	24.66
NDCP's(NVBDCP Tobacco)	15.75	52.95
Grand Total	311.14	257.73

## 3. Year –wise details of State Share

Years	Amounts required to be contributed (Rs. in Crore)	Amounts Credited (Rs. in Crore)	Short/Excess credit(Rs.in Crore)
2007-08	118.68	-	118.68

2008-09	103.66	120.90	-17.24
2009-10	169.29	119.81	49.48
2010-11	159.42	182.04	-22.62
2011-12	190.39	26.00	164.39
<b>Total</b>	<b>741.44</b>	<b>448.75</b>	<b>292.69</b>

4. **Physical and Financial progress of JSY in Maharashtra:**

S.NO	Year	No. of Beneficiaries	% of increase	Expenditure	% of increase	Average JSY Exp.
1	2005-06	20008	0	146.52	0	732.30
2	2006-07	46728	133.54%	640.58	337%	1370.86
3	2007-08	219552	369.85%	1628.96	154%	714.94
4	2008-09	224375	2%	2414.48	48%	1076.09
5	2009-10	347799	55%	2740.60	14%	787.98
6	2010-11	354108	2%	3181.86	16%	898.55
		1212570		10753.00		

(Source: Status report for 8 JRM State Family Welfare Bureau page no. 9)

5. **Details of Bank and Advances of Gondia and Pune DHS**

	NRHM	RCH
<b>Godia</b>		Amounts in Lakh
Advances as on 31-08-2011	280	212
Bank Balance as on 31-08-2011	314	77
<b>Pune</b>		
Advances as on 31-03-2011	176	11
Bank Balance as on 31-03-2011	0	15

6. **Key Observations of BG Women's Hospital- Gondia District Hospital Gondia and RH Deori:**

- No proper books of accounts maintained at BG women's District Hospital, gondia.
- JSY payment register is maintained. About 30 cases of JSY beneficiary is pending for payment at woman District Hospital Gondia. JSY, ASHA incentive is pending for payment.
- RKS funds are not being audited by the chartered Accountants firm at BG Woman Hospital whereas the total grant received at BG Hospital is Rs.25 lakhs as per IPHS,1 lakhs for RKS , United Grant of Rs. 50,000/- and Annual Maintenance Grant 1,00,000/-.
- Bank Reconciliation statement is not prepared on monthly basis at Women Hospital, Gondia.
- Family Planning register was not shown at Satara hospital. Invoices are not properly certified by authorized signatory.
- Civil surgeon has not submitted the FMR for year 2011-12 (July) to Pune DHS.
- Equipment purchased for RH Deori is not being properly used at Deori Rural Hospital.

7. **Key Observations for PHC (Mulla) /SHC(Sub Centre – Surtoli)**

- Books of Accounts are not properly maintained at PHC-Mulla.
- Lack of understanding of double entry system by PHC-Mulla level Accountant.
- No bank reconciliation statement is prepared at PHC-Mulla. Pass books are also not updated on weekly basis.

- Accounts Training has not been provided to PHC Accountant.
- Substantial delay in payment of JSY at PHC-Mulla and SHC-Surtoli.
- Payment receipts have not been obtained from the suppliers at SHC-Surtoli.
- Procurement system is not followed for purchase of equipment from IPHS funds at Surtoli SHC. The following payment have been made through cash withdrawal from the bank:

Particular	Equipment	Amounts
Solar Energizers (P) Ltd ,Mumbai	Supply and installation of Solar Water Heating system	54000/-
Bhawesh Enterpises,Nagpur	Medical equipment (BP Apparatus ,Glucometer Solar lantern Uristix, Bed Pan Hemoglobinometer Digital Thermometer Ambo Bag)	13175/-
Giri Elecricals ,Deori	Cooler, Cupboard ,Chairs	14400/-
Total Payment		68615/-

- Blank invoice and Xerox copy of vouchers found at Kerale SHC at Kolhapur DHS.
- Guidelines issued by GoI for Model Accounting Hand book for RKS, Sub Centres, Block -CHC/PHCs, not found at PHC -Mulla and SHC-Surtoli.
- Untied funds and AMG was not transferred from PHC to Surtoli SHC for the year 2011-12.

**STATE VISIT REPORT:**

**PASCHIM BANGA**

**JOINT REVIEW MISSION VIII: STATE VISIT REPORT: PASCHIM BANGA  
12-16 SEPTEMBER 2011**

**Executive Summary**

A team from the Ministry of Health and Family Welfare and Development Partners visited Paschim Banga from 12th to 16th September 2011 as part of the Joint Review Mission VIII. The team conducted a desk review at the state and visited districts Nadia and Dakshin Dinajpur to understand the implementation at the field level.

**Strengths**

- State has 111% registration of pregnant women for ANC as against target. Institutional deliveries are also increasing though marginally.
- Immediate breastfeeding has increased from 15% to an encouraging 66% and reported proportion of fully immunized children is 90%.
- The level of utilization for RCH programme activities has increased from 7% to 45%. Under Mission Flexible Pool, level of utilization has increased from 12% to 69%. Significant increase in utilisation in Routine Immunisation from 16 % to 100%. Overall expenditure under RCH, Mission and immunisation has increased from 18% to 63% till 2010-11.
- 123 CEmOC and 571 BeMOC facilities have been made operational and there is also a 10% decline in home deliveries.
- ANMs were found to be well informed and maintaining records at the Sub Centre level. The role of the BPHN in supervision is well defined and is being utilised effectively.
- A comprehensive training plan for all technical trainings is in place and most of the trainings are progressing well in the state.
- State has fully migrated to a single reporting structure i.e. the HMIS. Data is uploaded periodically and reports are used to review progress and shared with the service providers at all levels to strengthen services.
- State is successfully shifting to facility based HMIS and the reporting is increasing steadily.
- At the State level, the Health Department has a functional directorate. The new structure for the directorate as approved needs to be implemented with the requisite HR at the earliest.
- The state has a good cost effective referral transport mechanism for pregnant women.
- ASHAs in the state were found to be well informed and active.
- The State Health Society, District Health Society, Rogi Kalyan Samitis have been operationalized.

**Key Issues and Recommendations**

The two districts visited by the team gave a cross section perspective of the implementation of the RCH programme in the state. Dakshin Dinajpur, a high focus district, was found to be providing better quality of care for RCH services in comparison to district Nadia, which is among the better performing districts of the state. An intensive review of service delivery in both these districts highlights that the state has the capacity for high performance in RCH services. The good practices and gaps identified in these districts may be used to review the infrastructure, HR and service delivery framework and relook at the strategies for rationalisation and prioritisation.

RKS needs strengthening. The VHSCs are still in a nascent stage in the state and need to be strengthened.

ANMs are not conducting deliveries. Data shows a 61% decrease in SBA assisted home deliveries which are a cause for concern. While the quality of SBA training was found to be very good and trained SBAs were practicing the newer technologies including plotting partograph, it may be noted that the state has taken a decision to train only Staff Nurses as SBAs. The state may want to consider training ANMs also as SBAs so as to increase access to skilled attendance at birth for more women.

The process of JSY payments is being streamlined by the state. There is a marginal increase of 14% in JSY beneficiaries for institutional deliveries. At present, all payments are being made in cash and there are significant delays in payments. The state needs to migrate to cheques/bank transfers for JSY as well as ASHA payments to streamline and address delays.

Caseloads at facilities including District Hospital and Sub-Divisional Hospitals are very high while the lower facilities like BPHC and PHC are underutilized. The state needs to address this disparity and rationalize caseloads and human resources at facilities accordingly.

Data on outcomes of pregnancy highlighted that a significant percentage of maternal mortality is attributed to eclampsia. This is a cause for concern and needs to be investigated.

Many hospitals especially higher order facilities are operational in old and rundown buildings. The state needs to consider infrastructure Upgradation in terms of facilities and equipments at all levels given the huge demand for services on an urgent basis.

The state has a good cost effective referral transport mechanism for pregnant women. However, delays were reported due to shortage of number of vehicles contracted. The state needs to review the scheme and plan for vehicles at facilities as per case loads. A need for increasing the number of vehicles at tertiary hospitals was identified as a priority issue.

The state and district BCC/IEC cell need to be strengthened and plans for comprehensive BCC/IEC activities for all programmes highlighting government key initiatives ( i.e. JSSK, JSY, Compensation Scheme of sterilisation, FP Insurance scheme, Matri Yan etc) and service availability at all levels needs to be undertaken.

To ensure that the enthusiasm of the ASHAs is maintained, the state needs to ensure timely payment of incentives to the ASHA and completion of training especially HBNC.

The state needs to review the fund release and utilization system. At present, funds are being released from the state to the district in tranches as per activities. However, huge unspent balances were noted due to non completion of activities. The state needs to relook at this system. Further, the untied funds at the CHC/PHC and SC have significant unspent balances. The concerned staff needs to be oriented on the use of untied funds to facilitate proper usage of these funds.

## **1. INTRODUCTION**

A team from the Ministry of Health and Family Welfare and Development Partners visited Paschim Banga from 12th to 16th September 2011 as part of the Joint Review Mission VIII. The team composed of the following members.

**District Nadia**

Dr. S.K. Sikdar, Gol  
 Dr. Bhrigu Kapuria, Gol  
 Mr. Anil Garg, FMG/Gol  
 Mr. Rakesh Kumar, Gol  
 Dr. Sanjay Kapur, USAID  
 Dr. J.N. Chaki, SFWB, WB  
 Mr. Debashish Choudhary, SFWB, WB

**District Dakshin Dinajpur**

Mr. Rajeev Agarwal, Gol  
 Ms. Medha Gandhi, Gol  
 Dr. Anubhav, Gol  
 Dr. Dinesh Agarwal, UNFPA  
 Dr. Kaninika Mitra, UNICEF  
 Dr. Satpathy, SFWB, WB  
 Mr. Shubhro Chakraborty, DHS, WB  
 Ms. Srabani Majumdar, DHS, WB

The types of facilities visited during the visit are detailed below

Facility Type	Nadia	Dakshin Dinajpur	Total
DH	01	01	02
SDH	02	01	03
RH/CHC	01	00	01
BPHC	01	02	03
PHC	01	01	02
SHC	03	04	07
Nursing Training School	00	01	
<b>TOTAL</b>	<b>9</b>	<b>10</b>	<b>19</b>

During this visit, the team visited the State Health Department and facilities in two identified districts – Dakshin Dinajpur (one of the 6 high focus districts in Paschim Banga) and Nadia (one of the better performing districts of the state). As part of this visit, the team reviewed the programme management structure at the state and district and visited primary, secondary and tertiary level facilities in the identified 2 districts to understand the RCH service delivery.

The team was briefed about the RCH programme in the state by the Mission Director, Mr. Dilip Ghosh and officers from the State Family Welfare Bureau (SFWB) and District Health Society (DHS). This was followed by a discussion on key issues of facility operationalization, status and quality of services in maternal and child health, immunization, family planning, mother and child tracking

(MCTS), health management and information system (HMIS), maternal death review (MDR), village health and nutrition day (VHND) and gender and equity including PC-PNDT.

The team then visited various departments in the DHS, SFWB, SIHFW within the Swasthya Bhawan campus to understand the programme management structure, key priority issues, implementation concerns and financial management. Key data on infrastructure and service delivery since the inception of RCH II in 2005 was also collected during these meetings.

The team then visited facilities in the two identified districts and the key findings from the desk review and field visits was shared with the state during a presentation by Dr. S.K. Sikdar. The de-briefing meeting was chaired by the Principal Secretary Health, Mr. Sanjoy Mitra and attended by the Mission Director and officer and consultants from DHS and SFWB.

The team would like to acknowledge the efforts made by the Government of Paschim Banga for facilitating the review and field visits and responding to the issues raised during the discussions.

## BACKGROUND

The indicators as regards the RCH programme are better than the national averages as is evident from the table 1 below. While the MMR for Paschim Banga at 145 is significantly lower than the national average of 212, there has been an increase of 4 points in MMR in the state from 141 in 2004-06 to 145 in 2007-09.

**Table 1 – Health Indicators**

Indicator	Paschim Banga		India	
	Trend (Source and Year)		Trend (Source and Year)	
MMR	145 (SRS 2007-09)	141 (SRS 2004-06)	212 (SRS 2007-09)	254 (SRS 2004-06)
IMR	33 (SRS 2009)	40 (SRS 2004)	50 (SRS 2009)	58 (SRS 2004)
TFR	2.1 (SRS 05)	1.9 (SRS 09)	2.9 (SRS 05)	2.6 (SRS 09)

**Table -2 RCH Outcome Indicators**

Indicator	Paschim Banga		India	
	DLHS-2	DLHS-3	DLHS-2	DLHS-3
Mothers who received 3 or more antenatal care checkups (%)	62.7	67	50.4	49.8
Mothers who had full antenatal checkups (%)	14.8	19.5	16.5	18.8
Institutional deliveries (%)	47	49.2	40.9	47
Children 12-23 months age fully immunised (%)	50.3	75.8	45.9	54
Children age 6-35 months exclusively breastfed for atleast 6 months (%)	15.9	26.1	22.7	25.5
Use of any modern contraceptive (%)	51.2	53.3	45.2	47.1
Total unmet need for family planning – both spacing and terminal methods (%)	11.2	11.6	21.4	21.3

## Financial Management and Expenditure

### 1. Progress since inception:

- Under RCH Activities % level of utilization has increased from 7% to 45%.
- Under Mission Flexible Pool % level of utilization has increased from 12% to 69 %.

- Under Routine Immunisation % level of utilization has increased from 16 % to 100%.
  - Overall expenditure under RCH, Mission and Immunisation has increased from 18% to 63% till 2010-11.
2. Low utilisation of untied funds needs to be improved by orienting the units by training or other detailed guidelines.
  3. Books of Accounts are being maintained regularly but ledgers are not being updated and the FMR is being prepared on the basis of cash book. Hence Ledgers should also be maintained at the units.
  4. State need to take action for pick up of activities for which funds have been given but there is low utilization To utilize funds of all the activities like Compensation for Sterilization, GP Based Mobile Health Camp, Remuneration of Staff Nurse, SBA Training under RCH-II.
  5. TDS on payments to Contractors/ Suppliers and Contractual Staffs should be deducted regularly.
  6. Remarks of the earlier year auditors' regarding differences in opening

### Progress on Key Interventions:

The state reported the following progress on RCH II interventions:

- Against expected number of pregnancies (17.16 lakhs), state has registered 111% (19.07 lakhs) women for ANC. However, if progress in actual numbers for 2010-11 is compared with 2010-11, number of women registered for ANC has increased marginally (less than 1%);
- State has reported 14.27 lakh deliveries against an estimated figure of 15.60 lakh deliveries in the whole year (91%). However, if progress in actual numbers for 2010-11 is compared with 2010-11, total reported number of deliveries as against the expected number of deliveries has increased marginally by only 1%.
- State has reported 19.07 lakh beneficiaries registered for ANC while reported number of deliveries are 14.27 lakhs (75%); this implies that follow up/monitoring could be better.
- Proportion of first trimester ANC out of total pregnant women registered for ANC has increased from 46% to 52%.
- The state has operationalized **123 CEmOC** and 571 BeMOC facilities.
- The absolute number of home deliveries has declined in the state by 10%; however, the number of **home deliveries assisted by SBA has decreased significantly by 61%**.
- Deliveries at public institutions, at the same time, has increased by 5%; further, the proportion of deliveries out of public **institution deliveries discharged after at least 48 hours of stay have recorded a large slide by 27%**.
- The proportion of newborns breastfed within one hour of birth has encouragingly increased from 15% to 66%; and the proportion of newborns weighed at birth has also increased by 4% (from 85% to 89%).
- The reported proportion of fully immunised children (age up to 11 months) in the state is about 90%, i.e. 13.52 lakh children out of the estimated number of 15.06 lakh infants.
- State has reported 452685 JSY beneficiaries for institutional deliveries (14% increase); however, only 1932 ASHAs have received benefit for the same.
- State had reported no progress during 2010-11 with respect to the operationalization of FRU, 24x7 PHC, and Sick and New born Care Units.
- Parental Oxitocics, Inj. Magnesium Sulphate, monitoring of progress of labour using partographs initiated at all delivery points
- Sub Centres are being strengthened to test for Haemoglobin, Albumin & Sugar and measure BP

- Identification of severely anaemic pregnant women at SC level initiated for effective referral to CEmOC centre with blood transfusion facility
- State has reported 31,118 infant deaths in the year 2010-11; however, this appears to be low when estimated from the IMR of the state, i.e. 33 per thousand live births.
- IMNCI is being implemented in 10 districts and training has started in 8 additional districts in 2011. Medical College faculty are being involved in quality assurance for training and supportive supervision.
- In an effort to strengthen home based new born care, over 3500 ANMs & more than 2500 ASHAs have been trained in IMNCI in the state. About 70% newborns are being visited thrice within 10 days of birth. New WHO formula ORS and zinc tablets are being used for diarrhoea management in children.
- NSSK training has been rolled out throughout the state with the purpose of tackling birth asphyxia and essential newborn care at facility level.
- All 1<sup>st</sup> ANMs are trained in immunization; training of medical officers is ongoing. Cold Chain Handler's training is also ongoing in the state. Effective Vaccine Management Assessment is also being presently undertaken by the state with UNICEF's support, to improve vaccine & logistics management. A state level cell at Medical College in collaboration with UNICEF (West Bengal State Immunization Support Cell), and district level extenders in 10 low coverage districts, provides techno-managerial support for immunization programme in the state.
- State has shown a 12% drop in number of sterilisation cases in the year 2010-11 as compared to year 2009-10 (from 311722 to 274878); although, this is almost 96% of the ELA for the year.
- Male participation in sterilization is still low (7%), i.e. 17,131 adopters only
- As per HMIS data reported for 2010-11, there is decline in IUD services compared to 2009-10 (from 77935 to 74377 respectively)
- None of the training under Family Planning have achieved the planned target for 2010-11; moreover, reported expenditure for these training programme is very low (around 15-20%).
- A comprehensive training plan for all MH, CH, FP and ARSH training is available at the state level and trainings as being facilitated mostly as per plan

### Profile of the Districts Visited

The key indicators for the districts visited are detailed in table 3. As is evident, both the districts have very diverse demographic indicators and socio-economic patterns.

Table 3 – District Indicators

Indicator/ District	Dakshin Dinajpur	Nadia
Population	16.7 lakhs	51.6 lakhs
Administrative Blocks and Municipalities	8+2	17+10
SC+ST Population	45%	33%
Female Literacy		71%
Sex Ratio (at birth)	954	947
Medical College	0	1
DH/SDH/SGH	2	6
RH +BPHC+ PHC	7+19	7+7+49
SC	248	469
Percentage of BPL	30%	
Population density	753/sq km	1316/sq km

Dakshin Dinajpur, the smallest district in the state, in spite of its higher SC/ST population, lower female literacy and higher rate of poverty and so called backward district label was found to be providing better quality of care for RCH services. The motivation levels among providers and administrators were found to be encouragingly high and there was no significant human resource crunch. Nadia, a more urbanised and densely populated, is supposed to be a better performing district. However, facilities in the district were grappling with high caseloads at all levels of service delivery and inadequate human resources with low levels of motivation for various reasons.

An intensive review of service delivery in both these districts highlights that the state has the capacity for high performance in RCH services. The good practices and gaps identified in these districts may be used to review the infrastructure, HR and service delivery framework and relook at the strategies for rationalisation and prioritisation.

## **2. KEY FINDINGS**

### **2.1 Financial Management**

Fund flow mechanism – It was seen that Funds from State to districts and from districts to blocks are being transferred in online mode but the same below district is by way of cheques. State may explore the possibility for release of funds from blocks to other implementing agencies and for other payments. Payments for JSY may also be explored by way of cheques. It is also seen that due to activity wise release of funds from State and Districts few activities remains unattended therefore it may be re-looked that all the approved activities are undertaken with sufficient availability of funds under each activity. Funds remained unutilised for activities not fully utilised may be reviewed and re-appropriated timely.

### **2.2 Programme Management and Supervisory Structures**

**State Level:** At the State, the Health Department has a functional directorate. The new structure for the directorate as approved by the competent authority needs to be implemented with the requisite HR in place at the earliest. While the State has a transfer/posting policy, coordination between the Director and State Family Welfare Bureau (SFWB) needs to be strengthened to address irrational transfers/posting.

The state has a strong management and leadership structure with a Mission Director and a finance officer at the Directorate. The State has undertaken measures to strengthen the State Programme Management Unit (SPMU) with technical officers and dedicated programme consultants. However, to ensure better coordination within the SPMU and with the Districts, the state may consider filling the position of State Programme Manager (SPM).

The services of the Strategic Planning & Sector Reform Cell (SPSRC) are currently reactive in nature. There is a need for strengthening the strategic focus of the SPSRC to provide technical inputs to the state. As regards, training, the state has a SIHFW within the Swasthya Bhawan campus but roles and responsibilities of the SIHFW are currently diffused and linkages with directorate are not evident. The SIHFW is poorly staffed and a strategy needs to be put in place for effective utilisation of this training institute in training and quality monitoring.

The state needs to build a division/ cell for BCC/IEC which is currently not available at the state and district level. To ensure effective uptake of service and address issues of provider

attitudes, communication on health issues among providers as well as beneficiaries needs to be strengthened.

**District Level:** The District Programme Management Units (DPMU) was functional in both the districts visited. The system of monitoring and supportive supervision exists but needs to be implemented in a structured manner. HMIS is the primary and only source for data entry and analysis. This implies that the state has succeeded in ensuring no duplication in data and reports and managing the time of the staff as regards reporting in an organised manner. A system of sharing analysis of monthly reports for strengthening programme from the district to the block is being practised.

Behaviour Change Communication/ Information Education Communication (BCC/IEC) i.e. District and Deputy DEMO position are vacant at district level and there is no strategy for implementation. PC-PNDT committees have been constituted though their functioning needs to be streamlined. However, the District Level Committees (DLC) for MTP need to be constituted and made functional.

- *Functioning of State Health Society (SHS), District Health Society (DHS), Rogi Kalyan Samiti (RKS) and Village Health, and Sanitation Committee (VHSC)*

SHS meeting are held weekly and at the district level, DHS meeting under the Chairmanship of the DM are held monthly. It was reported that RKS have been established in all hospitals but their role is limited due to low revenue generation with high BPL inflow and no user charges below Sub-Divisional Hospital.

At state level, Health and Panchayat and Rural Development (P&RD) have a partnership for implementation of VHSC however this needs to be strengthened. In DD, VHSC are beginning to be constituted while in Nadia 50% of VHSC have been constituted.

- *Monitoring and Supportive Supervision (M&SS)*

The state is in the process of streamlining the monitoring and supportive supervision component aspect to strengthen the programme implementation. Officers at the State level have been assigned two districts each for supportive supervision. A checklist for these visits has been developed recently and this needs to be disseminated. In addition, to ensure quality, faculty of the 9 Medical Colleges have also been involved. However, this system of M&SS is still at a nascent level and needs to be strengthened.

A system of M&SS within the district is being put in place. Blocks are being divided among the DCMOHs for monitoring. In Dakshin Dinajpur visits have been initiated but no documentation was available. However, DPHNO and BPHNs are playing an important role in M&SS. It was also learnt that periodic visits by state officials have been made. On the other hand, in Nadia, there is no system of M&SS. There is a need to develop a structured supervision and feedback plan for the districts.

## 2.2 Quality of Services

State Quality Assurance Committees (QAC) has been constituted but needs to be active and regular to steer quality assurance of RCH service delivery. At the district level, District Quality Assurance Committees were found to be functional. As part of the quality assessment mechanism, standards for sterilization are being adhered to and to achieve the quality parameters, the State/district are in an effort to achieve get NABH accreditation.

- *Access to Services:* There is an increasing trend towards service utilization for RCH services in both the districts at the facility

- Facility – The OPD attendance at all levels from PHC to DH was found to be very high in both the districts. Inpatient services at the PHCs needs to be strengthened. It was encouraging to see that providers were aware of the guidelines especially for sterilisation and skilled attendance at birth. However, efforts need to be made to be ensure that client perspective is factored in ensuring service quality.
- Outreach – The outreach services from the SC were found to be systematic. Review of records and client interactions highlighted that ANC, immunisation, FP etc were being done in a proper manner. However, outreach for out-of-school adolescents is very weak.
- **ANM** – The ANMs were found to be knowledgeable and confident in both the districts. Their record keeping was up to the mark. Their daily work-plan was well chalked out including micro-planning for out-reach services. The enthusiasm in providing services was evident. The SCs visited were found to be maintained well with effective utilisation of untied funds, availability of stocks and supplies including Nischay kits, Haemoglobin



**Good use of Tickler Bags in both Districts**

colour scale and uristix, contraceptives including ECPs. MCP cards are also being maintained properly.



**Well informed ASHAs in District Nadia**

- **ASHA**: In Dakshin Dinajpur close to 70% ASHA are appointed and trained. However, less than 50% were in position in Nadia. It was observed that ASHAs have not been appointed in 7 out of 17 blocks in Nadia. ASHAs have been trained till the 5<sup>th</sup> module. ASHA were knowledgeable and clear about their role and responsibilities. For improved home-based newborn care, further training in the form of Module 6 and 7 or IMNCI need to be initiated on priority.

● **AWW** – The AWW is working closely with the ANM/ASHA in some of the areas of the two districts visited. However, the convergence needs to be strengthened. It was learnt that a weekly convergence meeting for the ANM, ASHA and AWW is held at the SC every third Saturday. In some places, these convergence meetings are held by ICDS as well.

An effort in improving access and quality of services at the facility was seen in the form of ‘May I Help You Desks’ or patient assistance units. These are functioning in collaboration with local NGOs in District and SDH at Dakshin Dinajpur. The services provided include support during registration, assistance to patients and attendants, monitoring food quality etc in a cost effective manner.

### 2.3 Thematic Areas

- **Maternal Health** – The overall service delivery for maternal health services was found to be good. Specific issues of infrastructure, skilled providers, etc have been detailed below. These may be addressed to further improve the quality of services.

– **Infrastructure**: The DH and SDH are being effectively utilised in Dakshin Dinajpur. The buildings were well maintained and hygiene was ensured. New labour rooms and SNCUs as per GoI norms were under construction. However, in Nadia the DH and SDH buildings need urgent renovation and expansion to cater to the high caseloads. Dilapidated buildings and rusted OT tables and inadequate availability of equipments are a de-motivating



**Old dilapidated OT table in use at DH Nadia**



for service providers and beneficiaries alike. Staff quarters were also reported to be in a very poor state very de-motivating for providers.

- **Skilled Providers** – Dakshin Dinajpur has a team of skilled providers including Doctors and SBA trained SNs at facilities and IMNCI trained ANMs at SC. Capacity building requires significant strengthening in Nadia. In Dakshin Dinajpur, evidence based protocols were found prominently displayed and adhered to but this needs to be implemented in Nadia.
- In Dakshin Dinajpur complications are being managed at DH and SDH although recording of complications needs improvement. While on the other hand, High Referral from SDH to DH, Nadia leading to overload at DH (sometimes on flimsy grounds)

**Privacy of pregnant women compromised at DH Nadia**



Dinajpur is 60%. However, in district Nadia, the institutional delivery rate is as high as 86%

**Good Practices at Dakshin Dinajpur**

- **Standard Protocols** - The evidence based new practices in maternal and child health interventions in District Dinajpur are being adhered to in service delivery and training. Despite that, the institutional delivery rate in Dakshin



**Poor Inventory Management in Nadia – expired drugs found in store**

(HMIS) but the service delivery was found to be weak and quality is being compromised. An encouraging observation was that women continue to stay in the facility for a minimum of 24 hours post delivery and in majority of cases, the duration of stay is 48 hours even when the facilities are dealing with high caseloads.

An important area for concern was the high proportion of maternal deaths as a result of eclampsia. This needs to be investigated. Another issue identified during the field visits was the reluctance of providers to offer MTP services to clients unless coupled with family planning services. This was observed at all levels of service delivery – DH, SDH and BPHC.

- **Drugs and Supplies**- Essential drugs were available at Dakshin Dinajpur while none of the essential drugs/ consumables for C-section were available at Nadia leading to out of pocket expenditure of Rs 1200-1500/- per C-section. A concept of “Fixed day C-section” was seen to be observed at the SDHs in district Nadia even though there is no shortage of trained providers. This is a matter of concern.



**Good management of Drugs and supplies in DD while Poor Inventory Management of Drugs**

Nischay Kits were easily available and were found to be in use at facilities. They were also available with ASHAs in DD but not in district Nadia. RTI/STI drugs were available but these are not being utilized effectively since the training has not been initiated. Medical Abortions drugs were not available in both the districts.

- **Rational Utilisation of Manpower** - In District Nadia, data shows high referral to DH for normal as well as



complicated cases even from the SDH where specialists are available. The SDH with 3 ObGyn and blood bank is under-utilised. To give an example – only 15 LSCS were conducted in 2010-11. On the contrary, The SDH in Dakshin Dinajpur is functioning efficiently catering to more number of deliveries than the DH.

- **Labour Room:** The labour rooms in the facilities visited in Dakshin Dinajpur were found to be meeting the prescribed protocols with infection prevention standards, hygiene, attached toilet, posters etc. However, labour rooms in Nadia were found to be in poor condition with no privacy or toilet facility.
- **Maternal Death Review** – Maternal deaths are being recorded at the facility level. However, MDR is in nascent stage. BPHNs have been trained on Community Based MDR but the actual investigation and review needs to be strengthened.



services for child

- **JSY Incentive:** Delays in disbursement of JSY incentive was noted in Nadia while regular payment was documented in Dakshin Dinajpur. All JSY payments are being made in cash across the state. It was reported that efforts are underway to address this issue.

- **Child Health:** To strengthen the quality of health, the state needs to take certain steps. Some of the issues identified during the discussions and visits are detailed below.



SNCU at District Nadia in need of better management

- **Facility Based Newborn Care:** New born corners are in the process of being set-up in all labour rooms but all the equipments were not in place. SNCU was under construction in Dakshin Dinajpur. In Nadia, the well functioning SNCU is also admitting very low birth weight newborns and providing quality care. However

the bed turnover rate is slow because of these newborns requiring long period stays. The bed strength at the SNCU may be increased. Simultaneously the paediatric ward quality should be improved so that all sick newborns get good quality of care. In Nadia, another important issue that needs to be addressed was Lack of AMC for SNCU equipment.

- **IMNCI** - The ANMs are trained on IMNCI in Dakshin Dinajpur however implementation needs to be strengthened. In Nadia, IMNCI is yet to roll-out. ORS and Zinc availability and use was found at BPHCs and SCs in both the districts. However, Vitamin A was in short supply in both the districts.
- **Breastfeeding** - Early initiation of breast feeding is being practiced for both normal and C-section deliveries. Interactions with women in the postnatal ward and in the community showed high levels of awareness of the importance of immediate breastfeeding. However, SNs need to play a more proactive role in preparing women for breastfeeding and teaching them about proper attachment and hygiene issues.
- **Home-based Newborn Care** – At the SC level, it was observed that home visits for the new born are being done by ASHA and she is incentivized for each visit. The training of ASHAs on HBNC needs to be completed on priority. Home visits by the ANM to provide newborn care however needs strengthening.

- **RCH Plus Camps** – The state has a concept of weekly RCH plus camps. This is an effort to improve access of primary health care and extending the reach of RCH, Immunization, Family Welfare and Clinical Services to larger population from the SC. These health camps are conducted on a fixed day and fixed time each week in all Gram Panchayat Head Quarter SCs throughout the State, where there are no PHCs/BPHCs for providing preventive and promotive services. Records of these camps were available at the SC but it was seen that general OPD services have a higher uptake than RCH services. The state may want to consider effective IEC for these camps to promote them for RCH service delivery.
- **Family Planning** – The family planning programme is being implemented in the state at both training and service delivery levels. Spacing methods are being promoted and offered at all facilities. Condoms and OCPs are being distributed by the ASHAs and proper records are being maintained. The PFP ToT has been facilitated in the state and the focus on the implementation of the same needs to be ensured.

ANMs are proficient in inserting IUDs and records of IUD insertions were verified during the field visits. As regards minilap and NSV, Doctors have been trained in Dakshin Dinajpur but training is still pending in Nadia. Standards for Laparoscopic Ligation Camps are being adhered to. QACs are active and sterilization failures are being investigated. It was also noticed that the performance in NSV is going down which needs to be looked into.

FP services are primarily being offered in the public sector and there is no private sector participation. Another issue that needs to be addressed is that MTP is being clubbed with adoption of a method of family planning.

- **Immunisation and Cold Chain:** Immunisation coverage in both the districts was more than 80%. Records of immunisation at the PP Unit as well as the SCs were found to be in order. Effective tracking of pregnant women and children upto 5 years of age is being done and tickler bags were being maintained.

Cold Chain needs to be strengthened. In Dakshin Dinajpur, thermometers and voltage stabilisers need to be made universally available and additional cold chain points may be considered as per need to strengthen the distribution network. DH and high load facilities should be conducting immunisation sessions daily.

At a BPHC in Nadia, open and partially used vaccine including measles vials were found in the cold chain and were being send back for next immunization session violating guidelines and increasing possibility of serious AEFIs. Further, new supply of cold chain equipments was still awaiting installation.



**Partially used vaccines stored in cold chain in Nadia**

- **Training** – RCH trainings are being coordinated by the ADHS Training in the Directorate with support from a consultant for training. A comprehensive training plan for all the trainings listed below has been prepared and is being followed.

S.No	Thematic Area	Trainings
1	Maternal Health	CEmOC, BeMOC, LSCS, BSU, CAC, SBA and MDR
2	Child Health	IMNCI, Immunization, NSSK, SNCU
3	Family Planning	IUCD, NSV, Minilap and contraceptive updates
4	Immunization	Cold chain

5	Adolescent Health	MO and ANM/LHV/GNM
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The training division is working in close collaboration with NGOs for some of the trainings including PPIUCD with Jhpiego, CAC with Ipas, SBA with SoMI. The state has taken the initiative of ensuring involvement of nursing tutors and staff nurses for ensuring quality in SBA training.

Some of the issues that need to be addressed are –

1. *Selection of Trainees and Posting* – Connect needs to be established between the selection of trainees and their deputation at facilities where the skills can be utilized needs to be ensured
2. Irrational deployment of trained professionals – The posting of trained providers must be in sync with the skills
3. Motivation Issues – Low levels of motivation results in inadequate utilization of skills acquired during training. This is especially the case in LSAS and CEmOC training. A need for refresher training is felt.
4. Quality Monitoring of training- A mechanism for monitoring the quality of trainings in the state is being devised. This needs to be implemented soon.

The role of the SIHFW is not very well defined. The SIHFW is involved in facilitating the ToT for SBA, IUCD, PPIUCD as regards RCH. For other public health issues, they facilitate the training on diarrhoea, leprosy and vector borne diseases. Some of the other trainings conducted by them include induction and management training. Their role in the monitoring of training quality needs to be strengthened.

- **Adolescent Health** – The state has been implementing the ARSH programme for the past 3 years. An Additional Director of Health Services is given the charge for the programme. To support the AD, a dedicated consultant for ARSH has also been appointed at the state level. Anwasha clinics (Anwasha means search for new) have been established at all DH, SDH and BPHC. Lady Counsellors have been



**Records being maintained at Anwasha Clinic**

trained on a specially designed module and posted at the Anwasha clinics. ARSH

training for Medical Officers has been initiated in the state. The training calendar for 2011-12 includes ARSH training for MO as well as GNM. The key issues for the programme as seen during the field visits are as below -

- Anwasha clinics are established and functional at the DH, SDH and majority of the BPHCs.
- Dedicated space has been allocated in most of the facilities and a trained counsellor is in position. However, the services were found to be extremely clinical in nature (ANC, RTI/STI etc) and not catering to the counselling needs of adolescents including psycho-social and behavioural issues.
- Records are being maintained but the service delivery needs to be strengthened.
- A provision for GNM in the Anwasha clinic has been planned but this is not required looking at the caseloads and the types of services being offered
- The linkage with the Medical Officer in OPD for clinical services for adolescents is well established and needs to be further strengthened.

- The state is planning to recruit male counsellors for the clinics which is a good idea
  - There is no BCC strategy or even stand alone IEC material for adolescents.
  - Contraceptives were not readily available at the Anwasha clinic which is a big limitation.
  - To strengthen the programme, the state has taken the initiative of involving 3 medical colleges for ARSH of which 1 is being established as a Centre of excellence.
  - Linkage with ICTC and Suraksha clinic was good. This must be leveraged further to strengthen the ARSH programme.
- **ICTC** - ICTCs were found to be well established and functional in Dakshin Dinajpur and in Nadia. In Dakshin Dinajpur, records were available to show effective management of positive delivery cases. PPEs were available. Link ART was functional at the DH. Referral of ART cases from other ICTCs in the district was also being done to DH or the ART centre in Malda. Early Infant Diagnosis has been rolled-out and Cotrimoxazole prophylaxis for exposed babies was being done.



**Mother's meeting called by AWW and attended by ANM, ASHA and BPHN**

anemia among adolescent girls and pregnant women in the state.

- **Village Health and Nutrition Day (VHND)** – This is still in a nascent stage in the state. The state needs to strengthen this and ensure effective utilization of services. During the field visits, it was observed that the infrastructure at AWC is not conducive for conducting ANCs. Further, the counseling component in the VHND is weak and needs strengthening. Nutrition counseling needs to be given specific focus owing to the high prevalence of malnutrition among children and

It was observed that VHND happens on certain Wednesdays at the village and on certain Wednesdays at the SC. In the weeks when the SC is open on Wednesday, VHND in the outreach happens either on a Tuesday or Thursday. This was reported to be confusing for women at the village level. The state may want to simplify this process and ensure that the work time ratio for ANMs is adequately utilized.

- **HMIS** - The state has ensured that there is only one system of reporting and that is through the HMIS. This is a step in the right direction to avoid duplication and streamlining the reporting process across all levels.
  - The state is using HMIS data to review the progress and monitor the programme
  - HMIS data being used periodically at the block level for review in MIES meetings
  - In both the districts visited, HMIS data entry and data verification process was in place. Data quality verifications is being done at the block and district level.
  - Reports are being uploaded in a timely manner
  - Role of BPHN in data validation is appreciable
  - Record keeping – The quality of records at the Sub-Centre was found to be of good quality. However, approximately 38 registers are being maintained by the ANMs at Dakshin Dinajpur which needs to be reviewed and reduced

- **Mother and Child Tracking Systems (MCTS)** – The MCTS registers were found to be in place and updated at the SCs visited. The data for MCTS is uploaded at the block level and this is being ensured periodically.
- **Referral Transport** – The state has a referral transport mechanism called Matri Yan for pregnant women and sick newborns. Matri Yans are available at the DH, SDH and block. Information about the free referral transport was evident among women in the postnatal wards and in the community. This is a cost effective means of referral transport where vehicles have been involved for this service and calls are managed through a call centre at the district level. The incentive for transportation has now been suspended and only the referral transport mechanism is being used. However, it was felt that the state needs to relook at the scheme and increase the number of vehicles to improve the access to services. In cases where transportation has to be ensured from village to facility, many women are unable to avail this facility. It was also observed that clients prefer to go to higher facilities like SDH or DH while the referral transport is meant to be used to the nearest delivery point. The BPHC is most often being bypassed.
- **Gender and PC-PNDT** – To ensure gender sensitive services, privacy and confidentiality for female clients is being ensured even at the sub-centre level. In Dakshin Dinajpur, attached toilets with labour room and maternity wards were in place and clean. However, in Nadia, the DH labour room also did not have a toilet. The privacy of women in labour was highly compromised. There was no waiting room and over 60 pregnant women were found waiting outside the labour room for their turn. Contraceptives especially ECPs were available at all service points.

As regards implementation of PC-PNDT, the following observations were made during the field visits

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- The PC-PNDT committees at the district level were found to be place. However action taken needs to be strengthened
  - No mass media activities observed on save the girl child
  - In Dakshin Dinajpur, there are a total of 9 machines of which 7 are in private and 2 at the DH. There is no portable machine in the district. F Forms are being maintained.
  - In Nadia there are 152 machines of which 92 portable. District inspection and monitoring committee meeting reports were available – Only 2 visits have been done since April. No complaints lodged and no prosecutions.
- **Nursing Training School** – The state is effectively utilising the skills of nursing professions and investing in their capacity building. This came up in the discussions at the state level as well as during the field visits. The nursing school attached with the District Hospital in Dakshin Dinajpur is not only executing ANM and GNM courses but is also coordinating the SBA training. They have a functional nutrition lab, skill training lab and well equipped library. The tutors were also active and well informed. It was encouraging to see effective utilisation of the nursing school, tutors and facility based nursing professionals.



**Well equipped demonstration lab at Nursing School**

### 3. KEY ISSUES

### 3.1 **State**

- Coordination between the DHS and SFWB regarding of posting of personnel based on their skill is lacking
- Accreditation of Private Health facilities for RCH services is weak
- A focused approach for implementing IEC/BCC activities is missing.
- Sanctioned posts for service providers are not as per current requirement vis-à-vis the case load of respective facilities and were done way back in 1980 since when the population of the state has increased substantially.
- Physical infrastructure is inadequate vis-à-vis the huge demand and utilization of the services across all levels.
- Service doctors who have given an undertaking for non-practicing and drawing non-practicing allowance were found to be practicing.
- System for rewards and recognition is not in place which leads to demotivation.
- There is no mechanism at present for payment of JSY beneficiaries through cheque.
- State needs to streamline the guidelines for procurement so that the officials may carry their functioning smoothly.
- Significant unspent balance in certain activities as a result of activity wise release of funds
- Lack of Monitoring of unspent balances
- Procurement Guidelines were not clear for procuring items under CMS Approved rates and vendors
- No TDS is deducted on payments to Contractual Officers/Staffs at District/Block and also on payments to Contractors/ Suppliers (Like payments to Matri Yan Vehicle Owners)
- Fixed asset register are not available at the facility
- Utilisation of Funds:
  - ▶ **Approved Activities** – Although funds are released for approved activity but many of the activities are not being undertaken and consequently huge chunk of the funds remain unspent.
  - ▶ Funds meant for Untied Funds of PHCs/ CHCs and SCs is not released because apparently huge unspent balances are available with the facilities.
- There are delays in transportation of pregnant women to facilities due to shortage of Matri Yan vehicles at high delivery load facilities particularly DH and SDH.
- Facilities with high delivery load and Pediatric OPD are not practicing daily immunisation.

### 3.2 **District**

- Utilization of Untied Funds by ANMs is low.
- Rational deployment of human resources based on case load at the respective facilities is not being practiced.
- Most of the cases are coming directly to the tertiary level hospitals, this is leading to unmanageable level of case load.
- Matri Yan network is present and call centres have been established at the district. Still delays due to shortage of vehicles and vehicles not reaching the beneficiary in time were observed.
- The pace of operationalization of BPHC and PHC to offer EmOC services is slow.
- District MTP Committees have not been constituted yet.
- Accommodation/ Quarters for Staff are in very poor shape.

### 3.3 **Facility**

- High proportion of Maternal Deaths due to Eclampsia.

- PHCs and BPHCs are not being adequately utilized for conducting institutional deliveries. This is resulting in over crowding at tertiary facilities.
- Records have shown that the number of MTPs in facilities is low even while the number of deliveries are increasing steadily.
- Daily immunization is not happening at some of the facilities including DH. As a result, newborns are not being given the mandatory vaccines at birth
- ANMs were seen to be maintaining more than 30 registers.
- Cold chain maintenance is poor.
- Contraceptives are not readily available at the Anwasha clinics.

#### **4. RECOMMENDATIONS**

- Additional posts need to be sanctioned for all categories of human resource at all levels in line with the increase in caseloads, population as per census 2011; further the existing HR need to be rationally deployed.
- State may consider appointing a Chartered Accountant as State Accounts Manager.
- Supportive supervision system should be implemented at all levels to ensure quality of care as well as increase capacity and motivation level of staff through constructive feedback and handholding support.
- System for rewards and recognition should be put in place for increased motivation among MOs and Paramedical staff.
- Operationalisation of delivery points in addition to DH and SDH needs to be done on priority. To ensure decongestion at tertiary facilities, state needs to ensure that additional delivery points as per the name wise list of delivery point sent to GOI, are made functional.
- The state should consider infrastructure upgradation in terms of facilities and equipments at all levels given the huge demand for services on an urgent basis.
- At present only Staff Nurses are being trained as SBAs in the state. To address the high percentage of home deliveries and ensure skilled attendance at birth, the state may consider training ANMs as well as SBAs.
- State may look into developing mechanism for payment of JSY beneficiaries through cheque.
- The state and district BCC/IEC cell need to be strengthened and plans for comprehensive BCC/IEC activities for all programmes highlighting government key initiatives ( i.e. JSSK, JSY, Compensation Scheme of sterilisation, FP Insurance scheme, Matri Yan etc) and service availability at all levels needs to be undertaken.
- MDR needs to be strengthened. This will also help identify causes for maternal deaths like high percentage of eclampsia related maternal deaths.
- Matri Yan is a good cost effective referral transport system. The state needs to strengthen the same by including more Matri Yan vehicles at high delivery load facilities particularly DH and SDH to avert delays.
- Release of funds from the State to the district for all activities should be simultaneous.
- State may plan orientation for ANMs on proper utilisation of untied funds to improve utilisation so as to increase their spending and reduce the level of unspent balances.
- District MTP committees need to be constituted and made functional. Medical Abortion drugs should be made available
- In terms of financial management, the state may consider the following issues
  - Streamline procurement guidelines for district and blocks.
  - Orient Blocks and Sub-Centre in charge for maximum utilisation of funds.
  - Maintain regularly ledgers also along with Cash Book.
  - Remarks of the auditors for earlier years with regard to differences in opening balances be taken up on priority for their adjustments.

## District Facility Visit Report – Nadia

### District Hospital Nadia

- The 495 bedded District hospital is located in a 75 year old building and is catering to a population 53 lakh. It has an average OPD load of about 20000/Month.
- There are a total of 49 full time doctors, including 3 paediatricians and 7 gynaecologists ( 3 MD and 4 Diploma) 4 anaesthetists, 4 surgeons, and 2 orthopedicians. There are 188 Nursing staff. The daily OPD attendance is about 800 per day. The hospital collects about Rs. One Lakh per month from user charges.
- The hospital is operational in two different buildings, one holding the maternity unit while the second caters to rest of the services. One superintendent manages both the institutions. There are seven residential accommodations for doctors
- The maternity unit is a 95 bedded hospital catering to more than 1100 deliveries per month. During peak season the bed occupancy goes to more than 400%
- During 2010-11, there were 13454 deliveries of which with nearly 50% caesarean section.
- Duration of postnatal stay in facility is 48 hours despite high caseloads.
- The labour room has a high delivery load. During the visit there were more than 60 pregnant mothers waiting for the turn to deliver. Similar queue of more than 5 pregnant mothers was seen waiting for their turn to undergo caesarean section. Each caesarean section cost an out of pocket expenditure of Rs 1000-1200 for drugs and consumables which were not available in the hospital supply. Labour room is grossly inadequate with 3 tables, no privacy and attached toilet facility.
- With excessive patient load there is no scope of monitoring for a normal delivery resulting into a caesarean section even without clear indications.
- The maternity ward was divided on ground floor and first floor and all CS patients were transferred to 1st floor after 3 days of surgery.
- With rampant private practice within the district, many patients were sent to private hospitals for delivery.
- The Sick Newborn Care Unit (SNCU) was established in 2008 and is the 10 bedded unit. There are 4 doctors and 10 staff nurse posted and is functioning well. With better survival rates, the enthusiastic unit has started admitting children with less than 1000 grams in SNCU. This has lead to increased duration of stay for each baby, thus leading to a bed shortage for admission of over 1800 gram children. There is no AMC for SNCU equipments.
- There is one PP unit with a Doctor, PHN and a GNM but it hardly functional.
- Even with 35 deliveries every day and heavy Pediatric OPD, immunization services are provided only on two days in a week. This is a missed opportunity with large number of children missing birth dose even after institutional delivery.
- Payment of JSY was long pending and long queue of people was observed waiting for the payment to be made.
- HMIS data is being uploaded on monthly basis on portal.
- Records and registers were available.
- Family Planning Performance is poor.
- Hospital waste management was very poor.

### DPMU and Blocks

DPMU is functioning with four consultants i.e. District Programme Co-coordinator, District Accounts Manager, District Data Statistical Manager & Computer Assistant. In addition to this District Health Society is managed by 3 RCH Officers called Dy. CMHO for RCH, 2 Dy. CMHO for Public Health

Programmes, 1 DTO for RNTCP, 1 District Leprosy Officer and there is one Engg. Section having 1 Asstt. Engineer and 2 Subordinate AE who looks after the civil construction work.

As regards the availability of infrastructure and logistic for DPMU - Desk Top computers, Internet connection, Printer, Scanner, Fax and for movement arrangement of vehicles are available for DPMU Staff.

At District there are 4 Bank Accounts – RCH (Sub Samiti Account), Main samiti Account for NRHM, Sub-Samiti Account for Public Health Programmes and one for RKS Funds. All bank accounts are under Joint Operation. All Blocks are having one Bank Account for all the programme activities and one Bank Account for RKS Funds. Maintaining a lesser number of bank account provides more control and effective utilization of funds. Account Books are being maintained in tally as well as manually also.

As regards the concurrent audit the auditor is yet to be appointed for the year 2011-12 and almost six months are expiring.

As per the visit of PHC, Blocks and SC following observations were made:

1. Each facility (except SC) was found maintaining proper cash book duly written up to date.
2. Books of accounts were duly tallied with FMR sent by them to their controlling unit.
3. Each Block was having Block Accounts Manager.
4. Bank Reconciliation is being made.
5. Payment to Medical Officers and other staffs on contractual basis are now being made through online bank transfer mode.

#### **SDH Ranaghat**

- This is a 171 bedded hospital with 26 medical doctors- 16 specialist, 4 performing specialist, 10 general duty.
- There are 55 Staff Nurses appointed to this hospital but a substantial number have been promoted as Ward Sister who just play a limited supervisory role only.
- There are 48 maternity beds and 3 tables in labour room with all emergency medicines.
- There are ~15 normal deliveries and 4-5 caesarean sections every day. All normal deliveries are conducted by staff nurses. There is no backlog for JSY payment.
- Although there are 5 gynaecologist, 3 anaesthetist and 2 surgeons in the hospital, still pregnant mothers are being referred to district hospital on trivial reasons.
- OT is under staffed and OT table in severe rotten condition which is hazardous to patient and doctor. OT lights are maintained by PWD and have only 60% of the required illumination which is grossly inadequate
- Although the hospital has a functional Blood bank, there is no MO in-charge in-pLakhe and the entire functioning is looked after by one technician on a 24 hours duty. There is a storage capacity of 1500 units and the monthly requirement is 200 units. Blood is collected through voluntary donations only and there is no exchange. There is no AMC for blood bank equipment such as centrifuge.
- It was informed that doctors avail NPA benefits and also do private practice.
- Though the delivery load is 350 per month yet the MTP load is only 2 indicating either referral to private facilities or forced to visit quacks leading to increased risk of maternal mortality. There are 15 USG machine in private facilities in the block and more than 20 facilities offering MTP. CMO and administration was not aware about the registration of facilities offering MTP in private hospitals.
- A SNCU has been planned and approved for this center

### **SDH Tehata**

- Caters to 3 lakh population. 68 beds, sanctioned for 100 beds. There are 13 MOs, out of which 3 are GDOs, 8 are specialists and 2 contracted by NRHM. There are 10 Nursing staff.
- 3 OT Rooms. In Labour Room Succession pump was not in the working condition.
- Acting as referral for 3 blocks-plaasipara, karimpur and theta II
- OPD 600 per day. Bed occupancy 120%.
- Delivery increasing may-123, 186, 196, 211: matri van is increasing – 2 van with 3-4 visit per day. There have been almost no Caesareans being done. CS is poor with only elective Caesarian Section being conducted on Wednesday.
- Data is uploaded on HIMS and MCTS on regular basis by DEO.
- 2 days training has been given to DEO for MCTS.

### **RH Bethuadahari**

- A 60 bedded hospital, labelled as FRU in the district, but Lakhks blood storage or linkage to a Blood bank. It has an OPD load of about 15000/month. It has an average OPD load of about 15000/Month.
- There are 8 doctors including 2 Gynaecologists and 1 Anaesthetist however there is no Paediatrician. There are 15 Nurses working in the hospital.
- There are 300-400 deliveries in a month (3636 in 2010-11) however CS is poor with only elective Caesarian Section being conducted on Monday and Saturday.
- The labour room is poorly maintained with non-functional radiant warmer and suction machine. No privacy at all in the labour room and also don't have an attached separate toilet.
- MO in-charge was not aware of entitlements under untied funds
- The hospital conducts 80-100 ligation operation per week and 60-70 cataract operations per month.
- There are no user charges at and below Rural Hospital in West Bengal. The institution uses the RKS fund for purchase of medicine which are not in supply from the District/State.
- Supportive supervision is Lakhking with unutilized mobility funds. All untied funds for lower level facilities are kept at Block level.

### **BPHC Pratimamahi**

- Caters to 1.56 lakh population. This is a 30 bedded hospital with 6 GDMOs and 9 Staff Nurses and no specialist. The hospital caters to a population of 1, 56,000 and has a OPD of 500 per day. There are 18 sub-centers under this BPHC.
- Residential quarters for all the doctors have been provided and are being utilized.
- The hospital conducts nearly 1500 deliveries per day with 1457 delivery in 2010-11 and 167 deliveries in August 2011 and is showing an increasing trend
- Facility-wise data is uploaded from this BPHC for the lower units.
- There are 2 ILR and 2 DF at the BPHC which store vaccine for further supply to the sub-centers during scheduled activity. In addition, 1 ILR supplied to the hospital is lying unpacked at the facility. During the visit, partially used vaccine vials were found inside the ILR and it was informed that they have been stored to be re-supplied in the next immunization session. This finding was totally in contrast to the national guidelines and a serious lapse in administrative supervision breeding ground for serious AEFI reaction. There were only two voltage stabilizers connected to two units while the other two units were operating on direct current. None of the Medical officers including MO in-charge were trained on immunization.
- There is an Adolescent friendly 'ANVESHYA clinic' being operated in the hospital with support of a lady Counsellor and a GNM (post vacant). The counsellor visits various high schools for health education and counsels 60-70 adolescent per month in her clinic. The room provided

is small and is shared with ICTC counsellor and Laboratory technician I, with little privacy. The clinic promotes linkages with the HIV/AIDS program through ICTC. There were no standard reporting formants available at the adolescent clinic.

- Since no major surgeries are being performed, the Operation theatre has been converted to conduct mini-lap operations. 1200 mini-lap operations were performed during 2010-11.

#### **PHC Debogram**

- Caters to 50,000 population. This is 10 bedded hospital catering to operation of 50,000. There are two medical officers and 4 staff nurse. Residential accommodation is provided for all the staff.
- The hospital is located in a newly constructed building and has good infrastructure.
- There is an OPD of 400 patients daily. Most of the patients admitted in ward are for daycare. There is one staff nurse night duty everyday for any emergency situation.
- The hospital conducts 25-35 normal deliveries each month and this number is steadily increasing. One major reason sited for the increase in hospital every is the availability of Matri van. During August 2011, 38 deliveries were conducted while last year there were only 59 deliveries during the entire year.
- The delivery room is of adequate size with three delivery tables however privacy was lacking. JSY payment is being done on fixed day in a week. The new born corner was not adequate.
- There was no IEC/BCC material displayed within or outside the hospital. Since this was a new building the in charge informed that all wall paintings activity is pending.
- MO in-charge not aware of entitlements of untied grants, AMG or RKS.
- Monthly HMIS report submitted from the facility to the block for uploading however no copy of previous month reports was available at the hospital.

#### **SC-Bethuadahari**

- This SC is located adjoining to RH Bethuadahari with one ANM in position. The ANM had good knowledge about functioning of SC and her role and responsibility.
- ANM is trained in IUD insertion and is also conducting follow up of IUD insertion. She reports that 25% women come back for IUD withdrawal following insertion.
- Adequate stock of all contraceptives was available and demand for all family planning methods was high. Separate table for IUD insertion and IUD kit was available and sterilization
- JSY payment of Rs 500 on completion of 3 ANC was being made on one fixed day in a week.
- Records and registers were available including MCTS register.

#### **SC Chadik Nagar**

- This SC caters to a population of 13450 and has 2 ANM and one male assistant in place and also has 10 ASHAs. The SC is located in a self owned premise and had good visibility and IEC displayed. No deliveries are taking place in this sub-centre.
- Both ANMs were well knowledgeable and had their geographical areas defined. The male Assistant helps in other public health programme, makes slides and aids in investigating an epidemic.
- JSY payment after 3 ANC is distributed on Friday only, leading to some backlog. This year no AMC grant has been released to this SC due to balance amount available with the SC.
- ANM was well aware about the use of tickler bags and was using it track missed children.
- MCTS registers are maintained.
- ASHA meeting
  - ASHAs are intelligent and articulate, education upto secondary school or higher and were appointed in Janaury 2011.

- All were well aware about their roles and responsibility and have been trained upto 5<sup>th</sup> module. They have a schedule of their activities well planned in advance.
- AASHA were de-motivated due to withdrawal of package scheme and have represented to WB government. Each ASHA was earning an average of Rs 800 per month
- There is a good coordination between the AWW and ASHA however they complained that Nurses at hospital do not accept ASHA and ask to leave. There are regular meetings at Anganwari or SC.
- PC-PNDT Act awareness is also there among the ASHAs.

#### **SC Sorapganj**

- There are 3 Villages under this SC, catering to a population of about 8500 and 1700 households.
- There is one ANM working and one Male Health Worker in place. The ASHAs have been appointed but not yet in place.
- The appointed Male Health Worker are not aware of VHNDs.
- Knowledge & confidence of ANM was satisfactory.
- JSY Payments are delayed and paid only on Fridays.
- Lots of stock are there of IFA Tablets and Mala-N which is going to expire in September 2011.
- The ANM is maintaining the required registers. MCTS registers are maintained and monthly reports send are being sent to BPHC for uploading.
- IUD insertion done & equipment are sterilized by boiling at SC.
- No deliveries happen in the SC.

## District Facility Report – Dakshin Dinajpur

### District Hospital Balurghat

#### Key observations:

- It is a 300 bedded hospital with a delivery load of nearly 3000 deliveries in 2010 out of which nearly 911 were C-section in the year 2010.
- Good OPD and IPD Attendance
- New Borns were weighed and also given zero polio and BCG at birth
- JSY payments are being given by cash at the time of discharge.
- In terms of HR and infrastructure, the District Hospital holds good strength.
- HR Position- 4 OBG, 4- Pediatrician, 128 SNs
- Diagnostic Facilities including Blood Storage unit are functional in the facility
- HIV Screening including Testing for all clients including PW is available through the well established ICTC.
- Most of the SNs conducting deliveries are SBA Trained.
- The records at the LR are well maintained with details of Normal, Breech, C-sections properly recorded.
- The District Hospital has a dedicated vehicle under the Matri Yan Yojana which is available for free transportation of PW to and from the facility.
- Provision of free diet for the PW available at the facility both for Normal deliveries for 3 days and C-section for 7 days
- All the Technical Protocols for care during delivery and child birth as per GOI norms were displayed prominently in the LR.
- The LR had the clean and functional toilets attached
- RKS Funds are been utilized for purchase of new-born kit which included 2 towels, 1 dress for the baby with cap, wrap, and plastic mackintosh.
- Random checks with the SNs on the knowledge on these protocols were checked from the SNs and they were knowing the technical protocols on AMTSL, Eclampsia etc
- Adequate supplies of essential drugs, consumables including emergency tray and new born corner were found to be as per protocol
- The average stay post normal delivery is 24-48 hrs
- Delivered women is not discharged without BCG and 1st OPV for the child
- MCP Card are maintained and Immunization Register are found to be updated post-natal ward confirmed initiation of breast feeding within 30 min-1 hr after normal delivery and immediately after regaining consciousness after C-section.
- FP Counselling is provided to the client at the time of discharge by the staff in the PP unit
- No out of pocket expenditure for PW
- Simplified Partographs are being maintained by Staff Nurses
- Revised MCH Card is been implemented
- Bio-Medical Waste Management as per GOI norms in been practiced in the LR and OT
- A new LR and 20 bedded SNCU are in the process of being made functional by Oct 2011.
- The District has a well maintained functional WIC as a storage centre for vaccines for catering to the district requirements
- The cold chain equipments were maintained as per the standard guidelines with a separate stabilizers for all the equipments including Deep freezers and ILRs with temperature charting and defrosting being done on regular basis

- The Staff has correct knowledge about the best practices of immunization and techniques.
- Bio-Safety Management Protocols were being followed.
- A well maintained Procurement system for RCH drugs
- Individual drug stock position maintained through Bin Card
- Centralized Inventory Control Management for drugs
- Norms for PC-PNDT has been adhered too

### **ANM/GNM Training Centre**

- Functional Nursing training school within the District Hospital Campus
- Training institute has capacity for a batch of 20 ANMs, 40 GNMs and 100 ANMs for the 2nd ANM programme funded by NRHM.
- All 3 courses are currently underway at the training institute and are running successfully.
- There is a shortage of tutors in the institute.
- Nursing school has a well equipped demonstration with simulators and well maintained library
- The faculty is also coordinating the SBA Training Program for the District. This nursing school provides ANMs and GNMs for 3 districts Malda, North and South Dinajpur
- The nursing tutors are facilitating the theory classes as well as demonstrations in clinical including conducting deliveries.

### **SDH Gangarampur**

- OPD-19030; Delivery Load-5085 in 2010-11, Expected nearly 7000 deliveries in 2011-12, % C-Section nearly 12%, Maternal Deaths-360, Lab tests-41885, Referred in 831, Referred Out -3271
- The facility showed a consistently high facility load in terms of bed occupancy rate higher than 100% in 2010-11. This is due to IPD patient pressure is very high, maximum referred in patient because of the facility being centrally located in District Dakshin Dinajpur. Bed Capacity needs augmentation by creating separate building.
- The facility showed an increasing trend on delivery load and the deliveries are expected to rise to more than 7000 in 2011-12. Despite an increasing trend it was observed that the safe abortion services were not being provided or being availed. This is especially important in the knowledge of the fact that 8% of the causes of maternal mortality in India is abortion and provision of safe abortion services may go a long way in reducing the deaths due to the same.
- The Infrastructure of SDH Gangarampur, however there is a need for construction of SNCUs at a faster pace.
- Labour Room had high load of deliveries and the SBA Trained SNs are practicing Labour Rooms protocols.
- Joint MCP card was available however Safe Motherhood booklet is not been disseminated to the facilities
- Interaction with mothers in the postnatal ward highlighted that immediate breastfeeding is taking place but SNs need to play a more proactive role in teaching mothers proper attachment and feeding procedure.
- It was also learnt that most women had an out-of-pocket expenditure in the range of Rs. 500 to Rs. 3000 for purchase of gloves, suture thread, medicines like vitamin syrup etc.
- Well equipped OT for Orthopedic and Surgical procedures in facility
- Fumigation is carried out regularly for disinfection
- Electricity Back-up was available 24x7
- Timely JSY payments, however payments are made in cash throughout WB

- Records were maintained properly, however there is a space crunch for keeping proper and systematic records. Record Section needs to be created urgently for proper and systematic keeping of records.
- There is also a need for a semi-auto analyzer at SDH seeing the caseload and the need to carry out biochemistry as well as hematological tests.
- Centralized Sterilization Unit is being used as a Drug Store. So a well planned and model store is required for proper maintenance of drugs supplies and consumables.
- Staff quarters are in a dilapidated condition. Needs renovation on priority
- Rational Deployment of manpower and equipments needs to be done at SDH seeing the caseload it is catering too.

### **Anvesha Clinic**

- DH has a dedicated ARSH Clinic called Anvesha Clinic. The clinic is operated daily by a trained counsellor between 9.00 AM to 2.00 PM. However, the case load is very low, approx 5 cases per day, even though there is a dedicated room for the clinic there is no proper signage, IEC Material or contraceptive available at the clinic
- There are no outreach or demand generation activities for adolescents in the districts or from the clinics.
- There are no linkages with the School Health Programme.
- Anvesha Clinic is presently fn as a extension of the ANC Clinic and has only a clinical focus and there is no male clients at the clinic.
- Monthly reporting to the State is being ensured

### **Challenges**

- MTP services needs to be ensured by the District Hospital. At present no MTP services are being provided.
- Post Partum FP Services needs to be strengthened.
- District Hospital has a Blood Storage Unit. Ideally it should have a BB
- JSY disbursements needs to be regularized and not paid in cash
- Role of ASHA need s to be strengthened to ensure increase in the Institutional delivery
- At present most clients are coming on their own. ASHAs were no where to be seen.

### **Block PHC Kumarganj**

#### **Strengths**

- It is a 30 bedded BeMOC Facility with a delivery load of nearly 100 deliveries per month. It was encouraging that out of nearly 300 deliveries in the last quarter, 130 deliveries were conducted between 8.00 AM to 8.00 PM. This implies that PHC is functioning as 24X7 PHCs.
- Protocols for Care during pregnancy and Child Birth were being followed and quality protocol posters were displayed at the labour room
- Referral Transport System is in place through 102 Matri Yan.
- SC/PP unit is attached to the Block PHC. Immunization and maintenance of MCP Cards is ensured from here
- ICTC and Anvesha Clinic are functional in the BPHC
- Motivated and trained staff 9 SBA Trained SNs including 6 MOs and Facilitating conduction of deliveries

## Challenges

- The system of recording complications, in and out referral and deaths including maternal and infant deaths needs to be strengthened.
- While The BPHN has been trained on verbal autopsy but needs support and hand holding
- There is no certified CAC Care provider. This needs to be addressed on PRIORITY.
- Partographs needs to be maintained for all clients
- Infection prevention norms need to be strengthened including disposal of used needles and syringes and bio medical waste management.
- Monthly Meeting of ASHA are not being facilitated at the Block PHC
- JSY payments to the beneficiary are being paid in cash
- Accommodation for Staff Quarters is in shambles. Block PHC building also needs minor civil work for its upkeep
- Only in-referred clients at the ICTC and Anvesha Clinics. No walk-ins
- Outreach from the Anvesha Clinic has been stopped following a recent meeting at the district level.

## SC Bishnupur

### Strengths

- Bishnupur SC comes under Tapan Block PHC. No deliveries at the SC
- Staff comprises of 2 ANMs
- The Infrastructure of the sub-center was good even though no deliveries are conducted in any of the SCs in Dakshin Dinajpur, but adequate privacy was maintained
- SC Untied fund was utilized for notice board, drugs, painting the facility
- 1 ANM was posted at the Sub-Centre who was SBA trained and 2<sup>nd</sup> ANM conducted out-reach activities and ANCs.
- No system for SCs waste management. Used Needles and syringes were kept in a store room attached to SC; however SC premises were apparently clean
- There were enough stock of FP consumables like condoms, OCPs available at the SC IFA Tablets and ORS were also available in sufficient quantity.
- Record Keeping was good. Eligible Couple register, MCTS Register, Due List, was properly maintained.
- VHND Plan was in place
- MCP Card was also available
- Routine Diagnostic Services were also available at SC

### Challenges

- IEC/ BCC need improvement. The posters displayed at SCs are old and should be replaced by new posters emphasizing key services and entitlements for beneficiary
- The ANM has to maintain at-least 30-40 different types of Register. This needs to be reduced by clubbing and rationalization of registers as far as possible.
- Convergence between ASHA, AWW and ANMs can further be improved for creating synergy and better implementation of requisite services.
- Referral Transport from the Village level to the Block PHC and above is weak and generally the pregnant women has to bear the cost of referral out of her own pocket. This needs strengthening.

## FINANCIAL MANAGEMENT – Paschim Banga

## State Level:

State's Financial Management is managed by FMG comprising Director (F&A) supported by support staff. Since inception the progress in terms of Allocation, Funds Released and Expenditure is outlined as under:

(Rs. in crore)

## RCH:

Year	Allocation	Releases	Expenditure	% of Expenditure
2005-06	95.13	59.83	3.97	7
2006-07	119.60	65.82	28.39	23
2007-08	117.88	71.10	73.14	44
2008-09	187.02	157.02	122.78	49
2009-10	198.32	197.94	146.63	45
2010-11	225.17	133.58	140.96	45
2011-12	247.97	177.82	22.68	NA
<b>TOTAL</b>	<b>1191.19</b>	<b>863.11</b>	<b>538.55</b>	<b>62</b>

## MISSION FLEXIBLE POOL:

Year	Allocation	Releases	Expenditure	% of Expenditure
2005-06	0	36.10	4.17	12
2006-07	109.03	115.71	18.36	12
2007-08	190.60	233.71	44.92	12
2008-09	160.77	160.77	180.13	38
2009-10	212.14	212.14	168.88	33
2010-11	249.72	187.29	365.46	69
2011-12	305.29	0	40.24	NA
<b>Total</b>	<b>1227.55</b>	<b>945.72</b>	<b>822.16</b>	<b>87</b>

## ROUTINE IMMUNISATION:

Year	Allocation	Releases	Expenditure	% of Expenditure
2005-06	11.28	9.72	1.52	16
2006-07	9.97	6.75	4.45	30
2007-08	9.50	5.37	5.53	35
2008-09	12.00	7.00	8.07	47
2009-10	15.07	11.10	9.12	45
2010-11	12.61	12.61	38.63	162

2011-12	12.58	0	9.56	NA
<b>Total</b>	<b>83.01</b>	<b>52.55</b>	<b>76.88</b>	<b>146</b>

**TOTAL:**

Year	Allocation	Releases	Expenditure	% of Expenditure
2005-06	106.41	105.65	9.66	9
2006-07	238.60	188.28	51.20	18
2007-08	317.98	310.18	123.59	23
2008-09	359.79	324.79	310.98	42
2009-10	425.53	421.18	324.63	38
2010-11	487.50	333.48	545.05	63
2011-12	565.84	177.82	72.48	NA
<b>Total</b>	<b>1935.81</b>	<b>1861.38</b>	<b>1437.59</b>	<b>77</b>

**Progress in utilization of Funds since inception:**

As per the table given above comments on utilization are outlined as under:

- Under RCH Activities % level of utilization has increased from 7% to 45%.
- Under Mission Flexible Pool % level of utilization has increased from 12% to 69 %.
- Under Routine Immunisation % level of utilization has increased from 16 % to 100%.
- Overall expenditure under RCH, Mission and Immunisation has increased from 18% to 63% till 2010-11.

**In the District visited following progress has been reported:**

**District Dakshin Dinajpur:**

Since 2005-06 till 2010-11 district was released Rs.1765.66 Lakhs under RCH Flexible Pool and reported expenditure of Rs.1238.82 Lakhs which is 70.16 %.

**District NADIA:**

Since 2005-06 till 2010-11 district was released Rs.3794.11 Lakhs under RCH Flexible Pool and reported expenditure of Rs.3120.30 Lakhs which is 82.24 %.

The data shows an appropriate level of expenditure in the districts.

**Progress in Accounting & Reporting:**

- At State and District accounting and reporting has improved as at each Block the team could notice that a proper cash book was maintained neatly and written up to date on manual basis in addition they are also maintaining on Tally ERP.9 customised version.
- Funds given down the line are now being treated as advances and only actual expenditures are being reported.
- Each Block is having a competent Block Accounts Manager who is maintaining proper books of accounts and reporting the expenditure on a regular basis.

**Progress in Internal Controls:**

- Since the start of concurrent audit in the state and district which covers blocks also the internal controls have improved as Bank accounts are being reconciled on regular basis, status of funds is being reconciled with bank pass book.
- More accountability and responsibility within the F&A Staffs.

**Progress in Audit issues:**

- Since the launch of open tender system for selection of annual statutory auditor and coverage of 40% blocks for audit the quality of audit and thus the true and fair view of the annual accounts has improved.

**Progress in Banking Arrangements:**

- With the introduction of e-banking solution under progress and funds being transfer online it has become more monitor able and fast transfer of funds. If e-banking solution becomes fully operational the monitoring of funds position and expenditure will be more effective.

**Key Findings****Good Practices/ Weaknesses:**

Since the inception of RCH-II/ NRHM in the year 2005-06 there is good improvement in the matter of accounting and reporting of expenditures. The level of funds utilization has increased. With the maintenance of a single Bank Account and one single cash book at Block level for all the programmes (RCH, Mission, Immunisation, PPIP and Other NDCPs) is appreciable as it gives a picture at one pLakhe and total funds available at each level. Only funds for RKS are being maintained in a separate bank account and cash book. With the pLakhement of Block Accounts Manager at Blocks level the systems has improved. With these remarks following weaknesses need to be addressed at appropriate levels:

State is releasing funds as per activity wise and getting reports accordingly. It was noted that during the year 2010-11: 48 times funds were released to districts and other implementing agencies as under:

1. RCH Outreach Camp
2. Pulse Polio Operating Costs
3. RI Strengthening Project
4. Ayushmati Scheme
5. JSY
6. Compensation for Sterilization
7. Referral Transport
8. Lady Counsellor
9. DEO – Adolescent Clinic
10. MTP Training
11. IUD Insertion Training
12. Skilled Birth Attendant
13. Community Incentive Scheme
14. Replicate Level II Sick New born Units

15. Minilap Training
16. Operationalise Sick New Born.

A review of the system of releasing funds activity-wise appears to be good in the sense that it gives a clear-cut demarcation for the district and blocks and getting report of utilization also becomes easier for every one. State/ district/ blocks may face difficulties in this system which are outlined as under:

1. There may be certain activities which may be left out to be released though the same are approved in the PIP by Govt. of India.
2. There are certain activities for which funds have been given in the last year but that if that particular activity is not approved this year and thus such funds remains unspent. Thus increasing the advance position at State and District level. An example of such items is Referral Transport the facts of which are given as under:

At NADIA District under activity for Referral Transport as on 31/3/2011 unspent balance was Rs.20.56 Lakhs. And at Dakshin Dinajpur it was Rs. 39.33 Lakhs against this NIL expenditure during the year 2011-12 has been reported by NADIA and by Dakshin Dinajpur Rs. 5.18 Lakhs thus still there is total unspent balance at these two districts is Rs.36.52 Lakhs.

3. Funds under various activities remain unspent for non-pick of that particular activity. Instances of such cases are as under:

District: NADIA

S. No.	Activity	Funds unspent as on 31.3.2011 (Bank & Advances)	Funds unspent as on 31.7.2011 (Bank & Advances) in Lakh Rs
1	Compensation for Sterilization	232.99	281.10
2	GP Based Mobile Health Camp	52.19	49.46
3	Remuneration of Staff Nurse	24.84	24.12
4	SBA Training under RCH-II	12.98	20.19

4. Officials and Staffs at Blocks are not able to spend such unspent balances for any other activities due to want of clear-cut guidelines and also due to remarks of the auditors not to divert the funds of one activity to other activity.
5. JSY is part of RCH Flexible Pool but due non-availability of funds under this activity payment to JSY beneficiaries are not being made due to shortage of funds under this activity. For example at Chakdinagar Sub Centre of Krishan Nagar-I Block of Nadia District there were 44 cases pending for payment of JSY since June, 2011.

Though the existing system may be easy to implementation and monitoring purposes even than State may re-think on the system of sending funds to Districts / Blocks etc. so that funds are not stuck up in activities and proper utilization of resources is made. At an appropriate time either in the m/o April may re looks and re-allocate all the available funds according to the priorities area or may start sending funds in a pool manner.

**Lack of knowledge / orientation / training of ANM for incurring expenditure at Sub-Centre:**

It is noticed that ANM are regular in maintaining their accounting records but reluctant in incurring expenditure on various items they can incur.

**Procurements:**

For items other than Central Medical Stores (CMS) approved rates and vendors procurements can be done for value less than Rs.20,000/- after getting three quotations and for Rs.20,000/- and above procurement has to be done through open tender system. For procurement of Drugs and equipments at Central Medical Stores (CMS) approved rates and vendors there are no clear cut guidelines at District and Block. It is therefore necessary to issue guidelines/ instructions along with funds being given for procurement for any drugs and equipments especially when it is for CMS approved rate and vendors.

As per the visit it was noticed that CMHO has powers up to Rs.50,000/- but for purchase of any equipments valuing more than Rs.50,000/- say for example 25 items each costing Rs.50,000/- he either has to issue 25 orders for each item for each block/ facility or issue a single order valuing more than Rs.50,000/- for all 25 items. So, State may either issue any specific instructions in this regard or raise the limit for procurement in such cases.

At Sub-Divisional Hospital Ranaghat, District Nadia it was noticed that one OT Table was completely damaged and even harmful to the patient and doctor both but Superintendent of the hospital even after getting approved in Samitte's meeting for procurement of new OT Table as per CMS approved rate is not able to procure due to financial powers only up to Rs.20,000/-. In such cases State may issue instructions in such a manner so that any emergency items can be procured on priority basis with prior approval of the competent authority like DM of the District.

**Audit findings in earlier years:**

As per the Audit Report for the year 2009-10 a major adjustment (impact of Rs.10 crore) in the audited opening balances, without any supporting documentation for the basis/ reasons for such adjustment and written it off from the audited opening balances. State has taken initiative to resolve this issue. It is again emphasized that state should prioritize in removing these issues by the auditor in the year 2010-11 with suitable clarifications / notes on accounts stating the nature of such differences and how the same has been dealt in the final accounts for the year 2010-11 so that Ministry can get reimbursed the expenditure from Development Partners for the year 2009-10 and 2010-11. It is also noted that the audit is being properly monitored on regular basis by State's F&A Officers in spite of this it should be ensured that audit report is submitted within 30<sup>th</sup> September, 2011.

**Deduction of Income Tax at Source:**

For making payments to consultants and suppliers Income Tax (TDS) at applicable rates has to be deducted. It was noticed that such TDS is being deducted at State Level but at District level it is not being deducted in all cases. Such cases noted are payments of Salary to DGMOs and other staff members and payments to suppliers of Drugs and Equipments etc.

**Other Comments:**

1. In some blocks Bank Account with State Bank not in use may be closed down.
2. Funds for Untied Fund for Sub-Centre of Rs. 10,000/- not released during the year 2011-12 in cases where there are already unspent balances lying out of earlier years. Since these are mandatory funds to be given every year the same may be released.
3. System of concurrent audit need to be done on regular basis without any interruption.
4. State should take action for rolling out the Accounting Hand Books circulated by the Ministry in the blocks in the State's local language.

**District Report - DD**

DISTRICT : D DNAJPUR	Total 2005-06 to 2010-11		% of Expenditure
	Grant Released	Expenditure Booked	
<b>Maternal Health</b>			
(a) JSY	62892098	43704462	69.49
(b) Others	34884970	22969526	65.84
<b>Child Health</b>	3442179	2439978	70.88
<b>Family Planning</b>			
(a) Sterilisation Compensation	22064766	12769577	57.87
(b) Others	671000	-57063	-8.50
<b>Adolescent Reproductive &amp; Sexual Health</b>	13000	13000	100.00
<b>Urban RCH</b>			
<b>Tribal RCH</b>			
<b>Innovations/PPP/NGO</b>	377000	113835	30.19
<b>Infrastructure and Human Resources</b>	3890000	2600294	66.85
<b>Institutional strengthening</b>	1841724	1083615	58.84
<b>Training</b>	6213474	3990618	64.23
<b>BCC/IEC</b>	383000	214919	56.11
<b>Procurement</b>	0	627086	
<b>Programme Management</b>	5655109	4163407	73.62
<b>Immunization</b>	33038985	29248895	88.53
<b>Total</b>	<b>17,65,66,305</b>	<b>12,38,82,149</b>	
<b>% of Expenditure</b>		<b>70.16</b>	

**Comments:**

1. Level of utilization of funds since 2005-06 i.e. 70.16% is good as compared to overall state utilization at 62%...
2. 100% Expenditure for ARSH is a concern, as how the exact amount is shown to have been incurred.

3. There is procurement of Rs.627086/- when there are no releases (as there is activity-wise) releases.
4. No releases and expenditure for Urban & Tribal RCH in the district.

District : NADIA	Total		% of Expenditure
	Grant Released	Expenditure Booked	
<b>Maternal Health</b>			
(a) JSY	123470625	116624599	94.46
(b) Others	59372301	48665232	81.97
<b>Child Health</b>	14105480	8739235	61.96
<b>Family Planning</b>			
(a) Sterilisation Compensation	66886680	43587458	65.17
(b) Others	945205	760110	80.42
<b>Adolescent Reproductive &amp; Sexual Health</b>	5440600	5422964	99.68
<b>Urban RCH</b>			
<b>Tribal RCH</b>			
<b>Innovations/PPP/NGO</b>	2880000	1743942	60.55
<b>Infrastructure and Human Resources</b>	12687892	8174682	64.43
<b>Institutional strengthening</b>	3880930	1859994	47.93
<b>Training</b>	12210892	8567807	70.17
<b>BCC/IEC</b>	762300	353851	46.42
<b>Procurement</b>	0	1716145	
<b>Programme Management</b>	9272604	7537109	81.28
<b>Immunization</b>	67495257	58277228	86.34
<b>Total</b>	<b>37,94,10,766</b>	<b>31,20,30,356</b>	
<b>% of Expenditure</b>		<b>82.24</b>	

**Comments:**

1. District funds utilization at 82.24% is good as compared to overall data of the state which 62%.
2. There is procurement of Rs.1716145/- when there are no releases (as there is activity-wise) releases.
3. No releases and expenditure for Urban & Tribal RCH in the district.

## **District NADIA:**

Facility-wise comments are as under:

### **DPMU and Blocks**

DPMU is functioning with four consultants i.e. District Programme Co-coordinator, District Accounts Manager, District Data Statistical Manager & Computer Assistant. In addition to this District Health Society is managed by 3 RCH Officers called Dy. CMHO for RCH, 2 Dy. CMHO for Public Health Programmes, 1 DTO for RNTCP, 1 District Leprosy Officer and there is one Engg. Section having 1 Asstt. Engineer and 2 Subordinate AE who looks after the civil construction work.

As regards the availability of infrastructure and logistic for DPMU - Desk Top computers, Internet connection, Printer, Scanner, Fax and for movement arrangement of vehicles are available for DPMU Staff.

At District there are 4 Bank Accounts – RCH (Sub Samiti Account), Main samiti Account for NRHM, Sub-Samiti Account for Public Health Programmes and one for RKS Funds. All bank accounts are under Joint Operation. All Blocks are having one Bank Account for all the programme activities and one Bank Account for RKS Funds. Maintaining a lesser number of bank account provides more control and effective utilization of funds. Account Books are being maintained in tally as well as manually also.

As regards the concurrent audit the auditor is yet to be appointed for the year 2011-12 and almost six months are expiring.

As per the visit of PHC, Blocks and SC following observations were made:

1. Each facility (except SC) was found maintaining proper cash book duly written up to date.
2. Books of accounts were duly tallied with FMR sent by them to their controlling unit.
3. Each Block was having Block Accounts Manager.
4. Bank Reconciliation is being made.
5. Payment to Medical Officers and other staffs on contractual basis are now being made through online bank transfer mode.