

Third

# Common Review Mission

State Report

## Haryana



# **NATIONAL RURAL HEALTH MISSION**

## **3<sup>rd</sup> Common Review Mission**

**4<sup>th</sup> November – 10<sup>th</sup> November 2009**

### **Haryana**

**Ministry of Health & Family Welfare  
Government of India**

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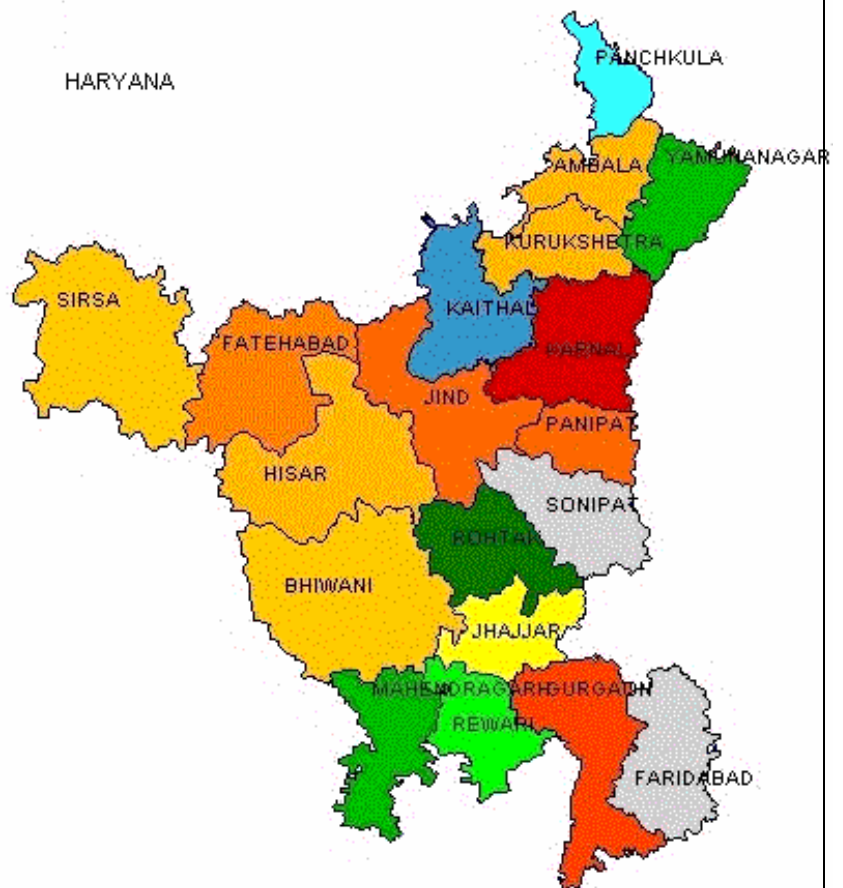
## State Profile

Haryana is located in north of the country, covering 44212 sq km area, representing 1.4% of total area of the country. Total population of state stands at 21144564 (2001 Census), which represents 2% of country's population, out of this 15029260 is rural (71%) and 6115304 is Urban (29%). Haryana has about 19.75% of Schedule Caste population, while the state has no tribal population. Male and female population of the State is 11363953 and 9780611 respectively, while the sex ratio is 861 (2001 Census). State has an overall literacy rate of 68.59%, while that for males is 79.25% and for females is 56.31%, respectively.

Administratively, Haryana is divided into 4 divisions, 21 districts, 48 sub-divisions, 119 blocks and 6955 villages.

### Administrative Set up

Area (Sq.Km.)	44212
Villages	6955
Towns	106
Blocks	119
Tehsils	67
Sub Tehsils	46
Divisions	4
Sub Divisions	48
Districts	21
Municipal Corporation	1



## Demographic Particulars (Census, 2001)

The total population of the State of Haryana according to Census 2001 is 21,144,564 persons. Haryana has shown a population growth of 28.06% between 1991-2001 as compared to 21.34 at the national average during the same period. The sex ratio (i.e. the number of females per thousand males) of population was recorded as 861 declining from 865 as at the 1991 Census. Total literacy rose to 68.59% from 55.85% in 1991 Census.

<b>Population :</b>
Persons : 21,144,564
Males : 11,327,658
Females : 9,755,331
Sex Ratio : 861
<b>Decadal Growth 1991 - 2001</b>
Persons : (+) 28.06 %
Males : (+) 28.32 %
Females : (+) 27.75 %
<b>Population (0 - 6 years):</b>
Persons : 3,259,080
Males : 1,790,758
Females : 1,468,322
Sex Ratio : 819
<b>Percentage of Population (0-6) to Total Population :</b>
Persons : 15.46 %
Males : 15.81 %
Females : 15.05 %
<b>Number of Literates :</b>
Persons : 12,225,036
Males : 7,558,443
Females : 4,666,593
<b>Percentage of Literates to Total population :</b>
Persons : 68.59 %
Males : 79.25 %
Females : 56.31%

## HEALTH INDICATORS OF HARYANA

The Total Fertility Rate of the State is 2.7 as per SRS 2006. The Infant Mortality Rate is 55 (SRS 2007) and Maternal Mortality Ratio is 162 (SRS 2001-03) which are lower than the National average. The Sex Ratio in the State is 861 (as compared to 933 for the country). Comparative figures of major health and demographic indicators of Haryana viz-a-viz India are as follows:

**Table I: Demographic, Socio-economic and Health profile of Haryana State as compared to India figures**

S. No.	Item	Haryana	India
1	Total population (Census 2001) (in million)	21.14	1028.61
2	Decadal Growth (Census 2001) (%)	28.43	21.54
3	Crude Birth Rate (SRS 2007)	23.4	23.5
4	Crude Death Rate (SRS 2007)	6.6	7.5
5	Total Fertility Rate (SRS 2006)	2.8	2.9
6	Infant Mortality Rate (SRS 2007)	55	57
7	Maternal Mortality Ratio (SRS 2001 - 2003)	162	301
8	Sex Ratio (Census 2001)	861	933
9	Population below Poverty line (%)	27.01%	26.10 %
10	Schedule Caste population (in millions)	4.09	166.64
11	Schedule Tribe population (in millions)	0	84.33
12	Female Literacy Rate (Census 2001) (%)	55.7	53.7

In spite of massive health infrastructure there is still a big shortfall of public health facilities in view of the rapidly increasing population and in migration from other states.

**CRM -3**  
**GOI Team from MoHFW, Non Government Organizations and others**

<b>Name</b>	<b>Designation</b>	<b>Place</b>
<b>Dr Dinesh Baswal</b>	Assistant Commissioner	Training Division, MoHFW-GOI, New Delhi
<b>Dr Jagvir Singh</b>	DPD, IDSP	New Delhi
<b>Dr Amitav Datta</b>	Prof. Depts. Of Community Medicine	AFMC, Pune
<b>Vikram Rajan</b>	Health specialist	World Bank, Delhi
<b>Dr Aboli gore</b>	Consultant-HRM	JICA, Bhopal (MP)
<b>Dr Sunita Abraham</b>	CMAI	Delhi

Team was divided in two groups and one team headed by Dr Dinesh Baswal and members Dr Sunita Abraham and Dr Amitav Datta visited District Rewari and Group Vikram Rajan , Dr Aboli Gore and Jagveer visited District Panchkula.

Team had a briefing from state on 4<sup>th</sup> Nov 09 and departed to field on 5<sup>th</sup> morning and stayed in field till 9<sup>th</sup> morning. List of places visited is given on following page. Team from Rewari has also visited few additional places in district Karnal and Mahendra Garh.

CRM visiting team presented their findings and recommendation to Haryana state health team (including Principal Health Secretary, Mission director and directorate official). In this meeting findings and recommendation are discussed in details and state has agreed to implement some of the suggestion on immediate basis.

**Officer from Haryana health department with CRM team during visit**

Haryana Health Department has deputed senior health officers to facilitate visit of Common review mission team in states.

1. Dr Veena Chugh, DGHS (Haryana)
2. Mr BK Singh (Nodal Officer)
3. Dr HR Yadav CMO Rewari
4. Dr Vijay Singh SMO District Hospital Rewari
5. Dr Ahlwat NRHM Consultant
6. Dr Rajesh Bali DoHFW
7. Dr Kamala Singh (CMO Panchkula)

### List of Places visited with official met at the site

3rd Common Review Mission				
3 <sup>rd</sup> November 2009 to 13 <sup>th</sup> November 2009				
Name of State			HARYANA	
Names of Districts visited				
S. No	Name	District HQ	Name of DM	Name of CMO
1	Rewari	Rewari		Dr. H.R.Yadav
2	Panchkula	Rewari		Dr Kamla Singh
Health Facilities visited				
S. No	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	Dharuhera		PHC with SC	Dr.Rajbir Singh
2	Rewari		DH	Dr.Vijay Singh Yadav
3	Rampur		SC	Mrs. Sushila MPHW (F)
4	Jadra		SC	Mrs. Bala Devi ANM
	Motia kalan			Krishna Yadav ANM
5	Nahar		CHC with SC	Dr Rajesh MO
6	Bachod		PHC	Dr Saini
7	Kosli		SDH with SC	
8	Kasola		SC	
9	Panchkula		DH	Dr V K Bansal
10	Hangola		PHC	
11	Nanakpura		PHC	
12	Sameldhi		SC	
13	Ram garh		SC	Ms Parveen Kaur ANM
14	Karanpur		SC	
15	Marranwala		SC	
16	Kalka		CHC	
17	Raipur Rani		CHC	
18	Bachod			Villages
19	Kasola			Villages
20	Panchkula		SIHFW	Dr Usha Gupta
21	Panchkula		DTC	Dr Simmi

## Item Reviewed during Desk Review and Field visits in CRM -3

According to the guidelines and directive from MoHFW Common Review Mission has reviewed health program and activities in Haryana on all 22 suggested ITEM. Given below is the detail on each ITEM, desk review of the information, reports and data made available to CRM team is done. Followed by the field visits findings. (Information received from State is annexed)

### 1. Infrastructure

#### a. Baseline resource mapping

##### Desk review

State of Haryana is one of high performing states and health infrastructure are more satisfactory than other EAG states but after dissemination of IPHS norms infrastructure requirements are redefined and hence population based availability of health facilities is still less.

Year	No. of District hospitals	No. of Sub-District hospitals	No. of CHCs	No. of PHCs	No. of SCs	No. of Urban Dispensaries
2005-06	19	24	81	408	2433	33
2006-07	19	24	85	410	2433	33
2007-08	20	23	83	420	2465	34
2008-09	21	22	89	429	2465	37
2009-10	21	22	93	437	2465	37
No required as per 2001			125	501	3006	
Gaps			32	64	541	

Since the launch of NRHM in 2005 only 32 SCs, 29 PHCs, 12 CHCs are added to the rural health services of Haryana. New districts are being declared and sub district hospitals of those areas are upgraded to the district hospitals hence number of sub district hospitals has decreased from 24 to 22.

Health Institution	Required (As per population based on 2001 census)	No. Functioning As on 31 <sup>st</sup> March 2008	No. Established during the year	Total Functioning 2009
(1)	(2)	(3)	(4)	(5)=(3)+(4)
Sub Centres	3005	2465	-	2465
PHCs	501	429	8	437
CHCs	125	89	4	93

Number of functional health facilities is less than required number of facilities as per IPHS norms. Health facilities required as per population of 2001 according to IPHS norms has still not matched with the present existing facilities. Only 2465 SC are operational against the required number of 3005 Sub Centers. Gap of Required and existing PHC and CHC is 66 (437/501) and 32 (93/125) respectively. This shows that some facilities may be overburdened.

### **Field visit**

#### **Rewari**

Health services in Rewari are delivered through one District and one sub district hospital. There are 5 CHC, 11 PHCs and 107 Sub centre. 42 private nursing homes are registered with health department. The connectivity of roads is exceptionally good. However transport facilities between villages appear to be limited. Water and electricity situation are satisfactory in the areas that we visited. At the state governments initiatives a system of ambulances will be launched through Red Cross next week which should help persons from the community to access health services even from the remote areas. Currently available ambulance services will be used to take women for antenatal care and children for immunization. At the district, sub-divisional hospital and CHC there will be one ambulance each and there will be one ambulance for two PHCs. Transfer from site of accident or home to the nearest medical facility or transfer from medical facility to another. There will be a fleet of 319 ambulances in the state with a centralized control room accessed by dialing 102. Two drivers will be hired per ambulance. Some equipment has been procured but the health facilities visited by the team were not equipped as per the norms of IPHS. All equipment for basic functioning of the visited sub-centre, PHC, CHC and district hospitals were not all available and the state has to make efforts to procure these items and reach the IPHS standards.

In sub district hospital in Kosli has 24 x 7 PHC and Sub center are located in same area. Five residential quarters are available (2 for MO, 1 for Nursing Staff and 2 for Staff-D)

#### **Panchkula**

District Panchkula is served by the one District hospital and 2 CHCs. 9 PHCs and 46 Sub centers are functional. All SC are having one or more ANM. Out of 46 SC only 26 are functioning in government buildings. Few

of PHCs are also functioning in rental or other buildings (i.e. Panchayat or others).

## **b. Infrastructure up gradation**

### **Desk Review**

Since the launch of NRHM strengthening of SC / PHC and CHC are given priority and presently out of 2465 Functional SC only 1502 Sub Centre are having their own governmental building ; 963 Sub Centre are having building from Villages Panchayat, NGO (without paying rents); 285 Sub Center building are under construction with Support from NRHM funds. Only 678 Sub Centers are without governmental building will be planned to have their own building in coming years of NRHM. Availability of the untied funds through NRHM flexi-pool has strengthened the SC with equipments and chairs etc.

306 of the total 437 PHCs are operational in government buildings 87 new buildings are under construction; few of them are having newer designed PHC with space for all facilities listed in IPHS.

87 of the 93 CHCs are operational in their government buildings and 6 are under construction with support from NRHM funds.

13 PHC and 4 CHC are in difficult area but state has not provided the number of Sub Center in these areas.

There is an issue of collocation of health facilities like PHC having subcentre,CHC having subcentre.In addition to that all PHC IS 24X7 which the state has taken a decision which needs to be revisited as the manpower requirement will increase.

Equipments in the district hospital in Rewari are under annual maintenance contract. However inspite of this the hospital had some difficulty in repairing an x-ray machine that was not working at the trauma centre. Infrastructure, water, environment in the district hospital is maintained by PWD. In the PHCs and CHCs funds from RKS are being used. Some uncertainty about whether this was RKS or VHSC funds. Inverter back up exists for PHC separately and for the labor room separately. This was available in all the CHCs, PHC and SCs that we visited.

## 2. Human Resource Planning

### a. Availability of HR and Gap analysis

#### Desk Review

##### ANM and MPW

Basic services guaranteed at the SC under NRHM are provided by ANM but 64 SC are functioning (?) without ANM and 58 of them are also not having MPW whereas total number of ANM posted in states are 2897 against the total functional 2465 SC.

<b><i>No. of Sub Centre</i></b>	<b><i>2465</i></b>
No. of ANM posted	2897 (1334 regular + 1563 Contractual)
No. of MPW	1093
No. of SC without ANM	64
No of SC without ANM and MPW	58

Despite of more ANM then number of Sub Centre 64 SC are without ANM, it may be due to the posting of ANM in DH, CHC and PHC and elsewhere. Gap in MPW is marked as only 1290 position are sanctioned for MPW against 2465 sub Centre, out of this only 1093 MPW are in position. In field visits it was observed that some SC is with two ANM and even then 64 SC are without a single ANM. However the 2465 functional SC has 1272 sanction post of ANM only. Issue of sanctioning the post of ANM at every sub centre may be taken up seriously to ensure availability of one full time ANM at each Sub Centre. Presently 1563 contractual ANM are recruited and only 1334 regular ANM are in place against the sanctioned 1272. Although NRHM provide opportunity of contractual recruitment to fulfilling the Human resource gap but more contractual ANM then Regular ANM shows the over dependency on NRHM while state has not responded to the need of increasing the sanctioned post for the all Sub Centre.

##### Medical Officer and Lady Medical Officers

<b><i>Number of PHC</i></b>	<b><i>437</i></b>
Sanction post of Medical Officer	228
PHC with MOs	427 (Contractual and Regular )
PHC without MOs	10 PHCs (?)
PHCs with Sanctioned post of Lady Medical Officer	30
PHC with LMOs	68 (Regular and Contractual)

Required Post of Medical officer at PHCs are 880 against the Total Number of PHC (437) but only 228 posts are sanctioned and 299 (Regular) Medical officers are in place. Only 30 post of lady medical officer are sanctioned and 68 Lady medical officers are in position. Medical Officers are more then sanctioned posts which indicate that state have some policy to recruit Medical Officer beyond the sanctioned posts. Similarly shortage of LHV (139/ 437), Lab Technicians (119/437) Staff Nurses (618/ 1748) is affecting service delivery at the PHCs.

In state sanctioned post are vacant and contractual staff is hired from the NRHM budget. It seems that states has not intended to filling up the sanctioned post from state budget. State should prioritize the filling up of the sanctioned posts so the attrition of the contractual staff could be minimized.

Community Health Centre

Number of CHC (all FRU)	93
Number of Gynecologists	24
Number of Pediatricians	27
Number of Anesthetics	19
Staff Nurse (Required 641)	490
GDMO (Required 372)	114

According to the NRHM and IPHS norms, the manpower required in Community Health Centre and First Referral Unit especially number of specialist and paramedics required needs urgent attention. Only 24 Gynecologists, 27 pediatricians and 19 Anesthetics are in place in all 93 CHC or FRU. In CHC role of nursing staff become crucial and even without availability of the specialist these CHC are equipped with satisfactory number of Nursing Staff (490 against the required 641 post) but 303 are contractual. This shows that recruitment of contractual staff is done without prior planning to equip CHC with specialist and these nursing staff might have been underutilized. State still have the opportunity to relocate the nursing staff of CHC to 24 X 7 PHC to bridge the gap of Nursing staff in PHC where Medical Officer are posted and PHCs are actually functional for 24 hours. Shortage of GDMO in CHC is also a concern, only 114 GDMO against required 372 are in place. It implies that GDMOs may be providing services in CHC in absence of Specialists.

Every CHC and Even majority of PHCs are having dental surgeons, availability of dental surgeons universally in all health services are unique

feature of Haryana and now state have planned to utilize these dental doctor in public health programs. Need and utility of dental surgeons in Rural PHCs may require urgent attention .

**b. Pre Service Capacity**

Haryana has 8 MPW-F training Centre, 2 MPW-M training Centers, 1 LHV training Centre are functional to provide pre service trainings for ANM, LHV and MPW in state. On yearly basis total numbers of the seats are 203 for ANM. LHV training Centre is providing trainings to pre and in service training to LHV but state has shortage of LHV as supervisory cadre. State needs to take a call whether they require more number of training centres.

**c. Recruitment and cadre management**

Recruitment of the medical officer and other cadre is through Haryana public service commission and Haryana staff selection commission. Under NRHM recruitment on contract basis are being done to fulfill the HR gap in health service. Despite contractual recruitments number of position are vacant at rural health services. There needs to be proper planning of manpower according to the future needs also.

**d. Plan for augmentation of HR**

To meet the deficit of the medical officer State has advertised the regular monthly basis recruitment of the Medical Officer in state. Aspiring candidates may send their application through E-Mail and interviewed at state level with appointment as per their preference of postings. Presently State has shifted its focus to meet the deficit of MOs in Difficult districts i.e. MEWAT, REWARI, PALWAL, JHAJHAR, BHIWANI and NARNOUL. In year 2008 onwards 634 specialists and 666 MBBS doctors are recruited and posted against the vacant positions.

**e. Skill Quality of HR**

**Training Institutions**

Status of training institution and their capacities are given

Name of Institution	Numbers	Total Seats	Place
SIHFW	1		Panchkula
Regional HFWTC	1		Rohatak

ANM (F)-TC	8	203	
MPW (M)-TC	2	60	Sonepat and Rohatak
LHV TC			
GNM TC	3	60	Hisar, Bhiwani, Karnal

State has taken up various initiatives under NRHM for skill up gradation of the present human resource, training like SBA, IMNCI, RTI/STI, ARSH, Immunization and multi skill training likes EMOC, and LSAS are being scaled up in state with support of GOI program division. SIHFW in state is the nodal agency for trainings and has taken few initiatives like situational analysis of health facilities and HR for assessing training load and training need of the health services. State level monitoring of trainings are also being initiated very recently to ensure quality of trainings and post training performances of the trainee in service delivery. SIHFW has also focused on post training follow up and collecting performance report of trained health staff and officer from district and specifically post training tracking of the activity of the EMOC and LSAS trained MOs is done systemically.

21 District Hospital are identified as centre for trainings i.e. SBA, Laparoscopy; IMNCI and 17 DH are providing training in NSV and Minilap; 13 DH are upgraded for EMOC trainings. IMNCI and SBA trainings are also imparted in few selected CHCs

State has taken a bold initiative to integrate trainings i.e. MTP + MiniLap and Immunization + IMNCI. Practically integration or clubbing of training in single duration is proposed and piloted to reduce pressure on district and state official in training planning and management.

#### **SIHFW Panchkula**

Building of State Institute of Health and Family Welfare is situated at Panchkula. The other infrastructure are sufficient for various RCH and NRHM trainings. Induction training has been initiated in the state for those joining the services as medical officer. 40 kinds of trainings and skill building / capacity building programs are being conducted by this institute. Only three full time faculties are posted while other technical posts are filled up by the Contractual Staff. 50% posts of admin and ancillary staff are vacant.

SIHFW has taken up mapping of trained health staff on health facility basis quarterly and presently all health facilities are having updated status. SIHFW also has taken up the training evaluation on regular basis.

#### District Rewari

CHC Nahar has 19 SCs with 30 ANMs posted and to the surprise of the team four SC were vacant (no ANM posted). Training of the ANM is also irregular 23 ANM are trained in IMNCI, only 3 ANM trained in SBA; only 7 are trained in IUCD training and none of them are trained in Immunization. In District hospital Rewari all doctors are trained in RNTCP whereas very few are trained in IMNCI, SBA and Immunization. Training should be in planned in way to saturate a District for all kind of trainings to provide quality health care.

District training centre are located within the District Hospital-Rewari with capacity of training to 20-30 persons with facilities of OHP and LCD with computer.

#### Training achievements and remaining training loads in Rewari District

Training	Total Trained	Training Load (to be trained )
NSV	9	59
Ayush	15	nil
SBA ANM	27	187
IMNCI MO	15	53
IMNCI ANM	144	70
IMNCI AWW	494	248
ASHA module-1	500	03
ASHA module-2	249	254
SMS /BCC	1445	2225

#### ANM training Centre, Narnoul

Building of training centre is spacious but residential facilities for staff are not available. 3 tutors are posted as per required norms of 10 to 1 trainee to trainer ratio. Training is according to syllabus of 1989 and trainings are given on old pattern (no use of power point and computer) library of training centre is poorly maintained with one nursing journal available to student. Library need to be upgraded for more books and journal.

#### **DTC Panchkula**

DTC is situated in the premises of GH Panchkula. 15 types of trainings and orientation programmes are being conducted at the DTC under NRHM. The centre has a good infrastructure with availability of teaching and training aids. Three training staff is posted in DTC. GH Panchkula is the training sites for skill based trainings. Services of Specialists from the GH are also utilized as guest faculties in the DTC.

### 3. Assessment of Case Load being handled by Public health system

#### Desk Review

##### State Data from Haryana

INDICATORS	2006	2007	2008	2009 (till Sep.)
Deliveries	68072	77915	91408	111866
OPD	16439175	15771321	15476445	
IPD	1387128	1411602	1503804	

Number of delivery at health facilities were 68 thousand in 2006 but due to JSY and other initiatives under NRHM in year 2009-10 (till September 2009) 1,11, 866 deliveries are reported. This increase is significant and shows increasing faith of community in public sector health services. Surprisingly OPD load is decreasing since year 2006. In year 2006 1.64 Crore OPD cases are registered but in 2008 a slight reduction in OPD (1.54 Crore). On the reverse IPD load is increased since 2006 and may be number of deliveries are registered are calculated in IPD (increase in IPD is matching with increase in Delivery cases). Since 2005 number of SC, PHC and CHC has been increased but Decrease in OPD need to be revisited with critical analysis of data.

	2006-07	2007-08	2008-09	2009-10 (Sept 09 )
Deliveries	25290	35926	41976	26247

Regular increase in the number of deliveries at district hospital may be because of JSY and other services provided under NRHM. In year 2009 up to Sept 2009 number of deliveries is more than the yearly total of the 2006 -07 which is significant and also supporting the DLHS data which are showing increase in institutional delivery. This increase should also be viewed in the availability of the required human resource in district hospital. To handle the double the case load of the year 2006 may need more specialists, GDMO as well nursing staff.

In SC number of deliveries have increased from 4414 (2006-07) to 23773 (2008-09) and in PHC from 9822 (2006-07) to 21375 (2006-07). Data speaks it self is the success of the JSY in state and increase in case load in health facilities but analysis may be needed to assess how many facilities

has started providing services and how many time increase in case load in already performing health facilities.

### **Field visits**

#### **District Panchkula**

##### Case load handled by District hospital

	OPD	Normal Delivery	MTP	LSCS
2006	254065	3110	700	713
2007	278012	3280	517	674
2008	289304	3634	522	838
2009	363596			

Except MTP, other case load has increased and LSCS increase may be due to increased number of complicated cases referred from periphery.

#### **District Rewari**

District Hospital, OPD cases are 3995 in Oct 09 and on average 150 / day. IPD cases in Oct 09 are 183. laboratory are conducting 40 tests per day. Dental OPD is 6-8 per day.

##### CHC Raipur Rani, Panchkula

Specialist are posted in CHC hence Number of delivery are increasing since 2005

Year	No. of Delivery
2005	85
2006	93
2007	83
2008	151
2009	263 (up to Oct 09)

In CHC Kalka number of Delivery have increased and number of LSCS has also increased.

	06	07	08	09
Normal Delivery	640	736	696	760
LSCS	122	144	161	200
Sterilization		1073	1007	374
IUD		1785	1847	1103

Number of CS has increased, 26% (09) of normal Delivery from 19% (06). Family planning achievements has decreased from 07 to 08. District officer should analyze the data and reasons for this drop may be explored.

#### **4. Preparedness of Facility for patient care services**

In Haryana 160 PHCs, 40 CHC, 21 Districts Hospitals and 22 Sub District Hospitals are operational for 24 X 7 and providing all RCH and other health services under NRHM service guarantee. 24 x 7 PHCs are equipped with three staff nurse or ANM and Medical Officers (+ Ayush Medical Officer) with basic logistics i.e. labor room, wards, drugs, electricity and water etc. In FRU, CHC, DH and Sub districts secondary level facilities are provided like Labor room, Wards, Operation theatre, ambulances for referral, neonatal care (proposed establishment of Neonatal Care Unit at DH, Neonatal stabilization unit in FRU, CHC and Sub district hospital) and specialist are on call is an arrangement for meeting the deficit of specialist in CHC, FRU and Sub district. In Sub Centre level neonatal corner are already established in delivery huts across the state. Static fix day Vasectomy and Tubectomy Operations are planned in FRU, Sub district and district Hospitals and selected CHC and PHCs.

##### Panchkula

Panchkula district Hospital is 150 bedded hospitals with unique feature of two shifts of OPD services (9 AM to 3 PM and 3 PM to 9 PM). This feature has distributed the work load on hospital and hence they are efficiently managing caseload (1200 to 1500 per day) and utilizing human resource (47 Doctors including specialist and physiotherapist with 65 Nursing staffs). OPD / IPD registration is computerized and treating doctor also keeps record of patient treated by them.

##### CHC Raipur rani

30 beds in the facility of which >90% are occupied. Basic amenities- 24hr water supply, electricity with backup facility, telephone, internet connection, and cleanliness is reasonable. 11 doctors posted at the CHC- 1SMO (ENT), 8MO (Pediatrics, Gynecology, Medicine, Surgery, Ophthalmology), 1 Dental surgeon, 1 AYUSH and Paramedical staff- 5 SNs, 2 ANM (regular contractual), 3 LT . Referral services is supported by 2 ambulances (1 Red Cross society + 1 SIP)

##### Kalka

This CHC covers a population of 236,136 people with 5 PHCs, 1 PPC, 27 SCs and 484 villages in its area. The staff position is as follows

	Sanctioned	Posted
SMO	1	1
MO	10	10
Dental surgeon	1	1
Pharmacist	3	2
Lab tech	3	3
SN	6+1	6+1
PHN	1	1

Labour room, Operational theatre and laboratory services are maintained but need further improvements like protective apron for radiographers, toilets beside labour room. Blood group is stored at facility.

#### Hangola

There are 2 MOs, 1 dental surgeon, 1 ANM, 3 SNs, 1 LHV, 1 pharmacist, 2 class 4 employees. The MO i/c is a local person and has therefore preferred to work at this PHC. There are 3 additional sub centres in the area covering a population of 26,247 (24 villages).

#### Nanakpur

The PHC has 2 MOs and a dental surgeon . The LMO is posted 2 months back and the dental surgeon for last 1 ½ years. There is a Pharmacist and a Lab Technician. PHC is situated in the outskirts of the village and being run in a 2 room building donated by Panchayat.A separate room is available for Dental OPD. New building is under construction at the back of the existing one

#### Rewari

Rewari district Hospital is 100 bedded, with two Gynecologists and no pediatrician but two dental surgeons (Dental Surgeons available at all facilities?) one ophthalmologist, One ENT Specialist, one skin and VD and two Physicians are posted in Hospital. A trauma centre is situated across the busy road and fully equipped with orthopedic surgeries with two orthopedic surgeons. Patients were admitted during the visit. The team enquired from some patient they were also given rebate. The approach between DH and Trauma centre is difficult because of traffic and need under pass or over head Foot Bridge.

Dharuhera PHC (24 X 7) 8 bedded and has two Medical Officers with one Dental surgeon, one Pharmacist, one Lab technician, one LHV, 3 ANM,

four Staff Nurse and one TBA also.. Only one patient was admitted in the ward during the visit. SC is collocated.

Nahar CHC is 30 bedded hospital but building is located in outer area of villages. CHC does not have specialist posted and X ray machine is non functional. OPD and IPD are less because of location and non availability of the specialist. One Sub Center is located within the building of CHC which is serving the Nahar villages but would be better utilized if this centre located in village. One hall in CHC is being used for trainings with sitting capacity of 30-40 Persons. At the time of the visit there was no patient admitted in the ward.

PHC Bachod of district Mahendra Garh is utilizing RKS funds for strengthening the PHC for making more patient friendly, waiting lounge & toilets for pateint and relatives were made by RKS. There was display of EDD of the patients to be delivered. There was display of all the list of essential drugs and their availability. Names of the RKS members and the last meeting held. The records were very well maintained.

Subcenter Rampura and Jadra each are having three ANM (one contractual ANM in each centre). As contractual ANM are recently recruited so they are more informed then the regular ANM.

There are some problems of access because CHC, PHC and SC are situated in the same buildings; staffs are being underutilized in some places. In Narnoul PHC where we visited, the district hospital, CHC, PHC are situated within a radius of 12kms on the same highway.

We visited a sub-center (Motla Kalan) where the ANM is conducting an average of 500 deliveries every year where it may benefit from additional staffing. The ANM has used the untied funds for repair of the flooring and other things. She has made a makeshift arrangement for the staying of the relatives who accompanies the pregnant woman. However state needs to support such individuals with infrastructure and other support. The team had noticed the chipping of the roof in which deliveries are conducted. ANM also requested some support for the facility.

## 5. Outreach activity of sub center

Under RCH, the Outreach Services play a major role where the health care services are provided to the people as far as possible. Through the fixed day outreach visits to the Sub Centres the entire reproductive health services are made available at the doorsteps of people. The elderly people, disabled and women with newborns are also taking benefit by this programme. The following services are provided in the Sub Centres by the team headed by the doctor:

- Treatment of minor ailments
- Antenatal care
- Post Natal care, Newborn care.
- Family Welfare Services
- Management of RTI/STI cases
- Diabetes and hypertension screening and treatment
- TB & leprosy case detection
- Nutrition counseling
- Health education.

Under the RCH Outreach Camps approach the doctors in the PHCs will provide Outreach services at 2465 Sub-Centers in Haryana. On an average, a PHC covers around 5 to 6 Sub-Centres. Each doctor at PHC will provide outreach services at all the Sub-Centres at least once a month i.e. the PHC doctor will work for 5-6 days in a month at the sub-centres in the area of PHC. In other words, the people in the area of sub-centre will get services of doctor twice in a month. (Each PHC doctor will visit the sub-centre once a month). For this purpose, Rs.200/- will be placed at the disposal of the doctor for each outreach visit, Rs.100/- for the doctor as his/her traveling expenses & Rs.100/- for refreshment or any other contingent expense deemed fit by the Medical officer.

## **6. Thrust on Difficult area and vulnerable social groups**

Although state does not have any specific strategy to address the difficult area and vulnerable social groups but all health activity are always have one of more element which prioritize the activity for these areas. In human resource recruitment process state has diverted newer recruitment of medical officer to places like Mewat, Palwal, Rewari, Jhajhar, Bhiwani district. Presently Mewat is having deficit of medical officer, nursing staff and ANMs. State is proposing and planning to establish newer pre service training centre for ANM and strengthening of existing training infrastructure. Out reach activities are prioritized locally at district level to provide services in these areas and to complete the back log of services in areas. Mobile team and camps are being organized in difficult and hard to reach areas.

District hospital and PHC collect information about various caste of patients seen. However no analysis is available on access of BPL population and other socially vulnerable groups.

At district hospital in Rewari there was linkage to an ICICI community based insurance scheme.

## 7. Quality of service provided

Except in district hospital there is no partograph or baby corner. Wherever we enquired, mother and baby were kept for 6 hrs only. Much emphasis has been placed on institutional delivery in the state and there has been an increase in institutional delivery in the public health system by nearly 20%. There are no apparent quality improvement processes being implemented. In the sub-centre that we visited, health education was being provided for adolescent girls.

In Karnal district, sanitary napkins are being made available through SHGs at a discounted cost of Rs.10/- for 10 napkins. If more than 20 packets are bought, then the cost per packet is Rs.7.50/-

Maternal death audits have started.. The PHC medical officer at Narnoul PHC related to us the experience of a maternal death audit which he had conducted for a mother who had died in a private hospital. However we were not able to see the audit form.

We found a copy of GOIs environment protection guidelines at the district hospital in Rewari, staff I interacted with were not aware of the guidelines.

Knowledge of ANM & ASHA needs to be improved for danger signs in obstetrics besides ARI & dehydration in children

The delivery huts that have been recently set up in the sub-centres are furnished fairly well in spite of the space constraints. There is display of information about JSY in all the centres that we visited. RTI/STI services were provided through syndromic approach. Abortion services are provided only at CHC or district hospital in Rewari district where trained lady doctors are available. In one CHC (upgraded sub-divisional hospital) that we visited the ANM and staff nurse complained that as no doctor was in residence they found it difficult when drunk relatives came at night and created problems.

### Surgical package program –

A surgical package program (SPP) has been developed and rolled out in the last 2-3 months. The package consists of about 100 different surgical procedures that are available at the facility but provides a standard price for the surgery including drugs, supplies, diagnostic tests and charges for use of OT and ward. This service is free of charge for BPL

and urban slum residents, including the cost of orthopedic implants as well as for cleft repair, c-sections, eye surgeries and tongue tie. A price list has been developed based on a costing exercise and comparing it with the existing insurance and similar government schemes such as RSBY, CGHS and ESI. The prices are a third to a half of what is being charged for similar procedures under other schemes. Of course, the other schemes take into account other costs such as salary costs and depreciation of infrastructure and maintenance. The hospital staff has developed detailed formats to capture actual costs of the procedure, which can lead to adjustment of prices over time. The advantage of such a scheme is to (i) provide a patient a single price and a single window system for any procedure thus increasing transparency and decreasing transaction costs for the patient; (ii) provide an incentive to the facility to increase productivity by reducing actual costs and increasing the “profit” to the hospital. In district Hospital Panchkula in the month of September 2009, the facility did a total of 423 surgeries (313 major and 110 minor) and collected a total of INR 356,100 with a profit of 139,524. A total of 28 BPL patients including other free cases were treated. It is *important that free services to the poor are reimbursed to the facility by the state to promote a pro-poor policy* as this would not then be seen as a loss of revenue to the facility. The state needs to analyse whether the BPL patients benefitted are in the ratios of the state ratios.

#### District Hospital Panchkula

The facility was clean considering the large crowd received and the outsourcing of cleaning services was working well. The toilets were ok but not really completely functional (leaking pipes, no soap) and this is an area for improvement across all facilities. There was some seepage observed in some areas of the hospital due to lack of preventive maintenance (clogged drains) or structural problems. It is important that these are fixed to ensure that the assets are maintained. In terms of implementing IMEP, segregation of waste is being carried out and an agency has been contracted to collect and dispose waste. This is calculated on a per bed basis and similar arrangements have been made at the CHC and PHC level. Very few written protocols are visible in the facility and it is important now that the facility focuses on improvement and standardization of clinical procedures. While accreditation is being planned, it is important that the state thinks in terms of improving quality processes by a 3 pronged strategy of improving institutional capacity at the state level to develop protocols, processes and systems, introduce a mechanism of external assessments and most importantly institute mechanisms to improve quality as a team process in the facility.

On interview with some clients, overall satisfaction was high. A person who had brought his child who had suffered lacerations following an accident was satisfied with the services received and said he did not have to pay any money except for a CT scan at the hospital rates.

#### Rewari District Hospital

District no separate female ward is designated less number of supporting staff (Class fourth attendants and sweepers etc.). Partograph were being practices and during visit team observed that drum is in place and optimally functioning. But neonatal care is not proper, even warmer is not functioning and staff posted in wards doesn't know the operation of warmer and it's utility. As district hospital Rewari does not have pediatrician so the neonatal care is compromised and not established.

Waste management is given to a private agency and waste is managed properly according to the norms. Hospital is not disable friendly with poor signage and display of required information.

## 8. Diagnostic

Diagnostic facilities seem to be affected by the shortage of the Lab technician in the PHC (119 LT in place against required 437). Investigation like AFB smears, PBF in malaria etc may be sent to other centre where facilities are available but investigation like Hemoglobin estimations, Wet mount and others are not being done in PHC without Lab technicians. Although PHC are provided with lab equipped with required instruments and consumables, state may plan for the multi-skilling of Nursing Staff and other paramedical staff for lab work.

District Hospital, CHC, PHC and SC are having diagnostic facilities as per IPHS but District hospital Rewari has all diagnostic facilities including lab, X ray but facilities for ultra sonography is not available. But at CHC Nahar X rays machine is installed but no technician posted.

In district hospital Panchkula diagnostic facilities are available at par with any tertiary level health facilities including CT scan, digital X-rays, cytology and all other basic diagnostic i.e. blood, urine etc. Blood bank facilities are available in hospital, with diagnostic facilities for HIV, Hep B, C and VDRL.

## 9. logistic and supply chain management

### Desk Review

An integrated procurement division has been set up at state HQ and is under Director NRHM. Agencies identified for procurement are 1. Director supply and disposable (drugs and equipments), 2. Public Sector Unit (Pharmacy), 3. UNOPS India for medical equipments and 4. HLL life care (Medical equipments).

Essential Drug List (EDL) developed at state contains 328 essential drugs for DHs, 112 items for CHCs & 84 items for PHCs, but dynamic EDL is being prepared with specialist consultation. WHO-GMP criteria and Annual Turn over of 35 Crores has eliminated sub standard companies. Only Indian and British Pharmacopoeia drugs are purchased. Broad based district level procurement committees are constituted and procurement is done on quarterly basis with flexibility to specialist to purchase in consultation with district committee. State level Weekly monitoring of drugs consumptions and procurement is also in place. Cost analysis is done on periodic basis and cost effective per capita expenditure is reported. Rs. 10 for DH, Rs. 8 for CHC and Rs. 6 for PHCs are observed. Cost of a cesarean section is around Rs. 1000, for casualty it is Rs. 50 and for normal delivery is Rs. 250 only.

Medical store procurements at District level out of NRHM funds being done. Procurements were slow. Even from state budget, orders placed for only 10% of budget with additional 10% in pipeline. Certain drugs were in short supply till funds released lately. Civil surgeon still in old mode - guarantee of government to provide free drugs to all now to be implemented

The ILRs at the hospital store in Rewari district hospital was not wired. Temperatures were being recorded by the pharmacist in a book. However we did not see thermometers in two of the IRS. One with ice-packs had only water (showing that temperature was incorrect). One had an external reading showing an error. Supervision of all aspects of cold chain management needs improvement

#### District Panchkula

The district drug store is located at a civil dispensary and is staffed with 1 pharmacist (from the civil dispensary), 1 asst. pharmacist and 2 data entry operators. Software has been developed to enter demand from the facilities, place orders, maintain receipt of orders, document

indents from the facility and releases made to these facilities. The facilities that are supplied from here directly are GH, SDHs, CHCs, PHCs and urban dispensaries. List of about 582 drugs are available for purchase and of these 328 are for GH, 102 for CHCs and about 82 for PHC level. While the drug store said that they had shared this list with all facilities, this was not available at the PHCs the team visited. The process followed is as below. This has been introduced 9 months ago.

Facilities provide a six month demand forecast to the drug store, Based on existing stock at store and facility, orders placed for 3 month supply using the following order. All suppliers to be WHO GMP compliant i.e. Central PSU, State rate contract firms, DGS&D firms and finally open bidding is taken up. On delivery of supplies, a team consisting of doctors, pharmacists and drug controller of district take samples from batch and send for testing to approved labs. It usually takes 6 weeks for the report to be available. In case any defective supplies found, the company has to replace entire batch across the state. After the process has been introduced, no batch has been found to be defective.

Supplies are made to the facilities based on indents made and a FIFO method is used while providing supplies. Monthly meetings are held to discuss stocks and supplies at District level.

Some areas of improvement required are –

Strengthening of demand forecasting from the facility level – which presently seems to depend on generic forecast (such as overall OPD % increase) rather than focused analysis of drug usage trends.

Further strengthening of the QA process to ensure drug quality – Is the sampling adequate (no poor quality samples at all?)

Capacity building of the chief pharmacist's office at the district and strong field supervision for capacity building of facility pharmacist as well as improved internal controls.

#### Rewari District

In Rewari District Hospital store and logistic management is poor, inventory is not maintained and drugs are kept without information on expiry dates so it is not possible to manage drugs with early expiry. State may think of computerization of the stores of GH initially and later may be extended to other facilities.

## **10.Decentralized planning**

Villages Health Action plan are taken up on pilot basis in district Jhajhar, Rohatak, Gurgoan and Sonapat. Medical officer of PHCs and CHC are trained in TOT and Medical officer (community medicine) is given additional responsibility to support the initiatives. Block level training for VHSCs members are planned. Prepared village health action plan would be incorporated in the District Health Action Plan for the year 2009-10.

District health action plan are also being prepared with the support of SIHFW. These district health action plans are to be incorporated in state health action plan for the year 2010-11.

## 11. Decentralized local health action

All expenditures at the CHCs and PHC that we visited are backed by formal decisions of the RKS/SKS. However the composition of the RKS has not been reconstituted from the SKS to have an adequate representation from PRIs.

### District Panchkula

#### District Hospital

Swasthya Kalya Samiti (SKS) – The SKS has been constituted with the Civil Surgeon as the Chairperson and the MS of the GH as the co-chairman. Other members include medical officers from various departments, matron, and drug controller, district AYUSH officer, locally elected municipal counselor, representatives from NGOs, IMA and others according to the guidelines. The SKS is meeting regularly and minutes of the meeting are well documented. In addition, financial records of income and expenditure are also being maintained. To ensure that SKS funds are used for activities not already covered under the NRHM budget (including all national program), two accounts are being maintained for SKS (user fees and untied funds) and NRHM (for example, IPHS up gradation, medicines). This is a positive movement as it ensures that SKS funds are used in the most flexible manner to improve the facility. The user fees collected per month is about 6-7 lakhs and expenditure is close to 6-7 lakhs per month as well. Given that most of these are now spent using other NRHM funds, the core SKS funds spent are about 1-1.5 lakh per month. Most of the money spent is for purchase of drugs and medical supplies, office supplies, minor repairs and items for facility improvement (e.g. – beds and sheets), patient satisfaction (e.g. - water coolers), contractual human resource and other operating costs.

#### Rewari

DH, CHC and PHC are utilizing SKS in upgrading patient care in hospital, in CHC Nahar patient lounge and toilet facilities are constructed, purchase of medicine and logistic is being done by SKS funds in case of need.

Meeting of SKS is regular and attended by members but on reviewing the records it was observed that only medical officers and health workers are attending meeting then community members, it need to be corrected to increase the community participation.

## 12. Community process

District Health and Family Welfare Society (DHFWS), Swasthay Kalyan Samiti (SKS), Village Health and Sanitation committee (VHSC) are well functional in state. All districts have DHFWS and meeting regular and monitoring district health achievement periodically. All 21 district Hospitals, 22 Sub district Hospitals, 91 CHCs and 337 PHCs are having SKS and meeting regularly. Total 474 SKS are constituted and 463 SKS are registered under society act. Linkage between the organizations is well established and periodic reviews are conducted. Total 2606 meetings are held in year (March-09 to Sept 09). SKS are functional and having bank accounts and user fees are also deposited in bank accounts for proper maintenance of accounts. Total Number of VHSCs constituted is 6282. In VHSCs participation of the community (SMS, SHGs etc.) and all sectors (Teacher, MPWs, Water supply department staff etc) are ensured under leadership or PRI. VHSCs are supported and mentored by the district level team led by DPM along with BEE.

Village Health and Nutrition day is activity organized with support from VHSC and health department. Against the Target of 75324 VHNDs only 18949 (25%) VHNDs are held. Panipat, Sirsa, Narnoul, Kurukshetra districts are performed poorly in holding VHNDs against their targets. Inter sectoral convergence is to be looked upon to integrate health and other than health activity in VHND.

Performances in Rewari (49%) and Panchkula (37%) are more than state average but field observation shows that immunization day is always seen as VHNDs and participation of VHSCs and community need to be encouraged in VHNDs.

**Sakshar Mahila Samooh (SMS)** is community based organization in rural area. In villages women educated (10<sup>th</sup> pass and above) are organized a group and taken up the community issues on periodic basis. These SMS groups are now included and proposed to be utilized in Behavior Change Communication activities. SMS groups are involved in program specific BCC/IEC activities i.e. HIV AIDS, RCH, NVBDCP etc. Although SMS is effective tool for community participation but within SMS representation from all population is restricted due to criteria of Tenth Pass women. Some places villages community has grievances on representation in SMS. The team had met the representatives of the SMS in Narnoul.

### 13.ASHA

Accredited Social Health Activist initiated in year 2005-06 and total Target for ASHA selection is 14,000 but till date 13275 (95%) ASHAs are selected in Haryana. Training to ASHA is area of concern for state. Slow pace of ASHA training needs attention of the district and state officer as ASHA without training may lead to ineffective communication between ASHA and community. Government of India has scaled up training in module -5 and few states has goes beyond module -5 and developed their own state specific Module -6.

#### ASHA selection and training status as on Oct 09

PROPOSED NUMBER OF ASHA		14000
Selected ASHA		12275
Training	Module -1	6749
	Module- 2	2146
	Module -3	1789
	Module -4	1418
	Module -5	TOT on

Payment to ASHS for JSY is always delayed by 3 or more months as it is observed in SC in district Rewari. Coordination with ANM is satisfactory and frequently meeting at SC and PHCs is not happening.State .The state also conducted TOT for the 5<sup>th</sup> module when the team was in the district.

Public partnership is in its early stages. There is some problem with ASHA payments. In one case in Kasola village, the ASHA had not received payments since Dec 2008. Nischay Kits will be given to ASHA in Kasola PHCs. The average payments received by the ASHA are between Rs. 400 – Rs.500 per month. In all but one of the sub-centre that we visited, the ASHAs were not getting the motivation fee for bringing women for delivery even though they were getting the fee for bringing them for ANC. In the CHC at Nahar One ANM told us that she was getting the fee for bringing women for institutional delivery as the pregnant women were from the same village.

No apparent evidence of a mentoring process for ASHA. In almost all the PHCs and SCs the ANMs felt that the ASHAs were providing support for linking the services to the community. In two SCs there was the impression that the ASHAs were not working. The ASHAs we interacted with were aware of their roles. The state and the district machinery has so far not made an attempt to calculate attrition rates. This possibly can

be done only after the payments for ASHAs are sorted out. ASHA are not being mentored at all by any of the health functionaries – State HQ down to ANM.

No ASHA in the state has been provided with the drug kits and on discussion it was found that due to misinterpretation of the guidelines drugs kits were not distributed. However after discussion and clarification by the CRM team state has agreed to provide ASHA drug Kits to all ASHA who are trained in first Module of training. There is no integrated compensation package formed by the state and state has not been able to utilize the resource.

#### In District Rewari

Presently 503 ASHAs are working against proposed and 500 are trained in module -1 and 249 in module-2. Total payment to ASHA as various program incentives in Rewari is Rs. 767461.

## 14.NDCP

### Desk Review

#### a. Overall effectiveness of NDCP

District level officers are implementing disease control program. Individual source of funding is affecting program activities. As district are facing shortage of district level program officer and in disease control program district has to assign a separate officer for program as District TB officer for TB, Leprosy officer etc. District is not seeing these all program as one so training programs; activities are planned and implemented independently.

Although RNTCP is well monitored program through network of RNTCP consultants but other program does not have such strong monitoring and supervision support. NVBDCP is more seasonal activity then a perennial activity hence may lose focus of district officer in absence of monitoring system.

#### b. NVBDCP

In 1996 number of malaria cases was at peak (126,000) but from 2006 to 2009 (Sept 09) onwards number of malaria cases are in ranges of 47077 (2006) to 35683 (2008). In year 2008 increase cases of Plasmodium Falaciparum malaria reported (1397 PF cases) and Dengue cases (1159 with nine deaths reported) were also higher in the year. In year 2009 up to September 09 number of PF (434) and Dengue (64 with one death reported). In Haryana sporadic cases of JE are also reported due to migratory population reaching to Delhi and adjacent districts of Haryana. In year 2007 32 cases of the JE were reported and 18 deaths were reported. In year 2009 (Up to Oct 09) only one JE case is being reported and also died.

Preventive measures are taken up by State, in rural area breeding site identification is promoted by incentive to rural volunteers, Urban Local bodies has taken up the drive to promote control of water bodies, checking of coolers etc. On diagnostic as well on treatment aspect. State has taken a decision on rational purchase of drugs at district level for vector born diseases and established 6 viral diagnostic labs.

#### Rewari

In district Rewari malaria cases are showing declining trends since 2006 onwards but dengue cases (45) increased in year 2008. In Panchkula

district malaria cases are showing declining trends but slight increase in this year (2009) due to more cases in one Block PHCs.

#### Panchkula

79 malaria positive cases were reported from District Hospital and put on treatment.

#### **c. RNTCP**

National TB program was initiated in 1962; RNTCP was launched in Haryana from 1st Qtr 2004. There is widespread network of 214 designated Microscopy Centers, 47 TB Units, and 6783 Dots Centers. All the three medical colleges (PGIMS Rohtak, Mullana and Agroha) are involved in the program.

Dots plus has been launched successfully in seven districts (Bhiwani, Jind, Jhajjar, Karnal, Panipat, Sonapat & Rohtak) since July 2008 and treatment activities started in Dec 2008. At present MDR treatment services have been given to 39 patients till date

State TB Training and Demonstration Centre and State Drug Store is functional at Panchkula. State level Intermediate Reference Laboratory exists in district Karnal is conducting training of RNTCP Key staff(STLS/LTs) and will conduct culture and DST of MDR cases following its accreditation.

Annual case detection rates, new smear positive case detection rates, Conversion of smear positive in 3 months rates and cure rates for smear positive cases are maintained since the initiation of RNTCP in year 2004.

#### District Rewari

Annual case detection rates have reached 181 / lac / year in 09-10 from 134 in year 2007. Conversion rates have also increased from 86% (07) to 92 % (Sept 09). Cure rate is not change significantly but success rates have dropped from 84 to 79 % in this period. Vacant position of program staff has affected program performances. Program needs a full time District TB officer (Presently a senior Medical officer has been given additional charge of DTO) and filling of the post of LTs.

**d. NBCP**

Cataract surgeries are one of major activities of the NBCP and since year 2007 states are achieving more than 100%. Screening for eye problem in school is also one of the important activities of NBCP. In year 2008-09 in 1857 camps 7817171 school children were screened for refractive errors 13047 were found to be having refractive problem and 2994 were provided with free glasses.

**e. NIDDSCP**

District Kaithal (0.20) and Sirsa (0.66) were surveyed for IDD prevalence rates in year 2009. Common salt testing is regular activity of the project and in year 2009 more than 18865 salt samples were tested by STK and only 12617 were having standard quantity of Iodine (more than 15 PPM). IDD laboratory is established in Karnal. IEC activities are taken up in Radio Spots, Wall paintings, and new papers advertisements.

**f. IDSP**

In Haryana state diseases of public health concern are Dengue, Viral Hepatitis, Japanese Encephalitis and meningitis. State and District Surveillance units have been established in states with Laboratory at all the three level (L1, L2 and L3). This Program was supported by World Bank till 2009 March but now extended up to the March 2010.

696 Medical officers, 4660 MPWs (male and female) and 160 Lab technicians are trained in IDSP and weekly reporting are in place and regular which include reports about outbreaks and sporadic cases. Last outbreak reported and managed by IDSP in Batra Colony Panipat in Sept 2009. Case of typhoid, cholera, hepatitis (A and B), Malaria (PV and PF), Dengue were regularly reported in IDSP reports and feedback to district health authority were sent regularly.

Rewari is having 127 reporting centre and no epidemics or out breaks were reported in last six months.

**g. NLEP**

State of Haryana has achieved the status of "Elimination of Leprosy" by WHO (less than one case per 10,000). In Haryana 21 District have District leprosy treatment centre with 420 leprosy patients.

District Rewari

Leprosy cases are showing declining trends. In 2008-09 total cases are 11 and in 2009-10 only 6 cases are reported and under treatment. Training to Medical Officer is proposed under the program. MCR foot wear has been prescribed to two patients and orders are placed. Drugs stocks are as per needs and well maintained in records. ASHA, SMS and SHGs are involved in the IEC activities.

## 15.RCH II

Under Reproductive and Child Health II various initiatives has been scaled up in state along with state specific innovations like Delivery Huts, Janani Suidha Yojana, Jaccha Baccha Scheme, Maternal Death Audit Scheme and Urban RCH Centre.

Institutional Delivery in government health facilities has increased from 83133 (16 % of the targets of year 2006-07) to 111866 (29% of targets up to Sept 2009 only). Delivery in private health facilities have also increased but not very significant but over all institutional delivery rates have increased from 49% (2006) to 66 % (Sept 2009). GOI scheme of JSY, State Sub Plan JSY and Jaccha Baccha Yojana and delivery Hut scheme has contributed significantly in increasing institutional deliveries in state.

Janani Surkhsa Yojana (GOI scheme) was launched in state in year 2007-08 and achievement of the years was 17685. In year 2008-09 the achievement has increased up to 57447.

State has also initiated Janani Surksha Yojana (SC/ST) in 2008 and number of beneficiaries is given in table below.

Year	Total no. of beneficiaries
2008-09	44787
2009-10 (Sept 09)	5899

State initiative Jaccha Baccha Yojana also has made impact on increase in institutional delivery. In year 08-09 numbers of beneficiaries are 16086 and in year 09-10 (Sept 09) beneficiaries are 12503.

### Delivery hut

Year	Total Delivery Huts (DH) sanctioned	Total Delivery Huts (DH) established	Total Deliveries conducted at DH	No. of cases referred
2005-06	300	258	4414	319
2006-07	500	429	16561	2271
2007-08	500	486	27180	4593
2008-09	544	511	23773	2785
2009-10 (upto Sep. 2009)	566	511	19016	2069

Well established and maternal health scheme of state "Delivery Hut" was launched in 2005-06 and started with 258 Delivery Huts and in year 2009 total of 511 huts are functional. Numbers of delivery conducted at Delivery Huts increase from 2005-06 to 2007-08 but starts falling from 07-08 to 08-09 (from 27180 to 23773). May be due to scaling up of JSY (GOI as well State sub plan) number of deliveries in delivery hut are decreasing. However state needs to develop the linkages with these delivery huts in case of complications.

To analyze and assessing the causes of the maternal deaths in state Maternal Death Audit Scheme was launched in state in 2009 and up to Sept 2009 total 60 Maternal Deaths are reported and detailed analysis was done.

Neonatal corners are established in Delivery Huts and planned to establish neonatal care unit in district hospitals. Neonatal stabilizing units are proposed in PHCs and CHCs. From March 09- Sept 09 total of 4652 neonates are admitted and registered in OPD; 184 neonatal are referred to higher centre and 64 deaths has been reported.

IMNCI is scaled up to 8 districts in state and 26 MOs, 670 Nurses and ANM are trained. 4 more districts will be included in IMNCI during next financial year.

Family planning achievement in states since 2005 are having mixed results, Permanent sterilization increased till 2005-06 and then declining trends till 2007-08 and increasing trends in 2008-09. Present year's (2009-10) Vasectomy achievement are showing declining trend in comparison to last years but tubectomy achievements shows increasing trends (32790 to 35160)

BCG, DPT, Measles coverage (Reported) is more then 90% across the state whereas NFHS data reports does not match with reported data. Weak micro planning, High Risk Area mapping, need of capacity building in skill & planning and poor inter sectoral coordination are affecting immunization quantitatively as well qualitatively.

Session held and planned are 100% and only 4 session are held with alternate vaccine delivery which shows that ANM or the health workers are carrying vaccines to session site whereas it is not clear that vaccine are collected in day advance or on the same day.

## Field visits

### Rewari

Institutional delivery has increased from 54 % in year 07-08 to 86.95 in year 09-10 (up to Sept 09). Under Delivery Hut Scheme number of delivery showing declining trends, 1298 delivery in 07-08, and delivery 1106 in 08-09 and in year 09-10 (up to Sept 09) only 843 delivery are reported. These declining trends are to be assessed for reasons.

In routine Immunization activities, District Rewari also has also 100% of session held. District RI core group meetings not held last month. RIMS are being used in district and feedback to blocks is regular. Reports to States are sent regularly. Cold chain is maintained. Vaccine van is in running condition and used in distribution of vaccine to Blocks and PHC. Ice lined Refrigerator and Deep Fridge is functional in district and PHC visited but district doesn't have refrigerator mechanic. Except JE and Hepatitis B stocks of vaccines are available since last six months. Waste Disposal has been outsourced to some agency. At district Rewari RI micro plan is not prepared for urban slums and underserved population. Monitoring visit to sessions is being done by block medical officers.

### Panchkula district

#### Case load handled by District hospital

	Normal Delivery	MTP	LSCS
2006	3110	700	713
2007	3280	517	674
2008	3634	522	838
2009			

Except MTP other case load has increased and LSCS increase may be due increased number of complicated cases are being referred from periphery.

50 beds are allocated to maternal health services with ten beds for post operative. Average delivery load is 20 per day. Three labour tables are operational with 24 hours MO and SN posted in labour room. New born corner is established in Labour room. SN are trained in SBA and using Misoprostol and Magsulf.

## **16.Preventive and Promotive Health Aspect with special reference to inter sectoral convergences and convergence with social determinants of health**

District health and Family Welfare Society is district level convergence forum for preventive health and promotion of coordinated health initiatives. District Health officers of the district are member secretary for the society and responsible for implementation of the decision taken and scaling up the Government initiatives.

NGO involvements in health program is also providing opportunity of converging other sector's expertise in health activities because majority of NGO are operational in various community development field like education, gender, poverty and socially exclusive groups.

SKS and VLC-VHSC are platform to increase participation of related sector for over all community ownership of the health services and community monitoring of health program.

In VHSC and SKS participation of School teacher, Water supply department personnel at villages and Block level, PRI members, CBO members, SHG members are desired to ensure effective convergence of all stake holders working in various areas.

Sakshar Mahila Samooh (SMS) are community based organization of educated woman who are recently looked up to for utilizing their potential in BCC for different health program.

## **17.Nutrition**

Despite leading food producing state, Haryana reported prevalence of malnutrition and anemia in children and women. Under the National Nutritional Program Iron, Folic Acid Tablets are provided. Department of Women and Child Development with coordinated effort of ICDS worker AWW and ANM are identifying severely malnourished children and referred to health facilities for treatment.

District Rewari has initiated testing of anemia and de-worming campaign in the district. They have taken up this campaign with cooperation of LIONS CLUB. Their objective is to cover all the schools children particularly girls of the district. Monday and Saturday have been fixed for visit to the schools. A team along with Lady medical officer, Dental Surgeon, ANM and LT visits the schools on the fixed days. Tests are conducted and anemic children are given with IFA tablets. De-worming tablets are also provided to the children. Private laboratory services are being utilized for this camp purpose. Two such Camps have been held till date. In the first camp 800 children and in second camp about 390 (Total 1170) children were treated.

## **18.NGO partnership**

NGO are involved in Mother NGO, Janani Suvidha Yojana, Hemophilia, Social marketing of sanitary napkins and VLC and VHSC for village health action plan. In Janani Suvidha Yojana for urban poor in eight districts were launched with the support of Regional NGOs. Performances of NGOs vary from district to district, coordination among the stake holders and capacity building of partners' needs attentions.

Community based Organization are involved in Social Marketing of sanitary napkins in all 21 district, subsidized sanitary napkins are sold to rural women at rate of 10 rupees (cost is 25 rupees and 15 rupees are subsidized by Department)

Social mapping of health and sanitation problem in four villages of Panchkula with the support of NGO is being piloted. Rangoli methods are used in village mapping and village planning for health and community development.

In District Rewari LION Club is involved in Anemia reduction and de worming campaign.

## **19.Overall program management**

The State of Haryana has NRHM Cell in state capital is responsible for overall management of the Program with one NRHM nodal officer. (state administrative services officer) and Program management staff i.e. State Program Manager and account managers and ancillary staff.

State has one public health manager in district head quarter in addition to District NRHM program Management unit to support CMO in program implementation and monitoring.

State is periodically reviewing the District performances on the basis of NRHM indicators and other related health programs.

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

District Program management unit with support from State NRHM management team support CMO in day to day basis in planning, implementation and monitoring of the NRHM and other health activities. Block management teams are supporting Block Medical officer in practically implementation of the NRHM and health activities. Reporting and financial issues are handled at block level before forwarding them to districts.

IDSP, RNTCP, NLEP, NIDDCP, NBCP, NVBDCP programs have their designated nodal officers or independent program staff like RNTCP (STLS and STS) are supporting districts and Block officers in program management.

HMIS is the tool for reporting and analyzing the data at district level, this has been utilized by the district officers in reviewing program performance.

## 20. Financial managements

NRHM funds allocations to the districts are via electronic medium but communication to district official and block official is delayed and often funds are transferred but official come to know only when they received communication though post. Precious time is lost.

YEAR	APPROVED BUDGET (ROP) IN CRORE	REMARKS
07-08	137.59	Includes states contribution with NRHM Resource Envelop
08-09	201.84	
09-10	285.80	

Budget expenditure of the 235.49 Crore is incurred in year 2008-09 and Rs. 55.00 Crore are spent in year 2009-10 up to Sept 09.

Financial management needs a lot of attention as the systems are not standardized in different districts and within the district itself. Clarity is needed what are procurement procedures at different levels – SC, PHC, CHC, DH and how are accounts to be maintained regarding payment of cash disbursements as well as account keeping. Role of banks in fund transfer also needs review specially e – transfer!!!. Funds are sent to district in time but time taken to reach district and communication to district regarding fund allocation and guidelines for the use of funds according to the program norms. Below the district the fund transfer is through cheques only.

Fund utilization is good in drug procurements, maternal health, family planning and Village Health and Sanitation Committee heads. No capacity building efforts for financial management. Funds transfer is based on activities and hence multiple times transfer of funds are being done by the states to district. Districts are not using tally software for accounting and book keeping.

ASHA and JSY payments are done in cash and those also delayed by three months and there are back log in these payments. JSY funds not available at all level (ANM, PHC MO and BPHC MO). JSY financial records are maintained in 3-4 registers and reconciling is a problem.

Bank accounts are opened for SC untied funds and these funds are being utilized for the health care services. District and Block account manager

are supporting districts in account keeping and utilization report of the NRHM funds. E banking is being utilized in fund transfer from state to district but not from district to block and below.

Concurrent auditors are designated in districts and state and they are supporting in book keeping and accounting. Even then delays in Utilization certification are there and affecting funds transfers. In last audited reports of 08-09 no major adverse comments were made.

Interest incurred on the funds in banks are not taken in accounts for expenditures and in year 08-09 Rs. 3,23,711 are generated as interest in funds at District Health Society.

## 21.Data management

Government of India launched Web Based Health Management Information System in October 2008 and under this program Haryana has recruited HMIS support staff at state HQ and assigned responsibility to district data entry person after trainings. Reporting formats up to sub Centre are available and reporting from districts is initiated. Presently 70-75 % data are uploaded from district in HMIS and state has forwarded it reports to GOI on regular basis. Despite HMIS established in state different data information reporting is still exists, about 80 various reporting formats are in use i.e. RIMS reporting, Immunization reports to District administrations and other.

Data is collected by a Data manager who prints out the template and fills it in with information from CHC, PHC level and from the district hospital. There is no analysis of data at district level and PHC level to help the PHC and district plans.

Civil Registration System (CRS) is also effectively established in state. Medical Officer of PHCs is registrar and sub registrar is pharmacist and Nurse. ANM, AWW, ASHA and PRI are source of information in villages and communicate to health worker and then to PHCs. PHCs prepare reports and sent to District registrar. 413 registration centers are operational in state then 175 before revision of CRS in state. 96 % of births and 90% of deaths are registered in CRS. CRS 2008 shows birth rates of 22.4 and death rate is 6.0 only.

There is neither Hospital Management System (HMS) nor any hospital information systems at the state level. At present, OPD registration is being computerized but nothing beyond this. An operator has been contracted to run this system and is working well. Given that the GH will play an important role across the state given the good road connectivity, the state should consider rolling out a HMS for all district level GHs and over time to well performing CHCs and SDHs.

## **State specific issues**

### Co located Health Facilities

The issue of sub centers located within PHC / CHC is acceptable provided clear geographical jurisdiction assigned to ANM / MPW(M). However PHC & CHC must be clearly segregated to different location to ensure more equitable availability of health services. Plan of evacuation of emergencies especially OBS cases must be planned and health facilities appropriately located. No point setting up 24 x 7 facilities in close proximity. Problems of female foeticide and increased maternal mortality need to be analyzed at state level, at district level or even lower. Encouragement to PG students for dissertations / ICMR short term fellowships for med college students plus govt sponsored research needed to identify exact causes of the problem before they can be addressed.

Waste management due to industrialization and aspects of town planning in the smaller hamlets / townships are urgently needed if these areas are not to develop into sanitation nightmares

### BCC through Sakshar Mahila Samooh (SMS)

This community based organization has evolved in rural Haryana with participation of the literate woman (educated up to 10<sup>th</sup>). This organization is being now involved in BCC activity at village level. These SMS members are trained at Block Level by BEE and other program officials. These SMS will be the over all in charge of health and IEC activities in villages. Fortnightly activities (Pakhwara) focusing on various health programs will be conducted by SMS as per activity calendar provided by health department. SMS will disseminate the information to school children as they are more receptive for the information. ASHA, ANM and MPW will be supporting activities of SMS in their area and report progress and constraints if any, to health department. Rs. 10000/- per SMS group were distributed for health education. Training of more than 60000 women in health education is proposed. BEE's will be overall supervisors for these activities and will be the link between SMS subgroup and health departments.

15 Radio Jingles on all health issues. Regular newspaper advertisement on major health programmes. Separate Guide booklets for Medical Officers of PHCs, ASHA & SMS under print. A DO letter by Hon'ble Chief

Minister, Haryana and folder on health schemes has been sent to 69000 Panches and Sarpanches.

SMS should also take up the issues of Tobacco, Alcohol in rural area. In rural community smoking and alcohol are rampant and also causing morbidity i.e. COPD, domestic violence, accidents, liver related illness etc. SMS can initiate BCC activity to reduce the use of Smoking and alcohol in community by educating children and adolescents. The other issue is inclusion of all women instead of only 10<sup>th</sup> pass.

### Urban RCH centers

Population migration, industrialization has led to the formation of slums in Haryana. Under phase II, it is planned to give focused attention to improve the health of slum population.

Under NRHM various activities are being implemented to improve the service delivery of the rural people. About 10% of the urban population in Haryana State is living in urban slums. More people from rural areas are moving towards the urban areas for their employment. Due to the increasing population, rapid industrialization the people living in the urban areas are exposed to various health problems such as pollution, communicable diseases, and nutritional problems. Primary health care available to rural population is not available to the urban poor in an organized manner.

Urban slums are concentrated in certain towns of Haryana like Faridabad, Gurgaon, Panipat & Yamuna Nagar. It has been seen that these urban slums are rapidly increasing in proportion in the increasing industrialization. These urban slums are posing a great challenge to our health programmes. Under NRHM action plan 2009-10, 50 urban health posts have to be established in the vicinity of urban slums so that people residing in these areas can avail facility of basic health service and RCH services.

### Delivery at Sub Centre level

In Haryana delivery are being conducted at Sub centers also and infield visits SC Motla Kalan number of delivery in year are more then 500. Hence strengthening (Buildings, equipments and HR) may requires to provide quality services at SC. Sub centre with high number of delivery should be equipped with referral services or linkages to support emergency referral.some of them can act as training site for the hands on training.ANM of such SC can act as trainer.state needs to look at these options.

### Delivery hut

State Of Haryana has unique concept of Delivery huts at Sub Centre with standardized Infrastructures and human resource. SC should have three rooms (one ANM office, one Labor room and one for newborn care), additional second ANM should be posted, quarter for ANM, 24 hours water and electricity. Both ANM should be trained in SBA. One female sweeper should be available for SC.

### Referral Services

Recently the ambulance service (102) was launched in states with NRHM support. This ambulance service is managed by Red Cross society of the Haryana. Presently provision of one ambulance at district hospital, CHC and Sub district hospital and 2 at every PHC is proposed and will be expanded as per requirement. Need of training to Driver and assistant staff is felt when team interacted with staff.

### PNDT

Since the inception of program 233 inspections were made and in the year 09-10 total 26 inspection were done and 4 premises were sealed but all this four premises were de sealed.

### Migratory population

Haryana is having migratory population from various states during corps seasons and these populations resides in very unhealthy and unhygienic conditions and their woman and children are not registered in any official records of health services and hence they are not being addressed in health planning. State should plan for services to these populations.

### Janani Suvidha Yojana (State Sub Plan for SC/ST)

This scheme was launched in April, 2008 under the State Sub Plan. Under this scheme an assistance of Rs.1500/- is given to each pregnant woman belonging to SC/ST family to get them delivered in the health institution both in Govt. and Private sector. This assistance is given in three installments i.e. Rs.500/- each on registration of antenatal case (1<sup>st</sup> trimester), second installment of Rs.500/- on getting check-up done in 3<sup>rd</sup> trimester and Rs.500/- on the day of delivery or maximum within 5 working days.

S.No.	Installment	When	Amount
1.	1 <sup>st</sup> installment	At the time of registration of 1 <sup>st</sup> trimester along with proof of entitlement	Rs.500/-
2.	2 <sup>nd</sup> installment	During 3 <sup>rd</sup> trimester	Rs.500/-
3.	3 <sup>rd</sup> installment	On the day of delivery	Rs.500/-

pregnant SC/ST woman coming directly for delivery to the institution without prior antenatal check-up full payment of Rs.1500/- is made to the beneficiary.

Haryana has SC population of approximately 40.91 lacs in the year 2008-09 and the total births are expected to be around 113000. Under this scheme around 16501 beneficiaries have availed benefit under this scheme till December 2008. The issue of delayed payments were noticed everywhere, state needs to streamline and also reduce the documentation papers. The average delay has been more than 3 months.

#### Janani Suvidha Yojana (upto January 2008)

Janani Suvidha Yojana is a State innovation launched in 2006 to provide for quality antenatal, natal and postnatal services easily accessible to women living in urban slums of Haryana. The population of urban slums in Haryana according to 2001 Census is 40.91 lacs and around 37000 deliveries are expected to take place every year in urban slums.

- i. Voucher scheme harnesses the available private infrastructure by involving the existing private healthcare providers
- ii. Scheme is being implemented through mother NGOs, working in the respective districts, along with the State Health system
- iii. Sakhi is a link between clients and private health providers and is responsible for facilitating the clients for availing antenatal checkups, institutional delivery, referral transport and immunization of the newborn at a private institution. The private institution is compensated as per norms under this scheme.

#### Jaccha Baccha Scheme

Jaccha Baccha Scheme was launched on 15<sup>th</sup> August, 2008 to provide incentives to the Multi Purpose Health Worker (F), Staff Nurses & Medical Officers who are skilled birth attendants. According to this scheme every SBA conducting an institutional delivery at Sub Centre PHC or CHC along with other required

parameters receives a cash incentive of Rs.400/- in case of male new born and Rs.600/- in case of female new born. In case of obstructed labour SBA ensures referrals and accompanies mother to the nearest FRU and is entitled to benefit of Rs.100/- in such case. In addition, Staff Nurse/ANM assisting the delivery is paid Rs.100/-, LTs paid Rs.50/- and Class-IV paid Rs.50/- per delivery

A communication received from Gol raised the concern that a blanket cash incentive scheme for all deliveries is unjustifiable. The incentives should be link to performance over and above that which is a part of normal duty of the health staff.

As per the recommendations of Gol, the Jaccha Baccha Scheme has been revised as under:

1. The incentive to the ANMs at the Sub Centres is applicable after conducting minimum 3 deliveries pre ANM per month.
2. The incentive to the Staff Nurses at PHCs & CHCs is applicable after they have conducted a minimum of 5 deliveries per Staff Nurse per month.

The incentive for the Doctors at PHCs & CHCs is applicable after they have conducted a minimum of 5 deliveries per Doctor per month. The mode of the delivery can be either vaginal or operative.

#### Alcoholism and Smoking in rural population

Team visited villages and observed that in rural area country made liquors is easily available to population , as it is observed that within one kilometer of travel by road three liquor shops are located. Similarly smoking is alarmingly practiced in rural population and smoking related morbidity on rise. State may develop a policy for discouraging the habits of smoking and alcohol consumptions. IEC activity and village woman groups (SMS) should be utilized in enabling community to promote healthier living.

## Recommendation

- ✓ Strengthen district planning process - state appraisal process and capacity building of district PMU and directorate staff
- ✓ Rationalize infrastructural expansion taking into consideration existing public and private sector capacity
- ✓ Outline job descriptions for all staff - demarcate responsibilities between regular and new contractual staff
- ✓ Greater use of PPPs by improved contract management systems
- ✓ Rationalize HMIS – eliminate redundant reports
- ✓ Build capacity of district and facility managers in use of data (HMIS, FM and surveys) for decision making
- ✓ Consider introduction of Hospital Management Systems for GHs and beneficiary tracking systems at the SC level
- ✓ Improve quality of services
- ✓ Strengthen QA function at state and district level
- ✓ Introduce a team based internal quality improvement process at the facility
- ✓ Use of external assessment system
- ✓ Link training process with HR planning
- ✓ Strengthen SIHFW to monitor and supervise quality of training, trainer's performance as well as post training follow up
- ✓ Integrate planning and implementation of VHNDs
- ✓ Evaluate SMS effectiveness and strengthen processes for improved demand generation and community monitoring
- ✓ Expand promising innovations and good practices across state – for example, maternal death audit analysis
- ✓ Rationalize compliance requirements for JSY in consultation with GOI for improved payments
- ✓ Improve FM internal controls by regular district visits and capacity building
- ✓ Increase community participation in SKS
- ✓ Better dissemination of the planning process under NRHM
- ✓ Attempt to involve community participation in planning process
- ✓ ASHA to be provided with Drug kits as per GOI norms
- ✓ Wide dissemination of improvements occurring at all levels of govt institutions to the people is urgently required to facilitate utilisation
  - ✓ Benefits under JSY to be disbursed as per stipulation without bureaucratic delays and insistence on documentation
  - ✓ Inter sectoral coordination needed at all levels to ensure that staff and resources are not duplicated. There was a visible disconnect between health dept and other depts. who were working for improvements likely to impact on health ( sanitation , water, ICDS, education, etc)

## Conclusion

Haryana is one of the high performing states with peculiar health issues/ activity like falling sex ratio, ASHA program with NGO support and state specific Jaccha Baccha Scheme and unique delivery hut schemes. Well connected roads and good power and water supply with good infrastructure of the health facilities. Although shortage of specialist, nurses and medical officers are concerns but availability of good number of private facilities may need re visit for implementation of PPP models. Interestingly Haryana has good number of dental surgeons and now started training them in public health and utilizing them in implementation of health programs. Health facilities are now over burdened with the beneficiaries from all sectors of population as well from the socially excluded population. Emergency Ambulance services (108) and IEC/BCC activity by Sakshar Mahila Samooh (SMS) is recently taken up by state shows their commitment of utilizing technical update in referrals and at same time utilizing community capacities in disseminating health education. Need of time is to re appropriation of the existing health human resource and health infrastructure to provide quality health services to community. NRHM has added thrust to the state to take up initiatives and fulfilling the gaps in HR and Infrastructures. It is vision of the state health department to provide cost effective, accessible and quality health services by efficient management of program and regular capacity building of professional.