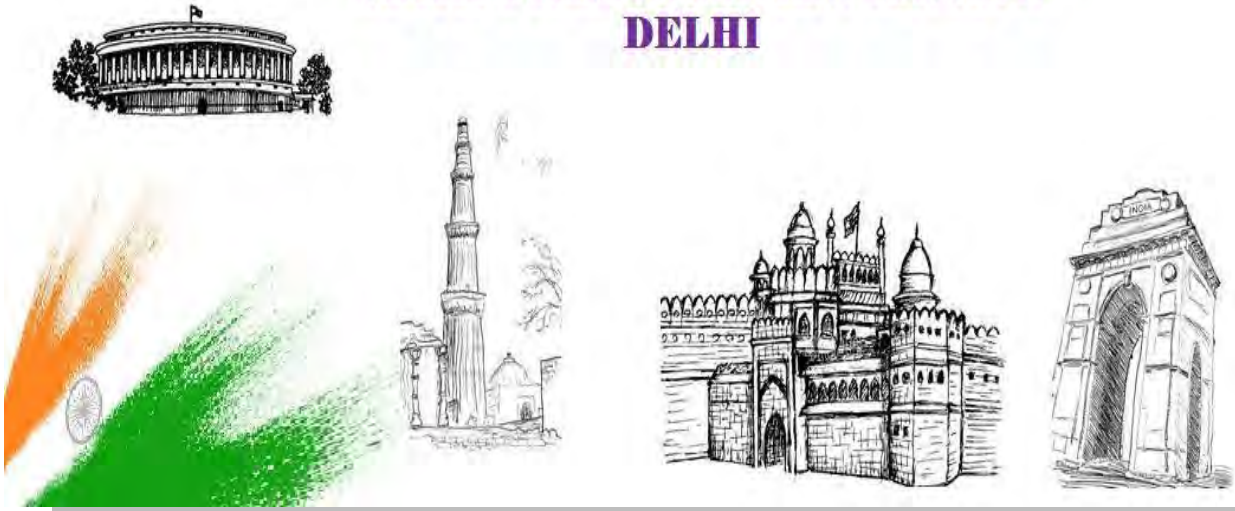




SIXTH COMMON REVIEW MISSION DELHI



Ministry of Health & Family Welfare, Government of India
2ND – 9TH November' 2012

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Acknowledgement

Delhi is unique and so was the experience of the Delhi Common Review Mission Team. All the members have been residing in Delhi for many years but everyone came to know about its unique and diverse Healthcare system scenario in this CRM only.

It has been great honour and privilege to be a part of First CRM conducted in the State of Delhi. The experience for the whole team was exciting since the institutional framework and programme implementation upto grass root level is just different from all other 34 States & UTs of India.

The CRM team has taken sincere efforts in conducting this review. However, it would not have been possible without kind support and help of many individuals and organizations. We would like to extend our sincere thanks to all of them.

The able leadership and an affable committed persona of Secretary Health & Family Welfare Mr. S.C.L. Das was exemplary and the work ethics and support was distinctly visible as percolated down to the whole team in the Health Department. Our humble gratitude to him and the State team.

We would also like to take the opportunity to express our sincere thanks to Spl. Secretary & MD-NRHM- Shri S.B. Shashank, Commisioner EDMC-Dr Sajjan Yadav , D.C.-North-East district-Shri L.R.Garg, D.C.-South-West district - Shri Vikas Anand, Dir. FW- Dr D.K.Dewan, Dir. HS-Dr. N. V. Kamat, CDMOs & Distt MDs, State and District Programme Officers & Programme managers, Officers from all the three Municipal Corporations and representatives of other contributing agencies/organizations, who led their constant support and willingness to share their vast knowledge that made us understand healthcare system of Delhi and its great depths to meet our requirements and helped us complete the assigned tasks, timely.

We extend our humble thanks to health care officials working in the field with special mention to the frontline workers.

We express our sincere gratitude to Secretary, Health & Family Welfare, Shri P.K.Pradhan, Spl Secretary (Health) Shri Keshav Desiraju, DGHS Prof. Jagdish Prasad, AS & MD-NRHM, Smt Anuradha Gupta, Joint Secretaries and their teams in the Ministry of Health & Family Welfare (Govt of India) for giving us this opportunity and providing all guidance.

Although there may be many who remain unacknowledged in this humble note of gratitude, there are none who remain unappreciated.

-CRM Team-Delhi

Executive Summary

The State of Delhi was included for Common Review Mission for the first time in the seven years of National Rural Health Mission. In accordance with the terms of reference that covered the key elements of the NRHM, the CRM team undertook in-depth review of documents and data, held interviews with the key stakeholders at community, district and state levels, had focus group discussions with community members & frontline workers, and visited a range of health care facilities in the South West and North East Districts of the State.

Public Healthcare System in the state is made complex by the presence of multiple institutions that are engaged in ensuring health outcomes for its population of 16.7 million. Health care services are provided by the State and Central Government, Municipal Corporation of Delhi, New Delhi Municipal Committee and various parastatal organizations besides a substantial and varied, largely unregulated private sector. Preventive and promotive health care and public health services are largely the domain of the state health services and the MCD. Of the total of 37,468 beds for the city, State Government contributes 20%, MCD-11%, GOI-28%, NDMC-1% and the private sector-40%.

These institutions have varying administrative and financial norms, roles and responsibilities, accountability structures, and capacities, necessitating coordination of a high order. The complexity of the institutional framework is further complicated by a high divergence in socio-economic and demographic attributes of the population, and constant in-migration particularly from neighbouring states. Like other urban agglomerates, reportedly 40% of the largely heterogenous population is migrant, thus posing a challenge to the provision of a seamless continuum care particularly for mothers, newborns and children.

Delhi's IMR is 28 against the national average of 44, (SRS 2011), and the trend of decline in U5MR and TFR is steady. However there are significant disparities in the indicators such as immunization coverage, ANC and PNC, between districts and within the districts (South and West being better off than the ones in the East and North). The state's annual health budget for FY 12-13 is Rs. 3389 crores, and the NRHM budget is Rs. 281 crores. Nevertheless this support acts as a key leverage, enabling the state to expand service access through building/renovating health facilities and increase the human resource capacity. Health spending through NRHM over the last few year's ranges between 62% to 65%.

District divergences for health outcomes are significant and do not solely relate to differences in population socio-economic characteristics, but also to the level of infrastructure, human resources, management support, technical assistance and supervision provided by the State.

TOR-wise summary is appended at the end of respective TORs.

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Abbreviations

ABER	Annual Blood Examination Rate
AIIMS	All India Institute of Medical Sciences
AMG	Annual Maintenance Grant / ASHA Mentoring Group
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
API	Annual Parasite Incidence
ARC	ASHA Resource Centre
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga Unani Siddha Homeopathy
BCC	Behaviour Change Communication
BEmOC	Basic Emergency Obstetric Care
BMWM	Bio Medical Waste Management
BPM	Block Programme Manager
BSF	Border Security Force
CDEO	Computer Data Entry Operator
CDMO	Chief District Medical Officer
CDPO	Child Development Project Officer
CES	Coverage Evaluation Survey
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CISF	Central Industrial Security Force
CPA	Central Procurement Agency
CRPF	Central Reserve Police Force
C-section	Caesarean section
CSR	Corporate Social Responsibility
CT Scan	Computerized Tomography Scan
DAM	District Accounts Manager
DC	District Collector / Commissioner
DDMSC	Dadadev Matru avum Shishu Chikitsalaya
DDT	Dichloro-Diphenyl-Trichloroethane
DFW	Director Family Welfare
DGD	Delhi Government Dispensary
DH	District Hospital
DHAP	District Health Action Plan
DHS	District Health Society / Director Health Services
DLHS	District Level Household Survey
DMO	District Malaria Officer
DOTS	Direct Observation Therapy Short-course
DP	Development Partner
DPM	District Program Manager
DPMU	District Programme Management Unit
DPT	Diphtheria Pertussis Typhoid Vaccine
DTC	District Training Centre / Delhi Tourism Corporation
DTT	District Training Team

EDMCD	East Delhi Municipal Corporation
EmOC	Emergency Obstetric Care
EMRI	Emergency Management Research Institute
ENMR	Early Neonatal Mortality Rate
ERS	Emergency Response Service
ESIC	Employees State Insurance Corporation
F-IMNCI	Facility based Integrated Management of Neonatal and Childhood Illnesses
FMR	Financial Monitoring Report
FP	Family Planning
GNCTD	Governor for National Capital Territory of Delhi
GNM	General Nurse Midwife
GoI	Government of India
GTBH	Guru Tegh Bahadur Hospital
Hb	Haemoglobin
HBNC	Home Based Newborn Care
HFWTC	Health & Family Welfare Training Centre
HMIS	Health Management Information System
HQ	Headquarter
HR	Human Resources
HSC	Health Sub Centre
ICDS	Integrated Child Development Scheme
IDHS	Integrated District Health Society
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In-Patient Department
IPH	Institute of Public Health
IPHS	Indian Public Health Standards
IRS	Indoor Residual Spraying
IUCD	Intra-uterine Contraceptive Device
IUD	Intra-Uterine Device
IYCFC	Infant and Young Child Feeding Centre
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LBW	Low Birth Weight
LHMC	Lady Hardinge Medical College
LHV	Lady Health Visitor
LS	Lady Supervisor
LSAS	Life Saving Anaesthetic Skills
LT	Lab Technician
MAMC	Maulana Azad Medical College
MC	Municipal Commissioner
MCD	Municipal Corporation of Delhi
MCTS	Mother and Child Tracking System
MC&WC	Maternal & Child Welfare Centre
MDR	Maternal Death Review
MDR-TB	Multi Drug Resistant-Tuberculosis
MH	Maternity Home

MIS	Management Information System
MLA	Member Legislative Assembly
MMR	Maternal Mortality Rate
MMR	Measles Mumps Rubella Vaccine
MMU	Mobile Medical Unit
MO	Medical Officer
MO I/C	Medical Officer in-charge
MoHFW	Ministry of Health and Family Welfare, Govt. of India
MoU	Memorandum of Understanding
MP	Malaria Parasite
MPW	Multi-Purpose Worker
MS	Medical Superintendent of Hospital
MSG	Mission Steering Group
MTC	Malnutrition Treatment Centre
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NBW	New-Born Weight
NDCP	National Disease Control Program
NDMC	New Delhi Municipal Committee
NDMCD	North Delhi Municipal Corporation
NFHS	National Family Health Survey
NGO	Non Governmental Organisation
NHSRC	National Health Systems Resource Centre
NIHFW	National Institute of Health and Family Welfare
NLEP	National Leprosy Eradication Programme
NMR	Neonatal Mortality Rate
NPCB	National Program for Control of Blindness
NRC	Nutrition Rehabilitation Centre
NSSK	Navjat Shishu Suraksha Karyakram
NSV	Non Scalpel Vasectomy
NVBDCP	National Vector Borne Disease Control Programme
OCP	Oral Contraceptive Pill
OPD	Out-Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
OT	Operation Theatre
PC&PNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PHC	Primary Health Centre
PHN	Public Health Nurse
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PNC	Post Natal Care
PPI	Pulse Polio Immunisation
PPIUCD	Post-partum Intra-uterine Contraceptive Device
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
PUHC	Primary Urban Health Centre
Pv	Positive Vivax / Plasmodium <i>vivax</i>
PWD	Public Works Department
RCH	Reproductive and Child Health

RDK	Rapid Diagnostic Kit
RHTC	Rural Health Training Centre, Najafgarh
RI	Routine Immunisation
RKS	Rogi Kalyan Samiti
RMNCH	Reproductive Maternal Newborn and Child Health
ROP	Record of Proceedings
RTRH	Rao Tula Ram Hospital
SBA	Skilled Birth Attendance
SC	Scheduled Caste
SCs	Sub Centres
SDH	Sub-district Hospital
SD Hosp.	Swami Dayanand Hospital
SDMCD	South Delhi Municipal Corporation
SDO	Sub Division Officer
SFM	State Finance Manager
SHM	State Health Mission
SHP	School Health Program
SHS	State Health Society
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SJH	Safdarjang Hospital
SNCU	Sick Newborn Care Unit
SOE	Statement of Expenditure
SPHC	Seed Primary Health Centre
SPMU	State Programme Management Unit
SPO	State Program Officer
SRS	Sample Registration Survey
ST	Scheduled Tribe
TB	Tuberculosis
TFR	Total Fertility Rate
TOR	Terms of Reference
U5MR	Under - 5 Mortality Rate
UC	Utilization Certificate
UCMS	University College of Medical Sciences
UF	Untied Funds
UNICEF	United Nations Children's Fund
VHC	Village Health Committee
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
VMC	Vardhman Medical College
WCD	Women and Child Development
WHO	World Health Organization

Part-I: Overview and Introduction

Introduction to Common Review Mission

NRHM uses an intensive accountability framework through a three pronged process of (i) community based monitoring, (ii) external surveys and (iii) stringent internal monitoring on a regular basis. Common Review Mission (CRM) is a part of this intensive accountability framework and CRM Teams visit States regularly to review NRHM programme. This is the 1st CRM visit to the State of Delhi.

Objectives of the 6th Common Review Mission:

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

Facilities & Offices visited

South West District	
RTRM Hospital (DH)	MCW Centre, Nangalraya
Dadadev Hospital(SDH)	DGD Nangalraya
Delhi Cantonment Board Hospital	CGHS WC Nangalraya
RHTC Najafgarh	DGD Inderpuri
PHC Ujjwa	DGD Budh vihar
PHC Najafgarh	DGD Mallikpur
Sub centre Mitroan	DGD Dwarka Sec-10
Sub centre Dilchoan	MH Narayana
AWC- Mitroan	ANMTC, RHTC, Najafgarh
AWC- Dilchoan	CDMO-AYUSH SW District
DPMU-SW District	HFWTC, Saraswati Vihar

North East District
GTB Hospital
Swami Dayanand Hospital
Seemapuri Maternity home
DGD Seemapuri PUHC
Mustafabad PUHC
Yamuna Vihar Maternity home
Soniya Vihar Zero Pushta PUHC
Soniya Vihar 4.5 Pushta PUHC
M&CW New Seemapuri
AWC Centre (Number 26)
St. Stephen outreach centre Sunder Nagri

State background:



DELHI IS UNIQUE.....

Delhi is Unique in almost all aspects of health care systems. Delhi is home to several tertiary level hospitals, medical colleges, and a multitude of primary and secondary health centers. However there is a multiplicity of implementing agencies (the State Government, the Municipal Corporation, central government managed facilities, and a large private sector ranging from world class hospitals to untrained providers in the informal sector). The Primary Health Care System of Delhi is strikingly different from the conventional health care delivery systems across rest of India. The Primary Health care system of Delhi is rendered as complex owing to many factors, few of them are as follows:

- Institutional framework of Health Sector is unique and complex with multiplicity and presence of various controlling agencies
- Unique Structure / functions / Nomenclature
- Inequitable distribution

- Variable population density compounded by Migrant / Floating population
- Catchment areas covered by different agencies , contiguous & poorly demarcated defined
- Dual burden of disease (Communicable & Non Communicable) given the epidemiological and demographic transition, and socio economic disparities
- Substantial proportion of patient load from impoverished communities states across the border

Demographic Profile:

Delhi, officially the National Capital Territory of Delhi (NCT) that includes the Indian capital New Delhi, is the second most populous metropolis in India after Mumbai, with a population of 16.7 million in 2011. The city is also the eighth most populous metropolis in the world. The NCT and its urban region have been given the special status of National Capital Region (NCR) under the Constitution of India's 69th amendment act of 1991.

The greater NCR urban, which includes the neighbouring cities Baghpat, Sonapat, Gurgaon, Faridabad, Noida, Greater Noida and other nearby towns, has nearly 22.2 million residents .

The name *Delhi* is often also used to include urban areas near the NCT, and to refer to New Delhi, which lies within the metropolis. Although technically a federally administered Union Territory, the political administration of the NCT of Delhi today more closely resembles that of a State of India with its own legislature, high court and an executive council of ministers headed by a Chief Minister. New Delhi is jointly administered by the Federal Government of India and the Local Government of Delhi, and is the capital of the NCT of Delhi.

- Area; 1483 sq. km
- Districts; 11, Sub-districts; 27, Villages; 369¹ and Census towns; 110
- Population of Delhi: 1.67 lac (Urban; 163.33 lac, Rural; 4.19 lac, SC; 23.43lac, BPL; 23.3lac)
- Population density :11,297 persons per sq. km,
- Annual Growth rate; 1.92
- Sex ratio : 866 women per 1000 men
- Literacy rate: 86.34%

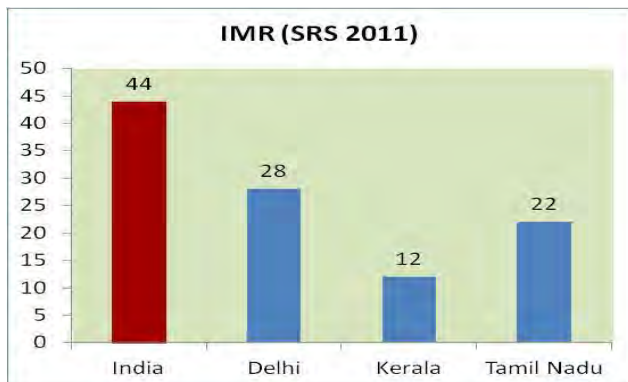
¹ http://www.delhi.gov.in/wps/wcm/connect/doiit_revenue/Revenue/Home/Organization+Setup/List+of+villages (as on 29th Sept 2011)

Health Indicators:

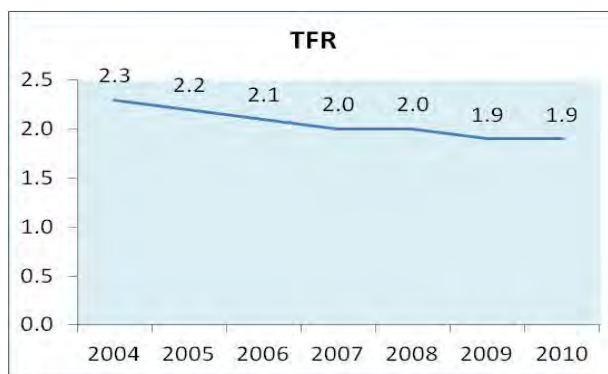
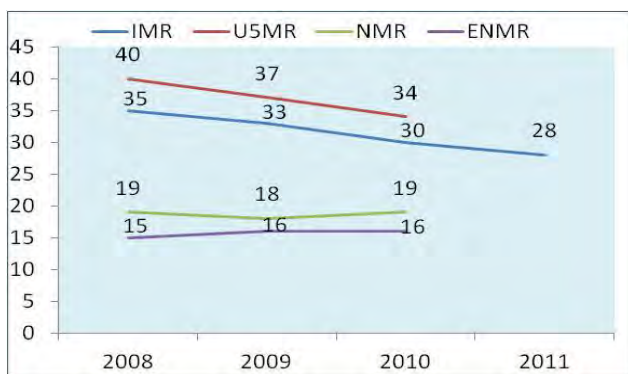
PARAMETERS	DELHI	INDIA	GOALS 2015/2017
IMR(SRS 2011)	28	44	<20 (BY 2015) & <15 (BY 2017)
MMR	134	212 (SRS 2009)	<100 (BY 2015) & <75 (BY 2017)
INSTITUTIONAL DELIVERY (CRS 2010-11)	83.6%	50.7%	>90% BY 2015 & 100% BY 2017
IMMUNIZATION COVERAGE (CES 2009)	63%	43.5%	100% BY 2017
CHILD-SEX RATIO (0-6 YRS)	866	914	
SEX RATIO AT BIRTH	893		956 F:1000 M AT BIRTH
BED:POPULATION RATIO	2.4/1000 POPULATION	1.03/1000 POPULATION	>5/1000 POPULATION

**Desk Review:
Outcomes**

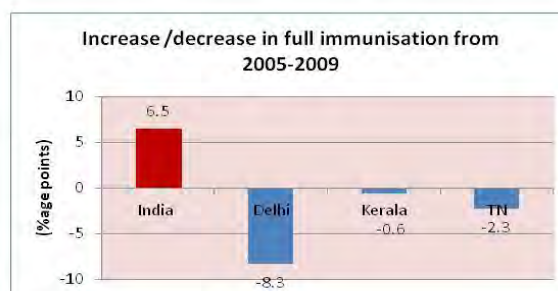
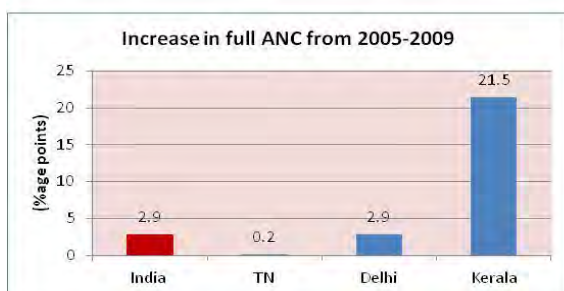
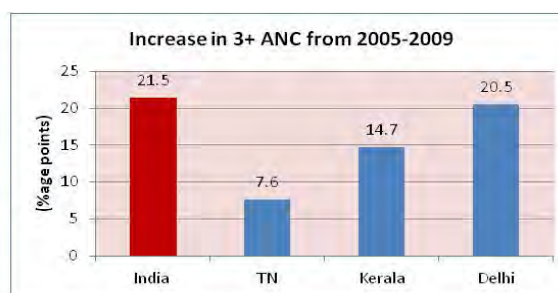
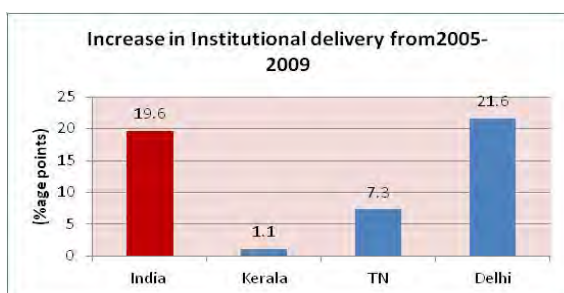
Delhi has met NRHM goals for IMR and TFR, while performance could be better vis-à-vis Kerala and Tamil Nadu:



U5MR, IMR and TFR have shown a declining trend, while NMR is a cause for concern, especially since it is likely to account for about 50% of infant deaths:



During the period 2005-2009 (CES) Delhi has improved at a faster pace vis-à-vis Kerala and TN on underlying indicators, although immunisation is cause for concern:

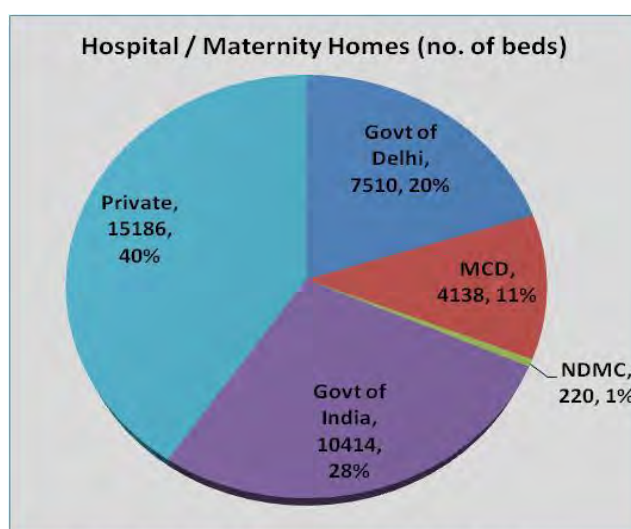


The issue of concern here is that the data for the state masks significant inequities in specific districts and sub-districts.

Relative shares of various agencies in provision of health care

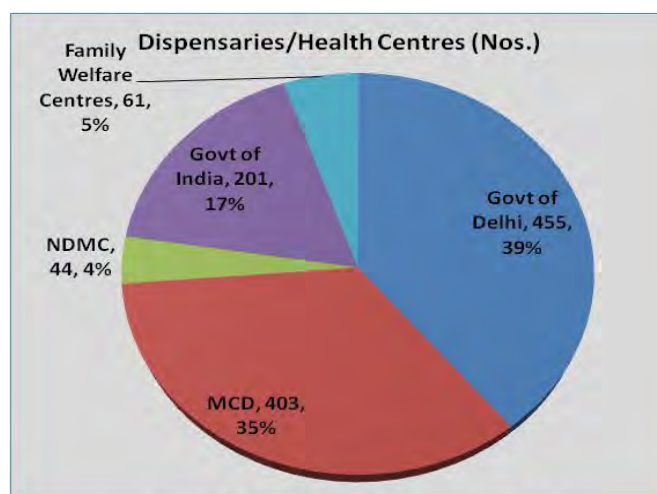
The improvement in outcomes is due to combined efforts of several agencies, in particular GNCTD, MCD (refers to the three local bodies), NDMC, Central Government institutions and the private sector.

Data on the relative share of these agencies in provision of health care is hard to come by. However, as on March 2009, the private sector accounted for 40% of beds, followed by central government agencies with 28%, GNCTD with 20% and MCD with 11%:



Total: 37468 (As on 31st March 2009)

MCD has a relatively much stronger presence in dispensaries/ health centres (OPD) accounting for 35% of facilities (excluding private sector units – data not available), while GNCTD has a relatively strong presence in both inpatient and outpatient care :



Total: 1164 (As on 31st March 2009)

Contribution by NRHM

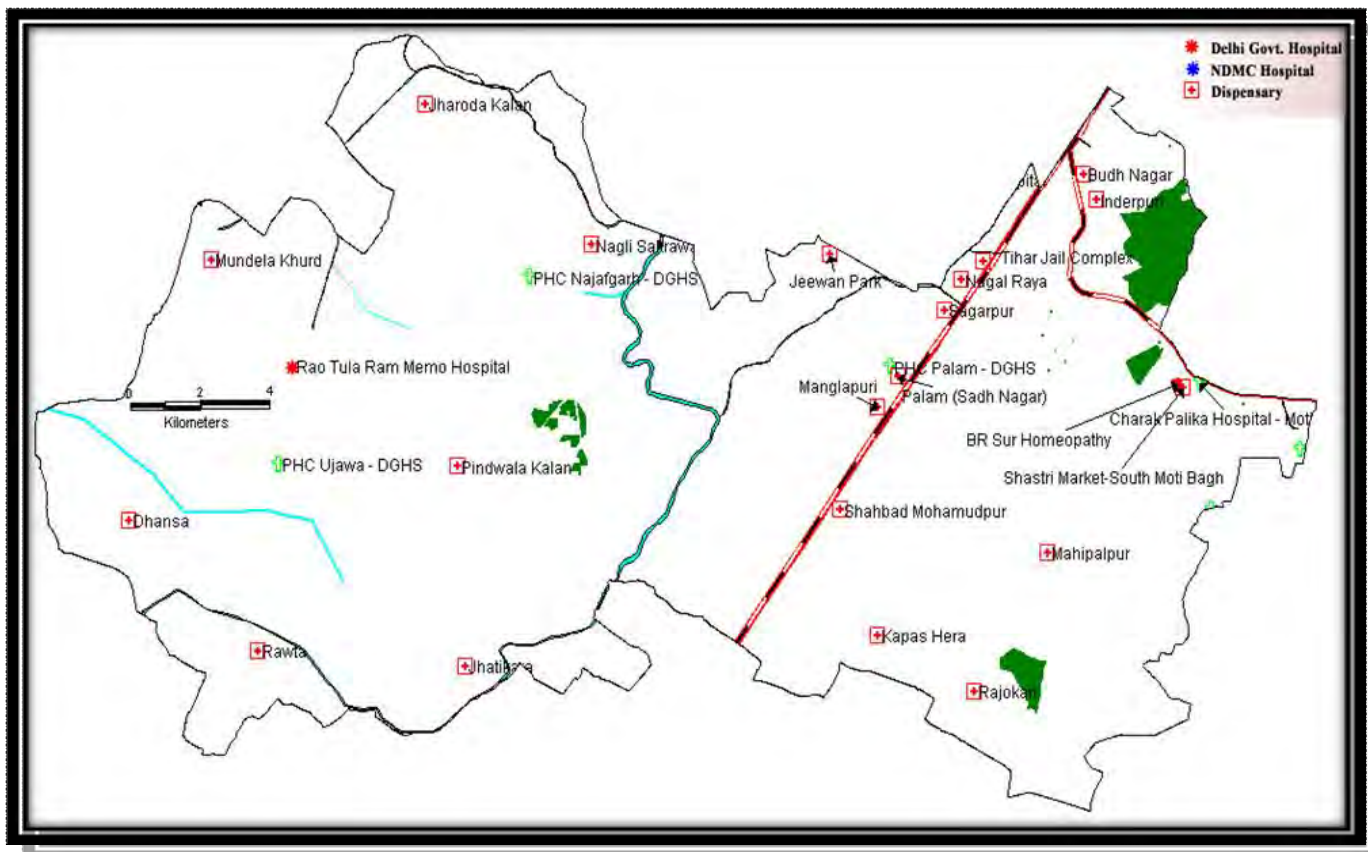
In terms of finance, NRHM contribution of Rs 281 crores in 2012-13 is less than 10% of GNCTD's health budget estimate of Rs 3389 crores (Plan : 50%; Non-Plan : 37%; Capital : 13%). However NRHM supports 5939 staff (ANMs, Staff Nurses: 1473; paramedics, Lab Tech, Pharmacists: 1141; MOs: 634 ; Specialists : 166; CDEOs: 418) , which is likely to be a significant percentage of total number of health staff.

Not surprisingly, HR constitutes 52% of NRHM budget followed by, JSSK (8%), PPI (7%), patient transport (6%) and infrastructure maintenance (6%). The NRHM expenditure (April-September, 2012) was low at 12%; this is an aberration, expenditure in the past 3 years ranged between 62-65% of the budget.

Share of NRHM funds to MCD is not clear. However, in one district, expenditure incurred by Delhi Govt. during April –October, 2012 is Rs 34 lakhs, while that by GNCTD in the same district is more than ten times as much at Rs 384 lakhs.

Introduction of the Districts:

South-West District



The South West District of N.C.T. of Delhi is located in between latitude 28 40' and 28 29' and longitude between 76 50' and 77 14'. The district occupies an area of approximately 420 sq km, inhabited by a population of 22.9 Lakhs having 88 villages in the District; the rural population being 9.3 percent. The population density of the District is 5445 person per Sq. km. as against 11297 of the state.

The District is surrounded by West District on its North, Jhajjar (Haryana) on its West, Gurgaon (Haryana) on its south and South District on its East. It is bounded by the border of Haryana comprising of Gurgaon, Bahdurgarh & Jhajjar and West, Central, New Delhi and South District of NCT of Delhi. The district is of strategic importance as it houses both the airports of Delhi - Indira Gandhi International Airport and Domestic Airport. It also has the strategically important Delhi Cantonment, which has a number of Defence installations, artillery, armoury etc. apart from a large number of Defence personnel living in the area.

District Demographic Profile

Statistical data of South West District	
Geographical area	420 sq. Km.
Assembly	7
Number of villages	88
Number of JJ Clusters	64
No of unauthorized colonies	180
Total population	22.9 Lakhs (Census report 2011)
Population: Sex ratio	836 (Census report 2011)
A. Male	1248700 (Census report 2011)
B. Female	1043663 (Census report 2011)
Decadal growth rate	30.62% (Census report 2011)
Density per square km	5445 (Census report 2011)
Literacy rate	88.81 % (Census report 2011)
A. Male	93.62% (Census report 2011)
B. Female	83.07% (Census report 2011)

North- East District:



Situated in the Trans Yamuna Area of Delhi. It is one of the nine administrative districts of Delhi, India. The District was established in 1997. North East Delhi borders Yamuna River on the west, Ghaziabad District of Uttar Pradesh to the north and east, East Delhi to the south, and North Delhi to the west across the Yamuna. North East district is predominantly rural but also has a sizeable urban area.

Statistical data of North East District	
Geographical area	60sq km
Assembly	8
Number of villages	31
Number of JJ Cluster	86
No of unauthorized colonies	119
Total population	22,40,749 (Census report 2011)
Population: Sex ratio	886 (Census report 2011)

A. Male	1,188,307 (Census report 2011)
B. Female	1,052,442 (Census report 2011)
Decadal growth rate	26.73 (Census report 2011)
Density per square km	37346 person (Census report 2011)
Literacy rate	82.8 (Census report 2011)
A. Male	88.39 (Census report 2011)
B. Female	76.51 (Census report 2011)

The two districts visited had very divergent profiles, with the South West district having a higher proportion of the population belonging to a higher socio economic strata, and the NE having an higher proportion of population comprised of migrant, (seasonal and daily), floating population and a population that accesses health care facilities from the bordering state of Uttar Pradesh. The NE district also has a higher proportion of minority population and a higher proportion of people in the lower wealth quintiles, as evident from the larger number of JJ clusters² in the district. Sex ratio in the SW however is substantially lower than in the NE district, likely on account of minority communities and those belonging to the lower economic categories.

The state has no ward level structures as per the 74th constitutional amendment. Ward Councilors are however elected. Resident Welfare Associations exist, but only in recognized colonies.

Part-II: Findings of the 6th CRM in the State

Findings of the 6th CRM in the State:

Progress of NRHM was reviewed on the following ten parameters each of which has ten components, thus describing a 10x10 matrix that factors in essential components of the NRHM.

- I. Facility based curative services-accessibility, affordability & quality.
- II. Outreach & Patient transport services-Sub-centres, Mobile Medical Unit/EMRI,ALS/BLS etc
- III. Human Resource for Health-Adequacy in Numbers, Skills and Performance
- IV. Reproductive and Child Health Programme
- V. Disease Control Programs-Communicable and Non Communicable
- VI. Community Processes including ASHA, PRI, VHSNC, Community Based Monitoring and NGO involvement
- VII. Promotive Health Care, Action on Social Determinants and Equity concerns.
- VIII. Program Management including monitoring, logistics and issues of integration and institutional capacity
- IX. Knowledge Management including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology
- X. Financial Management-especially fund flows, accounting and absorption

ToR 1. Facility based Health Care Services: Access, Affordability, Quality and Equity

1.1 Institutional framework of Health sector is unique and complex with multiplicity and presence of various controlling agencies.

Available Health Facilities:

S No.	Name of the agency	Units
1.	Delhi Govt Dispensaries (Allopathic)	250
2.	Delhi Govt Dispensaries (AYUSH)	131
4.	MCD Dispensaries (Allopathic)	50
5.	MCD Dispensaries (AYUSH)	165
6.	MCD M&CW Centres	129
7.	IPP (VIII) M&CW Centers	27
8.	NDMC M&CW Centres	7
9.	NDMC Dispensaries (Allopathic)	5
10.	NDMC Dispensaries (AYUSH)	13
	Total Primary Healthcare facilities	767
	Primary Healthcare Facilities (Allopathic mode)	468

Multiple Healthcare Providers:

S No.	Name of the agency	Units
1.	CGHS Dispensaries (Allopathic)	82
2.	CGHS Dispensaries (AYUSH)	10
3.	Railways Dispensaries	12
4.	ESI Dispensaries	32
5.	ESI (AYUSH)	5
6.	DJB	15

7.	RBI	12
8.	DTC	21
9.	SBI	7
10.	RBI (Autonomous Polyclinic)	5
11.	DVB	24
	TOTAL	219

Indian Army, Cantonment Board (Autonomous body of Ministry of Defense), Paramilitary Forces like CRPF, BSF, CISF etc. too, have a large number of health care facilities in Delhi. However these facilities are only accessible to the staff of the parent organizations and hence the target population is served by most of them.

There are also several missionary organizations and NGOs that have both outpatient and inpatient facilities.

The Private Sector has a large presence, with some estimates equating the number of facilities to those in the Public Sector.

Govt. of India has three PHCs operational under RHTC Najafgarh (Central Funding) with 16 Sub-centers covering 73 villages of population 10.5 lakhs spread over 432.6 kms area In SW district

District	Population in Lakhs (%)	Allopathic facilities	Centers required *
SOUTH	27.34	61	54
SOUTHWEST	22.93	50	46
WEST	25.32	67	54
NORTHWEST	36.52	93	74
EAST	17.08	41	35
NORTHEAST	22.41	44	45
NORTH	8.84	40	18
CENTRAL	5.79	42	12
NEW DELHI	1.34	13	5

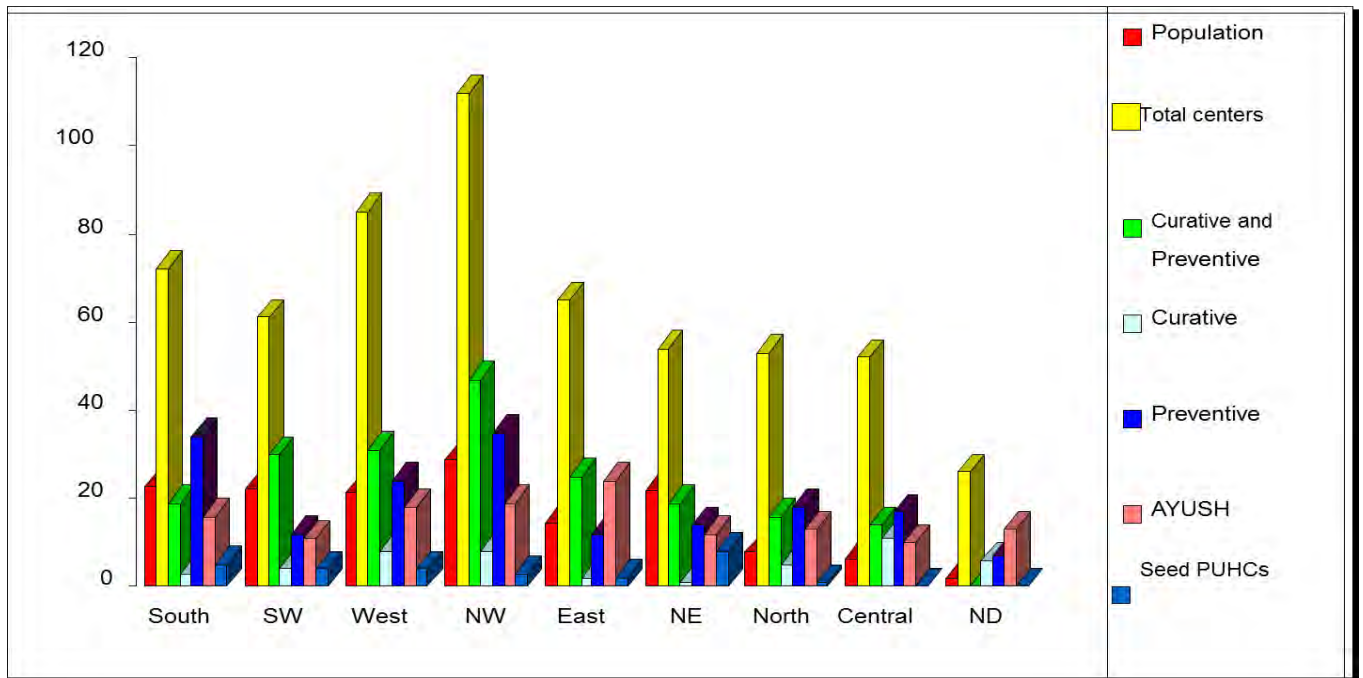
Source; State presentation

The numbers of health facilities are misleading as:

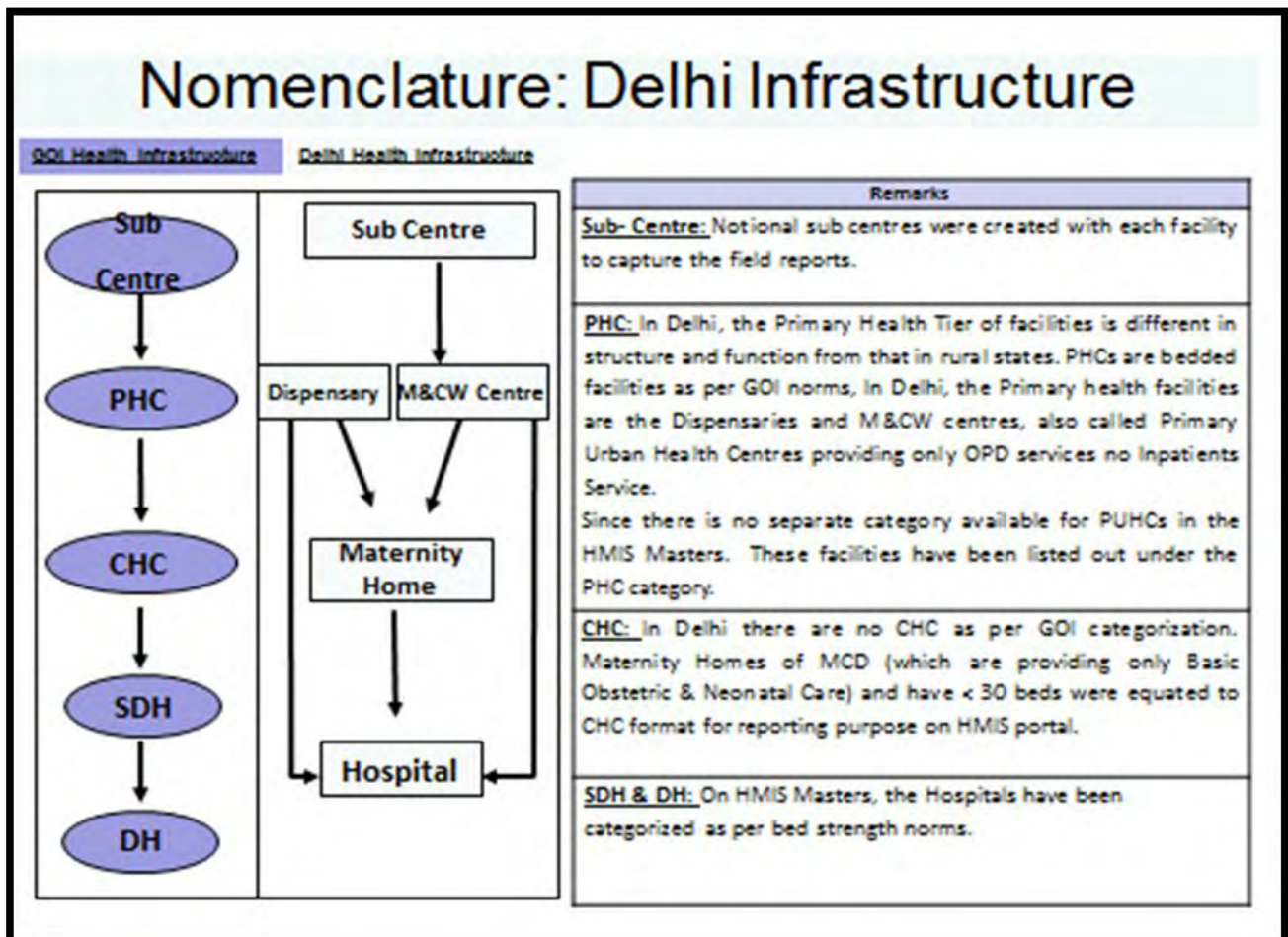
- Although at first glance it appears that most districts have higher than the required number of facilities there are several discrepancies. . E Various facilities provide a mix of curative and preventive, public health services. There are problems of co-location of facilities of different agencies, with neither being individually self sufficient , or both offering the same package of services, and not complementing each other. Some are located in the same lane, across the road. In many cases there two centres of different agencies operate in the same building, with overlap in services. The large numbers mask the fact that there are areas which do not have any facility or an insufficient number of facilities
- The table below exemplifies the lack of Standardization: Structurally / functionally heterogeneous health facilities.

S.No.	Type of Health Facilities	Curative	Preventive. (center)	Pr. Out reach	Basic Lab	Indoor	Staff
1.	GNCTD Dispensary(PUHC)	Yes	Yes	Yes	Yes	No	MO, Pharmacist , ANM , PHN , LHV , LT , NO, Class IV . Staffing norms different for all.
2.	MCD / NDMC Dispensary	Yes	No	No	No	No	
3.	M&CW Center (MCD / NDMC)	No	Yes	Yes	No	No	
4.	Maternity Homes (MCD/NDMC)	No	No	No	Yes	Yes	Ob/Gyn, Paediatrician, SN, ANM, LT- (not uniform, varies from one MH to another

Population / Infrastructure:



Nomenclature: Delhi Infrastructure:



Municipal Corporation of Delhi (MCD)

Municipal Corporation of Delhi is among the largest municipal bodies in the world, providing civic services (broadly Health, Sanitation & Education) to more 16 million citizens in the capital city of India, covering an area of 1,397.3 sq. km. Within its jurisdiction are some of the most densely populated areas in the world. It has also the unique distinction of providing civic services to rural and urban villages, resettlement colonies, regularised unauthorised colonies, Slum/Squatter Settlements etc.

Recently Municipal Corporation of Delhi has been trifurcated into three smaller Municipal corporations North Delhi Municipal Corporation, South Delhi Municipal Corporation & East Delhi Municipal Corporation.

- North Delhi Municipal Corporation – Revenue districts of Central Delhi, North Delhi, North West Delhi,
- South Delhi Municipal Corporation – Revenue districts of South Delhi, West Delhi, South West Delhi (excluding Delhi Cantt)
- East Delhi Municipal Corporation – Revenue districts of East Delhi, North East Delhi

Public Health Department of MCD is providing preventive & Promotive Health Care Services to citizens in the area under jurisdiction of MCD. These services are provided through a network of Departments. Department is headed by an officer called Municipal Health Officer cum DHS. All the doctors posted in Public Health Department have post Graduate qualification in Public Health. Organizational Chart is placed as annexure. MCD is providing MCH& FW services to the general public through a network of 27- Maternity Homes, 118- MCH centres, 42-Sub- Centres, 06-PP Units & 11- mobile units.

	Col hosp	Poly clinic	UHC	PHC	Disp	Mob disp	TB Cl& hosp	Mat home	MCW Clinic	Health post	SC	PP Unit	Mob unit
EDMC	1	1	0	0	4	3	3	8	22	0	0	1	0
SDMC	3	4	1	2	12	5	2	7	49	6	9	2	6
NDMC	1	13	2	-	28	8	6	18	68	2	3	3	3

MCD undertakes major activities under its various divisions such as

A) Anti Malaria Operations, headed by Dy MHO (Malaria & Other Vector Borne Diseases); This Department is providing all technical support, Policy Guidelines and logistics supply to Zonal Health department for Prevention and Control of Vector Borne Diseases. There are six Vector Borne Diseases namely Malaria, Dengue, Chikungunya, Yellow Fever, Japanese encephalitis and Kala Azar. Out of these challenge in Delhi objective of the Department is to reduce the burden of vector borne disease & avert mortality.

B) Public Health Division, headed by Dy MHO (Public Health); Under this Division following activities are undertaken such as Prevention and Control of Human Rabies, development and Management of Cremation Grounds, providing policy Guidelines for issue of health trade License and strict action against the sale of unhygienic food, cut fruit and sale of unwholesome Ice.

C) Epidemiology Division headed by Dy MHO (Epidemiology); Epidemiology Division of Health Department is concern with the various activities like Prevention and Control of Water Borne Diseases, Meningococcal Meningitis and Yellow Fever Vaccine Inoculation.

D) Vital Statistics; Headed by Officer I/c Vital Statistics; There Department are providing Policy Guidelines and logistics support to the Zonal Health Department. There is one Zonal health Department in all the 12 Municipal Zones. Zonal responsible for taking all measures as per directions issued by the four divisions for the H.Q.

NRHM support is in the areas of strengthening of laboratories in M&CW centers, RNTCP units and HR in maternity homes (MO, SN, LT, Pharmacist, ANM, Nutritionist, CDEO and ASHAs. JSY is well implemented in MCD centres.

No well demarcated Geographical / Demographic Catchment Areas

Rural Scenario:



Urban unauthorized colony



State funding in health sector is substantial with NRHM funds acting as key leverage. State has consciously mapped Hard-to-Reach & unserved areas and has established seed PHCs. However, inaccessibility in certain pockets still exists. There are no unserved areas in Central / North Delhi. In the remaining districts, although the list of polling stations areas that are not owned by any center has been generated from the data base, it is being examined and the truly unserved areas being identified at the district level.

80 % GIS plotting is complete. Some residual work is going on in the two districts. The main constraint to access reported were:

- i. In certain areas identified a couple of years ago , the centres have not been opened due to lack of availability of adequate space. .i.e. in slums and resettlement colonies.
- ii. In peripheral areas where villages are situated 4-5 km away from the health centre with intervening stretch of agricultural tract / barren land, , there is simply not enough space.

FACILITY SURVEY									
INFRASTRUCTURE SURVEY SUMMARY									
GNCTD DISPENSARIES & SEED PUHCs 2011									
Particulars	North-West	North	West	East	North-East	South-West	South	Central	New Delhi
Number of Centers: Dispensaries + Seed PUHCs	45+4	15+1	29+3	22+2	16+8	30+5	17+7	13+0	22 NDMC 1 GNCTD 1 MCD
TOTAL	49	16	32	24	24	35	24	13	24
OWNERSHIP:									
Government Owned	21	10	15	13	8	15	13	8	22
Shared with other Government Dept.	4	0	7	3	0	0	0	5	2
Rented	24	6	10	8	16	20	11	0	0

MCD M&CW Centers (except New Delhi)								
Particulars	North-West	North	West	East	North-East	South-West	South	Central
Number of Centers:								
TOTAL	33	15	21	12	14	9	20	17
OWNERSHIP:								
Government Owned	31	13	14	8	6	8	16	16
Shared with other Government Dept.	1	0	7	4	4	0	1	0
Rented	1	2	0	0	4	1	3	1

*Although most of the M&CW Facilities are in Govt buildings, the infrastructure / number of rooms / Building space is restricted to two to three rooms in keeping with their mandate.

There is no structured infrastructure plans in the State however, realising that the gaps in service delivery do exist and hence in order to provide universal quality assured primary healthcare coverage, the State Government plans to:

- Open new centers where required
- Identify at least one primary healthcare facility to cover a 50,000 population pocket. (Any agency)
- Strengthen it as per the Public Health Standards prescribed
- Document the attached population

HOSPITALS			
AGENCY	INSTITUTIONS	NUMBER OF BEDS	PERCENTAGE
			%
DELHI GOVERNMENT	38	9446 (SANCTIONED)	22.17
MCD	61	4138	9.69
NDMC	4	220	0.52
GOI	24	7757	18.17
OTHER AUTONOMOUS BODIES	4	2903	6.8
REGISTERED PRIVATE NURSING HOMES	752	18214	42.66
TOTAL	883	42698	100

TERTIARY CARE

	INSTITUTION	NUMBER OF BEDS
GOVERNMENT	8	6111
PRIVATE	26	6004

Apart from the Diagnostic Centres and Laboratories in Government Hospitals, there are 625 Private Diagnostic Centres in Delhi.

Progress made so far:

- 53 new health centers opened with assistance from the NRHM.
- Public Health Standards for Primary Urban Health Center drafted and approved by the Cabinet in 2010.
- Quality Assurance Manual prepared and the institutional mechanism for assessing / monitoring quality in a PUHC also prepared / approved.
- A detailed Facility Survey of around 600 facilities has been done in 2010-11.
- All Primary Health care facilities / Hospitals mapped.
- Basic data on services / staff / linkages mapped.
- Work is on regarding assignment / documentation of catchment areas.
- Common Platform for Reporting by all agencies functionalized through GOI HMIS System.
- Sub centers in Delhi: 41 sub-centers. Rest Notional (403) for the purpose of reporting.

The gaps have been identified and to increase accessibility of health services in dense urban slums, some planning is being done by the State.

- New primary urban health centres : 42
- New hospitals: 13
- Additional bed capacity: 2800
- Increasing the bed capacity of 100 bedded hospitals to 200 beds each.

Establishing PUHC's in 3 urban slum areas of NE district viz Ramnagar, Ghamdi and Harsh Vihar.

Delhi Cantonment Board General Hospital

Cantonment Board is an Autonomous Body under GOC-in-C, Western Command, Ministry of Defense, Govt. of India and has healthcare facilities all over India.

Delhi Cantonment General Hospital is a 30 bedded hospital in Delhi Cantt. New Delhi in SW District providing OPD/IPD services to general public while the employees of Cantonment Board get further support in terms of procurement of all drugs prescribed by the authorized medical attendant

Till December 2011 this hospital was providing only Primary Health Care services with part time visiting specialists from Ophthalmology and Dermatology and full time specialists are engaged on contractual basis in the fields of Medicine (1), General Surgery (1), Obstetrics & Gynecology (3), Orthopedics (1), ENT (1), Anesthesia (1), Pediatrics (1), Pathologist (1) and Physiotherapy (2).

Hospital has 18 functional beds, 8 as maternity beds and has 2 delivery tables

At the time of inspection on 07.11.12 there was no patient in the hospital and only one patient was in casualty (Acute GE) who was on IV fluids , under observation.

OT is in place but is being utilized only for minor surgeries. Casualty is providing 24x7 services with six beds. There is no Blood Bank / Storage Unit in the hospital

New infrastructure was constructed with a capacity of 100 beds but safety clearances are awaited for the past over 10 years.

There are 2 mobile ambulance vans and a hearse van in the hospital Mobile Unit goes to villages with a contractual doctor to provide mobile dispensary services 3 hrs / day. Cantonment Board School is covered under School Health Program

Only normal deliveries are conducted, Primi-gravida and complicated cases are not taken up. No admissions in other specialties care are done. Specialists are available from 9am to 4 pm only and normal delivery cases (uncomplicated) are managed by Staff Nurses / GNMs / ANMs on duty. 284 deliveries were conducted in 2010-11

JSY is in place and ANC and PNC services are provided besides Immunization, Dental and Physiotherapy services. It is a Pulse Polio Centre. The domestic refrigerator is the cold chain equipment storing vaccines and other drugs.

Hospital levies user Charges for all services provided (except for Immunization and Family Planning services)

NRHM supports the Hospital in terms of HR (ANMs posted). There is a proposal to make it a 50 bedded hospital from January'13. The hospital intends to provide 24x7 facilities and has sought NRHM support for HR (3 Sr.Residents for each of Gynae, Anesthesia & Pediatrics deptt. besides equipment (laparoscope set for sterilization @ Rs.10 Lakhs, 10 NSV Sets @Rs. 50,000/-, 4 Delivery tables @ Rs. 12 Lakhs and 1 portable USG Machine for Labor Room @ Rs. 5 Lakhs)

The kind of Infrastructure, HR and the laboratory facilities that are available, the hospital is labeled as Sub-district Hospital in the Delhi Govt. List and is a proposed FRU in the PIP of 2012-13 but it is functionally as a PHC only with huge I/s and HR - eventually sub-optimal utilization of resources.

Summary of status of infrastructure work renovation & new construction of DGD
(As collected from Districts)

District	Agency: PWD/IFC/MCD	No. of units: DGD/MCD	% OF COMPLETION OF WORK				
			0%	Upto20%	Upto50%	Upto90%	100%
North East	IFC=02 Other=02	DGD=04	02	0	01	01	0
East	IFC=19 Other=03	DGD=21	16	0	02	02	01
Central	PWD=05	DGD=05	05	0	0	0	0
North	PWD=01 MCD=01	DGD=01 MCD=01	0	01	0	01	0
North West	PWD=11 IFC=01	DGD=12	04	0	01	02	05
West	PWD=17 MCD=05	PWD=17 MCD=05	20	0	0	01	01
South West	PWD=06	DGD=06	01	01	01	02	01
South	PWD=01	DGD=01	01	0	0	0	0
Total	PWD=41 IFC=12 MCD=05 Total=58	DGD= MCD=	49	02	05	9	8

Status report on Infrastructure: Renovation of DGDS by NRHM funds

NRHM has supported the construction and renovation of health centres in the past year with a total 1569.80 lakhs. Break up and its status is as under:

- Fund for renovation of health centres under NRHM sanctioned in 2011-12 = 585.02 Lakhs
- Fund for renovation of health centres under NRHM sanctioned in 2012-13 = 505.64 Lakhs
- Fund for new construction of health centres under NRHM was sanctioned in 2012-13 = 600 lakhs + 969.80Lakhs

Sanctions have been conveyed to all Districts for further processing.

- a) In most of the places funds have been released to the concerned agency PWD/IFC/MCD.
- b) At many places work has started and is in various stages of completion
- c) In some places work has been completed.
- d) In some places in East district DUSIB has denied permission for renovation and hence work has not started as yet
- e) District wise status is enclosed as annexure 7
- f) Duration of work is two years.

Summary of status of infrastructure work renovation & new construction of DGD

Renovation of Health Centres (DGD & MCD & Hospitals)

Fund in 2011-12 = 585.02 lakhs for 33 units

Fund in 2012-13 = 505.64 lakhs for 55 units

Total fund= 1090.66 lakhs

To be utilized by March 2013

S. No.	Name of District	FY 2011-12		FY 2011-12		Total	
		No. of health Unit	Amt approved (in lac)	No. of health Unit	Amt approved (in lac)	No. of health Unit	Amt approved (in lac)
1	North East	8	263.79	6	58.92	14	322.71
2	East	8	180.87	12	65.91	20	246.78
3	Central	-	-	6	32.16	6	32.16
4	New Delhi	-	-	-	-	-	-
5	North	1	4.50	2	10.50	3	15.0
6	North West	7	43.85	5	96.17	12	140.02
7	West	2	24.55	17+5	76.23+40	19	100.78
8	South West	6	64.78	1	75	6	64.78
9	South	1	2.68	-	-	1	2.68
10	DHS (HQ)	-	-	1	17.75	1	17.75
11	Total	33	588.02	55	490.64	88	945.66

New Construction of Health Centres:

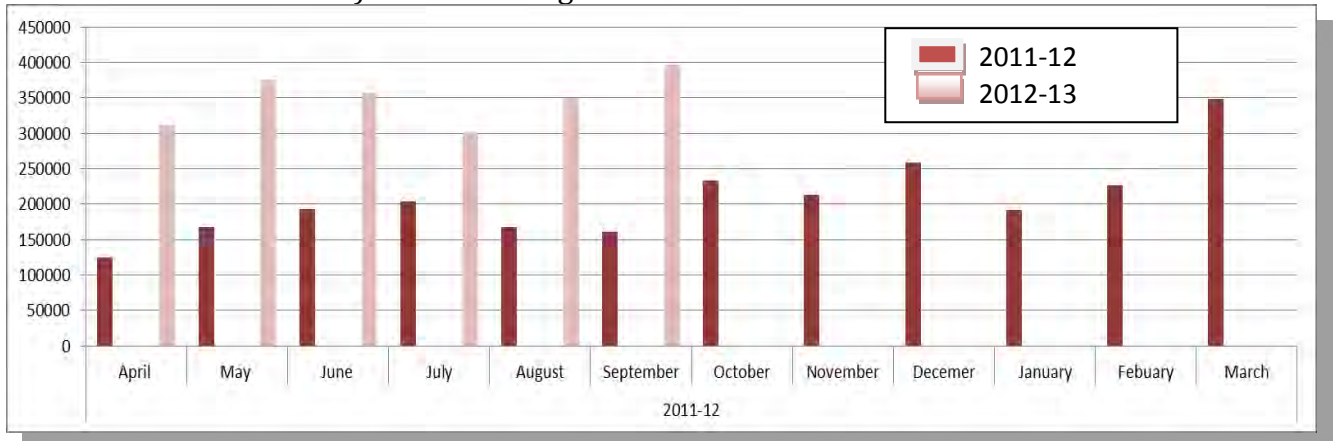
1. Sector 4, Rohini - 275.84 lakhs
2. Sector 21, Rohini - 242.86 lakhs
3. Sawada Ghevra - 239.81 lakhs
4. Gautampuri Molarband Ph II - 238.71 lakhs
5. Madanpur Khadar Pkt A-2 - 284.75 lakhs
6. Madanpur Khadar Pkt - B, Ph I - 287.83 lakhs

Total - 1569.80 lakhs

To be utilized in 2 years period. Approval of the building plan is awaited from MCD.

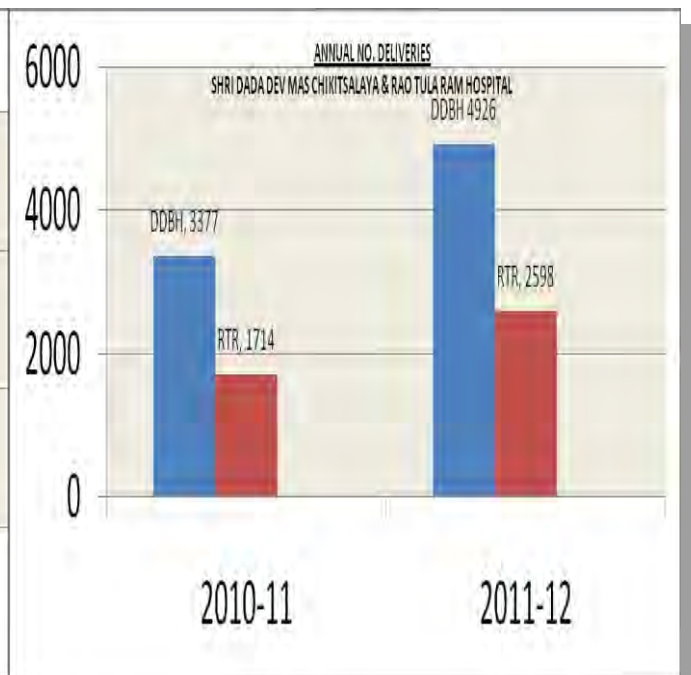
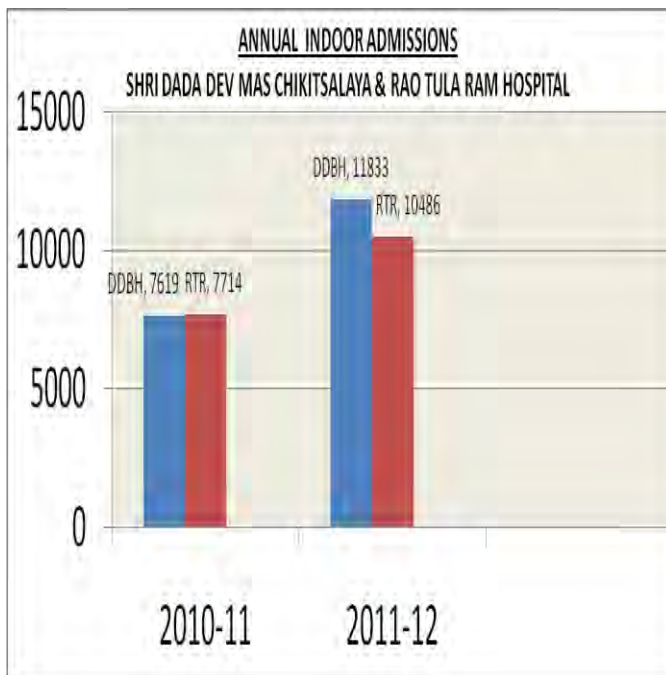
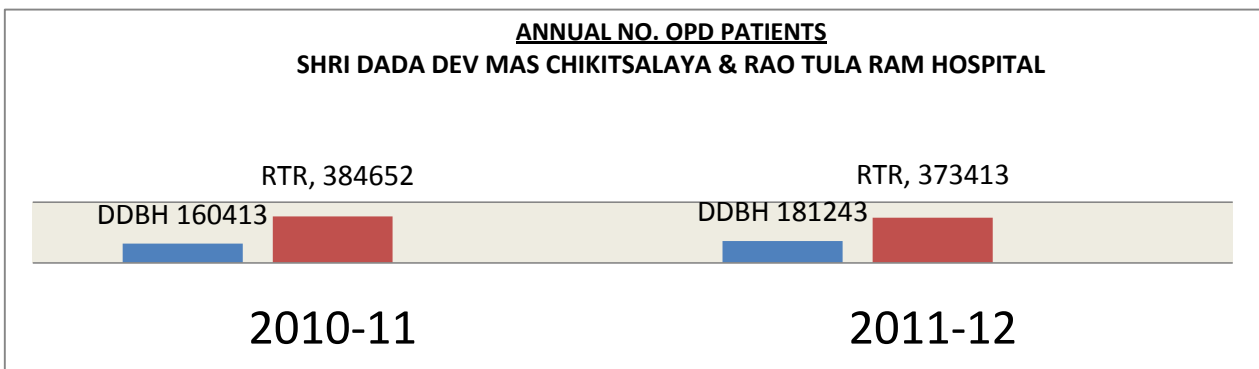
Modality of fund transfer for new construction to PWD is being finalized.

1.3 Across the board, all public health facilities visited had huge case load (predominantly women & children). An increasing trend in terms of demand is reflected below:



Month-wise comparison of OPD Attendance for 2011-12 and 2012-13 (till Sept 2012) (NE District)

Increasing footfall trends over the previous years were noted in the primary, secondary and tertiary level facilities.



In addition to the rise in demand for hospital services, it appears that there is a demand for AYUSH services in the community. Community FGDs in Nandnagri & Seemapuri areas reflected a demand for Unani System of Medicine.

1.4 Lab & Diagnostic services- all basic diagnostic services are available at all levels. However, there are certain constraints in procurement of reagents and timely AMC of equipment reflecting management issues at DHS

- One of the SDH visited had outsourced diagnostic tests not available in the facility to an agency which offered a certain discounts and services in respect of CGHS rate as benchmark
- There is Out of Pocket expenditure by the public because many peripheral units are not able to provide comprehensive diagnostic services in totality
- There is a CPA in DHS functioning for over 15 years. Nirantar, a software system introduced since Nov'11, has improved the procurement process however, at places there are still gaps
- There are 361 drugs in the EDL out of which 120 drugs are for Primary Care facilities. The government has been providing free drugs since 1994
- Most of the common drugs were available in the facilities as per Essential Drug List (EDL)
- Medical officers have been instructed to follow the standard treatment guidelines and are rarely prescribing medicines outside the EDL
- In Central Govt. PHCs like Najafgarh, Ujjwa and Palam both the generic and the branded medicines are available and they are procured through GMSD Delhi of Govt. of India
- Delhi Govt. Dispensaries procure their medicines from the store at DHS through CPA
- Delhi Govt. Dispensaries provide services to general public and Retired Employees of Delhi Govt. General public buys certain medicines not available in DGDs from open market but retired employees of Delhi Govt. are provided these medicines prescribed by Specialists of Delhi Govt. empanelled institutions by mechanism of Indent and a pharmacist (out of two posted in DGD) prepares indent (depends on case load) even for 1-2 prescriptions and goes to nearby authorized Govt. hospital and the medicines are provided to beneficiary the next day . It appeared as non-optimal use of manpower, energy ,money and time
- Delhi Govt. Hospitals procure 80% of their medicines from the manufacturers on the rate contract of CPA and payments are made to manufacturers directly by MS after receipt of medicines
- In cases of emergency, MS of the hospital is empowered to purchase medicines from the authorized local chemist through an open tender process

- Though availability of equipment was adequate but their maintenance mechanism needs attention of administration.
- Medicine procurement is not computerized at facility level, affecting the accuracy of the consumption pattern and demand forecasting resulting in possible supply gaps.
- Medical record keeping was found to be satisfactory, however, largely manual. Major databases and analyses in the hospitals was on computers
- It has been informed that lifesaving blood is being provided to all patients needing it, donor blood is insisted upon for planned/booked surgery patients.

1.5 The supportive services contributing to patient comfort, safety & satisfaction were found very good in some facilities visited (RTRH, DDMSCH and Delhi Cantonment Board hospitals) and were compromised in many (GTBH, many of the primary & secondary level facilities).



Dearth of beds in Maternity wards & labour rooms, (two-three beneficiaries on the same bed) was a big cause of concern because of huge caseload, demand but less supply.

Signages and Citizen's Charter were not conspicuously placed and where-ever observed, were in English language only



General upkeep of tertiary and secondary level of facilities is poor in NE District. The tertiary and secondary level of facilities in SW district visited, however, were satisfactory in terms of protocols being displayed at many places, hygiene was good, and infection control measures were in place.

Kitchen hygiene and quality of diet was found to be satisfactory in the facilities visited.



However, at Maternity home levels there was no kitchen facility and the food is procured from outside.

In tertiary level facilities, seating arrangement in the waiting area appeared inadequate owing to high number of footfalls, particularly in GTBH. Lifts meant for patients were being used by general public in GTB and SD hospitals and there was limited display of Signages and help desk arrangement.

1.6 Bio-medical waste management is in place and outsourced to 2 agencies in Delhi Govt. facilities with varying level of quality indicating a need to regularize and monitor the waste pick-ups by these agencies.

GTB and SDH have internal waste management system with incinerator & inspection staff, colour coded bins were available, and labelling is being done.

The SDH and DH facilities visited in SW district had a good level of hygiene and infection control measures in place, however the huge case load in the wards compromised expected infection control at places.

- 1.7 Services are provided free of cost (except for OPD ticket (Rs 5), Ultrasound (Rs 50), C.T.Scan (Rs 1000) and for diet (Rs 10) at some places). However, the charges in cases of pregnant women are covered under JSSK.
- 1.8 Besides user charges, as mentioned, interaction with patients and families revealed 1-2 instances of medicines procured from outside, by and large interaction with over 100 beneficiaries, relatives, it was noticed that there was no out of pocket expenditures in JSSK cases (except in few cases of transportation). Overall the beneficiaries were largely satisfied except for huge case load vs. facilities which is a very encouraging achievement.
- Instances of informal payments being made by beneficiaries at tertiary level facilities in response to demands made by some of the hospital staff were reported by few patients
- Other than this, the major out of pocket expenditure is in terms of transportation of patients and pregnant women. Even though 102 CATS is operational, its Geographic access is limited, inter facility transfer and drop back facility is not available in most places.
- In GTB hospital, some attendants were asked to procure syringes, Inj. Syntocinon and gloves owing to some irregularities in the supply.
- 1.9 Diagnostic services for Ultrasonography and other special diagnostic services were outsourced in Dadadev Hospital in SW district. An open tender was floated against which no response was received. The MS then decided to set CGHS rates as the benchmark and any organization giving further discount and 24 hours lab technician services to collect the samples and give the reports in specified time shall be awarded the contract. So currently a local diagnostic centre providing sample collection and reports and giving further 1% discount over the CGHS rates. There is scope for expansion of ancillary and supportive services particularly in tertiary facilities through public private partnerships for the benefit of patients and attendants. Help desks, better house-keeping, more lab & diagnostic services, guarding, etc should be offered. There is a management issue at DHS level since the end user i.e the Mother lab in charge at DGD, Nangalraya (SW district) is not provided information details about the equipments AMC rendering the equipments unusable for quite some time.
- 1.10 Lack of sensitivity to issues of privacy and respect for women's dignity was observed in many facilities in both districts. In the labour rooms in the SDH hospital in the NE district, there were two women on a labour table, and in the post partum wards there were three women with their newborns in one bed. Notwithstanding the acute shortage of space, there are ways to use existing spaces as waiting rooms so that all women are not crowded into the

labour room, or to provide for additional pallets so that mothers and newborns can lie in comfort. There is not much to be said about quality of outcome as indicators like average length stay, hospital acquired infection rate, cycle times for different services, patients satisfaction scores are not still being measured fully.

In GTB Hospital, Labour room was satisfactory but protocols were not displayed, lack of privacy for women was also observed. There is gross congestion of beds in Post natal wards, two beneficiaries lying on the same bed. Even 3-4 patients were being transported on a single stretcher/trolley. OT was lacking separate scrub area (placed inside O.T.). No standardised process for disinfection of O.T. Same mop was being used for O.T as well as ward. Good level of hygiene and cleanliness was observed at Maternity homes and lower levels.



Scrub area inside OT in GTB



Trolley or Lorry??

Though it was heartening to note that tertiary level hospitals are coping with high patient load in the face of such constraints as limited Human Resource and patient care spaces but the quality of care is unsatisfactory from a user perspective given the discomfort and compromised patient privacy. Infection control practices are difficult to adhere with this overburdened patient care areas.

In interviews, patients reported that they are satisfied that they are getting services in a public hospital. Their main dissatisfaction was with the expenses occurring due to non-availability of some drugs and poor hygiene of the premises.

Summary TOR -1

The state has undertaken GIS mapping for facility gaps towards developing an infrastructure plan, and created 53 new centres and strengthened/renovated others in underserved areas of the State. Outpatient and inpatient loads have increased significantly over the last few years. Diagnostic centres have been established and a majority of the dispensaries, M&CW Centres have functional basic diagnostic centres in place. Status of infection control measures and bio waste management, which are outsourced, is fairly good in most facilities, especially given the high caseloads. The state provides free drug supply with about 361 drugs in the EDL with 120 drugs for Primary Healthcare facilities. Drug Procurement, logistics and indent systems vary across the three administrative systems (Central, State and MCD). Out of Pocket expenditure among women seeking institutional delivery are largely on account of transport and informal payments to cleaning and support staff. Grievance Redressal systems were not fully functional and signages/citizen charters are not conspicuously displayed and wherever displayed were in English.

The high caseload for institutional delivery has compromised women's privacy in the secondary and tertiary facilities. Bed capacity in the public sector is about 6111 and in the private sector 6004, and the state plans to add 2800 additional beds. Despite improvements, there are several areas which do not have a sufficient number of facilities, and this is a challenge from an equity standpoint. (the NE district which has a population of over 22.4 lakhs has 14 maternity and child welfare centres). A major problem in the creation of new infrastructure is the lack of space for expanding or constructing new centres, especially in slums, and resettlement colonies. Delays in approvals of building plans hamper the pace and quantum of progress. There is overlap in services managed by the state and the MCD, often within the same facility.

ToR 2 Outreach & Patient transport services- (Sub-centres, Mobile Medical Units, EMRI- ALS, BLS)

- 2.1 There is no concept of sub-centre/PHC/CHC etc in Delhi except in Najafgarh block where it was observed that through RHTC, there are 3 PHC's (Najafgarh, Ujjwa & Palam) with 16 sub centres in the villages and all this are being governed by MoHFW, GoI ever since they started way back in 1955-1960. However, the sub centres visited in SW district as named above had adequate staff.

Rural Health Training Centre, Najafgarh, New Delhi

The population of the Najafgarh Block, situated on South West of Delhi, at present is 1.05 million. The registered population with the Rural Health Training Centre, Najafgarh is nearly 500,000. Rural Health Training Centre, Najafgarh, PHCs of Najafgarh, Palam and Ujwa and 16 sub centres is spread over an area of 432.6 kms covering 73 villages. It also carries out the functions of an Orientation Training Centre on regional basis as Rural Health Training Centre under the administrative control of Directorate General of Health Services (DGHS), Govt. of India to train the Rural Health Workers for shouldering greater responsibilities in the community development programs. It imparts community health training for Medical Interns of Lady Harding Medical College under Rural Orientation of Medical Education (ROME) Scheme. The centre has two more Primary Health Centres at Ujjwa and Palam . In 1978, it was declared National Scientific Institute. In 1981 a Post Partum Unit under All India Hospital Post Partum Program was set up with the assistance of Family Welfare Department. To strengthen the Rural Health services, an ANM School was started in 1985 and vocationalised in 1991. The Major Activities of RHTC Najafgarh are trainings, delivery of health services and conducts field studies aspects of Health & Family Welfare, RCH, Nutrition, Health Education and Communicable Diseases and also provides field services for research work to the various health institutions, i.e. NIHAI, AIIMS in public health. 45 ASHA Worker have been appointed in the field practice area of PHC Najafgarh area, covering the villages, Dichao, Jharoda, Gopal Nagar and Ghumanhera.

RHTC Najafgarh has implemented the **NRHM** in its three PHCs and 16 sub-centres in collaboration with CDMO (SW), Govt. of NCT Delhi. It organizes RCH camps, Village Health Nutrition Days with the help of AWW at SC level, HIV Counselling Workshops and JSY has already been implemented in PHC Najafgarh.

Rs. 108 crores project have been approved by the union government for developing this centre to that of National Institute of Paramedical Sciences.

Coordination with GNCT/MCD for All India Pulse Polio Programme, DOTS program. ICTC Centre and Malaria Clinic of MCD is functioning in this centre.

Delhi Government support to RHTC NAJAFGARH UNDER RCH/NRHM is on continuous basis.

- 2.2 By and large outreach services at public health dispensaries, especially DGDs, are adequate in terms of OPD, drugs, diagnostic, Immunization etc. At certain places apathy towards the needs of the beneficiaries was observed. The high outpatient numbers are testimony to NRHM support in enabling the hiring of additional ANMS and MOs.
- 2.3 Immunization services in the state are primarily through the VHND, fixed day clinics in the PUHCs, dispensaries and all days in the hospitals. Overall complete immunization coverage reported by the state is 63.5% (Lower for the NE district). The state has not used the ASHAs to track drop outs and reach unimmunized/dropouts in a systematic manner. While acknowledging the challenges of a high in migrant population, there are pockets of permanent settlements which are not being covered.



There appear to be pockets which are not reached by any of the strategies employed, however Pulse Polio Coverage reportedly 100% and remotest point is touched (Badarpur Khadar village in NE district) but similar efforts in RI are lacking. In the whole of the state the vaccines are stored in domestic refrigerators even in areas with power outages and insufficient backup generators.

State officials reported that there apparently was no need for ILRs as power shortage or blackout was a rare phenomenon and that power never went off for more that 4 hrs at a time and refrigerators could provide temperatures maintained for this period.



Power Outages were observed in Mustafabad PUHC in NE which does not have any power backup in the form of generator/inverter which causes inconvenience to staff and hampers services.

There is a proposal from GOI to replace domestic refrigerators with twin sets of deep freezers and ILRS as dedicated cold chain equipment for storing vaccines in the state. Required number of deep freezers has been received but state is yet to receive a large number of ILRs. . Shortage of ice packs and Deep Freezers kept on ground observed at many places.

ILRs were there in a few facilities visited but were never used for storing vaccines and the staff never knew the meaning of ILR, its purpose and the use.

S.N.	Item	Capacity	Quantity	Total	Equipment to be repaired	Current Break-down rate
	Walk-in -Coolers	16.4 Cubic Meter	2	2	--	--
1	ILRs	306L	6	234	1 ILR	0.18%
2		300L	10			
3		200L	31			
4		140L	95			
5		70L	92			
6	DFs	300L	17	324		
7		286L	5			
8		280L	1			
9		140L	89			
10		116L	212			
	Total			560		

All UIP vaccines are purchased at the Central level for distribution to the states. However, MMR and Typhoid vaccines are being purchased by the state through CPA of DHS utilizing State funds. Hib pentavalent vaccine is also to be procured shortly.

VHND's are reportedly being planned and conducted regularly every Thursday, largely limited to Immunization and health talks.

DATE	NAME	VACCINE
20/10/12	SEEMA	C-Block Auno-30
30/10/12	SAVITA	A-Block Part-4 Auno-07
31/10/12	PARVA	B-Block Auno-02
13/11/12	SARANYA	A-Block Part-3 Auno-04
14/11/12	SEEMA	C-Block Auno-32
22/11/12	SAVITA	A-Block Part-5 Auno-06
24/11/12	PARVA	A-Block Auno-13
NOVEMBER		
4/12/12	SARANYA	A-Block Part-2
13/12/12	SEEMA	C-Block Auno-34
20/12/12	SAVITA	A-Block Part-5: Auno-05
29/12/12	PARVA	B-Block Auno-25
DECEMBER		
JANUARY		
31/12/12	SARANYA	A-Block Part-2 Auno-12
10/1/13	SEEMA	C-Block Auno-36
15/1/13	SAVITA	A-Block Part-5 Auno-16
22/1/13	PARVA	B-Block Auno-21
30/1/13	SEEMA	A-Block Part-4 Auno-11
FEBRUARY		
7/2/13	SARANYA	A-Block Part-2 Auno-3
16/2/13	SEEMA	C-Block 1
24/2/13	PARVA	B-Block - Auno-28
28/2/13	SAVITA	Part-5 Auno-9 A-Block
MARCH		
5/3/13	SARANYA	A-Block - Part-1 Auno-26
14/3/13	PARVA	B-Block Auno-22
19/3/13	SEEMA	C-Block Auno-51
23/3/13	SAVITA	Part-5 th Auno-07

VHND Plans displayed at Soniya Vihar Zero Pushta



First VHND conducted at Badarpur Khadar Village in November'12

Mobilization of children, support to ASHA in reaching out to the reluctant and resistant families, BCC not in practice are few of the constraints in achieving 100% coverage.

For immunization the outreach services in some areas of RHTC Najafgarh are provided once a month when a van from PHC with vaccines & ANM reaches the village on a day planned well in time (a month advance notice) from 9am to 1 pm and even if clients are there, van leaves and the issue of non-supply of services becomes a factor even if demand is there. This was observed in SW distt in Govt. of India's RHTC Najafgarh managed PHCs and SCs (not governed by Delhi Govt.)

At state level, weekly report regarding occurrence of all VPDs is being collected from 24 identified major hospitals of the state (Both Government and Private)

Rapid response through District Immunization Officers (DIOs) in case of clustering of VPDs, which includes, confirmation of cases, immunization status of the affected children and the children of the nearby area and augmentation of immunization services in the area through fixed-site and outreach immunization services

The Ministry of Health and Family Welfare, GOI, is undertaking the exercise for validation of Elimination of Neonatal Tetanus in the state of Delhi. In this regard basic data required for this validation has already been reviewed by the team of experts from MoHFW, WHO, UNICEF and other partner agencies and in a meeting with the state program managers after reviewing the analysed data North East district is identified for planning field survey in Nov 2012 . A team of international and national experts, MoHFW and partners will facilitate LQA assessment

State and District AEFI Committees are in place. Reports (FIR, PIR and DIRs) are being sent by DFW to Immunization Division in MoHFW regularly In one dispensary in the NE, the ANM reported that AEFI monthly reports are sent to the district HQ, but the dispensary itself had no record of the AEFI report.

The State Objectives in Immunization are:

- To achieve Measles Coverage of > 95%
- To achieve DPT 3 coverage of 95% from current DPT coverage of 73.7%
- To increase full immunization coverage from 63% to 95%
- To reduce BCG to measles dropout rate to <10% from current level of > 15%
- Achieve 100% coverage of pregnant women with 2 doses of T.T
- Increase access to safe injection techniques

The Strategies to achieve the Objectives by DFW are:

- Focus on Biweekly immunization services in dispensaries/ M & CW centers/ FRUs/ Tertiary hospitals.
 - Focusing on missed Vulnerables
 - Listing and identifying unreached pockets (mapping)
 - Micro planning and Sessions for this group regularly
 - Mobile immunization services through partnering with existing mobile health clinics under DHS
 - Deployment of additional trained ANMs and Supervisors
-
- Fixed days - fixed site strategy for immunization during outreach sessions
 - Bringing NGOs to fill up Gaps in Unserved & Underserved areas
 - Better convergence with other sectors like ICDS for avoidance of duplication of efforts , ensuring that full coverage is achieved to those who are most vulnerable - VHNDs
 - Onsite supervision
 - Focus on quality immunization services – AD syringes, training to workers, monitoring etc..
 - Cold chain management
 - Focus on monitoring of Programme- regular state level, district level and block level quarterly review meetings
 - Four rounds of special immunization weeks with 4 weeks interval in between are planned in NE district starting from first week of Oct 2012 to rapidly improve coverage
 - Special Immunization weeks are conducted twice in a year in the month of November and March as catch up rounds to cover the unimmunized children. This year also, the activity is being planned from 15 Nov to 21st Nov 2012

Immunization service points and tracking children using MCTS have been strengthened by the State and VHNDs are optimally utilized for the purpose. Mobilization of children, support to ASHA in reaching out to the reluctant and resistant families is one of the major constraints in achieving 100% coverage. In the NE district, 37 VHND have been held this quarter against the 125 planned, a significant shortfall that may account for the lower vaccination coverage.

2.4 It has been observed that under the Menstrual hygiene programme, sanitary napkins are being provided to the adolescent girls in the adolescent clinics held as ARSH clinics which

are being held on fixed days (Saturdays) on a weekly basis, however, counselling is being done largely by untrained paramedic personnel. Contraceptives are available in adequate quantities in health facilities. IFA tablets are being distributed regularly.

2.5 Preventive, Promotive and Curative services are being provided by PUHC/ Seed PHCs in urban slums with good case loads. Apart from basic out-patient service, diagnostic services are being provided. In NE district it was observed that there is no provision of generator/ invertors hampering the services. Outreach activities are done by ANMs on household basis and covers family planning services, tracking for immunization, ANC, high risk case detection and adolescent counseling etc.

2.6 There is no MMU deployed by the state. There are 92 Mobile Vans with a MO, PHN, ANM, Pharmacist Dresser and peon operating across the state in association with NGOs as per schedule in the Jhuggi Jhopri (J-J) clusters/unserved areas/construction sites etc. Mobile Health Scheme is a branch of Directorate of Health Services. Since the J J clusters/unserved areas/night shelters selected to be catered by the Mobile Health Dispensaries are scattered all over Delhi therefore, for better management 17 control room have been set up. Mobile Dispensaries have been distributed to these control rooms depending upon the number of J J clusters and availability of manpower. These mobile teams provide basic health care (examination/ consultation/advice), free distribution of required essential drugs, health education and are also involved in National Health programmes, Immunization and other Family Welfare activities.

Medical coverage during events like; Haz Manjil pilgrims, Urs Mela, Kawariyas Camps, NCC Camps/Sports Events, Bhartiyaam, Sant Nirankari Sammelan, Chhat Puja, and for control of Cholera/ Gastroenteritis/Jaundice outbreak/Any other epidemic, Services at Bangladeshi Prisoners, Arya Orphanage Pataudi House, G.B. Road Sex Workers area, Tahir pur Leprosy Complex, Lampur Beggar Home/ Resettled JJ clusters, Night Shelters and 13 Mobile Van Dispensaries have been deployed by DHS at pre-identified construction sites communicated by Labour Department to provide basic health care services to Delhi Building & other Construction Workers & their families.

At present, 41 NGO's are participating under the scheme and 45 MHS Dispensaries have been allotted to them by the Mobile Health Scheme. Department is receiving the monthly

reports from the NGO on regular basis. Monitoring of the NGO's is done by the Department on regular basis.

- 2.7** Centralized Ambulance & Trauma Services (CATS): Good use of 102 (CATS) ambulance round the clock with a response time of 30 minutes to reach facilities was reported by several beneficiaries at different places in both the districts. The trips per day being 4-5 per day. However, geographic access is limited, inter facility transfer and drop back facility under JSSK is not available in most places. There is no provision of ambulances at PUHC level to transport patients in cases of emergency and for other purposes.
- 2.8** AYUSH: Dispensaries of the Directorate provide all types of curative, promotive and preventive services to the needy public at primary health care level.
- 2.9** The method of BCC/IEC for outreach is mainly through IPC. Limited use of printed/AV aids.
- 2.10** No outsourcing of services to private partner for outreach activities has been done.

Summary TOR 2

Outreach is through dispensaries, PUHCs, Seed PHC and the VHND. NRHM support had added staff and equipment to these centers making it possible to expand access for outpatient care and services such as Immunization and ANC. Complete immunization coverage is reported at 63% and unless the state adopts a proactive community outreach mechanisms through deployment of ASHAs and ANMs, improvements on this front would lag behind. There is a shortfall in ILRs, deep freezers. Domestic refrigerators were observed to be the major equipment for storing vaccines at many sites. Immunization and Health Talks are the primary focus in the VHND. Sanitary napkins and spacing contraceptives are being provided free of charge through schemes run by the Delhi government. There are no MMUS, although the state manages a mobile health scheme with NGO partnerships, for JJ clusters, slums, and construction sites. There is no systematic monitoring mechanism in place for this. There are AYUSH dispensaries co-located with primary health facilities.

ToR 3. Human Resource for Health- Adequacy in Numbers, Skills and Performance

3.1 Existing scenario:

PARAMETERS	NUMBERS
NO. OF DOCTORS (DELHI GOVT.)	1630
NO. OF DOCTORS (PVT.)	50000
NUMBER OF NURSES (DELHI GOVT.)	25000
NUMBER OF NURSES (PVT.)	5450

The contractual manpower approved under NRHM is acting as a significant leverage to the State's existing human resource pool. However, against the total approved positions of 5939 in State approval (RoP 2012-13) approximately 2/5th (40%) of the positions are still lying vacant in State.

	Total NRHM	RCH / Mission Flexi-pool
Approved	5939(5564 sanctioned)	3553
In Place	3609	2329
Gap	2330	1206

S. No.	Post	Sanctioned	Filled
1	Anaesthetist	9	4
2	Gynaecologist	12	9
3	SR Gynaecologist	34	0
4	SR Anaesthetist	19	0
5	Paediatrics	58	24
6	Pathologist	9	6
8	Medical Officer	558	360
9	Pharmacist	170	122
10	Staff Nurse	404	270
11	ANM	946	706
12	LT/LA	313	238
13	PHN	119	63
14	CDEO	368	284
16	Others	2920	1467
	Total	5939	3553

- No additional Human Resource had been approved in the current financial year 2012-13.

3.2 In South-west district almost 307 recruitments are done under NRHM which includes Specialist (3 Gynaecologist & 1 Anaesthetist) and paramedic staff such as lab technicians, Pharmacist, staff nurse, medical officers, OT Assistants, ANMs and some support staff. The filling of gaps in manpower through contractual postings has addressed the manpower requirement and facility need to a greater extent, still as per the population and quantity of case load on facilities it seems that more positions need to be sanctioned and filled. eg in DGD Nagalraya, has a well equipped Mother lab facility on its first floor which cater to the need of almost 50, 000 population. Four Basic labs are supervised by this lab. This Mother lab is manned by a Pathologist who is on contractual basis under NRHM supported by an additional lab assistant (contractual). As reported by Dispensary authority appointment of this Pathologist for the last two year has made a remarkable progressive change in lab services catering to the needs of DGD having 70-130 OPD/day. Also, as discussed with pathologist herself they are working under the circumstances where they do not have consistent supply of reagents and consumables, AMC of equipment not done, the company contact details of company personnel's are not known.

The positive impact of NRHM support was distinctly visible at MCD Maternity Home, Naraina. Detailed interactions were done with Additional DHA of NDMC who informed that with 2 MO's at Maternity Home with Staff nurses support, the output was 16-20 deliveries/year. IDHS South West provided support under NRHM in providing additional MO's (3/5) and other paramedic staff (8SNs, 1LT, 1 CDEO) so that the Maternity home could provide 24 hour service in catchment area population of about 4 lakhs and the number of deliveries (following NRHM support) has increased to 126 deliveries/month in past 6 months with 24 hour Medical care.

3.3 AYUSH system of medicine is well established. Dispensaries of the Directorate provide all types of curative , promotive and preventive services to the needy public at primary health care level. Directorate provide free Medical facility to all general public.

The demand for the AYUSH system of medicine was observed in the facilities visited. The FGD with community in Nandnagri & Seemapuri areas reflected a demand for Unani System of Medicine.

AYUSH facilities breakup with co-location- Details of AYUSH facilities in Delhi are as under-

Dispensaries-

S. No.	Government Agency	Ayurvedic	Unani	Homoeopathic
1	Govt. of NCT Delhi	32	15	93
2	M.C.D.	126	26	32
3	E.S.I.	14	0	4
4	N.D.M.C.	12	0	13
5	CGHS	15	1	14
	Total	199	42	156

As per Cafeteria approach, Directorates opens the AYUSH dispensaries in the buildings of Allopathic dispensaries. Out of 140 dispensaries of the Directorate 136 are co- located with Allopathic dispensaries.

- One Research Council in Homoeopathy has been started
- A proposal for Up gradation of AYUSH dispensaries PUHCs (Infrastructure) has been initiated by Delhi State

- There is a plan to set up a PMU exclusively for AYUSH

AYUSH staff position (sanction/ vacant/ filled)- The AYUSH staff in terms of Medical officers is largely in place. The para-medical staff of AYUSH needs to be further strengthened with Unani pharmacists.

Sr. No	Post	Sanctioned	Filled	Vacant
1	GDMO- Homoeopathy	111	102(93- Regular,9- contract)	9
2	Pharmacist- Homoeopathy	106	80	26
3	Nursing Orderly- Homoeopathy	110(68 – R,42- outsourced)	54- R	14-R, 42- Outsourced
4	GDMO-Ayurveda	35	30	5
5	Pharmacist- Ayurveda	30	21	9
6	Nursing Orderly- Ayurveda	42(20-R,22- outsourced)	20-R	22- Outsourced
7	Panchakarma Specialist	2	1	1
8	Ksarsutra specialist	1	0	1
9	GDMO-Unani	8	8	0
10	Pharmacist- Unani	8	0	8
11	Nursing Orderly- Unani	8	8	0
12	Drug Inspectors- Ayurveda	3	3	0
13	Drug Inspectors- Unani	2	2	0

There has been no training on national programme undertaken by AYUSH Doctors of the Directorate in last 2 years.

AYUSH staff is regularly participating in the Pulse Polio Immunization programme and RCH programmes and also participating in training programmes organized by family welfare department.

ASHAs have not yet been trained in the AYUSH component. They were provided with AYUSH Kits (Drug kits) but no one knew what to do with those drugs.

There is no specific IEC to promote AYUSH

A proposal to enhance the activities of AYUSH sector has been submitted by EDMC to Delhi State Health Mission but reportedly not yet been considered

3.4-3.6 There is no defined HR policy, with specific incentives to attract and retain HR, place them in difficult areas or for any training plans, and career progression opportunities.

There are instances of irrational deployment of manpower e.g. Placement of 2 MOs with an OPD of 70-100/day while one MO catering to an OPD of 150-200/day at some places

Services at facilities of parallel agencies , such as MCD, are affected adversely by abrupt shifting out of contractual staff , at times, even in well performing sites.

At some places a major part of work force in facilities are deployed by NRHM e.g. in Central district of Delhi Ajmeri Gate Allopathic dispensary (Code-06001)-GNCT) has 8 contractual NRHM staff out of 10 in facility.

An apt comment from MCD officer narrates a rethink need for frontline worker policy in urban Delhi with a large No. of JJ Clusters and Slums right near posh/poshest areas :

“Under Project India Population Project VIII (IPP-VIII), which was implemented in Delhi along with Bangalore, Kolkata and Hyderabad about 12.5 Population of slums was covered for primary level services. The project was implemented from 94 to 2001 and since then the services have been continued with support from Corporation. The slums covered were of the lowest category i.e. Jhuggi Jhompri (Clusters). Several surveys and internal reviews were conducted during and after implementation

As part of the implementation strategy outreach was carried out by ANMs for at least 15 working days in the month. During this period they covered each Basti Sevika area of 2000 population (Basti Seviks was the precursor of ASHA in Urban area and was selected from

community and paid a fixed honorarium of Rs 500 per month) thrice. The services given included Immunisation, ANCs, PNCs and family planning (distribution of Condoms, OCs and follow up of IUD and Tubectomy cases).

Besides this mahila mandals, school visits etc were carried out. Each ANM was supervised by PHN (Public Health Nurse) who visited each ANM at least twice each month. Further the whole arrangement was supervised by Medical officer who visited each ANM area at least once i.e, 05 field visits each month. All of them had to share their plan in advance and also submit a report on fixed format for each day of field visit.

This type of outreach activity was very effective and was the core of implementation strategy in JJ clusters which were otherwise difficult to target due to number of issues such as – language, social, economic, physical barriers. As per data available 70-85% of primary services were given in outreach and only about 15 – 30% in health centres. The population of JJ Clusters at that time (1994) was estimated at 12.5 Lakhs. This has now gone above 35 lakhs. Further we have large amount of equally vulnerable population living in many slums and un-authorized settlements all across Delhi. But unfortunately this type of outreach based service strategy does not find acceptance today in Delhi. In fact the emphasis is on giving all services from the main health centres and ANM/ASHA is only for health education as well as referring patients from community to health centres.

The challenge with this strategy is that – The population in JJ clusters and similar slums is migrated from different states and has come to Delhi for economic reasons. They have little time and inclination for spending dedicated time for health centre visits unless the situation is serious. Each visit does cost them as it is an opportunity loss in purely financial terms. Therefore unless we provide services at a place and time of their access, the coverage will remain inadequate. Secondly if this is the strategy (services from health centre) then why do we need 01 ANM for 10000 population in Urban area along with 05 ASHAs, as their role is similar and overlapping? Therefore there is a need to re-think exclusive health centre based strategy and if we are sticking to this then we need to re-evaluate our staff requirement especially ANM in areas where we have ASHA also.”

A consideration to the observation made made by an MCD officer, needs attention

- 3.7 Deficit of part time cleaning staff/ supportive staff was observed in tertiary level facilities resulting in the poor upkeep of these facilities and patient support. This category of staff was largely outsourced.

3.8 There is clearly a difference between the levels of remuneration and perks/incentives between regular & contractual staff. This has resulted in resentment among the contractual employees. With no security and less remuneration, contractual staff take these jobs as time-gap-arrangement and are in constant look out for better paying and longer duration job opportunities and leave with short notice. The output, too, is less of a focus as neither are they accountable nor are they big losers. Further, discrepancies were observed among the contractual staff in different programmes divisions, also contractual Human resource of Disease Control Programme like RNTCP is facing large number of transfers, frequent vacancies due to resignations etc. Low salaries of all RNTCP staff in comparison to NRHM/Regular scales

- Medical Officer in RNTCP gets Rs. 28000/- per month while NRHM Medical Officer gets Rs. 53000/-. Similar is a case for other staff as well.
- Few wish to join, if joins leave early Therefore number of posts remains vacant for quite a large period of time. For example the posts of State MO & District MO are still lying vacant.

There is no provision to move the contractual staff in permanent cadre under already sanctioned post/by creation of sanctioned post.

3.9 Gender equity is visible. Maternity leave are applicable as per Maternity Benefit Act 1961. No grievances were reported related to women security, harassment or working milieu.

3.10 The TORs for the entire workforce under NRHM are in place. However, at some places, the Recruitment rules & Eligibility criteria is stringent which leads to:

- Difficulty in recruiting staff
- Difficulty in getting competent staff

e.g The TORs of State Accountant are such that during last recruitment process RNTCP division had three candidates as CA & MBA by qualification but could not recruit them because they did not have the primary essential qualification of Post Graduation in Science/Commerce with 60% marks. As two candidates were just graduate & one was post graduate in Economics with 58% marks with the result there is no State Accountant for last five months. Similar problems were reported in other category of staff and also in IDSP.

Summary TOR 3:

Of the total approved positions of 5939 contractual staff, nearly 40% are still vacant. The 60% contractual staff in place has made a significant contribution to increasing the access. ANMs form the large bulk (706), followed by staff nurses, MOs, and LTs. This filling of the HR gaps could have been more productive if the state had expedited the selection. However the terms of the contractual engagement, lack of in service orientation or training, arbitrary transfers have diminished the potential outcome of additional HR. There is no HR policy in place and instances of irrational deployment were noticed in some instances. There is a difference in levels of remuneration and incentives between regular and contractual staff, and this is the reason the state had not been able to fill all sanctioned posts. There is no initiative to move contractual staff to regular posts within the administrative system. The State government control allocates staff to the MCD managed facilities. There does not appear to be any joint planning on staff deployment, with MCD perceiving the allocation as being arbitrary. There are only nine vacancies in the AYUSH (GDMO) positions, and of the 140 dispensaries, 136 have co-located AYUSH facilities. CATS ambulances are available and the state plans to add more to the fleet. The average number of trips appears to be about 4-5/day.

ToR 4 Reproductive & Child Health Programme

4.1 Institutional deliveries:

The most visible service in the RCH package is that of institutional delivery. In the NE district, which has the highest proportion of in-migration, floating population, and patients from across the border in Uttar Pradesh accessing the institutions for delivery, the load is extremely high, especially at the Level 3 facilities.



The GTB (Medical College and Hospital) which is an over 1000 bedded hospital has just started had a 300 bedded MCH wing and is functioning well. Around 40% beneficiaries are from outside the state.

The Swami Dayanand hospital also is readying a separate MCH wing, but clearly even this is likely to be inadequate. In the NE there were no private hospitals accredited for institutional deliveries.

Institutional delivery in the NE district based on HMIS data for FY 11-12 show a reported delivery rate of about 68%, of which 2 % is reported as home delivery and 32% as unreported. For the six monthly period of this current year, reported deliveries against the expected load is about 33% with unreported deliveries being as high as 67%.

Discussions with ASHA, ANM and AWW and MOs however indicate that home deliveries could be in the region of 30%, and account for part of the unreported deliveries. Most of the home deliveries appear to be assisted by local Dais living in the area. Every maternity home and dispensary that the team went to had at least one practising dais in the vicinity.

The NE district has identified eight delivery points of which one is a medical college hospital, two are at the level of a district hospital and the remainder are Level 1 facilities. Between

them they accounted for roughly 12254 deliveries in the last six months. All centres were functioning well beyond their capacity, with resultant compromise in quality.

Protocols were not displayed in any centres visited in the NE.

In SW district there are 10 Delivery Points - two tertiary care hospitals (Safdarjang and RR Hospital) , two district hospitals (RTR Hospital and Delhi Cantonment Board Hospital- which is only delivery point and functionally not a DH) , 3 SDHs, 2 CHCs and RHTC Najafgarh and has 5 PP Units. RTR Hospital has a large load of cases from nearby Haryana State's Jhajhar district and Dadadev hospital caters to a huge population and because of services and cleanliness available with JSSK, there is huge caseload for this 60 bedded hospital

SW district reported 17577 deliveries in public institutions in the past 6 months and 502 in accredited private institutions. 949 deliveries were reported as Home deliveries in SW district (5.39% of total deliveries) in past 6 months out of which 839 (88.4% of home deliveries) were by Non-SBA trained attendants . Dais concept is hardly seen in SW district as compared to NE district.

In both the districts, emergency transport systems appear to be working well, but given the good access and private transport such as autos, patients appear to be using these more than the CATS ambulances, and reported spending was between Rs. 80 and Rs. 120. . The issue here is however the high rate of refusal of multi-parous pregnant women at the Level 2 and 3 facilities, and no inter facility transfer to the maternity homes. While several women do go to the maternity home, several women either going to the private sector or back home, and possibly accounts for the “unreported deliveries” No records of such refusal exist, but the specialists at the facilities said that they did indeed send them back and interactions with ASHAs confirmed that in both the districts patients were sent back home and there were home deliveries because of these reasons. 48 hour stay is reported in about 39% of deliveries in the NE district and about 30 % in SW district on account of high caseloads.

- C-sections in the NE are taking place in three facilities in the public sector. HMIS reports a nearly 12% C-section rate in the public sector and about 33% in the private sector. In Seemapuri Maternity home despite the availability of , One gynaecologist, one paediatrician, and one anaesthetist on call with 4 SNs, no CS done despite having a well-equipped OT due to the shortage of regular MO's, as round the clock MO's are required.
- Rate of normal delivery Vis-a-Vis C-section appeared to be normal. In SW district: Deliveries about 5450 deliveries annually, of which 23% are C sections. Only 192 are JSY.

Only 4% eligible for JSY). Total C-sections performed in the SW district were 2846 in public facilities and 217 in private facilities

- The medical college hospital (GTB) reports about 23.5% C-section rate. All three facilities in NE and 3 in SW district had blood banks and 2 facilities in SW district had Blood storage Units . There were no accounts of obtaining blood from the private sector.

No out-referral records were seen by both the teams , in the maternity homes. Complications were mostly managed at the Level 2 facilities. None of the MOs were trained for BEmOC.

SBA trained SNs were not much seen. In the SW protocols were seen in some facilities.

Partographs were not being used in any facility in the state

Child Mortality	SRS 2007	SRS 2008	SRS 2009	SRS 2010	SRS 2011	Trend Analysis	Child Health Goal MDG 2015
NMR	20	19	18	19 (India-33)		Slow decline since 2007	< 20
IMR	36	35	33	30 (India-47)	28	Slow but Steady decline in IMR	28
U5 MR		40	37	34 (India-59)		6 Point decline	< 38

There are reportedly 32 NBCCs, 14 SNCUs, 14 NBSUs, 21 IYCFCs and 11NRCs in the State

Of the three maternity homes visited in the NE, facilities for essential newborn care were lacking. Ambu bags and radiant warmers were not seen. While in SW district the ENMC equipment was in place in delivery points and staff nurses were efficient in using them at most of the places. In the level two and three facilities the number of beds was not as per norms, however the SNCUs were well equipped. The admissions in SNCUs are mostly for inborn with 10-20% outborns. No providers in any centres that the team met had been trained in NSSK. Eight ANMs were reported to be trained as SBAs but none that the team met.

Waste management practices were good in all facilities seen. This has been outsourced and barring a few occasions appears to be working well.

Nutritional Rehabilitation Center established in the GTB and RTR Hospitals are functioning well. In the SDH two beds were dedicated to SAM children but no NRC has yet been established. The level of awareness of frontline workers in both districts including AWW in growth monitoring and detection of SAM was low. IYCF centres are functioning well in both the districts especially in GTB Hospital (tertiary care hospital in NE District) and RTR Hospital (District hospital in SW district) that were visited by the team. 21 IYCF Centres are functional in 9 districts



IYCF and Breast-feeding Promotion being done in a district

- Safe abortion services, mainly SE, and medical abortion and D and C are provided in all eight delivery points in the NE. MVA is not being used in any public sector facility in the State. There are a total of 59 private sector facilities registered for MTP in the NE. In the SW district, MTP service is in in DH and Tertiary care hospitals. Community FGD in the SW showed low women's awareness of MTP services in the public sector. Civil registration data for the state shows a decline in the sex ratio at birth. Delhi's civil registration system is among the best in the country, and thus this data must be taken seriously. The NE district reports the highest sex ratio and activities under PCPNDT are being followed actively in both the districts

4.2 Comprehensive RCH services are being provided at all maternity centres; prioritization of facilities appears adequate- access is reasonable. Quality of care seemed to be appropriate though the ANM & MO needs to be trained in BEmOC and SBA training latest protocols

Training of service providers for RCH related services is very slow, in the NE district. Eight MOs have been trained as SBAs, 26 in IMNCI, 89 in Immunization, and 33 in IUCD insertion. 50 ANMs have been trained in RTI/STI management, nine in IMNCI, 80 in immunization, and 30 in IUCD insertion. ANMs were inserting IUCDs in the maternity homes., the fundamental issue with the slow pace of training is that the state lacks a training strategy. The NE district had no training calendar or plan on how to ensure provider training. In the NE no MOs or staff nurses had been trained in FIMNCI or NSSK

One PUHC reported not having Hb kits for three years, and an ANC load of about 4-6 per day. In another, eleven of 14 ANC seen in one day had a Hb of less than 11gms% and two had Hb of 7.5gms% and 6 gms%. The management for all was just the same – two tabs of IFA for ninety days and Hb less than 7 gms% cases referred to MO (no follow up whether they reach MO or not)

Diet for mothers was being provided at all delivery points but quality varied. Hot cooked food was given only in the Level 3 facilities.

Breast feeding initiation in the facilities was observed, but follow up counselling in the post natal wards particularly for primis needs attention.

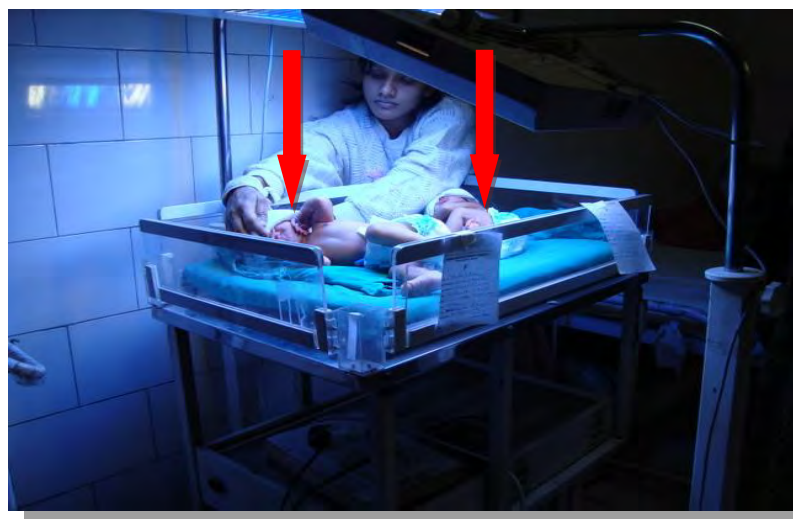
- It was found that due to low number of EmOC level facilities and a poor management of referral, most of the pregnant women are waiting for services; overcrowding of the facilities and hence push back or refusal in terms of higher parity observed resulting in increased incidences of home delivery. (In NE district, persistent home deliveries and refusal for Immunization despite motivation by ASHA & ANMs, reported 20% while the same was very low in SW district – being 2%). Given the high levels of overcrowding, women tend to leave within 24hrs of delivery. At most of the facilities, 2 pregnant women lying on single labour table and 3 post natal women on a single bed with their new-borns was visible indicating a huge case load for services in Public Health Sector but not enough infrastructure and HR to manage the influx.

- ANMs wherever they are, conduct ANC, examine and provide services like Inj. TT, counselling, motivation, IFA tablets distribution, benefits of JSY and counselling for PPIUCD
- One of the best practices observed was initiation of breastfeeding in institutions within an hour of birth or at the earliest possible (as the case may be) all across and at every level. Lot of emphasis on IEC, BCC and supportive supervision and mention by the senior staff, indicating that a focused effort on any activity does produce results.



IEC Campaigns for Breast Feeding promotion

- Quality of sick new born care was seen appropriate in SNCUs however; the services providers (especially staff nurses) were not duly trained in New-born care at most of the places and need training. At places there were two children in one bed in SNCU indicating case load vs facilities gaps and lack of supportive supervision & monitoring mechanisms.



- The designated facilities are able to achieve the standard of care required and very much capable of providing full range of services.
- Labour room were satisfactory but technical protocols were not displayed in the LR at most of places visited. There was a general apathy attitude towards the privacy for women.
- Referral transport is not readily available. Many women in FGD with communities expressed that they had to spend almost Rs.80 (to & fro) every time to reach the facility more so in cases of ANCs

At many places amongst frontline workers and even the beneficiaries, it was observed that there was not enough of preparedness to understand identifying complications and then initial steps to be taken for handling the complications. This indicated a less focussed IEC and BCC activities

Infant Death Review- Guidelines were not available at any of the facilities and it was not being done anywhere in the state.

4.3 **Quality Assurance** mechanism seemed to be appropriate in the facilities however , QA committees are set up but only for Family planning services, immunization and Maternal Death Review.

➤ **Infrastructure:** The infrastructure was in sound condition. Swami Dayanand Hospital (SDH) in NE district and Rao Tula Ram Hospital & Dadadev Hospital in SW district. There was no structural issue like major seepage, cracks, irrational planning , breached boundary walls, stray animals, encroachment etc. These Hospitals have a well functioning ICU with state of the art equipment, though there is no step down/HDU for ICU where patient can be kept in transition before shifting them into general wards.

Arrangement of service in ANC clinic were quite near to best practices what is called as-structure should follow the processes. A user can start with registration and counselling and at the end get medicines in unidirectional flow without any criss-cross or confusion.

In NE District:

- In SDH, Emergency was well planned with dedicated reception area, triage area, resuscitation area and observation ward. As reported by the hospital staff none of the 6 multi-parameter was fully functional in ICU at SDH. At emergency a defibrillator was provided but it was out of order for the last two months Maternity Center at -Yamuna Vihar does not have any radiant warmer in labour room w hich was situated on first

floor with no access given by ramp or lift providing no other option but pregnant women climb stairs on their own in labour pain or lifted by relatives, otherwise. No stretcher was found in the hospital. There was not even an Oxygen Cylinder in whole of the hospital.

- At GTB a tertiary care teaching hospital there was no scrub are in OT complex. A wash basin is provided in the OT itself which is against any antisepsis standards. Zoning of OT was also not done and it was hard to identify clean, sterile and dirty utility in the OT complex. One out of two lifts was not working at GTB, so the only operational lift was shared by both patients and visitors. Safety way guidance system for fire evacuation was being placed at the time of visit.

Services though well planned are greatly compromised by the huge patient load. So even in surgical wards it is hard to maintain recommended bed distance of 3.5 feet. At most the areas it was less than 1 feet as additional beds and floor are being placed to accommodate extra patients. Similarly at DGD Old Seemapuri waiting area at OPD has been provided but it cannot decently take a patient load of 350 plus per day.

In SW district:

The hospitals had lifts for patients, the Labour rooms & OTs are on First & 2nd floors with lifts and patients received due care. The drugs and Gloves shortage was efficiently managed by Medical Suppts. of RTR Hospital & Dadadev hospital. Quality of care was compromised due to case overload , less HR and deficient infrastructure but not much efforts were visible that issue was being addressed except now that a plan to develop another 100 bed facility at RTR hospital was in place & in progress. There is an urgent need for developing at least 400 beds more in RTR and at least 200 beds more in Dadadev hospital area to serve the population in right earnest or to construct more facilities.

The reasons for non upgradation, as narrated by the hospital staff and the community, was lack of political and administrative will even when the space was available in both the places Similarly there is huge space available at PHC Ujjwa (under Central Govt. sponsored services) but deficient infrastructure and deficient HR are the causes of compromised quality care

The most encouraging fact was the pro-active attitude of recently appointed DC / District Collector in SW district who wanted to do the best possible to provide land for new infrastructure development activities for health care services

➤ **Processes -**

- Facility level inventory management is an area of concern. Though state has policy of free drugs for all since quite a long time, it cannot be effectively implemented as facilities do not have in-house capacity of estimation of reorder level and buffer stock. This is done arbitrarily, leading to frequent stock outs. At the labour room in GTB the team found consumables like gloves and syringes are being purchased by patients. Nursing staff reported frequent stock out of Oxytocin and other essential drugs in labour room though the district health administration claimed that they have an adequate supply of drugs. The problem perhaps lies in faulty inventory management and indenting practices. Similar incidences were observed in labs where there was no supply of reagents and slides for the last four months.
- No Maintenance of records on Near Expiry Drugs was maintained in any of the facilities.
- As observed in NE Distt. : A major issue is maintenance of clinical records. At SD Hosp., ANC records are maintained on MCP cards and given to pregnant woman but no record of the same is maintained at the facility leading to irretrievability, while at Maternity Center Yamuna Vihar records of ANC are kept at facility but not given to the pregnant woman, so may not confirm the continuum of care.
- Nursing handover during the shift change is also not recorded as observed a nursing station of GTB, Labour room at maternity centre and emergency department of SDH.
- Certain processes were mapped through time motion study, and there were lot of duplication and redundant activities. For example at DGD Old Seemapuri (average case load of OPD > 150/day) a patient has to join queue three times for finally getting the drugs. First registration counter for taking the OPD slip, after consultation again they have to join queue at registration counter to get a registration no. and to enable the registration clerk to note down diagnosis and prescription in his records. This registration official is a Group-D non-technical staff and whether he can read diagnosis and prescription correctly from the OPD slip, is a question. After that patients have to wait at drug dispensing counter where again pharmacist writes down patient details and drug endorsements in his records, data elements of which are quite similar to what registration clerk has already recorded. This leads to increased waiting time and overcrowding at the facility .
- Admission, discharge and referral protocols need to be clarified and documented. As told by the HOD-OBG at SDH there is lot of referral and back referral happens between their hospital and GTB, due to ambiguity in referral protocols.

- In SW district in the hospitals it is not so and there is smooth flow of beneficiary with minimal duplication of activities at all level facilities

➤ **Outcome**

- There is not much be said quality of outcome as indicators like average length stay, hospital acquired infection rate, , cycle times for different services, patients satisfaction scores are not measured fully.
- Though from facility visits, it can be inferred that facilities are catering huge load of indoor patients. In Maternity ward itself the bed occupancy may range from 150 to 250 % at any given time.

Even at labour room it was seen that two pregnant women were sharing the same delivery table.



4.4 Community level arrangements- ASHAs are distributing ORS for diarrhoea but no management for ARI, HBNC is in place and PNC is low.

For JSSK, there was full awareness among ASHAs, ANMs Staff nurses and doctors. The CATS service for transport was available and response time was 30 minutes among those who used it. There is still no inter-facility transfer and drop back to the residence

Of the three home deliveries reported in the last two weeks in the NE no post partum visits were undertaken by the ANM.

4.5 There are fixed day services for NSV and Tubectomy in the level 2 and 3 facilities. PPIUCD services are being emphasized in both districts, but in the NE no providers had been trained in PPIUCD. PPIUCD is not being undertaken in Seemapuri MH, as the gynaecologist was hesitant due to lack of formal training and supportive manpower. A focused effort by NSV Surgeon at RTR was distinctly visible as a well equipped OT was set up near OPD and surgeon would perform NSV on any day the beneficiary agrees to and no case was lost due to fixed day services approach.

- 71 facilities have been accredited either by state or districts for performing sterilization operations s per fixed standards.
- 959 doctors have been empanelled for performing sterilization operations out of which 867 are for Tubectomy and 99 for NSV while 418 have been empanelled for Minilap & lap. Sterilization
- State and all district level QA Committees have been formed to oversee and monitor the services
- Eight hospitals in each district (except South East) are strengthened to provide 6-day service. Out of 16 NSV Camps approved in PIP 6 Camps have been conducted and 73 surgeries performed. 5 Tubectomy Camps were approved and 3 camps conducted had 75 cases done. 9 IUCD Camps out of approved 18 Camps had 267 cases.

Status of Sterilization services:

S No.	Indicator	2011-12	2012-13	
			Q 1	Q 2
1.	% of total Sterilization against ELA	63% (19844/31500)	45.3% (4532/10000)	48.59% (4859/10000)
2.	% Post partum Sterilization	8.35% (2631/31500)	20.87% (946/10000)	31.19% (1516/10000)
3.	% Male Sterilization	39.5% (2568/6500)	22.28% (390/1750)	28.1% (491/1750)
4.	% IUCD insertion against planned	137.5% (44803/32000)	85.44% (10680/12500)	107.1% (13389/12500)
5.	% of complication following sterilization	0.02%	0.17%	0.08%
6.	% Doctors trained in Minilap	-	-	-
7.	% Doctors trained in NSV	124% (31/25)	-	-
8.	% Doctors trained in Laparoscopic Sterilization	100% (7/7)	-	-
9.	% ANM/LHV/SN/MO trained in IUCD insertion	MO-123% (59/48) PMW- 178.3%(107/60)	-	Cu T-375 MO-2TOTs (unplanned)

3 cases of Sterilization deaths were reported in 2011-12 and analysed in the state. 2 cases were given compensation by the insurance company while documents of third case have been submitted

- FP: fixed day sterilizations services available; NSV small minority;
- PPIUCD high in secondary and tertiary facilities; in MH level only routine IUCD; no training of ANM in IUCD in facilities visited.

4.6 102 CATS services are available in the state but per se for RCH services the ambulance service is not available. Average trips being 4-5 per vehicle per day per vehicle

- In & out referrals and inter facility referrals are not happening moreover the facility to provide service is not available. This was found one of the causes for home delivery.
- In some hospitals (Dadadev in SW District) MS has made alternate arrangement with a local taxi operator to provide transport facilities for JSSK beneficiaries but most of the places for bringing in pregnant women , CATS Ambulance services were available in many places

4.7 Since Delhi is a non high focus state, JSY payments are subject to several conditionalities which (are rigidly complied with) are :

- The woman should be above 19 yrs. of age.
- Should belong to SC/ST/BPL category with evidence – either a certificate or an NOC from the local counselor.
- The benefit is available for first two live births.
- Must have 3 ANC check up, TT1,TT2 & 100 IFA tablets
- Financial Assistance
 - Rs. 600 Urban
 - Rs. 700 Rural
 - Rs. 500 Home Deliveries
- Needless to say, this puts a large number of women who deliver in institutions ineligible for the JSY entitlement. It also ensures that ASHA will not reach such women to motivate them for institutional delivery, since they would not get the payment anyway.
- In the GTB hospital payments were being made in cash.
- JSY: All payments are as reported by State are made on time and through bearer cheque.

e-SLA:

The Govt. of NCT of Delhi has taken a number of citizen friendly initiatives. One amongst them is monitoring and ensuring timely release of payments and completion of defined tasks and works of the citizen in a time bound manner through a system which monitors the same through software connected to all the service delivery units and with a provision of its regular online surveillance and watch by the respective programme heads. This system is called as Electronic Service Level Agreement (ESLA).

On the recent initiatives of the Secretary (Health), Govt. of NCT of Delhi, the Directorate of Family Welfare has included the Janani Suraksha Yojna also under this ESLA mandate with the objective of ensuring promptness and efficiency at obstetric delivery units so that the eligible women who delivered in the institution are provided their financial incentive under the JSY scheme well within the time frame of 7 days. All the doctors, staff and para-medical staff engaged in service delivery in obstetrics unit have already been sensitized and trained on the requirement under this mandate of ESLA.

A dedicated software has been designed and installed in all such units and the software captures important information like date of delivery, date of payment, mode of payment, woman's full details, confirmation of eligibility criteria etc.. The level of responsibilities have been defined so that in case of default at any level, the prescribed financial penalties @ Rs. 10 per day of delay is paid for by the erring staff in the obstetrics unit. To monitor and implement this scheme passwords have been assigned to all the respective programme officers at the state and district level who are monitoring the same.

As a part of this software a provision of 18 digits of the MCTS has also been kept so that tracking of pregnant women for the purpose of scheme implementation and follow up could be facilitated.

There are challenges :

- Non availability of computers and at times intranet, there is manual transfer of data to the facility with computer and internet leading to delay more than 7 days
- In NE district, there were no challenges observed while in SW district- at few places (RTR Hospital and facilities around like PHC Ujjwa, DGDs, SCs etc. the payment of JSY was delayed since the EmOC facilities have stopped giving JSY payments due to limitation of HR and overcrowding. They have shifted their responsibility to the lower facility for the dispersal of money which does not get the JSY money. Few beneficiaries had lot of grievances and so the ASHAs and beneficiaries spent over Rs. 500 to get Rs. 600'- that, too, not received due to procedural difficulties and since beneficiary does not get , ASHA doesn't get. There is a confusion in perception of procedure needing immediate intervention
- There was no mechanism in place for 5% random check of JSY payments.

Year	2010-11	2011-12	2012-13 (For two Quarters)
JSY beneficiaries	19446	20145	10816

	Target (Annual)	Target for two Quarters	Achievements (For two Quarters)	Financial Expenditure (For two Quarters Apr.-Sep.)
Home Delivery	2000	1000	110	
Institutional Delivery				
Rural	3400	1700	340	
Urban	22000	11000	10368	Total- Rs.67,70,691/-

S.No.	Gaps Identified	Suggestive Action
1	Issue of BPL certificates by MLA/Counselor	Meeting by chairperson IDHS of MLA/Counselor
2	<ul style="list-style-type: none"> Submission of documents 	<ol style="list-style-type: none"> BPL/SC/ST certificates Self certification for age, No. of children JSY Card Discharge slip For Home delivery certificate form ANM Stamp on Discharge slip regarding payment
3	Delay in issue of cheque in Hospital	Opening of sub account for Family Welfare Department under JSY at the Hospitals with three signatories
4	Tracking of Home delivery(As most of the Pvt. clinic/small setup not registered under DHS)	ANM's and ASHA's to be monitored
5	Low achievement in JSY accredited Pvt. Centers	All nursing homes registered under DHS to be considered for accreditations under JSY
6	Delay in payment	<ol style="list-style-type: none"> Monitoring through ESLA Sensitization of JSY Nodal and MIS Expert done Software , ID's and Password shared with all the District Nodal's All Districts shared the same with all the primary health facilities Problem persists at the level of Hospitals <ul style="list-style-type: none"> MCTS not functional No dedicated Staff No dedicated Computers and logistics

- At GTB Hospital in NE district a mobile ATM of nationalised bank was visible and JSY payment could be made by cheque through these or kiosks instead of cash.



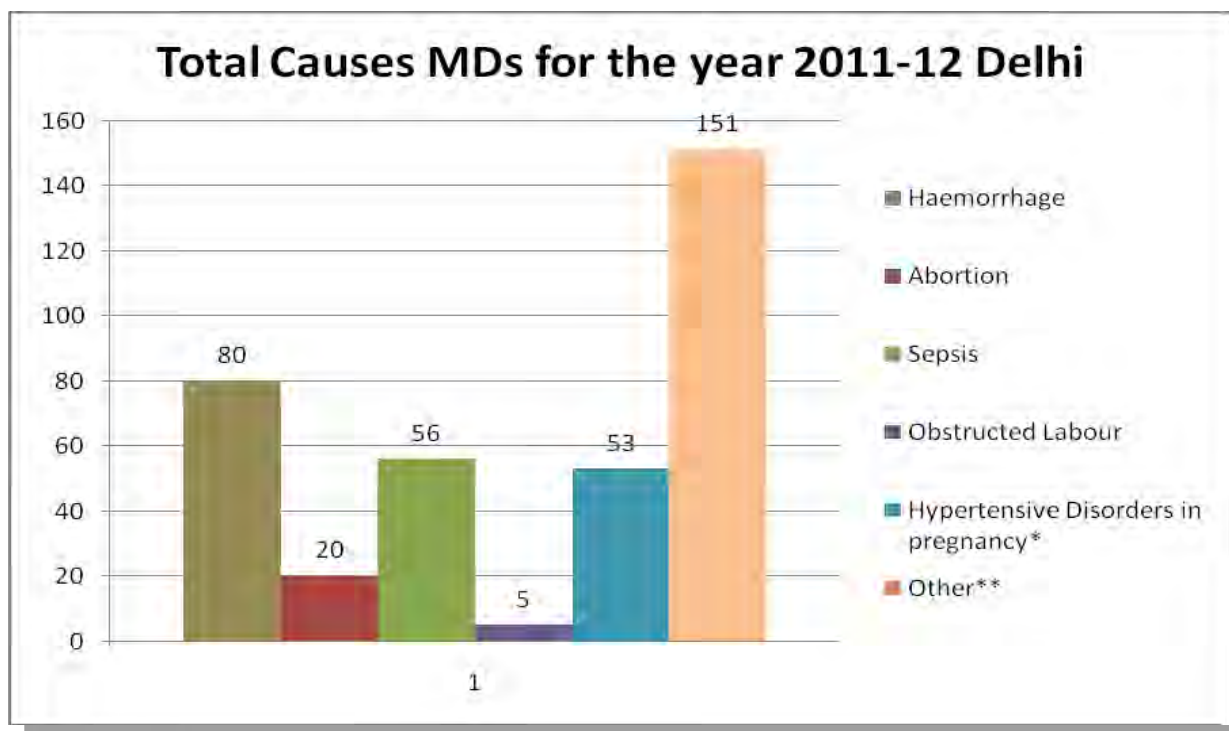
- JSSK is in nascent stage with no display of entitlements (print material not provided by mission yet. Still health care staff, many of beneficiaries was aware of JSSK and its benefits.
- Govt Order was passed on 01.09.2011 for implementation of JSSK.
- Review on JSSK Scheme was done by Secretary Health on 03.10.2012 and scheme was operational w.e.f. 15.09.2012.
- All strategic directions were discussed and issued to see that no OOP expenditures gets done by pregnant women and on newborn children.
- In the NE Out of Pocket expenditure was not reported in the maternity homes. In the GTB hospital patients were observed to be buying gloves and syringes and the residents informed the team that they were out of stock. The team was later assured by the Superintendent that this was not the case. There were several episodes of cleaning staff/security staff demanding payments (the services are outsourced to a private agency).
- In the delivery points visited under JSSK there was no Out of Pocket expenditures on user charges, admission, drugs, surgical items, blood or investigations and interactions with beneficiaries, patients, relatives indicated a great degree of satisfaction.
- No Grievance Redressal System was observed in the facilities visited

Budget Approved Under JSSK (2012-13)	Expenditure (First Quarter)	Expenditure (Second Quarter)
Rs. 1716.25 Lakhs	Rs. 1.36 lakhs	Rs. 24 lakhs

- Steps taken for effective implementation of JSSK in the State :
 - Upgradation of EDL – after receiving inputs from Nodal officers of various health facilities , request has been sent to EDL committee for inclusion of some of the drugs considered essential by obstetricians and paediatricians of the state , so that these drugs are available through CPA of DHS in future.
 - Meeting of all the MSs and JSSK Nodal officers of Delhi government and MCD hospitals and Administration heads of maternity homes of all the Municipal Corporations under the chairmanship of Secretary (health) on 3rd October 2012
 - Preparation of revised GO (draft) in consultation with previous Mission director to streamline the implementation of JSSK
 - Creation of separate link at CPA web site “*Nirantar*” for placing indent under JSSK
 - Institution wise fund allocation under JSSK for year 2012-13 has been done and conveyed to all the districts and centres.
 - Information regarding fund allocation to MCD hospitals and maternity homes under JSSK has been sent to all the three commissioners of the MCD

4.9. The data on deliveries/maternal deaths/Infant deaths from Private facilities was not available.

- FBMDR & CBMDR is happening but at a slow pace. Of the 223 maternal deaths this year only 92 have been subjected to an MDR. (Central Govt. Hospitals not providing all support to State Govt. officers and hence an issue to be considered for attention & intervention)
- There is no system of Infant Death Review observed in the districts visited. No guidelines disseminated till date. The NE team encountered three cases of maternal death, (one at home and two in facilities) reported by ASHAs but the ANMs were not aware of them.
- Three Meetings on MDR have been held in both the districts visited this year



- 4.10 **ARSH services** are provided on fixed days – Saturdays 12pm to 2 pm . There are 162 ARSH Clinics in the state. The adolescent beneficiaries are mainly girls and an average outpatient load reported in a Seed PUHC in the NE was reported at about 30 while it was 4-8 in SW district. Generally girls are motivated by ASHAs and ANMs and boys do not come
- Complaints raised and discussed are primarily related to menstrual disorders, hygiene and other minor ailments besides very little on sex education.
 - 379 MOs and 535 Paramedic workers have been trained on ARSH in the state but it is likely that counselling gets short shrift, but unfortunately very few of the workers (AMNs, pharmacists BE Educators and even doctors & nurses) in periphery providing counselling to girls, the major part of attendees, (males very occasionally come) are not trained in ARSH as per modules and guidelines and are counselling as per their acquired knowledge only.
 - Sanitary napkins were available at every Primary Health Care facility in abundance (500 - 1000 in a facility) while uptake was 30-40 a week. The girls were taking Sanitary napkins from ARSH Clinics on Saturdays but there was no repeat uptake and no repeat visits by the girls. ANMs and ASHAs were able to motivate some new girls every time
 - At places, doctors trained in ARSH, were taking part in ARSH (e.g. Inderpuri DGD), who modified narration as per local Slums/JJ Cluster needs. Proper counselling leads to demand generation and hence repeat uptake with greater numbers. Other motivated staff played an important role on their own (e.g. pharmacist in Inderpuri DGD) and supported MO.

- The meeting of Technical Group of Experts on **WIFS** was held on 27/09/12. The operational guidelines of Govt. of India have been vetted and modified as per the state requirements specially the Adverse Event Management Protocol. The meeting that was tentatively scheduled on 23.10.12 could not be held due to administrative changes at the Mission and Secretariat level
- Tender for IFA tablet was opened on 31st Oct 2012 through CPA Cell of DHS. Two bidders have been technically qualified. State procurement meeting was held on 2nd November, 2012. Once the successful bidder is identified work order for quarterly requirement of IFA would be placed.
- 8 master trainers trained in “National Level Workshop on implementation of WIFS held in NIHFW in August, 2012. Two state level workshops before the launch of WIFS would be conducted
- Monitoring formats for implementation of WIFS in the State have been finalized as per the State requirement and the same have been forwarded to the State IEC/BCC coordinator for inclusion in the e-tender process. IEC plan has been finalized
- It is expected that WIFS shall roll out in the state by May-June 2013.

Summary TOR 4

Institutional delivery is the most visible component of the RCH package, with high caseloads burdening the Level 2 and 3 facilities where quality of care and patient privacy and safety stand to be compromised. Reporting of home deliveries was found to be lower in the NE districts in comparison to the SW district. (2% versus 5.39%). This is contrary to the higher proportion of unreported deliveries, AWW and ASHA reports of higher home deliveries and sizeable population groups with poor health seeking behaviour. C-section rate is about 23% in both districts and across the state in tertiary centers. A critical challenge is the prioritization of facilities so that more women access the maternity homes, rather than directly accessing the tertiary institutions. But in order to do this there has to be better outreach, birth planning and close contact with pregnant women, an expected role of ASHA, that has not been optimally utilized. Newborn care facilities in secondary and tertiary level facilities were adequate, but gaps were seen in provisioning of Essential Newborn Care in the maternity homes. Training progress for F-IMNCI, SBA, or NSSK was very slow. Safe abortion services are being provided in all delivery points, but MVA is not in use anywhere. JSY beneficiaries are low on account of stringent conditionalities. Payments in GTBH were being made in cash, and it was here that patients reported high OOPs on account of informal payments and on drugs and consumables. Given the high levels of overcrowding, patients tend to leave earlier than 24 hours. Facility level inventory management is an area of concern. There is no uniformity in the availability of checklists and protocols. QAC have been established largely for family planning services. Fixed day services for NSV and tubectomy are being provided in Level 2 and 3 facilities, and PPIUCD is being undertaken in all maternity centres. 71 facilities in the state have been accredited for sterilization services. Both facility based and community based MDRs are being undertaken but the pace is slow. Of 223 deaths so far, MDRs have been conducted in 92 (State is not able to receive co-operation from Central Govt hospitals and hospitals of other agencies). ARSH services are provided primarily through fixed clinics on Saturdays, but it appears that services are restricted to curative care, largely to girls, with little scientific counselling taking place. WIFS is yet to start in the State.

TOR 5 Disease Control Programs- Communicable & Non-communicable Diseases

5.1 Integrated Disease Surveillance Programme (IDSP): Surveillance Sites have been prepared under IDSP with IT Components. All 9 District Surveillance Units established and are fully functioning. Data Units (Edu-sets) in all 5 Medical Colleges viz- Maulana Medical College Hospital, Lady Harding Medical College, Vardhman Mahavir Medical College & SJH, University College of Medical Sciences & GTBH and All India Institute of Medical Sciences & Hospital established. National Institute of Health & Family Welfare, National Board of Examinations, Air Port Health Organization and Maharishi Valmiki Infectious Disease Hospital have also been included in the network of CSU/SSU-Delhi. One Epidemiologist at SSU is in place leaving 9 vacant posts at present. One Data Manager for State Surveillance Unit and 2 Data Managers for East and South West are in place leaving 7 district positions vacant at present. Microbiologists at the SSU and District Priority Lab are not appointed yet. No Entomologist, Consultant (Finance/Training/Veterinary) has been selected at the SSU-Level. Only 10 DEOs have been selected against a vacancy of 17. 28 vacancies are still lying vacant at SSU/DSUs till date.

State and District – (South west and North east)observation on Reporting :

One State Surveillance Unit (SSU) is present at Directorate of Health Services. District Surveillance Units (DSUs) are functional in the districts visited i.e. SW and NE. Government and few private hospitals are reporting to the SSU through the DSU. Active District Programme officer in SW district but staffing is inadequate as there is no epidemiologist at the district level. Only one epidemiologist is in place, at present, for Delhi. Data entry operators are appointed but have other responsibilities also. There are no accountants and administrative assistants present to help out in office work.

State

Since Delhi is a multi-disciplinary/municipality state with full independence, the SSU has collaborated and coordinated with MCD, NDMC, Delhi Cantt, ESIC, CGHS etc and enhanced the reporting units. SSU is trying to bring all Medical Colleges, Hospitals (Govt/Pvt) and Nursing homes into the network of IDSP. S, P, L reporting formats and Case Definitions have been shared by all districts regularly and able to capture Early Warning Signal / Outbreak etc. Online S, P & L form reporting is regularly done from all District Surveillance Units. Analysis of data at the SSU level is done and shared with the respective DSO on feedback basis and informed about unexpected increase of number of cases. Any doubtful rise of cases

or any death due to communicable disease is reported to SSU as and when it occurs. H1N1 Pandemic Influenza and Avian Flu surveillances in the state are being monitored /reported by SSU/DSU/CSU. Dengue outbreaks in the state are being monitored/ reported by IDSP SSU/ DSU to CSU. Cholera outbreaks are identified and preventive measures taken in collaboration with DHO-MCD, DJB officials, DMC, DCs etc. Hepatitis and Typhoid Fever outbreaks have been identified during analysis of routine IDSP portal data and controlled in time through advocacy and networking.

The P forms (presumptive cases) filled by the doctors are the forms being reported regularly at present in both districts. Out of the 9 districts in Delhi, 7 are submitting P forms

SW District:

- There are 61 Government facilities in SW district and 57/61 facilities that are reporting on a weekly basis. And 4 private hospitals are reporting regularly. All the health facilities visited by the team, except Delhi Cantonment General Hospital, are regularly reporting to the DSU on a weekly basis (every Tuesday). However, timely reporting is a problem and reports are sent late (by Thursday).
- 28/57 facilities in SW district report on time and Reporting (P forms) is 85% from the Govt. sector in South West district
- The L forms (laboratory confirmed cases) filled by health workers are being submitted regularly at the SW district DSU. The S forms (suspected cases) are filled by ANMs at the field level and are being reported at SW-DSU. Nil reporting being done in SW
- SW has reported 6 outbreaks in 2011-12
- Rapid Response Team (RRT) has been formed from DDU and RTRM and MoU has been signed with Safdarjung Hospital in SW District
- Successful investigation and control of outbreaks done in cooperation with NCDC, MCD, DJB and local health centre. RTRM hospital is the referral hospital and is well equipped to manage outbreaks. Reports of outbreaks (ATR) well maintained and thorough in SW.

NE District:

- 6 hospitals in NE district are reporting to DSU
- Reporting (P forms) is above 80% from the Govt. sector in North-east district
- No reporting of L forms and very minimal reporting of S forms from NE district.
- No outbreak reported from NE district.

Training of Medical Officers & Paramedics in IDSP

S. No	Districts	Training load		Training load		Training load	
		MO	trained	Para	trained	MLTs	trained
1	North	38	20	112	40	17	0
2	South	145	0	138	0	23	0
3	East	102	26 (JE)	95	19 (IDSP) 21 (JE)	20	0
4	West	95	16	254	80		
5	North East	117	31	288	76	43	0
6	North West	139	39	422	82	38	0
7	South West	97	53	300	133	62	0
8	Central	41	17	70	0	17	0
9	New Delhi	NA	NA	NA	NA	NA	NA
10	SSU	No post	-	No post	-	No post	-

Districts- Observation

DPO in SW has undergone training in field epidemiology. Data entry operator is also trained. All MOs in visited health facilities were trained in IDSP

Strengthening of Laboratories

Pt. Madan Mohan Malviya Hospital Laboratory of South District is fully functioning. Microbiology lab of Maharishi Valmiki Infectious Disease Hospital is fully functioning. Four additional District Priority Labs have also been proposed for strengthening and referral i.e. Aruna Asaf Ali Hospital for North district, Deen Dayal Upadhyay Hospital for West District, Baba Saheb Ambedkar Hospital for North West District and Lal Bahadur Shastri Hospital for East District) in Delhi.

There are total of 9 Mother Labs in Delhi, 4 in SW and 5 in NE district.

Strengthening is required because at present the mother lab in SW district can conduct only supportive tests in Dengue and availability of kits is a problem in Typhoid diagnosis.

Training of laboratory personnel is also planned for November 2012.

5.2 National Vector Borne Disease Control Programme (NVBDCP):

Malaria

Laboratory testing for malaria is not adequate in the districts due to problems in kit availability and manpower. The mother lab in MCD Nangal Raya has a malaria clinic. Regular fogging and spraying is being done.

Japanese Encephalitis

Management of JE done in selected hospitals. Adequate field control measures being taken after mosquito borne diseases' outbreaks. MCD plays a major role in this activity.

Dengue

Regular field control measures being done with other agencies. Intensive IEC activities being done exclusively for Dengue. Integrated vector borne disease management like personal protection measures promotion, LLN, adult mosquito and larvicidal measures are being carried out. MCD plays a major role in this activity.

Kala-Azar

Not much IEC activities and awareness in Kala Azar and Chickungunya. Hospitals have been identified for management of these diseases.

5.3. Revised National Tuberculosis Control Programme (RNTCP):

State-Challenges

Multiplicity of agencies and authorities managing government health services. There is a large powerful private medical sector not agreeing to DOTS while large employee health beneficiary schemes (CGHS, ESI) practicing DOTS

In human resources, there are obvious discrepancies in salaries of all RNTCP staff in comparison to NRHM. Regular scales Medical Officer gets Rs. 28000/- per month & NRHM Medical Officer gets Rs. 37000/- to Rs. 53000/- and similar issues for other posts as well and hence there is high attrition as well as difficulties in recruitments resulting in number of posts remaining vacant for quite a large period of time. Though the posts of Medical officer at District, State level, APO at State level & TB HIV Coordinator at State level are at the same level and requiring same essential qualification as prerequisite for recruitment, the salary structure is different for these categories varies from Rs. 28,000/- , Rs. 30,000/- Rs. 35,000/- & Rs. 40,000/-.

All these post are crucial with different job responsibilities. Hence there is difficulty in getting competent staff. Eligibility criteria of the different posts should be revisited and reformatted.

District Observations

The Chest clinics are treating all categories of TB patients including MDR-TB. The DOTS centre in DGD, Inderpuri had adequate drugs. In the month of October'12 there were 32

patients on Cat-I, 13 patients on Cat-2 and 2 patients on DOTS Plus for MDR-TB. Paediatric drugs also seen in stock. New cases for October'12 were 4 in SW district .

The NGOs like Rama Krishna Mission in SW district and St Stephen's Hospital in NE are actively involved in DOTS services. All patients diagnosed with TB were sent for HIV testing and test reports available at the DOTS centre.

Constraints mainly in staffing due to recruitment difficulties and salary structures. Project NIKSHAY is found to be very useful for central monitoring purpose. RNTCP is not fully incorporated into NRHM in Delhi.

5.4. National Program for Control of Blindness (NPCB):

State

1250 cataract surgeries have been done in NE and 1406 in SW district. SW district also reported 232 other eye diseases in 2012. All cataract surgeries given IOLs; (surgery done in GTB, SDH, JPC). Referrals done by all staff and ASHAs, ANMs only to Govt. hospitals. In NE, School children identified by teachers (class 6-12): 4000 - no checking of refraction error yet. e-Tendering for spectacles ongoing in NE district. In SW 296 spectacles given to school children in 2011-12. 11 schools were screened in collaboration with SHS in 2012. List of 1219 children with refractive errors received spectacles from SHS. Procurement of spectacles is ongoing.



A Vision Center through NRHM support is functioning well in the DGD, Seemapuri of NE district.

There is no vision center in SW district. 2 eye donation counsellors recruited in SW in Safdarjung hospital for eye collection. In 2012, donation bank collected 22, out of which 15 have been utilized.

5.5. Iodine Deficiency Disorders Control Programme (IDDCP): Monitoring of use of iodized salt is not adequate. Screening is being done by ASHAs in SW by verbal autopsy but no kits were available. Consumption of non-iodised salt was still happening in SW district and few places in NE district.

5.6. National Leprosy Elimination Program (NLEP): There is Decentralized planning and Implementation in 9 districts of Delhi with integration of Leprosy services in general health care system. District wise referral centers have been identified and strengthened. Trained manpower for quality services is available. Reasonable community awareness favoring stigma reduction was observed and involvement of ASHA through ASHA sensitization and incentivization was being done.

MCR Footwear Unit in one of the leprosy colony in NE district is established

Good reaction management in tertiary care institutions is resulting in prevention of disabilities. There is Medical rehabilitation of Leprosy affected persons. Decreasing PR (0.78) and NCDR (7.58) with low child proportion (7%)

District Observations

NLEP – Drug availability was satisfactory. MCR footwear provided by NE district to the entire State.

Prevalence is 0.9. No cases currently on treatment on record in any of the health facilities visited. Leprosy Prevalence Rate –reduced from 1.8 per 10,000 in 2005 to less than 1 per 10,000 thereafter

DLO and NMS in place. No vertical staff in district.

Challenges

Skeletal manpower in District Nucleus results into poor utilization of funds

There is multiplicity of authority in health sector. A large no. (50%) of leprosy patients are reporting from neighbouring states (Spl. UP, Bihar, Haryana)

There is poor treatment completion rate due to high mobility and migration of patients

There is poor response/involvement of tertiary care hospitals in Reconstructive services in spite of provision of incentives under NLEP.

Innovations

- Central Registry for leprosy patients to avoid duplication
- Use of UID/Aadhar Card Number in detailed Patient card
- GIS Mapping of Patient Addresses
- Patient Centred Services
- Personal Monitoring of each and every patient by DLOs
- Greater involvement of ASHA
- Strengthening of RCS Centres in Government Hospitals

General Observations in the districts

ASHA involvement is minimal in all DCPs. Incentives for DCP needs to be emphasized. Training for ASHAs and ANMs required.

IEC activities w.r.t. DCPs in all health services is inadequate except for Dengue.

Multiplicity of agencies can be an issue for proper and adequate reporting. For control measures, it is an advantage.

No documentation is being done of outbreak investigations at the state level because of no budget allocation.

Observations from Data given:

- Malaria Mortality Reduction Rate - 50% up to 2010, additional 10% by 2012.
- Kala Azar Mortality Reduction Rate -100% by 2010 & sustaining elimination until 2012.
- Filaria/Microfilaria Reduction Rate-70% by 2010, 80% by 2012 & elimination by 2015.
- Dengue Mortality Reduction Rate-50% by 2010 & sustaining at that level until 2012.
- Cataract operations-increasing to 46 lakhs until 2012.
- Leprosy Prevalence Rate –reduce from 1.8 per 10,000 in 2005 to < 1 per10,000 thereafter.
- Tuberculosis DOTS series - maintain 85% cure rate through entire Mission Period and also sustain planned case detection rate.

5.7. The Report on Medical Certification of Causes of Death in Delhi 2011 published by Directorate of Economics & Statistics and Office of Chief Registrar (Births & Deaths), Govt. of NCT of Delhi throws much light on further Non-Communicable diseases like Cancer, Diabetics and chronic

heart diseases and the deaths occurred thereon as a result of them for the period from 2001 to 2011.

Year	Total Deaths	Deaths due to Cancer	%	Deaths due to Diabetic Mellitus	%	Deaths due to heart attack	%
2001	81100	1117	1.38	620	0.76	8136	10.03
2002	86176	1552	1.80	657	0.76	11892	13.79
2003	87743	1489	1.69	757	0.86	11721	13.35
2004	85378	1533	1.79	782	0.91	12669	14.83
2005	94187	2009	2.13	1133	1.20	8576	9.10
2006	98908	2060	2.08	5296	5.35	8836	8.93
2007	100974	2597	2.57	3920	3.88	15442	15.29
2008	107600	3070	2.85	4626	4.29	15876	14.75
2009	112013	3936	3.51	4671	4.17	16158	14.42
2010	124353	5728	4.60	1379	1.10	8236	6.62
2011	112142	9925	8.85	1642	1.46	10694	9.53

The above table shows only the statistics of non-communicable diseases culminated in death, whereas the statistics and plights of patients with NCD including cancer and genetic diseases and suffering at home in the absence of any curative options, is yet another area of grave concern in the public health management for the State Government to handle. Under NRHM, Delhi state has not been included in the list of NCD (Non Communicable Diseases) implementing states for 2012. Other states have action plans in place under the NRHM to combat NCDs. e.g Kerala.

The Delhi State Cancer Institute (DSCI) and the Institute of Human Behaviour and Allied Science (IHBAS) are found to be two centres of excellence addressing the curative options of Cancer and Mental Health illnesses respectively for patients of not only NE district, but also from across the Northern States of India. However, none of the primary, secondary or tertiary care institutions in either in Government or private sector in Delhi has earmarked any supportive care / palliative care / terminal care facilities for patients who are beyond cure, except a 6 bedded palliative clinic in AIIMS in public sector and a 36 bedded Hospice Centre run by an NGO viz., Shanti Avedna Sadan both for cancer patients only.

- 5.8.** AYUSH doctors are regularly participating in the Pulse Polio Immunization programme and RCH programmes and also participating in training programmes organized by family welfare department, however their role in NCD's is limited.

- 5.9.** Thalassemia: A Thalassemia unit is functional from 9.00 A.M. to 6.00 P.M. on six days a week under the Department of Paediatrics of GTB Hospital in NE district. The Thalassemia diagnostic facility and Thalassemia characterization investigations are done on a regular basis. AIIMS also has a separate Thalassemia Unit operational in the institute. The Blood transfusions are provided on regular basis besides maintaining the progress profile of the patients. It has also been noticed that their registered Thalassemia patients are being provided required blood throughout the year on receipt of two units of blood from donors in respect of the concerned patient.
- 5.10.** Disability screening and treatment, linkages with school health program in Delhi is limited to screening for refractive errors. School Health Check-ups are conducted by a mix of Private and Governmental agencies. State has an initiative plan to start Chacha Nehru Sehat Yojana for School Health Program.

Summary TOR 5

In all the districts, surveillance sites have been established. There is only one epidemiologist at the State level. There are several vacancies. Of the nine districts, only seven are submitting P-forms. There is no reporting of L- forms and minimal S-form reporting in the NE district. Malaria testing is irregular owing to problems in lack of supply of kits. The RNTCP faces challenges viz. poorly paid HR, a large private sector unwilling to partner but undertaking diagnosis and treatment on its own terms, and inconsistent reporting across facilities. Missionary organizations are providing effective DOTS therapy to poor patients. Cataract surgeries under NPCB were primarily being performed in the public sector, with adequate supply of IOL observed. School level screening for refractive errors is taking place. A vision centre in NE at Old Seemapuri dispensary is an innovation that needs to be further explored for scaling up. There is no planning for NCDs in the State.

TOR 6: ASHA, Community Based Monitoring, NGO Participation, Involvement of Local Bodies

- 6.1 The only element of the community processes components that the state has so far implemented is the ASHA programme. There are no urban counterparts to the Village, Health, Sanitation and Nutrition Committees (VHSNC) established by the state. The state has not yet involved NGOs in the community processes component. Community based Monitoring has also not been initiated in the state. State and district health officials are insistent that community fabric in urban areas, is so heterogeneous that it does not permit of building community institutions. Thus this section focuses only on the ASHA programme.
- 6.2 ASHA Selection: Being a non high focus state, ASHA selection was initiated in the state of Delhi in the year 2010, vide guidelines issued by the state to the districts. The selection process followed by the state, although not in complete conformity with the national guidelines, (the ASHA was mostly selected through the ANM or “polio” team members, rather than through an active process of community meetings), identified local women who were known to be active through outreach structures set up for the polio programme, and was thus able to ensure a fairly robust selection process. An ASHA in Delhi covers a population of about 2000, or roughly 400 households. The programme is being implemented in Slums / JJ Clusters / Resettlement Colonies / unauthorized colonies/ Villages of all nine (now 11) districts. The target for 2012-13 is about 5357, of which 4692 ASHAs were selected till date. 3707 are in position, and about 985 either resigned or have been dropped (deleted) from the programme. 1650 ASHA need to be selected this year and the selection process is underway. There are 18 ASHA units with 719 ASHAs in place in the SW District. There are 13 units in the NE district with 520 ASHAs.
- 6.3 ASHA Training: The state clubbed the national modules 1,2 and 3 and converted the 15 day training into an 11 day training based on state needs. The GOI developed Module 5, focused on leadership development, empowerment and community rapport building was adapted and renamed Module 4. Training in Module 4 has already been initiated. While ASHAs selected before 2010 were trained in the 11 day modules, ASHAs selected after that were first trained in Module 4. The state took over two years to adapt the National Modules 6 and 7, which have just been printed with small modifications.. A batch of 30 state trainers has just completed the training, facilitated by NHSRC. Trained ASHAs in the NE and SW districts

confirmed that they had received the modules. 140 ASHAs in the NE and 241 in the NE have been trained in Module-4.

There is repetition in the contents of the modules,. State and district trainers have been identified and the vast majority are drawn from the system itself. In the NE district training evaluations were not being maintained, and no training plan or calendar was made available, while in the SW district there was training plan and the calendar prepared. The RHTC Najafgarh auditorium is being used for ASHA trainings

ASHA Module wise Training Report as on 01-11-2012						
Sl.No.	Name of District	Total Number of ASHA in Place as on 01-11-2012	Trained In Module-1	Trained In Module-II	Trained In Module-III	Trained In Module-IV
1	South	633	507	419	417	267
2	South West	719	549	549	575	719
3	North	157	119	119	119+38	119
4	North East	520	484	176	158	241
5	North West	687	628	559	460	316
6	West	540	451	451	451	492
7	East	355	330	329	330	312
8	Central	108	108	69	11	11
9	New Delhi	13	13	13	13	13
Total		3732				

6.4 **ASHA support staff:** As per the national guidelines for states with fewer than 10,000 ASHAs, management and support of the ASHA is through existing staff. At the state level, there is one Nodal officer of the Directorate of Health Services, who provides oversight to the programme. She also has other responsibilities as well, both being quite onerous (HMIS and MCTS). All nine districts have a district nodal officer in charge of the ASHA programme, who also have several other responsibilities as well. At the district, ASHA nodal units have been formed at the level of a population of 100,000, affiliated to the Urban Health Dispensary, (with the Medical Officer being the Nodal officer). There is no state level ASHA mentoring group. At the district level, District level mentoring committees have been formed to oversee the selection, training, and monitoring of the ASHAs. While the state recommended that the committee consists of a range of stakeholders including NGOs, in the districts visited, the composition is largely restricted to the district nodal officers. The Medical officers and the ANMs are the direct support for the

ASHA. The support and guidance provided to the ASHA depends largely on their initiative and creativity. No Community level structures established to serve as a support to ASHA and address social determinants. The state and district programme management and support systems for ASHA are not adequate and do not include representatives with the right profile. ANMs can play the role of a facilitator but have not been trained to do so and they have little clarity on the functions of the ASHA. In the SW district ANMs seem to be a source of support to the ASHA. In the NE district, the ANM-ASHA interaction took place largely in the facilities with limited outreach support. In the SW district, every ASHA had Kit and drugs are replenished regularly from the respective PHC / DGD. Besides they are provided I-card and a bag. While ASHA in the NE had I cards, they had not yet received the drug kit.

- 6.5 ASHA Performance Monitoring: The state has a database of all ASHA in the programme maintained at the district level and uploaded to the state level on a monthly basis. Performance indicators in are in place, being are being measured sporadically.
- 6.6 The State has now developed a computerized ASHA database, and the data for 3500 out of 3707 has been uploaded. It also includes bank account details, and the state perceives that this will facilitate online calculations of incentive, online transfer, and allow the state to directly monitor the timeliness and the amounts paid. This software (e-SLA) will also help to generate the fund utilization report activity wise . This has not yet been operationalized fully. The concern of the team is that the state is looking to the SW to substitute the role of supportive supervision, mentoring and monitoring of the ASHA and district and sub district structures.
- 6.7 Field Observations: In the North East district, the team met with ASHAs (n=42) in three of the 13 units. The ASHAs were selected between 2010 and 2012. The majority of those met, reported undergoing the 11 day training. About 30 of the 42 ASHAs, reported that they had received training in Module 1 and were asked to read Module 2 and 3 on their own. About 25 had received training in Module 4. Currently all of them are engaged in completing a survey form for each family in their allocated areas. They will receive Rs. 10 per form filled after completion. All forms are likely to be completed by December. Most of the ASHAs we met have been engaged in a service facilitation role particularly for immunization and institutional delivery. **So far none of the ASHAs we met in NE District have been paid any incentive, and are being dubbed as being “non functional”** by the District Health Society. Given the enthusiasm, and commitment of a preponderant number of women, who spend on an average

about two to three hours a day, supporting the state to achieve the levels of coverage they show case, this seems exploitative. Besides this, the state has lost a valuable opportunity, to reach the marginalized, which all grass roots staff indicate are likely to be between 20% to 30% of the population and likely higher in slums and JJ clusters. The opportunity that NRHM provided to expand community outreach has not been utilized by the State, represents a missed opportunity. In three of the community interactions one maternal death was reported as having occurred in the past month. No community level maternal review was undertaken at any place. Two of these were institutional deliveries and one was a home delivery.

In the SW the team conducted FGDs with 60 ASHAs. ASHAs expressed satisfaction with their work, but stated that they wanted more compensation. ASHAs also had issues related to payment modalities. Some ASHAs expressed that since all incentives for pregnant women, only related to institutional delivery their efforts at motivating women for ANC came to naught, in cases of migration for delivery or refusal of admission resulting in home delivery, and this acts as a demotivating factor.



- 6.8 ASHAs reported persistent home deliveries and persistent refusals for childhood immunization by some families. The ASHAs do not perceive that they can call upon the ANMs to support them in persuading such families to access services. ASHAs had not been provided with a drug kit, or communication material for BCC in NE district while in SW district ASHAs had Drug kit and services of ANM and PHN were available to them for persuading families.

6.9 ASHA Incentives: Incentive payments in SW and for few ASHAs in NE regular, through bank accounts. HH Survey of all ASHAs in the SW district is complete and ASHAs are receiving payments on a regular basis which range from Rs. 1300 – Rs. 1800 per month and payments are made by cheque. Few ASHA in both districts reported lack of knowledge about available incentives for which they are eligible, and were also unhappy about forfeiture of payment if JSY incentive was not claimed within seven days. ASHA performance and therefore incentives affected by lack of services, or because of patient migration. Given that Delhi falls in the category of non high focus state, with stringent conditions for JSY payments, when mothers are found ineligible for JSY incentive, the ASHA is also refused the incentive, resulting in demotivation. This was reported from both the districts.

The State pays an incentive of Rs. 500 which is linked to performance on a set of seven indicators. Lower than 50% achievement for three consecutive months results in ASHA being dropped from the programme. Non Payments to ASHA pending survey completion is a de-motivating factor; despite this ASHAs remain enthusiastic and committed. No Grievance Redressal Systems for ASHAs have been set up. ASHAs of the SW district requested that a fixed incentive of Rs. 2000 be provided.

The ASHAs in the SW district also complained that motivation incentives, for family Planning are only given to her at fixed times, (after four pm) and if reporting of the case is delayed, she is denied payment. Most ASHAs in the SW were aware of various types of incentives that they were entitled to, except for 3-4 activities in DCPs

6.10 Delays in fund releases for printing of survey registers were reported for the NE districts, this delay resulted in ASHAs not being paid the incentives.

The ASHA have a potential to play a key role in newborn, and child health and in the future- NCD, gender based violence, social issues, but have not received the requisite inputs. The ASHAs represent a powerful tool for community outreach but are not being used, particularly in reaching the marginalized and unreached; particularly those not accessing the health system, where the need is the greatest.

The ASHAs are involved in distributing condoms but women are required to come to the dispensary to obtain OC pills. The state has not yet initiated WIFS as part of NRHM, although there was some anecdotal reporting of an IFA supplementation programme in certain schools in the state. Delhi is not part of the NRHM supported Menstrual Hygiene Programme.

Summary TOR 6

The state has only undertaken the ASHA component of the entire package of community processes interventions. Of the 5357 ASHAs 3707 are in place. Commitment and motivation levels of the ASHAs was observed to be high despite the fact that in one of the districts (NE districts), ASHAs were not paid incentives till date and they felt that State has not given them their due importance . Attrition is high, and is due to a mix of voluntary opting out or because the state has dismissed non functional ASHAs based on remuneration. Average take home by ASHA ranges between Rs 1300-1800/month. Pace of ASHA training is slow, and new ASHAs have yet to receive even the training in the first four modules. ASHA support structure is through existing staff, but there is little clarity of their own roles and that of the roles of the ASHA. The state has a database and a performance monitoring system, but neither is used for programme planning and monitoring. The state has just initiated state trainer training for Modules 6 and 7.

TOR 7: Promotive Health Care, Action on Social determinants and Equity

Concerns

- 7.1 Convergence: At the field level convergence of ANM and ASHA with the AWC is very effective. AWW are familiar with families in their area, and appear to have an effective network with the ANMs. The district health society reported quarterly convergence meetings with the Gender Resource Centres (an initiative of the State Government), ICDS (CDPO/Supervisors), Health (MO) and NGOs. The team was unable to see any records of the meetings and there appears to be limited follow up. The district health plan in the North-east was not available for review while in SW district a well defined DHAP was available to the team.
- 7.2 Reaching the vulnerable is a key challenge. The state has initiated action on this by appointing ASHAs in these areas, and setting up infrastructure and human resources, but much more needs to be done particularly with reference to mapping, prioritizing households and developing purposive strategies. This skill needs to be built across the board, from senior district leadership to the ASHA.

Badarpur Khadar a village in the NE District of Delhi, but with access via Uttar Pradesh and was completely left out of all services, till a few years ago when the Polio Surveillance Unit identified it to be as part of Delhi . It is now attached to Chauhan-patti PUHC. A VHND was conducted here with fanfare on 3rd of November in the presence of the DC and other Health officials at a middle school opened 4 months back. It has been well received and an OPD of 600 was reported. Around 207 school children have been admitted in the middle school. Interaction with community revealed that health seeking behaviour of community is largely through the private sector of U.P. (Loni district which is 6km from the village). Lack of regular transport aggravated by a lack of stationed ambulance at nearby Chauhan patti PUHC. The CATS ambulance does not reach here. Immunization session is being conducted on a monthly basis. However, the MO has to assist and transport the ANM. There is no courier for vaccine delivery.



VHND being conducted at Badarpur Khadar village of NE district

7.3 In both districts, the IYCF centres appeared to be functioning effectively, but there was no NRC. The SDH (main tertiary hospital in the NE district) maintained two beds for SAM children in the paediatric ward. High levels of maternal anaemia were seen, from review of lab records in the - from data in the PUHC. In one day, of the 14 cases of ANC, 2 women had HB levels of less than 6 gms%, and the remaining ranged between 9 gms% and 10gms%. There was no follow up beyond administration of therapeutic IFA. ANMs , ASHAs when asked about their action after knowing that a woman has Hb levels below 7gms% , informed that they referred patient to doctor and no special activity planned for proper follow up and monitoring.

7.4 Water and sanitation is under the management of the MCD. There was no involvement of the health department in promoting effective sanitation measures. District level monthly meetings are held in SW district for inter-sectoral convergence. MO visits AWW centres and a regular interaction to encourage better coordination and data reporting and the process has provided encouraging results. Coordinating activities by SW district CDMO and DPMU staff with other agencies like MCD, Delhi Cantonment Board, and ICDS-WCD for NRHM support, convergence for many inter-related activities is are very encouraging. This is unique as the rest of the districts expressed lack of coordination between various agencies as a key factor that hampered progress.

7.5 State is making very sincere efforts towards implementation of PC&PNDT Act. The State level SIMC has been constituted and operational. The uniform monitoring format has been devised and is in use.

1544 facilities have been registered till date and database of Ultrasound machines has been prepared. Software for filling of F-forms has been created by Delhi Government where each registered facility has to fill F- Form online and the F-forms are being filled.

Year	Units inspected	Show-cause Notice	Suspended	Cancelled	Sealed
2010-11	602	117	15	128	22
2011-12	517	50	8	113	23
2012-13	35	8	3	0	2
SW					
(2 qtrs)	53	18	1	14	5
NE					

Source; SPO-PNDT, Delhi Govt.

Three State Advisory Meetings have been held and 3 Advisory meetings in SW District and 2 meetings in NE district have been held in this year.

Nodal Officers appointed at Govt. Hospitals. Reviews have been done at state level with all districts' CDMOs and Nodal Officers five times.

There are 10 new court cases since last SSB

- SW district : 3 till March 2012
- SW district : 2 from April 2012 till date
- NW district : 2 till date
- W district : 3 till date

IEC and Social Mobilization “Beti Shakti Abhiyan” was celebrated from 24th to 30th September 2012 in Delhi in which the major activities were : Health Talks, Group discussions & Role Play , FGDs, Nukkad Natak, Competetions and rally besides few other IEC activities.

As per directions from MoHFW, Govt. of India, the World Population day was celebrated and a week long program as Population Week emphasised both on family Planning as well as Girl Child and in Delhi under the Slogan “ BETI SHAKTI ABHIYAN “ lot of IEC was done using rallies, posters, meetings, road-shows etc.



Workshops have been planned for judiciary and manufacturers in the months of November 2012 –January 2013.PCPNDT: Of the 22,40,749 population as per the 2011 Census in the North East District, 53.03% are male and 46.96% constitute female population indicating a fair sex ratio despite the district being densely populated with people belonging to poor socio-economic status and predominantly of minority population. In the NE district, about 67 (eight Govt and 59 facilities) are registered. The committees meet regularly and the meetings are recorded. Ultrasound machines are registered and inspections are being

carried out. Eight applications were rejected and 19 show cause notices were issued. The NE district also carried out the Beti Utsav campaign which appears to have been popular.

- 7.6 A BCC Officer and a CDEO have been appointed in SW district and this dedicated cell is expected to do planning implementation and follow-up for various BCC activities in consultation with MOs and CDMO. The material developed for Maternal Health (ANC, PNC, Delivery) and JSY are under print. The NE district has implemented IEC/BCC activities for promoting gender equality and Save the Girl Child, (Beti Utsav/Beti Shakti Abhiyan). Most activities planned upto Oct'12 have been more or less achieved except for Health Talks and Group Discussion with role play. However, the overall expenditure on account of IEC/BCC activities for the year 2012-13 in the NE district, so far is 11.79%.
- 7.7 Delhi has no high focus district.
- 7.8 Delhi is reported to have one of the most complete birth and death registration systems in the country. In the NE, Swami Dayanand Hospital (SDH), has instituted a hospital based birth registration system in which birth certificates are provided to all newborns within 24 hours of birth. Janam Sookhana Inami Pariyojana facilitates birth registration
- 7.9 There are no mechanisms instituted for social accountability. In the district the District planning and Vigilance Committees are just being established. No differential financing for more difficult districts is visible. Overall the NE district performance is very low and also the state has done seven monitoring visits while in SW district 53 monitoring visits were done. This needs attention of the state.
- 7.10 School Health Melas are organised in collaboration with the Education Department. Many IEC activities are done for educating the children and teachers and the specialists provided expert care in the field of ophthalmology in the schools. The school health programme in the district is managed by State Govt. and MCD. The MCD component covers only children in classes V upwards, and is undertaken sporadically.
- State has a new initiative in the form of Chacha Nehru Sehat Yojana under which in the first phase through 120 teams the Delhi Govt.'s 954 schools' children - shall be covered and in the second phase all MCD schools, pvt. Schools' and out of school children shall be covered. A total of 14 Lakh children shall be covered under the scheme.
- No RMNCH counsellors have been recruited by the State and Recruitment Rules are under process of being finalized by the Committee under Chairmanship of Director, Health services.

Summary TOR 7

At the field level, there is effective convergence of ANM and ASHA with the AWC, and quarterly convergence meetings are being held with the Gender Resource Centres (an initiative of the state government), ICDS (CDPO/Supervisors), Health (MO) and NGOs. Water and sanitation is under the management of the MCD, with little involvement of the health department in promoting effective sanitation measures. In both the districts, the IYCF centers appeared to be functioning effectively, but there was no NRCs. Reaching the vulnerable remains a key challenge despite state level action such as appointing ASHAs in these areas, and setting up infrastructure and human resources. Much more needs to be done particularly with reference to mapping, prioritizing households and developing purposive strategies to reach the vulnerable. Delhi is reported to have one of the most complete birth and death registration systems in the country. SDH has instituted a hospital based birth registration system in which birth certificates are provided to all newborns within 24 hours of birth. State is making sincere efforts towards implementation of PC&PNDT Act. The NE district has implemented IEC/BCC activities for promoting gender equality and Save the Girl Child, (Beti Utsav/Beti Shakti Abhiyan). School Health Melas are organised in collaboration with the Education Department. There are no mechanisms instituted for social accountability. In the district the District planning and Vigilance Committees are just being established. No differential financing for more difficult districts is visible. RMNCH counsellors have not yet been recruited by the State

State Programme Management Unit

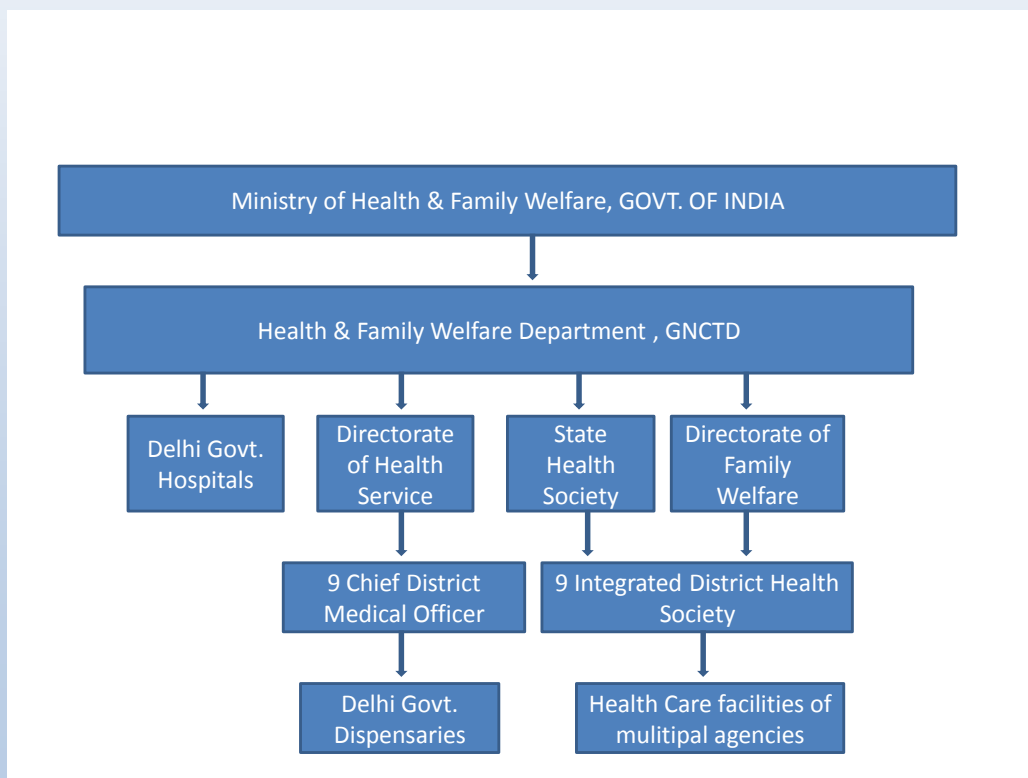
Programme Manager, Finance Manager, IEC Consultant , Training Coordinator, MIS Consultant, NGO Coordinator.

District Health Society (known as Integrated District Health Society – IDHS)

Chairperson	:	District Commissioner (Rev)
Co- Chairperson	:	Zonal DC.
Executive Secretary & Convenor	:	CDMO
Co-Convenor	:	Addl. CDMO

- Members :

- District Program Officers , Ayush, Area Sanitation Incharge & DJB Rep , Representatives of Local bodies –MCD , NDMC, Cantonment Board, IPPVIII, School Health ,Rep from Education Dept. SWD / ICDS Representative, Rep from SHS,BDO/SDM, Development Partners , NGO Rep/ MNGO/SNGO, Rep of Professional Associations
- District Programme Management Unit
- District Programme Manager, MIS Consultant , Accounts Manager, Computer Data Entry Operator



- Unlike other states, in GNCTD, Health Department officials head the SPMU and DPMU 9 unique but very Encouraging) ; further, while the Directorate of Family Welfare and Directorate of Health Services are responsible for RCH and Disease Control Programmes respectively, the SPMU primarily concentrates on Mission flexi-pool activities. This appears to be a very good model leading to better integration between SPMU / DPMU and the Directorates of Health Services and Family Welfare. Synergy and coordination is visible.
- System of preparation of NRHM District and State Program Implementation Plans (PIPs) is in place.
- Integrated web based data base / GIS mapping (refer section IX for details) is a major step forward and has the potential to lead to more evidence based district and state PIPs.

8.2 Manpower Details: (Existing & Vacant): Out of 76 positions at the SPMU level 45 positions are lying vacant. The positions of State Program Manager, State Finance Manager & State Accounts Manger are filled however, the position of Deputy Director Finance among several others are vacant. At DPMU level, one position of Program Manager and Accounts Manager are also lying vacant. Status is as under:

SPMU	
Existing	Vacant
State Program Manager-1	Deputy Director (Finance)-1
State Finance Manager-1	State NGO Coordinator -1
State Accts. Manager-1	Mat. Health Consultant-1
Logistics Consultant-1	Child Health Consultant-1
Accounts Assistants-1	Accounts Assistants -4
Admn. cum data assistant/ Establishment Clerk - 1	Executive Engineer-1
Steno cum Computer Assistants-4	Astt. Engineer-1
Peon -3	Jr. Engineer-1
SHSRC	
Consultant HRD-1	Consultant Community Participation-1
Steno-1	Consultant HMIS-1
	Consultant PPP-1

	Consultant Health insurance-1
	Administrative Assistant-1
	Peon-1
M&E	
M & E Officer-1	Team Member-2
MIS Expert-1	Statistical Officer-1
MIS Asst./Sr. Data Asst.-3	Public Health Consultant-1
CDEO -2	CDEO -12
ASHA Resource Centre	
CDEO -2	State Level Trainer (ASHA)-2
Accounts Assistant-1	
Training Cell	
Library Assistant-1	State Training Coordinator -1
	CDEO-1
	Attendant-2
BCC Bureau	
IEC/ BCC Consultant-1	Media Assistant-1
Graphic Designer -1	

DPMU	
Existing	Vacant
District Program Managers-7	District Program Managers-1
District Accts. Managers -7	District Accts. Managers -1
Accounts Assistants-11	Accounts Assistants-4
Establishment Clerk/Admn clerk/Admn Assistants - 7	Establishment Clerk/Admn clerk/Admn Assistants- 8
MIS Expert-7	MIS Assistant-5
MIS Assistant-4	
DFW	
Accounts Assistant-4	Accounts Assistant-1
Bio Medical Engineer-1	CDEO-3

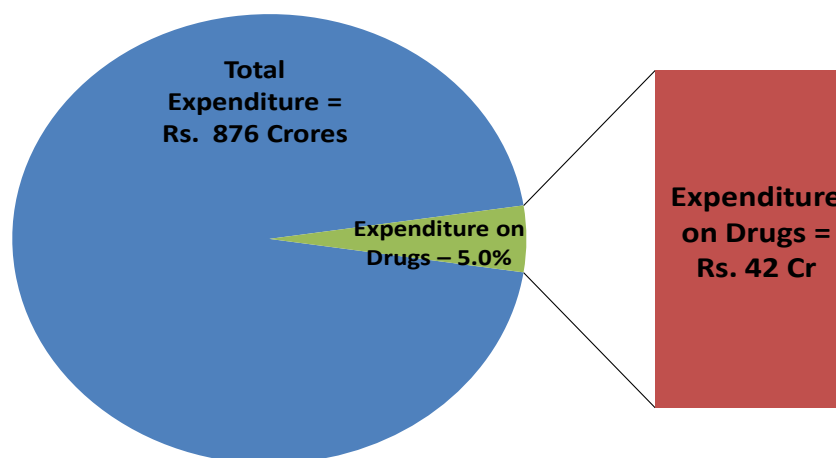
CDEO-3	Child Health Consultant-2
Data Analyst-1	Establishment Clerk-1
Establishment Clerk-1	Legal Consultant-1
Gynaecologists-1	Logistics Officer-1
Medical lecturar-1	Medical Officer-2
Medical Officer-5	Maternal Health Consultant-2
Medical Social Worker-1	OT Asst.-7
MIS Expert-1	OT Technician-3
Peon-2	Pharmacist-1
	PHN-1
	Procurement Specialist-1
	Public Health Consultant-1
	Quality Assurance Specialist-1
	Steno-2
	PNDT Consultant-6
	RCH Consultant-9
	Family Planning Consultant-1
	ARSH Consultant-1
	QAC Consultant-2
	Family Planning Counsellor-5
DHS	
CDEO-10	

Source: State

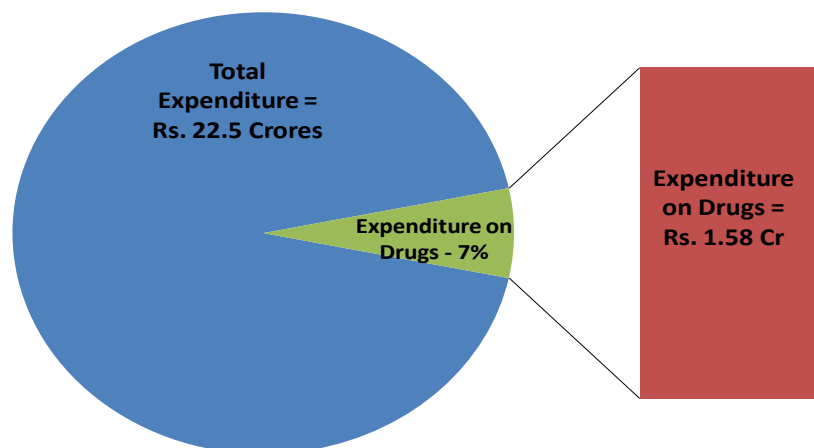
- 8.3** Capacity Building of SPMU / DPMU is done on regular basis. Workshops/ trainings conducted by the State on various programme aspects are attended by SPMU/ DPMU staff. Coordination between SPMU & DPMU was found to be very smooth.
- 8.4** Supervision & monitoring mechanism are in place however, the No. of field visits conducted was sub-optimal and varied between districts. During April-Sept, 2012, the south west and north east districts have carried out 50 and 9 monitoring visits respectively. Further, the system of report submission, follow up & review mechanism is not in order.

- 8.5 The Mission Director at State level and CDMO as District Mission Director have all the financial and administrative powers. All the matters need their approval. Program manager / Accounts manager does not have any signing authority.
- 8.6 **Drug & Equipment Procurement distribution system:** There is a CPA in DHS functioning for over 15 years under manual processing. A software, **Nirantar**, introduced since Nov'11, has 3 cases improved the procurement process however at places there are still gaps. There are 361 drugs in the EDL out of which 120 drugs for Primary care facilities. Most of the drugs are available in the facilities as per Essential Drug List .
- Medical officers have been instructed to follow the standard treatment guidelines and they are rarely prescribing medicines outside EDL
 - In Central Govt. PHCs like Najafgarh, Ujjwa and Palam the generic and branded medicines are available and procured through GMSD Delhi
- 8.7-8.8 DGDs procure medicines from the store at DHS through CPA. Delhi Govt. Hospitals procure 80% of their medicines from the manufacturers on the rate contract of CPA and payments are made to manufacturers directly by MS after receipt of medicines. In cases of emergency, MS of the hospital is empowered to purchase medicines from local chemist through open tender process. Medicine procurement is not computerized at facility level, affecting the accuracy of the consumption pattern and demand forecasting resulting in supply gaps.

Total Healthcare expenditure vs. Expenditure on Drugs at Delhi Government for Primary Healthcare



Total Healthcare expenditure vs. Expenditure on Drugs at Rao Tula Ram Hospital



- **Lab & Diagnostic services-** all basic diagnostic services are available at all levels. However, there are certain constraints in procurement of reagents and timely AMC of equipment reflecting management issues at DHS
 - One of the SDH(DDMSC in SW District)visited had outsourced diagnostic process to an agency which offered a certain discount in respect of CGHS rate as benchmark
 - There is Out of Pocket expenditure by the public because many peripheral units are not able to provide diagnostic services in totality
 - Hb testing of women was not being done in PUHC for last three years. (Sonia Vihar 4.5 Pushtha)
 - The pathologist posted at one of the Mother labs in SW district through NRHM support has made a distinct impact on the range of diagnostic services and quality and even trainings of the HR in DGDs nearby.
 - In facilities visited, quality of Typhi dot kit in NE district was reportedly unsatisfactory

8.9 All construction plans need to be approved by Minister of Health. All plans are reviewed and there is a dedicated position CMO (Plan) to look after all constructions. Since department has no defined review committee of its own, all plans are taken up by Irrigation & Flood Control department.

8.10 State has no system for accreditation of private providers for JSY or any other scheme.

Summary TOR 8

Health department officials head the SPMU and DPMU; further, while the DFW and DHS are responsible for RCH and disease control programmes including curative healthcare services, respectively, the SPMU primarily concentrates on Mission flexi-pool activities. This appears as leading to better integration between SPMU / DPMU and the directorates. The MCD or Central Government (for facilities and services provided in the NCT) are represented on all NRHM institutional structures, but have no co-convening or executive role. Of 76 positions at SPMU 45 are vacant, and the post of DPM are vacant in one of the districts. State level monitoring, review and follow up particularly in the poor performing and challenging districts, is weak. Insufficient tenure of senior officers affects programme implementation and functioning, especially as all authority is vested with the senior officers, leading to long delays in decision making. Although MCD accounts for provision of public health services and a significant proportion of service delivery, there is little attempt at joint planning, monitoring and supervision. The state has had a CPA in place for over 15 years and has recently introduced software (Nirantar) for better management, but gaps still exist since medicine procurement is not computerized at the facility level, affecting the accuracy of the consumption pattern and demand forecasting resulting in supply gaps

TOR 9 Knowledge Management including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of IT

9.1 State has no dedicated state level training/technical support institutions (SIHFW, SHSRC); A Health & Family Welfare Training Centre, HFWTC (under Centrally Sponsored Scheme of Govt. of India) exists which caters to the need of RCH trainings of the state and has limited role in respect to overall training needs of the state including other aspect of technical support. This Centre has inadequate infrastructure, HR and designated resource pool. District Training Centre (SW district) is in place and coordinates with HFWTC for nomination in RCH trainings from SW district. This centre also plans and manages all training programs related to program updates like contraceptive updates, gender sensitization, induction trainings for MO, PMWs etc. SW district DTC has completed two batches of ToT of ASHA Module IV against target for current FY.

MCD has a Training cell located at Lala Hansraj Polyclinic Campus, NDMC, Sector VIII, Rohini, Delhi-110085 and imparts various trainings . The Training Cell was established under India Population Project –VIII Delhi in 1994 .It aimed at orienting the beneficiaries and other stake holders to the health care delivery system under IPPVIII and enable the health functionaries to carry out their job responsibilities in a proficient manner to achieve the goal of providing primary health care in J.J. Clusters of Delhi.

Presently, the training cell is working under Deptt of M&CW.

There is one Training Programme Officer, 3 Health Education Officers and one Driver .The Cell has a well equipped training hall with a seating capacity of 35 participants , Library has references on MCH care and public health, Video Cassettes covering community health issues ,LCD- Computer unit and A-V Equipment ,Models and Human Body Simulators etc.

The MCD Training Cell has Staff from HQ ,IEC Cell ,MIS cell and health units under IPP VIII and utilises services of Guest Faculty, Specialists from MCD, Medical Colleges & other Teaching Institutions/Hospitals and NGOs and has collaboration with hospitals & Maternity Homes under MCD, K.L. Wig Centre for Medical Education & Training, AIIMS, Central Health Education Bureau, DGHS, GOI, National Institute of Health and Family Welfare(NIHFW) New Delhi, Health & Family Welfare Training Centre, Govt of NCT Delhi, Indian Institute of Health Management Research (IIHMR) Jaipur, Indian Institute of Public Administration(IIPA), New Delhi, Administrative Staff College, Hyderabad and International agencies.

Major training activities undertaken by MCD Training Cell are:

- **Orientation Training Programmes** for awareness generation about India Population Project –VIII (NGOs, Private Medical Practitioners, Community leaders, Political leaders etc) - 80 Courses
- **Orientation Training Programmes for various National/ State health Programmes / campaigns** - 46 Courses
- **Induction Training Programmes for various level of functionaries**- 44 Courses
- **Training of Trainers (TOT) in Training Methodology** – 10 Courses
- **Training of Trainers (TOT) in Adolescent Reproductive & sexual Health for Trainers of MCD, Delhi Admn & CGHS** – 2 Courses



Paramedics in a training session at Vaccine store in MCD

- **Training of Trainers (TOT) in various National/ State health Programmes / campaigns**- 7 Courses

The Training Cell runs various Technical training Programmes:

- Information, Education and Communication (IEC) -36 Courses
- Maternal and Child Health - 18 Courses
- Prevention and Control of Epidemics- e.g. Dengue/ DHF and Viral Hepatitis etc.- 54 Courses
HIV/AIDS, STDs/ RTIs and Sexual Health - 21Courses
- Integrated Training Programmes for Community Health Volunteers- 23Courses

Skill based Training Programme

- Maternal and Child Health -69 Courses

Management Development Programmes

- Health Management- 10 Courses
- Management Information System(MIS)- 12 Courses
- Computer Management and Applications-19 Courses
- Participatory Learning and Action (PLA) -8 Courses

Training programmes under RCH & RCH II

- Integrated Skill based Training Programmes under RCH- 67 batches
- Training programmes in Adolescent Health – 59 batches
- Training Programmes in Infant and Young child Feeding (IYCF)- 8 courses
- Skilled Birth Attendance(SBA) -8 batches
- Training programmes in contraception -15 courses
- Training programmes in Safe immunization practices- 21 courses

Delhi Govt. and MCD Training Units could work together and utilise all resources available in National Capital for providing capacity building and skills development to the HR in healthcare system.

9.2 Eight District Training Centres existed in the State earlier but are no longer functional now except the one in SW district doing certain activities. There are two ANMTCs in public and a few in private sector.

It was reported that the bank account of HFWTC has been closed by state officials. Closure of the bank account has lead to delay in rolling out the smooth trainings in the state whatever small efforts were in place.

9.3 There is notional effort noted at field by a technical agency working in the state for providing technical or financial support to the state. USAID has provided support to Mission convergence on IEC materials for WASH education for communities under its HUP program. This is disseminated through Gender Resource Centres (GRC) at slum sites. GRC at the Sundernagri site is a beneficiary of this outreach effort. However, it is felt that state needs

some technically equipped people for providing support in Programme implementation and monitoring. Efforts in WASH in health education are a potential space to be engaged.

9.4 State does not have any functional SHSRC. However, the State Program Management unit is managing the functions of district planning and trainings. State has recently started using resources and support from NHSRC. Recently one training programme of Medical Officers (Training of Trainers) has been organised. State officials have expressed their desire for more active involvement of NHSRC for developing and supporting a comprehensive training plan for the state. State is exploring the possibility of other institutions of repute in Public health for the development of the comprehensive training plan and then provide technical support to the state.

9.5&6 Common platform of GOI - HMIS is being used for data reporting by all agencies. Use of information from HMIS & MCTS for planning and programme monitoring and management is very limited. It has been observed that in “District Health Action Plan” HMIS data is referred but it has not been optimally utilised for setting the targets for the facilities or for performance monitoring of the programme. District and State level Programme Officers are planning to develop some monitoring formats on the basis of available information on HMIS. It has also been observed that there is lack of formal feedback mechanism, however, DPMUs communicates with the facilities under Delhi Government frequently on data quality related issues. Lack of compliance related to observance of instructions/ recommendations are felt at DPMU level with intra- agencies like MCD, CGHS, NDMC. etc.

State has also proposed to introduce “grading of facilities and districts” on the basis of HMIS data. The grading would be a direct reflection of performance of the Medical Officer Incharge (in case of facility) and CDEO (in case of district). Three parameters selected for this grading are as under;

- Completeness of information provided
- Timelines
- Accuracy/validation errors

It has been observed that data on various indicators is collected through available RCH registers in the facilities. It is also observed that these HMIS formats are not being vetted by authorised signatories.

State is facing many constraints due to inequitable distribution of health facilities, fluid population and not well defined catchment areas and population. Out of 407 sub-centres on HMIS only 41 are physically existing, rest are created notionally to capture field data. One of the constraints faced by the state in regard to consolidation of data is streamline the data uploading done by different agencies other than Delhi Govt. Lack of dedicated “data entry operator” for HMIS & MCTS at District Hospitals is also a matter of concern for the State. At present most of the District Hospitals are sending data to the concerned DPMU and from there the data gets uploaded on HMIS/MCTS portal. It contributes to delay in data uploading by about a month. Uploading of data from Private Hospitals is another challenge.

Lack of basic infrastructure availability like internet connectivity at some villages viz, Dhansa, Rawta, Malikpur, Mundela Khud etc. is another deterrent factor for capturing data at source.

9.7 The Mother & Child tracking system has been initiated in the State as per national guidelines but is not operational in an optimal manner because of lack of infrastructure in the facilities. However, State has initiated process for improving the pace of registration of pregnant women and children under MCTS. The month-wise pregnant women registered under MCTS are as under;

Period	Pregnant women registered in MCTS during the month	Percentage Pregnant women registered in MCTS during the month (%)
Aug-11	4,368	15.46
Sep-11	11,504	40.72
Oct-11	8,779	31.08
Nov-11	8,565	30.32
Dec-11	11,757	41.62
Jan-12	11,799	41.77
Feb-12	15,332	54.27
Mar-12	15,671	55.47
Apr-12	18,289	66.23
May-12	21,715	78.64
Jun-12	15,157	54.89
Jul-12	17,592	63.71
Aug-12	14,745	53.4
Sep-12	16,899	61.2

Total registered pregnant women and children in Delhi during 2012-13 (April to October) are 1,14,913 and 1,19,043 respectively. 20% facilities are not yet reporting under the MCTS

central server. In South West district 15.38% facilities are not reporting under MCTS while in North East 25.45% facilities are not reporting for the same..

ASHAs are being sensitised for capturing pregnant women under MCTS and tracking of high risk women. For verification of data entered on MCTS, small call centres having 2-3 health workers are established in both South west and North East districts of Delhi. ASHAs are also getting SMS alerts as reminders for services due. ASHAs have also suggested for Hindi SMS and work plans for their better understanding.

“Grading of facilities” on the basis of MCTS data is also in the pipeline. Following parameters would be used for grading the facilities;

- Number of new pregnant women/newborns and children registered on MCTS portal in last month by the health facility
- Services overdue for high risk women
- Errors found on call verification
- Utilisation of work plans by the ANMs

Nodal officers have been appointed at State and District level for MCTS. Nomination of nodal officers has been done across all the hospitals except four central government hospitals. Record of line listing of severe anaemia in pregnancy and births with low birth weight has started in most of the facilities. This tracking is less effective in the areas where ASHAs have not been appointed. There is an urgent need for appointing ASHAs in left-out areas. Synchronization of HMIS & MCTS facility master is another challenge area for the State. Other applications/modules run by Department of Health & Family Welfare, Delhi are as under;

- i. Payroll & Bills- Which entails data storage for around 2000 employees, computerized salary preparation/ disbursal/processing of all bills/ advances.
- ii. HR
- iii. Transfer / Posting
- iv. Court Module
- v. Hospital Statistics
- vi. Inspection Module
- vii. Legacy data for Employee
- viii. PNDDT – Module with complete databases/ PNDDT report online entry by all registered clinics.

- ix. DGEHS (Delhi Govt Employee Health Insurance Scheme) – Under this scheme, databases for all beneficiaries shall be maintained which shall increase with time. The bills/ processing/ payments is being computerized and made online.
- x. Nirantar (Store) – E-tendering/ online requisition/ ordering/ distribution, and stock keeping for all drugs and logistics. Computerized Inventory Management in all hospitals. Subsequently to be started at Primary Health Facilities also.
- xi. School Health Scheme – Where medical records of lakhs of children shall be maintained. The same shall be updated periodically and increase with time.
- xii. ASHA – ASHA Database/ activity entry/ monthly incentive calculation/ disbursal/ planning/ implementation and recording of trainings.
- xiii. Finance
- xiv. Other Miscellaneous Modules :
- xv. Health Facility data capturing contains all details of the facility like – physical/ agency wise/ system of medicine/ services/ staff/ catchment areas/ performance details.
- xvi. E- Recruitment – Online recruitment process (Is being developed).

9.8 Training and skill development plans for medical health system managers exist as is evident from the training plans shared. However, targets are not optimally met. 90% post of Epidemiologist posts are lying vacant in the state. Only 26 % of medical officers targeted for training of IDSP could actually be trained by the state.

9.9 Almost 68% of sanctioned contractual position of non clinical staff in North-East district are occupied which indicates the urgent need to fill the gap for service position.

9.10 New Initiatives - M & E

- State of the art IT platform exists. [“Integrated web based software”](#) containing complete GIS mapping of facilities including personnel, infrastructure, performance, catchment area etc. is ready to roll out
- “Dashboards” for monitoring of facilities based on key indicators have already been developed
- Existence of “Public Health Standards” and “Quality Assurance Manual” for PUHC is a very encouraging and promising initiative of the State Evaluations of training programs – done at state level; minutes of trainings recorded.

- Health Watch – A software used by an NGO (St. Stephens- Sunder nagri) as a community based monitoring tool for health care facilities and outreach, needs evaluation.

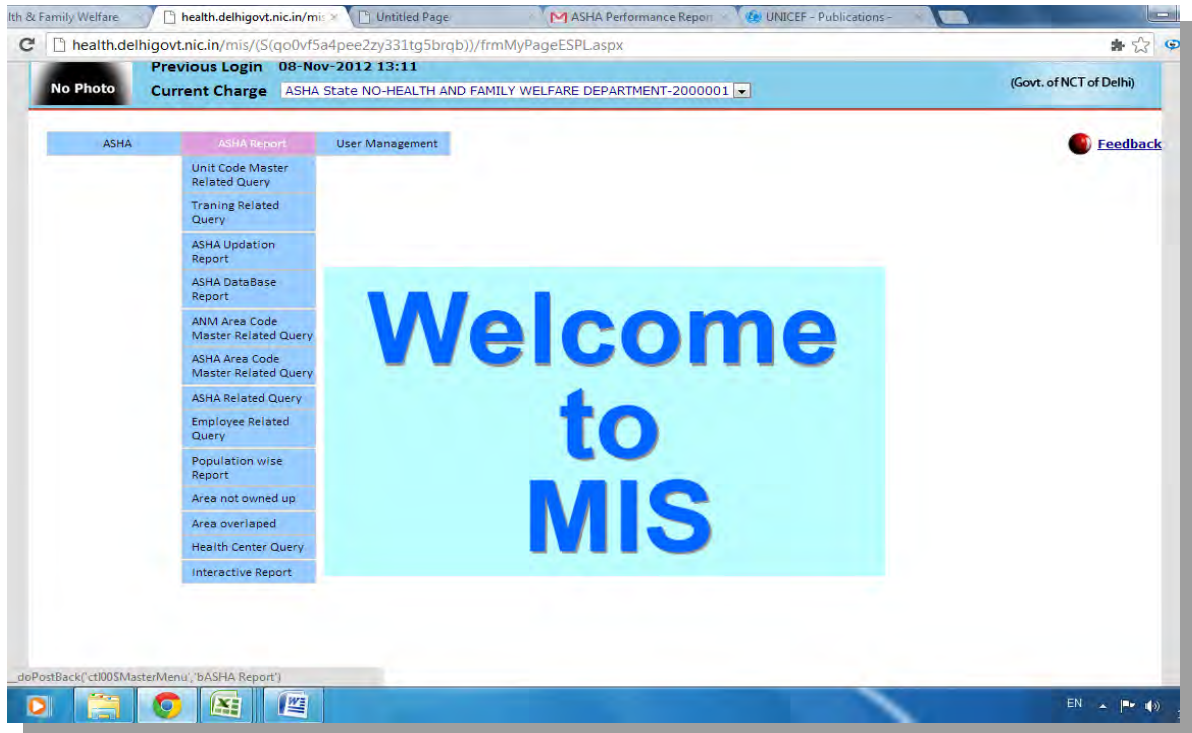
Integrated Web enabled database with population mapping has been developed by State Programme Management Unit, Delhi. It captures following data sets;

- i. Name / address / type / parent agency / system of Medicine of the health facility.
- ii. Services being provided by the centre and the referral linkages.
- iii. Staff details of the centre with details of each staff member of different categories.
- iv. Population being covered by the health centre. ANM Areas falling in this catchment area.
- v. Facility survey component (At present in image form , shortly to be converted to dynamic form)
- vi. Performance on selected 10 indicators. A link to be prepared from HMIS portal with permission from GOI.

Uses of this dynamic integrated web based information system :

- i. To help in ensuring universal coverage of each and every corner of the state .
- ii. To help in removing / minimizing the catchment area overlaps between centres belonging to same / different agencies.
- iii. To assist in ensuring accountability of the health centre / MO / ANM / ASHA for the promotive and preventive to all residents in the catchment area.
- iv. To help in defining facility specific benchmarks / expected outputs and thus facilitate meaningful evaluation.
- v. To help in planning of resources – manpower / logistics for each centre as per the requirements and thus prevent wastage.
- vi. To help in ensuring two conditionalities under NRHM :Facility wise need based deployment of staff & Facility wise performance audit as the staff / expected workload and actual achievements shall be available on web.
- vii. Back referrals / linking up of primary health facility staff / and field workers to the patients reaching the hospital directly.
- viii. Can provide at any given point of time the list of facilities conforming to the prescribed minimum standards .
- ix. Can any given time provide the list of slums / J Clusters / resettlement colonies / village and the centres to which they are attached thus providing areas for targeted interventions.

The application has tremendous potential. The huge data has to be checked and validated and then frozen, with rights and responsibility of regular updation of data to be defined at different levels and the process institutionalized.



Summary TOR 9

The state has no dedicated state level training/technical support institutions (SIHFW, SHSRC). All RCH training is coordinated by a HFWTC, funded by the GOI, but this has a limited role for State's training needs. Eight District Training Centres existed in the State earlier but are no longer functional now. There are two ANMTCs in public sector. The bank account of HFWTC has been closed by state officials, leading to delays in rolling out the smooth trainings in the state. The SPMU oversees district planning and trainings. The state has recently started using resources and support from NHSRC for ASHA training. USAID has provided support to Mission convergence on IEC materials for WASH education for communities under its HUP program. This is disseminated through Gender Resource Centres (GRC) at slum sites.

The state has developed an integrated web based software system based on GIS mapping, which is soon to be rolled out. A dashboard system of indicators is ready for implementation. The platform of GoI HMIS is being used for data reporting by all agencies. Use of information from HMIS & MCTS for planning and programme monitoring and management is limited. While HMIS data is referred to in planning documents, it is not used for performance monitoring. Data on various indicators is collected through available RCH registers in the facilities, and not being vetted by authorised signatories. State has also proposed to introduce "grading of facilities and districts" on the basis of HMIS data. Out of 407 sub-centres on HMIS only 41 exist and the rest are created notionally to capture field data. A constraint the state faces is the need to streamline the data uploading from varying agencies. Lack of dedicated "data entry operator" for HMIS & MCTS at District Hospitals is also a matter of concern. Most District Hospitals send data to the concerned DPMU for uploading on HMIS/MCTS portal, leading to delays by about a month. Uploading of data from Private Hospitals is another challenge. MCTS reporting is from 80% of facilities. Tracking is less effective where ASHAs are not involved.

TOR 10 Financial Management-especially fund flows, accounting and Absorption

10.1 STATUS of HR:

A. State Programme Management Unit:

Sanctioned posts for Deputy Director-Finance, SFM and Accounts Managers are three (1 each) and for Accounts Assistant there are 6 posts. But posts of one SFM and 1 Accounts Manager are filled and out of six only 2 Accounts Assistant are in place.

There is an urgent need for filling up crucial Finance Management Unit posts to avoid financial mishaps and mismanagement besides delays due to less staff.

B. **DPMU South-West District:** All sanctioned posts (one District Accounts manager, two district Account Assistants) in SW Distt. DPMU are filled.

C. **DPMU North East District:** All sanctioned posts (one District Accounts manager, two district Account Assistants) in NE Distt. DPMU are filled however it was reported that one official posted as Accounts Assistant was working as CDEO at Delhi Secretariat

UTILIZATION:

State Programme Management Unit, DPMU South West and DPMU North East: Fund Utilization is low because the implementation of approved activities as per approved ROP is not occurring. However, the Utilization of funds is as per approved activities.

Activity wise budget is not available with both of the districts. DHAP is available only in South West District.

Utilization under RCH and MFP for 1st quarter of FY 2012-13 is as under:

Under RCH

(Rs. in Lakhs)

Delhi				
S.No	Activity	SPIP Approved	Utilization	%age Utilisation of PIP
A.1	Maternal Health (other than JSY)*	2129.63	1.61	0.08%
A.2	Child Health	424.53	0.19	0.04%
A.3	Family Planning Services (other than sterilisation)	51.03	0.07	0.14%
A.4	Adolescent Reproductive and Sexual Health/Arsh	87.11	0.00	0.00%

A.5	Urban RCH	59.23	2.53	4.27%
A.7	PNDT Activities	49.90	0.65	1.30%
A.8	Infrastructure & Human Resources	10109.72	704.62	6.97%
A.9	Training	334.16	5.10	1.53%
A.10	Programme Management	739.87	42.39	5.73%
	Total RCH II Base Flexi Pool	13985.18	757.16	5.41%
A.1.4	Janani Suraksha Yojana / JSY	184.59	18.94	10.26%
A.3.1.2-5	Female Sterilisation camps, NSV camps, Compensation for female sterilisation, Compensation for male sterilisation	387.66	11.87	3.06%
	Total RCH II Demand Flexi Pool	572.25	30.81	5.38%
	Grand Total	14557.43	787.97	5.41%

Under Mission Flexible Pool

(Rs. in Lakhs)

Delhi				
S. No.	Activity	SPIP	Utilization	% Utilization
B1	ASHA	727.58	13.42	1.84%
B2	Untied Funds	74.75	0.00	0.00%
B3	Annual Maintenance Grants	82.75	0.00	0.00%
B4	Hospital Strengthening	75.06	0.03	0.04%
B5	New Constructions/ Renovation and Setting up	4591.60	17.41	0.38%
B6	Corpus Grants to HMS/RKS	185.88	0.02	0.01%
B7	District Action Plans (Including Block, Village)	13.00	0.00	0.00%
B9	Mainstreaming of AYUSH	162.98	0.00	0.00%
B10	IEC-BCC NRHM	618.46	4.22	0.68%
B11	Mobile Medical Units (Including recurring expenditures)	46.45	0.00	0.00%
B12	Referral Transport	1367.84	0.01	0.00%
B13	PPP/ NGOs	9.78	7.59	77.61%
B15	Planning, Implementation and Monitoring	1050.35	89.07	8.48%
B16	PROCUREMENT	1838.92	5.80	0.32%
B17	Regional drugs warehouses	20.77	0.55	2.65%
B18	New Initiatives/ Strategic Interventions (As per State health policy)	1586.75	0.06	0.00%
B21	State level health resources centre(SHSRC)	49.43	2.12	4.29%
B22	Support Services	616.20	0.67	0.11%
B23	Other Expenditures (Power Backup, Convergence etc.)	127.68	0.03	0.02%
	Total	13246.23	141.00	1.06%

10.3 AUDITING PROCEDURES:

State Programme Management Unit:

Statutory Audit for FY 2011-12 is under finalization process and for FY 2010-11 the ATR is in process.

Concurrent Audit for FY 2011-12 has been completed and for FY 2012-13 the appointment of auditor has been finalized.

CAG AUDIT: AG Audit has been undertaken by the State for FY 2007-2010.

DPMU South West District:

Statutory Audit for FY 2011-12 completed but the signature of auditor is left to be put.

Concurrent Audit for 2011-12 had been completed and ATR has been submitted to the State.

For FY 2012-13 Concurrent Auditor has not been appointed, yet.

No CAG audit has been done.

DPMU North East District:

Statutory Audit for FY 2011-12 completed but the report is awaited by the auditor.

Concurrent Audit for FY 2011-12 is completed but no action taken report is done. For FY 2012-13 Concurrent Auditor has not been appointed.

No CAG audit has been done.

10.4 Delegation of Financial & Administrative Powers at all level as per GOI guidelines.

10.5 **Funds Transfer:** State transfers fund by Cheques as well as by electronic fund transfer.

Districts also transfer funds through cheque and electronic fund transfer.

Signatories to Bank Accounts:

- **At State level signatories are**

Mission Director

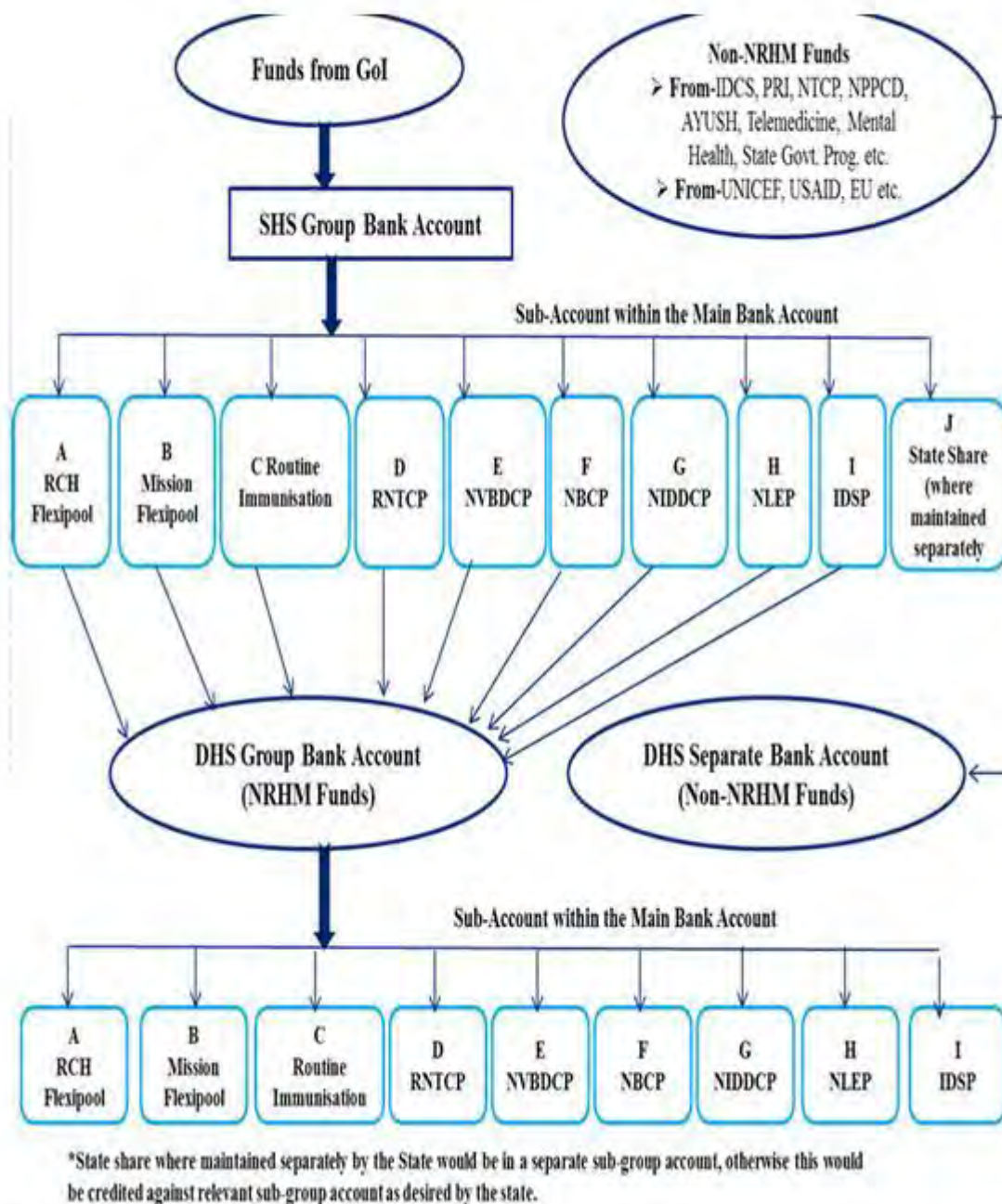
Respective Program Officers

- **At District level signatories are**

Mission Director

Respective Program Officers

Banking Arrangements



10.6 **Pending UCs:** Pendency of Utilization Certificates till FY 2011-12 is there. There is a mismatch between data of State and Govt. of India in respect of the pending Utilization Certificates amount, which is to be reconciled. The payment made to AMG and Untied Funds to the peripheries are treated as “advance”. List of pending UCs are under:

RCH				Amount in Rs.
Year	Sanction Letter No.	Date	Sanction Amount	Balance
2009-10	G27017/4/2009-NRHM (Finance)/1/EAC	22.05.09	6,98,00,000	-
	G27017/4/2009-NRHM (Finance)/1/GC	13.08.09	4,03,00,000	-
	G27017/4/2009-NRHM (Finance)/2/GC	20.10.09	1,66,00,000	-
	G27017/4/2009-NRHM (Finance)/GC/3	16.12.09	7,45,00,000	-
	G27017/4/2009-NRHM (Finance)/GC/5	25.02.10	13,89,00,000	3,50,27,787
Total				3,50,27,787
2010-11	G.27017/18/2010-NRHM (Finance)	18.12.2010	9,43,03,000	9,43,03,000
	G.27017/18/2010-NRHM (Finance)	18.12.2010	19,58,97,000	19,58,97,000
Total				29,02,00,000
2011-12	G.27017/4/2011-NRHM (Finance)	29.02.2012	5,11,80,000	5,11,80,000
	G.27017/4/2011-NRHM (Finance)	29.02.2012	26,52,20,000	26,52,20,000
Total				31,64,00,000
Grand Total				64,16,27,787

MFP				Amount in Rs.
Year	Sanction Letter No.	Date	Sanction Amount	Balance
2009-10	G27017/5/2009-NRHM(Finance)/2	16.06.09	6,16,00,000	1,98,87,883
Total				1,98,87,883
2010-11	G.27017/17/2010-NRHM (Finance)	16.12.2010	26,70,00,000	26,70,00,000
Total				26,70,00,000
2011-12	G.27017/5/2011-NRHM (Finance)	28.02.2012	38,95,00,000	38,95,00,000
Total				38,95,00,000
Grand Total				67,63,87,883.00

10.7 **Training:** Only CPSMS training for registration process is being done. Regularly financial data updating is done on HMIS. Financial training is not yet organised and will be organised as and when required.

10.8 **Funds flows:** The process of receipt of funds and disbursements of fund takes up in time. The expenditure done is as per approved activities but not as per approved targets as there is

low utilization reported. Expenditure done is not as per the accounting procedure under North East District as they performing the cash transactions more than Rs. 5000\ - that needs to be regulated. Monitoring on financial reporting has been done by the supervisors/ authorities.

State Share: State share under NRHM is pending with the State. There is a mismatch with the Govt. of India figures.

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	9.76	3.23	6.53
2008-09	17.58	7.05	10.53
2009-10	14.65	10.00	4.65
2010-11	19.14	20.06	-0.92
2011-12	18.06	20.00	-1.94
Total (2007-08 to 2011-12)	79.19	60.34	18.85
2012-13	56.65	5.00	51.65
Total (2007-08 to 2012-13)	135.84	65.34	70.50

Income tax related fields such as TDS is being deposited in time. Interest earned against NRHM funds is being capitalized. There is no diversion of funds.

Other Important Issues:

- a. In Statement of Fund Position (SFP) the amounts of different programmes are not shown separately. In North East District the SFP till 30.09.12 and is not updated.
- b. In North East District different payments are being made by cash without verification on the bill, without stamp of paid and cancelled etc., The Financial Norms are not appropriately followed in NE District needing attention of States Finance officers and MD_NRHM
- c. RKS meetings are not held as per the guidelines and the Statutory Audit is being not done in any of the RKSs. The Medical Superintendents of the hospitals interviewed, had less clarity on TORs, Bye-laws and fund utilization under RKS.

Dada Dev Hospital in South West District

- The hospital incurred expenditures (approx. Rs.19 lakhs) without having / demanding funds under JSSK Scheme on transportation and mobility mainly. An open tender was floated and as reported no one turned up and since that a single agency has been paid the transportation money under JSSK. This needs kind attention of MD-NRHM and there is an urgent need to impart training to Medical Superintendents in respect of GFRs, RKS and Basic Finance Management Rules.
- The Statement of expenditure under RKS for FY 2012-13 is being submitted to CRM team on two different dates (i.e. 05.11.12 and 07.11.12) with different amounts, which shows the irregularity in accounting procedures, as well.

Summary TOR 10

The state has one SFM and Accounts Managers, with the position of Deputy Director, Finance vacant, and of six accounts assistant only two are in place. At the district level all positions related to Finance were filled. Utilization Certificates till FY 2011-12 are pending. Statutory and concurrent audits have been held. There is a mismatch between data of State and Govt. of India in respect of the pending Utilization Certificates amount, which is to be reconciled. Fund utilization is low on account of slow pace of implementation in accordance with the ROP. Expenditure in the NE is not in accordance with accounting procedure with cash transactions for amounts more than Rs. 5000. Financial Norms are not appropriately followed in both the districts (one hospital in SW and many facilities in NE) reflecting poor monitoring. RKS meetings are not held as per the guidelines and the Statutory Audit are not being undertaken. The Medical Superintendents of the hospitals interviewed, had little clarity on TORs, Bye-laws and fund utilization under RKS.

Part-III: Strengths, weaknesses and Overall recommendations

Strengths:

- The leadership in Delhi Government is committed, proactive and truly enthusiastic toward synergizing the efforts to bring about transformations in the public health sector and make Delhi a benchmark in respect of setting the gold standards.
- The Program Managers in State and District Program Management units are in service employees of Delhi Govt (DHS & DFW) and there is complete synergy amongst program managers and all senior officers in both DHS & DFW.
- The coordination & joint efforts by two major agencies namely Delhi Government & Municipal Corporation of Delhi in bringing about the best of health care delivery services was visible at every level (Primary health care to tertiary health care to senior most administrative functionaries) However, there is a need to have formal convergence at every level (including political).
- The making of institutional mechanism, format structuring, implementation framework designing, documentation and data management is very strong.
- State has an essential drug list of 361 drugs out of which 120 are for primary health care facilities. Free drugs are being provided and are available in sufficient quantity. NRHM support in form of JSSK in which State has provided a separate link in their *Nirantar* software (of CPA) enabling Medical Superintendent of hospitals to place the order at their own level and from authorized local chemist in case of emergency, also various modalities to access diagnostic, diet & transport facilities has strengthen the mechanism as a leverage and general public is benefited in having minimal out of pocket expenditure.
- The first ANC registration and overall ANC services are available in every facility (of any agency) all across the facilities visited in both the districts.
- State of the Art ICT platform available and in use to collect data into MCTS and HMIS.
- Sincere effort by the State visible in the areas of implementation of PC-PNDT act, initiation of breast feeding within one hour of birth, promotion of spacing methods especially PPIUCD, other spacing methods and every health care functionary is actively taking part indicating a focussed effort that could be scaled upto all areas as well.

Weaknesses:

- The tenure of senior officers in the health department is apparently insufficient to absorb, act and deliver the desired outcomes and it does affect the program implementation.
- The major weakness perceived was in terms of non-uniformity of governance and nomenclature due to multiplicity of agencies leading to duplication of services, lack of accountability and wastage of resources. This weakness can duly act as a major strength if all the agencies come on board and channelize their efforts in a coordinated and complementary manner.
- The Program Managers in both SPMU & DPMUs are still not able to give their best outputs (despite having great deal of synergy) because of lack of any administrative, communication skills, management & finance management trainings and support.
- ASHA program is not being given its due importance and ASHAs are serving more as the last rung of the health system, than as a representative of the community.
- The dropout from ANC-1 to ANC-3, still a large no of unreported home deliveries, lack of institutional mechanism on the ground to track high risk and severe anaemia cases was observed.
- Supportive supervision & monitoring of programme implementation at field level by the officers and managers is sub-optimal. There is no formal monitoring plan & follow up.
- There is no apex training institute to cater the need of all RCH/ NRHM and disease control trainings in the State. Training infrastructure, deployment of dedicated manpower and overall focus on training mechanism is very weak in state.
- Awareness about the entitlements about the JSSK program is poor among the beneficiaries due to the lack of IEC for JSSK across the state. Utilization of MCTS/HMIS data for policy and other program implementation is sub optimal at this stage.

Overall Recommendations of 6th Common Review Mission:

- There is an urgent need to increase effectiveness of management structures, convergent action and joint accountability & strengthening capacity for decentralized planning, implementation and monitoring in order to achieve the goal of universal health care.
- To enable this, institutional structures, rules and regulations will need to be examined and modified

Incremental steps towards such modification include:

- Constituting an Executive Committee at the level of the State Health Society that includes Municipal Commissioners, Mission Director, DHS, DFW and heads of other major agencies contributing to health care service delivery in public health sector.
- Constitute Programme Committees including representatives of the MCD and officers of the Directorate at State & District levels
- SPMU and DPMU need to be strengthened by staffing with multi skilled personnel
- Existing program management arrangements and planning and monitoring processes are primarily for NRHM. Expanding the remit to all sources of funds may be considered.
- Tenure of senior officers may be scheduled in due consultation so as to enable the officer concerned to deliver desired outcomes
- The program management arrangements and planning and monitoring processes are primarily for NRHM. Governor for National Capital Territory of Delhi (GNCTD) may wish to consider expanding the remit to all sources of funds through eg a single plan for Delhi and strengthening program management within each municipality. To take this forward, it may be necessary to ensure a shared understanding of roles of different agencies in provision of health care including regulation of private sector.
- There is a need to emphasize the development of district Health Plans with clear strategies and outcomes to enable universal health care; address inter-sectoral convergence, with a flexible financing mechanism. The DHAP should use data from socio-epidemiological surveys and HMIS to plan the package of services to be delivered at community and outreach level, secondary level, and tertiary levels
- SPMU and DPMU need to be strengthened by staffing with multi skilled personnel
- Allocate resources to where need is greatest ; at present NRHM allocation is Rs 100 per capita across all districts

- Job descriptions of all staff should have specific deliverables, linked to performance appraisal
- There is an urgent need for the State to formulate clear cut HR policy in order to minimise regular vacancies; expeditious recruitment (e.g. taking recruitment of MOs out of Public Service Commission purview); merit –based and transparent selection; opportunities for career progression and professional development; rational and equitable deployment; effective skills utilization; stability of tenure; sustainability of contractual human resources under RCH / NRHM, providing monetary and non monetary incentives, enabling positive practice environments and plan for their inclusion in State budget taking parity into account. Job descriptions of all staff should have specific deliverables, linked to performance appraisal. There is a need to monitor performance against the plan in terms of outcomes, physical progress and expenditure; prepare variance analysis reports, highlighting constraints and proposed solutions

Supportive supervisory visits need to be increased and should focus on progress against the district health plan, and follow up on recommendations and actions taken with reference to previous monitoring visits. Supervisory visits need budgetary provision for travel, logistics and other arrangements. Introduction of work plan with time line and focal point responsible may be considered.

- The state should consider commissioning special studies and independent evaluations to assess programme performance
- It is important to fast track the GIS mapping including AWCs and Pvt. Sector facilities, validation & prioritization of the areas having limited access.
- In densely populated areas, additional teams to be added, rather than opening new facilities, and outreach to be expanded.
- ASHA to be skilled and supported to enable her to fulfil her three roles (facilitation, social mobilization, and community level care provider), especially in areas with high marginalized populations
- The state must ensure completion of ASHA selection and work closely with local bodies and NGOs, including polio team members to ensure that ASHAs are particularly selected in areas with large migrant and marginalized areas. For particularly difficult areas, the state should consider additional incentives for the ASHA, with adequate justification, and only after a strong mentoring and monitoring system is in place.

- ASHA training in Modules 6 and 7 must be expedited to enable the ASHAs to address issues of birth planning, nutrition, and management of sick child and newborn.
 - The state should ensure that ASHA incentives are paid immediately. The backlog needs to be cleared and a system for timely payment instituted.
 - A district and sub district monitoring and support system needs to be established with the state taking an active role particularly in poorer districts, where the need for an ASHA is high. Since there are at least two ANMs in a PUHC, they could serve as ASHA facilitators, and need to be trained in the Facilitator module.
 - ASHA performance should be measured on her functionality on key tasks rather than the payment she is given.
- Strengthening inter-sectoral convergence would provide impetus to action on social determinants and also serve to enable the ASHA, ANM, and AWW to work as a team. The state needs to engage with NGOs and consider scaling up of innovations piloted by NGOs & Govt. to support the community processes intervention. Social audit through local RWAs needs to be instituted, Where such RWAs do not exist, the state needs to pilot other means of community based system for social audit. State should endeavour to introduce quality management processes in all facilities and enable quality certification and prominently display Citizens' Charter in English and Hindi (if possible other locally prominent language), and services available. There is an urgent need to bring about a change in the attitude of apathy amongst health care functionaries towards issue of privacy of women in facilities especially in MCH wings. This can be brought about by sensitization workshops involving BCC and communication skills. There is a need to have BCC experts and sociologists in every district and at the State level. Institute a public health cadre, and enable management & financial training /orientation for clinicians.
 - State should make provision for Patient transport ambulances for inter facility transfer and ensure drop back facility.
 - State may try to implement “integrated web based mapping of facilities” on pilot basis in any two districts , setting of “facility level targets” for key indicators and initiate regular monitoring of facilities based on “dashboard” indicators
 - There is need to synchronize HMIS & MCTS facility masters and give impetus on MCTS – computerization of all the facilities along with competent manpower

- RKS meetings should be held on regular basis with proper documentation and follow up. AYUSH representation in RKS meeting may be considered. Orientation Trainings may be organized for RKS members to get clarity on TORs, Bye-laws and fund utilization under RKS.
- AYUSH MOs may be involved in National Health Programmes especially School Health Programme.

Medicinal Plants Garden could be developed in the premises of health facilities and financial assistance through State Medicinal Plants Board could be sought.

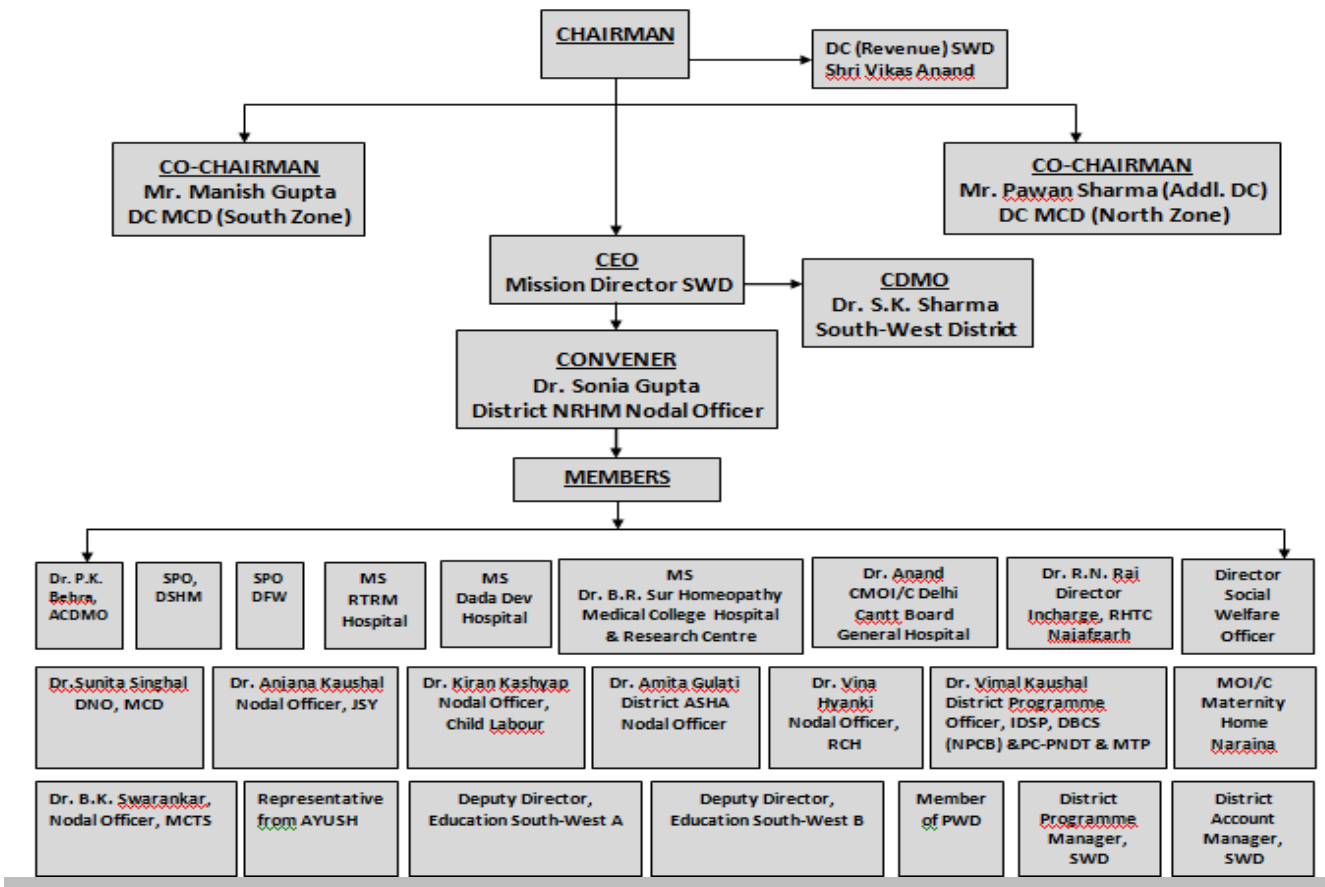
- Post of Finance & Accounts personnel to be filled on priority basis. Contractual service procedures to private agencies by the hospitals (e.g. for RKS, JSSK) need to follow finance guidelines. Advance and timely financial planning is necessary. Regular review mechanisms with MD, State/district FMG group, MS of hospitals supported through secretariat and MO I/c of institutions handling finance independently.
- Full operationalisation of existing SHSRC is important. Further, HFWTC at Saraswati Vihar may be upgraded as SIHFW for the State as state does not have any apex training institute of its own. The account of HFWTC which is closed reportedly for no specified reason is hampering the regularity of trainings in dearth of finances, should be re-opened as soon as possible to smoothen the trainings in state. State should also ensure the optimal utilization of existing institutions for training and technical support

The MCD Training Centre at Rohini reportedly has a good infrastructure and a robust institutional mechanism utilizing most of the training resource pool available in the Capital and if the same could be integrated/becomes initial part of the ensuing inter-sectoral convergence with the MCD in near future and at the same time State builds up on establishment of SIHFW and revive the erstwhile 8 DTCs which have become non-functional.

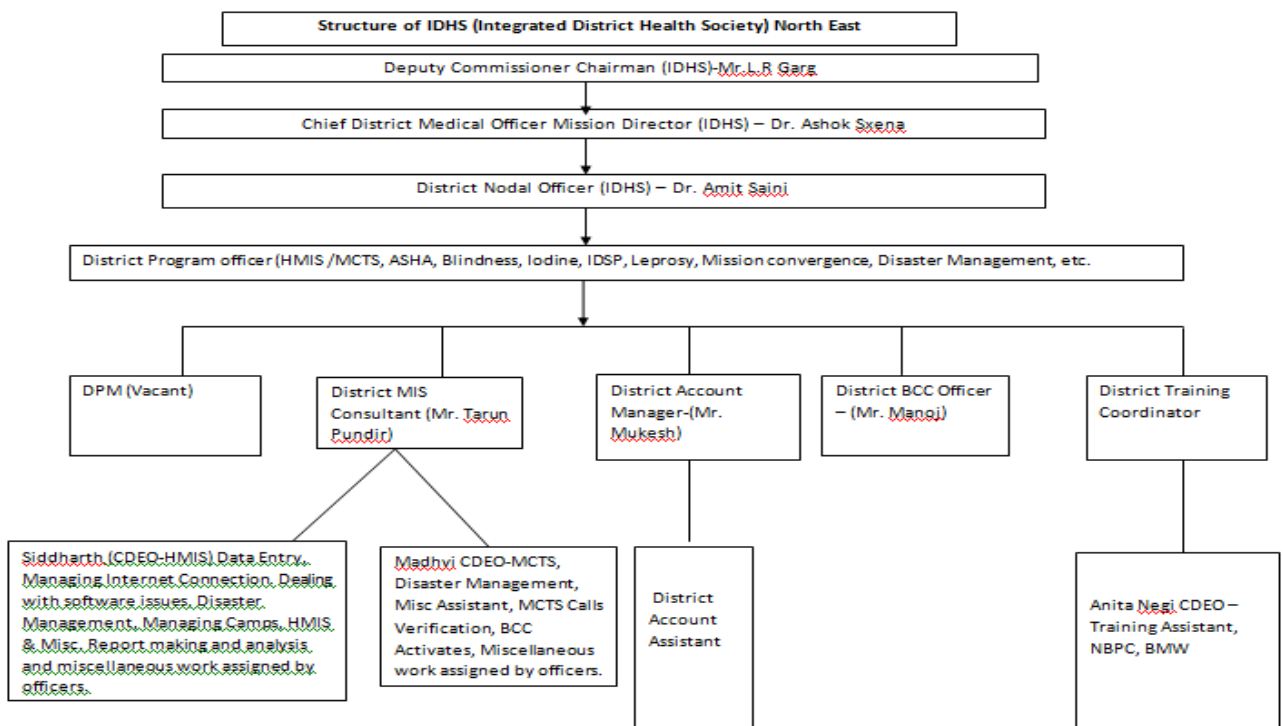
Annexures

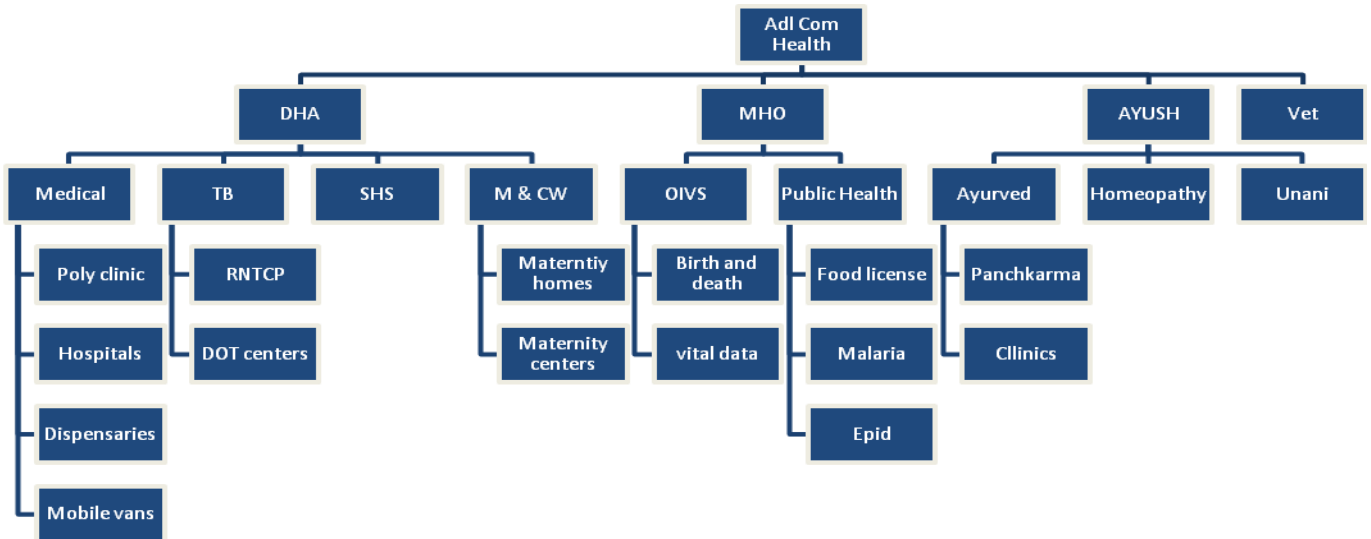
**Organogram of PMUs:
South West District:**

Annexure 1

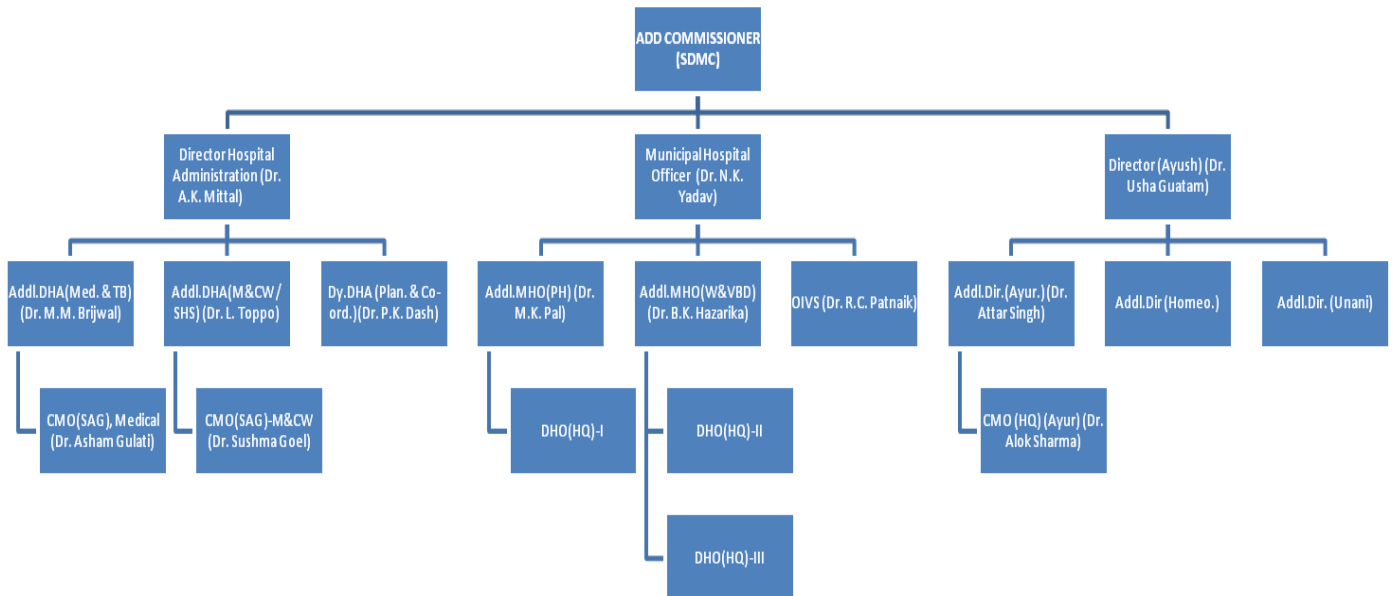


North East District:





South Delhi Municipal Corporation



List of NBCCs in the State

Annexure 3

1	Mty. Home Shakti Nagar-North
2	Mty. Home Gulabi Bagh-North
3	Mty. Home Kamla Nehru-North**
4	Mty. Home Jawarhar Nagar-North
5	Mty. Home Naraina- South West
6	Mty. Home Chandiwala-North East
7	Mty. Home Karawal Nagar-North East
8	Mty. Home Seelampur-North East
9	Mty. Home Seema puri-North East
10	Mty. Home Yamuna Vihar-North East
11	Mty. Home Badarpur-South
12	Mty. Home Defence Colony-South
13	Mty. Home Jungpura-South
14	Mty. Home Srinivaspuri-South
15	IPP VIII, Jawalpuri-West**
16	Mty. Home Madipur-West
17	Mty. Home Subhash Nagar-West
18	Mty. Vishnu Garden-West**
19	Bhai Parmanand M/H-North West
20	Bhaktavar Pur M/H-North West
21	Mangolpuri -A M/H-North West
22	Mty. Home & Health Centre IPP VIII, Haiderpur-North West
23	Narela M/HHaiderpur-North West
24	Rana Pratap Bagh M/HHaiderpur-North West
25	Rohini-3 M/HHaiderpur-North West
26	Shahabad IPPVIIIHaiderpur-North West**
27	Shakur Basti M/HHaiderpur-North West
28	Shakur Pur M/HHaiderpur-North West**
29	Tri Nagar M/HHaiderpur-North West

30	M/H Geeta Colony-East**
31	M/H Khichdipur-East
32	M/H Patparganj-East

List of SNCU/NBSU

Annexure 4

List of identified SNCU(14)	List of NBSU (14)
	Dada Dev Hospital-South West
BSA Hospital-North West**	Maharishi Balmiki Hospital-North
Dada Dev Hospital-South West	Hindu Rao Hospital:North
Guru Gobind Singh Hospital-West**	Lal Bahadur Shastri Hospital-North East
Dr.Hedgewar Arogya Sanshthan-East**	
Hindu Rao Hospital-:North**	Guru Gobind Singh HospitalHospital-West
Lal Bahadur Shastri Hospital-North East	Pt. Madan Mohan Malviya Hospital-South
Maharishi Balmiki Hospital-North**	Sanjay Gandhi Hospital-North West
Pt. Madan Mohan Malviya Hospital-South	BSA Hospital-North West
Achraya Bikshu Hospital-West	Mty. Home Kamla Nehru-North
Sardar Vallabh Bhai Patel Hospital-West	Mty. Home Chandiwala-North East
Sanjay Gandhi Hospital-North West**	Mty. Home Seema puri-North East
Swami Dayanand Hospital-North East**	Mty. Home Srinivasपुरi-South
Jagparvesh Chandra-East**	IPP VIII, Jawalपुरi-West
Kasturba Hospital-central	M/H Khichdipur-East

List of IYCF centers

Annexure 5

<u>List of IYCF Centres (21)</u>	<u>List of NRCs (11)</u>
Acharya Bhikshu Moti Nagar	Hindu Rao Hospital**
Aruna Asaf Ali Hospital	Guru Gobind Singh Hospital**
BSA Hospital	Sardar Vallabh Bhai patel Nagar Hospital
Dr.Hedgewar Arogya Sansthan	Swami Dayanand Hospital**
Guru Gobind Singh Hospital	Lal Bahadur Shastri Hospital
Guru Teg Bahadur Hospital	Baba Saheb Ambedkar Hospital**
Hindu Rao Hospital	Pt. Madan Mohan Malviya Hospital
Kalawati Saran Children Hospital	Dada Dev Hospital
Lal Bahadur Shastri Hospital	Jagparvesh Chandra
LNJP Hospital	Sanjay Gandhi Memorial Hospital**
Maharishi Balmiki Hospital	Acharya Bhiskshu Moti Nagar**
Malviya Nagar Hospital	
Mty. Home Naraina	
Mudela Khurd	
PP Unit Kalkaji	
RTRM Hospital	
Sanjay Gandhi Hospital	
Sardar Vallabh Bhai Patel Nagar	
Seed PUHC Qutub Vihar	
Swami Dayanand Hospital	
Mty. Home Haiderpur	

Allocation of Manpower under NRHM

Annexure 6

Allocation of Manpower under NRHM																	
S. No.	Programs	Sanctioned						Working					Vacant				
	Posts	Total as per ROP	Total	GEN	OBC	SC	ST	Total	GEN	OBC	SC	ST	Total	GEN	OBC	SC	ST
1	Anesthetist	9	9	8	0	0	0	4	3	0	0	0	4	4	0	0	0
2	Accounts Assistant	26	26	15	0	0	0	18	13	0	0	0	8	2	0	0	0
3	Accounts manager	9	9	6	0	0	0	7	5	0	0	0	2	1	0	0	0
4	Administrative Assistant	12	12	8	0	0	0	4	4	0	0	0	8	4	0	0	0
5	ANM	946	946	371	186	111	51	789	360	149	82	24	157	17	32	29	27
6	Asst. Engineer	2	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0
7	Attendent	13	13	4	1	2	1	4	0	0	0	0	9	4	1	2	1
8	BCC Officer	8	8	6	0	0	0	4	3	0	0	0	4	3	0	0	0
9	Bio Medical Engineer	1	1	1	0	0	0	1	1	0	0	0	0	0	0	0	0
10	CDEO	397	397	160	68	39	17	312	137	54	36	3	95	23	14	3	14
11	Child Health Consultant	3	3	2	0	0	0	0	0	0	0	0	3	2	0	0	0
12	Clerk	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
13	Community Mobilization Officer	70	70	39	11	5	0	0	0	0	0	0	70	39	11	5	0
14	Consultant Communitization	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
15	Consultant Community Participation	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
16	Consultant HMIS	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
17	Consultant HRD	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
18	Consultant PPP	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
19	Control Room Staff	26	26	13	7	4	2	18	18	0	0	0	8	-5	7	4	2
20	Cook	5	5	4	0	0	0	0	0	0	0	0	5	4	0	0	0
21	Counselor	4	4	0	0	0	0	2	0	0	0	0	2	0	0	0	0
22	Data Analyst	1	1	1	0	0	0	1	1	0	0	0	0	0	0	0	0
23	Deputy Director	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
24	Dresser	29	29	12	4	2	0	14	6	2	1	0	15	6	2	1	0
25	Driver	427	427	202	106	59	29	248	128	62	34	5	179	74	44	25	24
26	Electrical Technician	3	3	2	0	0	0	0	0	0	0	0	3	2	0	0	0
27	Establishment Clerk	41	41	26	5	1	0	37	23	4	2	0	3	2	0	-1	0
28	Executive Engineer	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
29	GIS Consultant	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
30	GIS Programmer	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
31	Graphic Designer	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
32	Gynaecologists	12	12	11	0	0	0	9	7	1	0	0	2	2	0	0	0

33	Consultant Health insurance	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
34	State BCC/IEC consultant	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
35	Junior Engineer	2	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0
36	Lab Assistant	26	26	13	3	2	0	23	12	2	1	0	3	1	1	1	0
37	Lab Technician	509	505	100	43	27	11	398	108	39	19	5	100	9	12	12	6
38	Legal Consultant	1	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0
39	Libraray Assistant	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
40	Logistics Consultant	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
41	Logistics Officer	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
42	M & E Officer	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
43	Media Assistant	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
44	Medical lecturar	1	1	1	0	0	0	1	1	0	0	0	0	0	0	0	0
45	Medical Officer	633	574	153	73	44	19	342	175	30	32	6	193	7	57	20	13
46	Medical Social Worker	1	1	1	0	0	0	1	1	0	0	0	0	0	0	0	0
47	Maternal Health Consultant	3	3	2	0	0	0	0	0	0	0	0	3	2	0	0	0
48	MIS Asst./Sr. Data Asst.	12	12	6	0	0	0	7	4	0	0	0	5	2	0	0	0
49	MIS Expert	11	11	7	0	0	0	9	7	0	0	0	2	0	0	0	0
50	NO/Ayas	601	333	36	14	5	5	116	10	0	0	0	217	26	14	5	5
51	Nutritionist	6	6	4	0	0	0	6	4	0	0	0	0	0	0	0	0
52	OT Asst.	49	48	25	6	3	0	31	20	3	3	0	17	4	4	0	0
53	OT Technician	19	16	10	1	0	0	2	2	0	0	0	14	8	1	0	0
54	Paramedic	396	396	202	106	59	29	231	173	33	7	18	165	29	73	52	11
55	Pathologist	9	9	6	0	0	0	7	5	0	0	0	2	1	0	0	0
56	Pediatrician	58	58	30	6	3	0	10	7	1	0	0	48	23	5	3	0
57	Peon	16	17	10	0	0	0	10	6	0	0	0	15	8	1	2	0
58	Pharmacist	215	214	55	22	13	5	127	60	18	12	0	81	10	10	4	5
59	PHN	119	119	44	17	9	4	63	39	6	9	1	48	17	16	3	3
60	Procurement Specialist	1	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0
61	Program manager	9	9	6	0	0	0	7	6	0	0	0	2	0	0	0	0
62	Public Health Consultant	2	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0
63	Quality Assurance Specialist	1	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0
64	Refregeration mechanic	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
65	Multi Tasking Staff	6	6	0	0	0	0	0	0	0	0	0	6	0	0	0	0
66	S/R Anesthetist	19	17	11	2	0	0	0	0	0	0	0	17	11	2	0	0
67	S/R Gynaecologists	34	29	14	5	2	0	0	0	0	0	0	29	14	5	2	0
68	SCC (Sweeper /Chowkidar)	121	120	55	26	15	7	37	7	11	11	0	83	48	15	4	7
69	Secretarial Asst.	2	2	0	0	0	0	1	0	0	0	0	1	0	0	0	0
70	State Finance Manager	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
71	Staff Nurse	408	400	142	63	45	14	272	121	53	22	11	122	32	15	26	3
72	State Ngo Co-ordinator	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0

73	State Level Trainer (ASHA)	2	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0
74	Steno	9	9	2	0	0	0	6	1	0	0	0	3	1	0	0	0
75	Ambulance Supervisory	12	12	0	0	0	0	0	0	0	0	0	12	0	0	0	0
76	Senior Manager (A/c/ HR/ Maintc/Stor/CT)	4	4	0	0	0	0	0	0	0	0	0	4	0	0	0	0
77	System Analyst	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
78	Assistant Programmer	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
79	LDC/LDC(A/c)	13	13	0	0	0	0	0	0	0	0	0	13	0	0	0	0
80	Helper	4	4	0	0	0	0	0	0	0	0	0	4	0	0	0	0
81	Mechanic	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
82	State Training Coordinator	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
83	District Training Officer	8	8	6	0	0	0	5	4	0	0	0	3	2	0	0	0
84	Youth Consultant	1	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0
85	Specialist	24	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
86	TB HIV Coord	198	198	0	0	0	0	191	0	0	0	0	7	0	0	0	0
87	Accountant	26	26	0	0	0	0	25	0	0	0	0	1	0	0	0	0
88	IEC Officer	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
89	STS	38	38	0	0	0	0	34	0	0	0	0	4	0	0	0	0
90	STLS	38	38	0	0	0	0	32	0	0	0	0	6	0	0	0	0
91	DOTS Plus Statistical Assistant	4	4	0	0	0	0	4	0	0	0	0	0	0	0	0	0
92	Sr. DOTS plus & TB HIV	26	26	0	0	0	0	25	0	0	0	0	1	0	0	0	0
93	Store Assistant	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
94	consultant program coordinator, logistics and communitization	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
95	consultant -dental public health	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
96	dental surgeon	10	10	0	0	0	0	0	0	0	0	0	10	0	0	0	0
97	chair side assistant	7	7	0	0	0	0	0	0	0	0	0	7	0	0	0	0
98	Dental Hygienist	2	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0
99	Technical Officer	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
100	Statistical Officer	2	2	0	0	0	0	1	0	0	0	0	1	0	0	0	0
101	Family Planning Counsellor	5	5	5	0	0	0	0	0	0	0	0	5	5	0	0	0
102	PNDT Consultant	6	6	6	0	0	0	0	0	0	0	0	6	6	0	0	0
103	RCH Consultant	9	9	9	0	0	0	0	0	0	0	0	9	9	0	0	0
104	Family Planning Consultant	1	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0
105	ARSH Consultant	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
106	QAC Consultant	2	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0
Total		5815	5440	1857	775	450	194	3508	1482	468	271	73	1881	464	342	202	121

Vertical Programmes																	
IDSP																	
107	Data Entry Operator	17	17	0	0	0	0	10	0	0	0	0	7	0	0	0	0
108	Data Manager	10	10	0	0	0	0	2	0	0	0	0	8	0	0	0	0
109	Entamologist	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
110	Epidemiologist	10	10	0	0	0	0	1	0	0	0	0	9	0	0	0	0
111	Microbiologist	2	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0
112	Consultant Finance	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
113	Consultant Training	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
NLEP																	
114	Administrative Assistant	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
115	Data Entry Operator	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
116	Medical Officer	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
117	Non Medical Supervisor	10	10	0	0	0	0	8	0	0	0	0	2	0	0	0	0
118	Budget & Finance Officer	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
119	Driver	3	3	0	0	0	0	3	0	0	0	0	0	0	0	0	0
120	Leprosy Assistant	11	11	0	0	0	0	8	0	0	0	0	3	0	0	0	0
NPCB																	
121	Paramedical Ophthalmic Assistant	39	39	0	0	0	0	3	0	0	0	0	36	0	0	0	0
122	Eye Donation Counselor	10	10	0	0	0	0	5	0	0	0	0	5	0	0	0	0
123	Data Entry Operator/ Steno/LDC	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
124	Administrative Assistant/ Statistic Assistant	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
RNTCP																	
125	Microbiologist	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
126	TB HIV Coordinator & Epidemiologist	1	1	1	0	0	0	1	1	0	0	0	0	0	0	0	0
127	Epidemiologist	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Total		124	124	1	0	0	0	44	1	0	0	0	80	0	0	0	0
G. Total																	
G. Total		5939	5564					3552					1961				

DETAILS OF INFRASTRUCTURE WORK UNDER NRHM FUND

Annexure 7

Name of Distt.: EAST DISTRICT

S. No.	Name of Health Center	Amount approved (Rs. in Lacs)	Year in which approved	Amt. released to agency as advance responsible for work	Name of Agency - PWD/ I&FC	Amt. utilized by Agency	Probable % of work completion	Probable time required for completion of remaining work (mths/ yrs)	Remarks Bottle necks if any for delay in work
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	Shashi Garden (civil works)	24.95	2011-12	Nil.	N.A.	N.A.	Not applicable.	N.A.	NOC/permission for carrying out repair/ renovation work has been denied by DUSIB. As per the approval of DHS, request for proposed civil works has been submitted to DUSIB vide letter dt. 14/08/2012 and a copy of the estimates of proposed electrical repair works has been provided to DUSIB vide letter dt. 27/9/12.
2.	Mandawali Fazalpur (civil works)	14.51	2011-12	Rs. 73 lakhs {Rs. 37.00 lakhs (as first installment) and Rs. 36.00 lakhs (as second installment) of the total estimated cost}	I&FC	Amount released as 1 st installment	Around 25% works completed.	-	
3.	Himmat Puri (civil works)	17.05	2011-12		I&FC		Under progress.	-	
4.	Kalyan Puri (civil works)	16.72	2011-12		I&FC		Under progress.	-	
5.	Trilok Puri (civil works)	17.17	2011-12		I&FC		About 70% work completed.	-	
6.	Geeta Colony (civil works)	17.48	2011-12		I&FC		About 60% works completed.	-	

7.	Karkardooma (civil works)	21.24	2011-12		I&FC		About 50% works completed.	-	
8.	Mukesh Nagar (civil works)	06.79	2011-12		I&FC		Completed	-	
9.	Electrical works in r/o DGDs mentioned at S.No. 2 to 7	44.96	2011-12	Rs. 15.00 lakhs {as first installment of the total estimated cost (33% of the total estimated cost)} has been released. Further, request has been received from the Executive Engineer (Mechanical Division –II), I&FC Deptt. for release of balance funds which is under process.	I&FC	Amount released as 1 st installment	Under progress.	-	
10.	Bank Enclave (civil works)	3.09	2012-13	Nil	I&FC	N.A.	Sanction conveyed by the Nodal Officer (NRHM Cell), DHS in Sep., 12. Further action is being taken.	-	
11.	Mayur Vihar, PH-III (Kondli) (civil repair work (Rs. 11.01 lacs) & Installation of water Harvesting system (Rs. 3.50 lacs))	14.51	2012-13	Nil	I&FC	N.A.	-do-	-	

12.	Trilok Puri (Construction of disabled friendly toilet)	2.98	2012-13	Nil	I&FC	N.A.	-do-	-	
13.	Himmat Puri (Construction of disabled friendly toilet)	2.98	2012-13	Nil	I&FC	N.A.	-do-	-	
14.	I.P. Extension (Installation of water Harvesting system)	3.50	2012-13	Nil	I&FC	N.A.	-do-	-	
15.	Mayur Vihar, Ph-I (Installation of water Harvesting system)	3.50	2012-13	Nil	I&FC	N.A.	-do-	-	
16.	Vasundhara Enclave (Installation of water Harvesting system)	3.50	2012-13	Nil	I&FC	N.A.	-do-	-	
17.	Vivek Vihar (Installation of water Harvesting system)	3.50	2012-13	Nil	I&FC	N.A.	-do-	-	
18.	Mukesh Nagar (electrical works)	6.41	2012-13	Nil	I&FC	N.A.	-do-	-	
19.	Shashi Garden (electrical works)	6.94	2012-13	Nil, as NOC/permission for carrying out renovation work has been denied by DUSIB. However, request for proposed work has been submitted to DUSIB vide letter dt. 27/09/2012.	N.A.	N.A.	N.A.	-	NOC/permission for carrying out repair/ renovation work has been denied by DUSIB. The funds approved earlier (Rs. 24.95 lacs) for civil repair works are also lying unutilized. Further, as per the approval of DHS, request for proposed civil works has been submitted to DUSIB vide letter dt. 14/08/2012 and a copy of the

									estimates of proposed electrical repair works has been provided to DUSIB vide letter dt. 27/9/12.
20.	Kalyan Puri	5.0	2012-13	Nil	I&FC	N.A.	-	-	Funds for up-gradation/ renovation work (Civil as well as electrical) had been approved earlier and the repair works are already being carried out by the I&FC Dept. (by the Ex. En. CD-X and Ex. En. MD-II). Further, no other proposal has been sent by this office for obtaining approval.
21.	Surajmal Vihar	10.0	2012-13	Nil	I&FC	N.A.	-	-	No proposal was sent by this office for obtaining approval. However, estimates received from I&FC Dept. for up-gradation/ renovation work (Civil works); which are amounting to Rs. 18.39 lacs; have been submitted to DHS(HQ) for obtaining approval of the competent authority in Sep., 2012.
	Total	246.78	-	Rs. 88.00 lakhs	-	N.A.	-	-	-

Name of Distt.: CENTRAL

S. No.	Name of Health Center	Amount approved	Year in which approved	Amt. released to agency as advance responsible for work	Name of Agency- PWD/ I&FC	Amt. utilized by Agency	Probable % of work completion	Probable time required for completion of remaining work (mths/ yrs)	Remarks Bottle necks if any for delay in work
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	DGD Paharganj	5,61,000	End of sep. 2012	5,61,000	Funds are just released to the Health Centres				
2.	DGD Suiwalan	4,05,000	End of sep. 2012	4,05,000	Funds are just released to the Health Centres				
3.	DGD Nabi Karim	5,20,000	End of sep. 2012	5,20,000	Funds are just released to the Health Centres				
4.	DGD Gali Guliyan	3,80,000	End of sep. 2012	3,80,000	Funds are just released to the Health Centres				
5.	DGD Dujana House	3,89,000	End of sep. 2012	3,89,000	Funds are just released to the Health Centres				
	Total	22,55,000	-	22,55,000	-		-	-	-

FORMAT FOR GIVING DETAILS OF INFRASTRUCTURE WORK UNDER NRHM FUND

Name of Distt.: O/o CDMO WEST DISTRICT

S. No.	Name of Health Center	Amount approved	Year in which approved	Amt. released to agency as advance responsible for work	Name of Agency- PWD/ I&FC	Amt. utilized by Agency	Probable % of work completion	Probable time required for completion of remaining work (Months/ Yrs)	Remarks Bottle necks if any for delay in work
1	DGD Pashchim Vihar	20.31 Lac	2011-12	NIL	PWD (Civil) GNCT of Delhi	NIL	About 70%	1 month (Approx.)	DDO power is not available in PWD GNCT of Delhi
2	DGD Ranjeet Nagar, DGD Pashchim Vihar & DGD Pashchim Puri	4.24 Lac	2011-12	2 Lac	PWD (Electric) GNCT of Delhi	2 Lac	completed	NA	Balance payment will be released as soon as PWD Submits completion certificate
3	DGD Pashchim Vihar	1.02 Lac	2012-13	NIL	PWD (Civil) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
4	DGD Ranjeet Nagar	18.23 Lac	2012-13	NIL	PWD (Civil) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12
5	DGD Nangloi	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
6	DGD Chowkhandi	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
7	DGD Khyala	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
8	DGD Baljeet Nagar	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
9	DGD Tikri Kalan	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
10	DGD Janakpuri, C-4B	18.64 Lac	2012-13	NIL	PWD (Civil/elect.) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12 (A seprate Estimate of Rs. 3,02,600 was forwarded to DHS for civil works. This work has been undertaken by PWD by sanction provided by DHS).

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11	DGD New Ranjeet Nagar	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
12	DGD Raghubir Nagar	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
13	DGD Jwala Puri	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
14	DGD Prem Nagar	6.13 Lac	2012-13	NIL	PWD (Civil) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12.
15	DGD Tilak Vihar	11.13 Lac	2012-13	NIL	PWD (Civil) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12.
16	DGD Madipur	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
17	DGD Pashchim Vihar	1.02 Lac	2012-13	NIL	PWD (Electric) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12. for RO system
18	DGD Pashchim Puri	11.90 Lac	2012-13	NIL	PWD (Civil) GNCT of Delhi	NIL	N/A	N/A	Approval of fund received on 01/10/12.
19	M&CW, HASTSAL	1.50 Lac	2012-13	NIL	PWD GNCT of Delhi	NIL	N/A	N/A	Nature of works not communicated
20	Maternity Home, Subash Nagar	1 Lac	2012-13	NIL	PWD GNCT of Delhi	NIL	N/A	N/A	Nature of works not communicated
21	Maternity Home, Vishnu Garden	7.50 Lac	2012-13	NIL	PWD GNCT of Delhi	NIL	N/A	N/A	Nature of works not communicated
22	Maternity Home, Madipur	15 Lac	2012-13	NIL	PWD GNCT of Delhi	NIL	N/A	N/A	Nature of works not communicated
	Total	126.80 Lac		2 Lac		2 Lac			

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Name of Distt.: o/o CDMO (NED), Dt. of Health Services, Dilshad Garden, Delhi-95

S. No.	Name of Health Center	Amount approved	Year in which approved	Amt. released to agency as advance responsible for work	Name of Agency-PWD/I&FC	Amt. utilized by Agency	Probable % of work completion	Probable time required for completion of remaining work (mths/ yrs)	Remarks Bottle necks if any for delay in work
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	DGD Nanad Nagri Extension	Rs.263.79 Lacs	2011-12	Rs.80 Lacs @30% of released amount	I & FC	-	60%	3 months	
2.	DGD Gautampuri		2011-12		I & FC	-	40%	4 months	
3.	DGD New Seemapuri								
4.	DGD Yamuna Vihar								DGD Yamuna Vihar, the proposal for renovation of third floor withheld because of uncertainty regarding the strength of building w.r.t. disaster proneness.
	Total	Rs.263.79 Lacs	-	Rs.80 lacs	-		-	-	-

Name of Distt.: NORTH DISTRICT

S. No.	Name of Health Center	Amount approved	Year in which approved	Amt. released to agency as advance responsible for work	Name of Agency-PWD/I&FC	Amt. utilized by Agency	Probable % of work completion	Probable time required for completion of remaining work (mths/ yrs)	Remarks Bottle necks if any for delay in work
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	Hindu Rao Hospital - Out Born Nursery (SNCU)	Rs. 27,98,768/-	2010-11	Rs. 27,98,768/- vide Ch. No. 011544 dt. 17/3/11	MCD Commissioner	Rs. 13,38,015/-	60-70%	Till end of Nov'12	Delayed by implementing agency.
2.	DGD Sarai Rohilla	Rs. 4.50 lac	2011-12	Rs. 4,49,500/- vide Ch. No. 100136 dt. 24/2/12	Ex. Engg. PWD (Civil)	Repair work started on 27/9/12 and work is under process	Approx 10%	Till Dec'12 as informed by MOI/C, DGD Sarai Rohilla.	Delayed by implementing agency.

Name of Distt.: Integrated District Health Society-SOUTH DISTRICT

S. No.	Name of Health Center	Amount approved	Year in which approved	Amt. released to agency as advance responsible for work	Name of Agency-PWD/I&FC	Amt. utilized by Agency	Probable % of work completion	Probable time required for completion of remaining work (mths/ yrs)	Remarks Bottle necks if any for delay in work
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	DGD Dakshin Puri	2,67,500	2011-12	Executive Eng. M422 ,PWD via Ch. No. 539855 amounting Rs. 2,67,500	PWD , Malviya nagar	Report is awaited	Report is awaited	Report is awaited	

Name of Distt.: SOUTH WEST DISTRICT

S. No.	Name of Health Center	Amount approved (in lacs)	Year in which approved	Amt. released to agency as advance responsible for work	Name of Agency-PWD/I&FC	Amt. utilized by Agency	Probable % of work completion	Probable time required for completion of remaining work	Remarks Bottle necks if any for delay in work
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							(mths/ yrs)		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	DGHC Sec-2 Dwarka	16.50	2011-12	16.50	PWD		80 % complete		UC awaited
2.	DGHC Rawta	1.78	2011-12	1.78	PWD				UC awaited
3.	DGHC Pandwalan Kalan	16.25	2011-12	16.25	PWD		85 % complete		UC awaited
4.	DGHC Sadh Nagar (Mangla Puri)	9.25	2011-12	9.25	PWD				UC awaited
5.	DGHC Mahipal Pur	11.00	2011-12	11.00	PWD		10 % Complete		UC awaited
6.	DGHC Budh Nagar	10.00	2011-12	10.00	PWD				UC awaited
7.	RHTC Najfgarh	45.63	2011-12	45.63	Pending		Work complete		Payment in Sept'12 & UC awaited
8.	RHTC Najafgarh	16.00	2012-13	16.00	CPWD				UC awaited
9.	Shri Dada Dev Matri avum Shishu Hospital	20.00	2011-12	10,74,686 (4,52,000 for civil & 6, 22,686 for elect. Work)	PWD		80 % complete of civil work		UC awaited
10.	RTRM Hospital	45.00	2010-11	43,24,577	PWD		Work complete		UC awaited
	Total	191.41	-	1,80,40,263	-		-	-	-

FORMAT FOR GIVING DETAILS OF INFRASTRUCTURE WORK UNDER NRHM FUND

Name of Distt.: NORTH WEST

S. No.	Name of Health Center	Amount approved (estimate in Lacs)	Year in which approved	Amt. released to agency as advance responsible for work (in Rupees)	Name of Agency- PWD/ I&FC	Amt. utilized by Agency	Probable % of work completion	Probable time required for completion of remaining work (mths/ yrs)	Remarks Bottle necks if any for delay in work
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1	DGD Mukhmeilpur	1.50	2011-12	Not claimed, as yet,inspite of repeated reminder	PWD		Complete	----	
2	DGD Sector-13, Rohini	4.56		Rs. 113938/- + Rs. 170906/- = Rs. 284844/-		Complete	----		
3	DGD Sector-2, Rohini	22.28		Rs. 891200/-		70%	03 months		
4	DGD Model Town	1.22		Not claimed, as yet,inspite of repeated reminder		Complete	----		
5	DGD Wazirpur Ind. Area	9.37		Rs. 374800/- + Rs. 562200/- = Rs. 937000/-		80%	02 months		
6	DGD Wazirpur J.J.Colony	3.91		Rs.144400/-, Rs.216600/- =Rs.361000/-		Complete	----		
7	DGD Bhorgarh	1.31		Not claimed, as yet,inspite of repeated reminder		Complete	----		
8	DGD Model Town	13.27	2012-13	NIL	PWD	Yet to start			
9	DGD Bhalswa Dairy	27.84							
10	DGD Jahangirpuri B Blk	12.91							
11	DGD DSIDC Ind. Area Bawana	12.15							
12	Mty. Home Nithari (New proposal)	30.00	2011-12	Rs.8,00,000/- + Rs. 10,00,000/- = Rs.18,00,000/-	I&FC		30%	06 months	Repair of Mty.Home Nithari in MPCC building was started in 2011 under the fund received from NRHM. The work is in process.
13	Total	140.32	-						


Sign of Authority



**Sixth Common Review Mission (2nd - 9th November 2012)
National Rural Health Mission
Ministry of Health & Family Welfare, Government of India**