

6th Common Review Mission Report – Madhya Pradesh



November 2012

Contents

SI No.	Particulars	Page No.
1	Composition of Team and Facilities visited	
2	About NRHM Common Review Mission	
3	Background of Madhya Pradesh	
4	Report on thematic areas (ToRs)	
	I. Health Care Facilities: Access, Affordability, Quality	
	II. Outreach & Patient transport services-Sub-centers, 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	

1] Composition of Team and Facilities visited

Team Composition:

Gwalior Team	Hoshangabad Team
GOI Representatives	
Mr. Deep Shekhar, Director, MOHFW	Dr. Sila Deb, Deputy Commissioner, Child Health, MoHFW
Dr. Sher Singh, NVBDCP	Ms. Geetanjali Agrawal, Consultant, Adolescent Health, MoHFW
Dr. Anuradha Jain, Senior Consultant , National Health Systems Resource Centre (NHSRC)	Ms. Mona Gupta, Management Support Group, TMSA
Mr. Will Starbuck, The World Bank	Dr. Nimisha Goel, Consultant, Family Planning, MoHFW
Mr. Surojeet Chatterji, Population Foundation of India (PFI)	Dr. Dinesh Jagtap, Sr. Program Manager, Public Health Foundation of India (PHFI)
Mr. Sanjiv Rathore, FMG, MoHFW	Dr Rashmi Kukreja, DFID
Dr Navneet Ranjan, NHSRC	
State Representatives	
Dr. K.L Sahu, Director, Family Planning	Dr. P. N. S. Chauhan
Mr. Vishal, State Accounts Manager	

Places Visited:

Facilities	Gwalior	Hoshangabad
District Hospital	Morar Prasuti Grih	General Hospital Hoshangabad
Sub District Hospital	-	Itarsi
CHCs	Bhitarwar, Dabra, Mohna	Babai, Sukhtawa, Seoni Malwa, Panchmari, Pipariya
PHC	Chinnaur, Atari, Barai, Pichaur	Semari Harchand
Sub centre	Rahi, Simaritaka, Sukhapada, Chinnaur, Ghatigao	Ghana, Doomer, Kaisla, Paraswada, Matkuli, Pagara, Pathroudha
NRC	Mohana, Thatipur	Hoshangabad, Itarsi, Sukhtawa, Pipariya
SIHMC, RHFWTC	Gwalior	
DPMU	Gwalior	Hoshangabad
Drug warehouse	Regional Drug and Immunization warehouse, Gwalior	
Early Intervention Clinic		Hoshangabad
AWC	Rahi	Matkuli, Pagara
VHSC & VHND	Rahi, Ghatigaon	Amlakala, Ghana, Doomer, Matkuli, Pagara
ASHA Training	PHOTC, in front of Madhav Dispensary	
Community Interaction	Village & urban slums: Rahi, Simaritaka, Chinnaur, Ghatigaon	Paraswada Village
Urban Field Centre	Thatipur	
Civil Dispensary	Shabd Pratap Ashram	
Urban delivery Points	Harijan Basti Ausdhalaya	

2] About NRHM - Common Review Mission

Annual Common Review Mission is one of the important monitoring mechanisms under NRHM. Five Common Review Missions (CRMs) undertaken so far have provided valuable understanding of the strategies which were successful and those which warranted mid-course adjustments.

6th Common Review Mission (CRM) under National Rural Health Mission is scheduled to be held from 2nd November 2012 to 9th November 2012 in 15 States / UT namely Bihar, Chhattisgarh, Madhya Pradesh, Rajasthan, Orissa, Uttar Pradesh, Uttarakhand, Assam, Manipur, Tripura, Kerala, Punjab, Tamil Nadu, West Bengal, & Delhi. For the purpose of CRM, teams are constituted comprising Government Officials, Public Health Experts, Representatives of the Development Partners and Civil Society Organisations.

The teams are envisaged to visit the states (two districts) for a period of five days and conduct extensive field visits followed by detailed state level debriefings culminating in a final report which shall be submitted to the Govt of India. The teams shall document progress of NRHM broadly in the formats.

Objectives of 6th CRM

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.

Terms of Reference (TOR) of 6th CRM

Progress of NRHM will be 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-centers, 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

On each of the above the CRM team has noted progress towards the NRHM, assessment of gaps and possible remedial measures which will help State to improve. Thus a CRM team has included specific recommendations for every TOR, which are based on data and findings.

3] Background of Madhya Pradesh

Demography:

The state of Madhya Pradesh has a population of 7.26 crores (Census 2011). There are 50 districts in the state. The State has population density of 236 per sq. km. (as against the national average of 312). The decadal growth rate of state is 24.3% (against 24.54% for the country) and the population of the state continues to grow at a much faster rate than the national rate.

The Total Fertility Rate of the State is 3.1(AHS 2011). The Infant Mortality Rate is 62 (SRS 2010) and Maternal Mortality Ratio is 269 (SRS 2007-09) are higher than the national average (i.e.

212). The Sex Ratio in the State is 930 and child sex ratio is 912. Comparative figures of major health and demographic indicators are as follows:

Table 1: Demographic, Socio-economic and Health profile of Madhya Pradesh State as compared to India figures

Indicator	Madhya Pradesh	India
Total Population (In Crore) (Census 2011)	7.26	121.01
Decadal Growth (%) (Census 2011)	20.30	17.64
Crude Birth Rate (SRS 2010)	27.3	22.1
Crude Death Rate (SRS 2010)	8.3	7.2
Natural Growth Rate (SRS 2010)	18.9	14.9
Infant Mortality Rate (SRS 2010)	62	47
Maternal Mortality Rate (SRS 2007-09)	269	212
Total Fertility Rate (SRS 2010)	3.2	2.5
Sex Ratio (Census 2011)	930	940
Child Sex Ratio (Census 2011)	912	914
Schedule Caste population (in crore) (Census 2001)	0.91	16.6
Schedule Tribe population (in crore) (Census 2001)	1.22	8.43
Total Literacy Rate (%) (Census 2011)	70.63	74.04
Male Literacy Rate (%) (Census 2011)	80.53	82.14
Female Literacy Rate (%) (Census 2011)	60.02	65.46

Table 2: Health Infrastructure of Madhya Pradesh

Particulars	Required	In position	shortfall
Sub-centre	12314	8869	3445
Primary Health Centre	1977	1156	821
Community Health Centre	494	333	161
Health worker (Female)/ANM at Sub Centres & PHCs	10025	12516	*
Health Worker (Male) at Sub Centres	8869	3696	5173
Health Assistant (Female)/LHV at PHCs	1156	546	610
Health Assistant (Male) at PHCs	1156	140	1016
Doctor at PHCs	1156	814	342
Obstetricians & Gynaecologists at CHCs	333	73	260
Paediatricians at CHCs	333	67	266

Total specialists at CHCs	1332	227	1105
Radiographers at CHCs	333	191	142
Pharmacist at PHCs & CHCs	1489	331	1158
Laboratory Technicians at PHCs & CHCs	1489	606	883
Nursing Staff at PHCs & CHCs	3487	2467	1020

(Source: RHS Bulletin, March 2011, M/O Health & F.W., GOI)

Situation Analysis

Table 3. Health Indicators (State Vs District Visited)

Indicators	State		Gwalior	Hoshangabad
	AHS 2011	SRS	AHS 2011	AHS 2011
MMR	310	212	262	296
IMR	67	62	51	68
Neonatal Mortality	44	44	35	49
Post Neonatal Mortality	22		17	18
Under 5 mortality	89	82	69	80
Sex ratio at birth	904		807	918
Sex ratio 0-4 yrs	911		815	931
TFR	3.1	3.2	2.3	2.7

4] Report on thematic areas (ToRs)

I. Health Care Facilities: Access, Affordability, Quality

	Total Population	Urban	Rural
State	72597565	20059666	52537899
Gwalior	1629881	1242740	757803
Hoshangabad	1240975	389849	851126

	DH/SDH/CH	CHC	PHC	SHC
State¹	50+47CH	333	1156	8869
Gwalior	1DH+3CH	2	15	101
Hoshangabad	1DH+1CH	7	15	152

Nearly 60% of the state's population resides in rural area. In Gwalior 40% population is rural. Hoshangabad follows state trend

Table 4. Per capita institutional availability for all services

	Per Capita total population being served by facility DH/SDH/CH	Per Capita rural population served by facility CHC	Per Capita rural population served by facility PHC	Per Capita rural population served by facility SHC
State ¹	1/7.4lakhs	1/1.5 lakhs	1/.45 lakhs	1/.05 lakhs
Gwalior	1/4.0lakhs	1/3.7 lakhs	1/.50 lakhs	1/.7 lakhs
Hoshangabad	1/6.2lakhs	1/1.2 lakhs	1/.56 lakhs	1/.06 lakhs

Specialised health care services at public institution are available at 7.4 lakh population in the state. This would lower down if medical college and private sector are included .Still the range of services available in these tertiary care public hospital still remains a concerned as visible from Table 4. This data from various blocks of Gwalior is representative of low access to services, limited availability. Situation in Gwalior is better as compared to Hoshangabad .As far as non specialised services are concerned availability per capita of facility seems better in Hoshangabad but being tribal area the access ,healthcare delivery and range of services all remain a problem as observed by team in the field. DH Morar in Gwalior offers a wide range of

¹ Source: RHS Bulletin 2011

IPD services-Delivery-normal and C-Section, MTP, Trauma care all orthopedic surgeries, Major general Surgeries. Medical legal cases and postmortems performed in large numbers in block level facilities this is good in terms of service range but adds on extra work burden on staff

Range of Health Services

Table 5. Range of Health Services in District Gwalior

	Bhitarwar Block	Dabra Block	DH Gwalior	Ghatigaon Block	Gwalior Urban	Medical College	Morar Block	Pvt Hospital
OPD	22980	33568	42050	3874	123812	0	4526	0
IPD Admissions								
Male	57	408	223	0	354	0	198	0
Female	810	2519	431	976	1567	0	354	0
Operation								
Major			207		4			
Minor			380		592			
AYUSH	1972	0	2486	309	0	0	3174	0
Dental Procedure	0	0	992	0	2416			
Adolescent counselling service	256	46	1659	0	0	0	0	
Hb Test	1849	1851	4470	165	4481	0	965	0
Widal Test	0	0	654	0	33	0	0	0
VDRL	0	0	913	0	16	0	0	0

Source: District HMIS April 2012-Oct 2012

In Hoshangabad DH and SDH are providing good range of services and are performing well but all other facilities having limited range of services. Only 8.2% of the total people attending OPD were tested for Hb and 0.5% of the total OPD attendance is less than 7gm/dl of HB. This figure would rise if more people are screened .Since this is a malaria endemic area hence Hb testing holds a special relevance in the area to save mortality in pregnant and under 5 children (Details in table below)

Table: 6 Details of Diagnostic Tests performed at Hoshangabad District

Total Population	Total HB tested		Total HIV tested		Total VDRL Tested	Total Widal Test Conducted	Blood Smear Examined
1,240,975	41,414		13,804		4,061	1,688	125,796
Total OPD	HB test conducted as %age of OPD	HB<7gm as %age of HB tested	HIV test conducted as %age of OPD	HIV positive as %age of HIV tested	VDRL test conducted as %age of OPD	Widal test conducted as %age of OPD	Blood Smear Examined as % of Population
505,157	8.2%	5.9%	2.7%	0.4%	0.8%	0.33%	10.14%

Source: Lab Services - Apr'11 to Mar'12 HMIS

In Gwalior reasons reported for poor availability of lab service was non availability of lab reagents even though lab technicians were present almost in all facilities visited. The state has not even outsourced services.

Table 7. Availability of facilities for RCH Services

	FRU	24x7	SC
State	47DH+17CH+17 CHC ²	11 CH+240CHC+315 PHC	142
Gwalior	1DH+1Medical college	2 CH+2CHC+6 PHC	9
Hoshangabad	1DH+1CH	14 CHC+4PHC	1

Table 8. Per capita population availability of facilities for RCH Services

	FRU per capita total population	24x7 per capita rural population	Level I Delivery point per capita rural population
State	1/8.96 lakh	1/.91lakh	1/3.69lakh
Gwalior	1/8.14lakh	1/.75lakh	1/.84lakh
Hoshangabad	1/6.20lakh	1/.47lakh	1/8.51lakh

Table 9. Delivery load in the visited Districts

	Expected Delivery	Reported Delivery 2011-12	Institutional delivery	Caesarean Section
State	1813124	1487149	1280621	70302
Gwalior	38523	38235	36884	6178
Hoshangabad	28,486	24,536	23,022	3,748

² Source State CRM briefing presentation,

Expected C Section rate in state (15%) is 271968. The met need of the C Section in state is 25% of expected complications. C Section expected in Gwalior (15%) is 5778. Met need of C- Section is more than 100%. The DH Morar has 3 Gynaecologist who on an average perform 15 C-Section per month. It was observed that 60% of the totals C Section were performed by private sector.

C Section rates expected in Hoshangabad is 4272. Met need for C-Section is 87% and 67% of this met need is catered by private sector. In DH Hoshangabad 3 Gynaecologist perform nearly 105 C-Section per month and SDH Itarsi 1 Gynaecologist performs nearly 15 C-Section per month. Thus performance of existing staff in Hoshangabad is better.

Status of Blood Bank and Blood storage Units:

There are 49 blood banks are functional in the state, out of these 46 are in district hospital and 3 in civil hospital. 53 blood storage units are functioning at Cemonc level. Total 102 blood bank /BSU are functioning at Cemonc level. 10 BSU are proposed to be established at CHC level in 2012-13. In Gwalior DH Morar has a functional blood bank . Hoshangabad has two blood banks. The DH of Hoshangabad is well functional and on an average transfusing 140 units per month and SDH Itarsi is also providing transfusion to nearly 100 beneficiaries per month.

Table 10. Maternal Deaths & Causes-Apr'11 to Mar'12

Causes	State(782 deaths reported) % against total reported	Hoshangabad	Gwalior
Abortion	2.7%	8.3%	0.0%
Obstructed/prolonged labour	4.9%	0.0%	0.0%
Severe hypertension/fits	10.7%	0.0%	23.1%
Bleeding	26.5%	25.0%	15.4%
High Fever	6.4%	25.0%	0.0%
Other Causes	48.8%	41.7%	61.5%

Of the total reported mortalities 12 (HMIS 2011-12) in Hoshangabad 8% were due to abortion, 25% due to bleeding and another 25% were due to high fever. In Gwalior of the 13 (HMIS 2011-12) deaths reported 23% were due to hypertensive fit and 13% were due to bleeding the rest

were due to other causes. Thus both the mortality and severe anemia figures in Table 6 above points to the need of increasing the blood banks .The rising trauma figures in the district Gwalior also is an indication for rising need for more blood banks.

Signages and IEC Display

Display of IEC material and signages, citizen charters were found adequate and impressive in almost all the facilities visited in Gwalior and Hoshangabad. The Display of JSSK entitlement, Janani express phone numbers had been adequately displayed outside on walls of facilities up to PHC level in Gwalior.



Figure 1 CHC Bhitwar

Quality of Health Care Services

The Civil Hospital in Morar is undergoing a complete renovation and hence it is no more conducting any deliveries or providing any services .Thus complete load of IPD and OPD has been transferred to DH Morar. Thus, though it is a temporary problem but will still remain for a year or so till the construction gets completed .Thus, till then the quality in terms of overcrowding will be compromised. In other facilities visited there were leakages found in the roof of newly renovated PHC whenever the overhead tank is filled. As observed by the Gwalior team the construction and renovation work in facilities had not been prioritized as per the case load .At CHC Mohana-Huge infrastructure was unused. CH-Dabra 60 bedded sanctioned -28 exist (18 LR+10 general).32 beds have to be added for which construction completed but beds procurement process pending. They have attached MOs from PHCs and using them to run Dabra as 24x7. 30-40 MLC per day.OPD load 50000 per year, 5000 delivery load per year, no C-section conducted till day.

Issue of Manpower affecting quality of services-observations from Gwalior district

Manpower problem specially ANMs affecting quality .It was seen the proportion of ANMs posted against sanctioned is good but most of these ANMs are filling the vacancy created by absence of enough staff nurses in higher facility .Thus at PHC level and at Sub centres are not covered by ANMs this affects both outreach as well as puts extra pressure on ANMs as

observed in Picchor PHC-80 to 90 deliveries conducted per month. All delivered by one ANM .590 babies delivered in last 6 months. ANM had delivered 5 babies the night previous to team visited and was exhausted.

In CHC Dabra-7 sanctioned MOs 4 in position+1 training, they have attached MOs from PHCs and using them to run Dabra as 24x7.ANM nil in sanctioned and 7 in position, SN 21 sanctioned 5 in position, There was neither LHV sanctioned nor in position, Specialist 11 sanctioned -3 in position, Lab tech 1 sanctioned 3 in position, Ward boy 5 sanctioned and 8 in place

Biomedical Waste Management

In DH and Civil Hospital are exceptions and is performing very well in terms of biomedical waste management. Biomedical waste management remains a concern in most of the facilities visited- sharps spread around in open, soiled clothes and placenta are dumped in open pits. The officials in the district of Gwalior repeated confirmed that vehicle collects the waste as a part of systemic biomedical waste management but it was not confirmed during facility visit .The photograph below displays the same. The use of colored bins was not clear to the category IV workers.



Figure 2 :CHC Bhitwar

Supportive Services

Supportive services like electricity, water supply remains a problem at all delivery points visited. Either generators are not available or not functional or the outsourced agency or the worker running it has not been paid for it. PHC Garhi (deliveries conducted) -Generator out of order and new generator ordered was sent to some other PHC. Poor electricity supply and erratic. The District Hospital OT that was performing C-Section was using a CFL hanging from wires as the inverter could only support that in DH Morar, Gwalior. At PHC Picchor- Lab technician not able to work due to load shedding thus he works in Dabra. In PHC Picchor- there was a baby warmer, but no power to use it. The Water tank was in the field.

Availability of Equipment

The DH Morar, and all other facilities did not appear to be problem, not even consumables at facilities like BP instruments, thermometer. Buffer stocks of consumables was available at block CHC. The condemnation policy of the facilities is nonexistent.

Gender sensitivity

Female doctors and other staff complained that they do not have a rest room available for night duties and their security remains a concern right from DH to PHCs.

II]Out reach Services(VHND,MMU,EMRS)

Village Health and Nutrition Day:

There are 18247 VHND held against 18657 VHND planned in Hoshangabad. Similarly 15556 VHND held against 16124 planned in Gwalior.

Table 11. Status of Routine Immunization in state

	State	Hoshangabad	Gwalior
% achievement of BCG	94.2	98.8	95.8
%achievement of DPT3	66.6	72.6	72.7
Full immunization	54.9	65.9	60.5
BCGto DPT 3 dropout	1	8	15
DPT 3 to measles dropout	-3	-11	-3

Source AHS 2011

Children who have not received any vaccination in rural area is 5.1% in the state and it is 6.2% in Gwalior. In Hoshangabad it is 1.1%.

The main reasons ascertained by district for dropouts between BCG to DPT3 is a major vaccine stock out. This was informed to the team at the state and was confirmed at drug ware house and facilities in Gwalior.

The second reason for almost 10% drop in VHNDs planned and held is both shortage of ANM at peripheral level. More over there is on an average one sub centre at 7000 population. Thus she has to do almost 7 sessions in a month on an average. This leads to a gap and in planned and held session. In Gwalior of the 234 ANM only 40% are posted at sub centres as SN are in short supply and ANMs are substituting them. Thus a lot of sub centre remain unmanned. For example in block Barhi out of 15 SCs 7 have ANMs and 8 do not have. The story in Dabra is same.

The other problem is vaccine wastage that is because GOI supplies vaccine on individual numbers where as the vial wastage is high in small villages. If the micro planning would have been monitored properly this problem could have been solved.

There has been no supply of vaccine van for last 10 yrs. There has been no supply of vaccine carriers and cold boxes from GOI since 2004 as reported by state

Hoshangabad: SHCs inadequate as per population norms, old buildings need renovation / reconstruction. Efforts needed to mobilize children and track dropouts for immunisation. Door-step delivery of contraceptives being implemented dismally as ASHAs finding it difficult to do social marketing and ask for money.

Medical Mobile Units: There are 90 MMU sanctioned to the state as per ROP 2012-13.3 are running in 3 blocks namely Morar, Bhitwarwar and Dabra. The team in Gwalior visited one MMU in Block Dabra had following findings

MMU runs under PPP mode with 1 doctor, 1lab tech, 1 ANM, 1driver.MMU hired from Dr Jain video on wheels limited New Delhi-under contract from MP govt. In a month it had just13 destination -8 are sub centre. MMU was parked near a sub centre under the sun- Monthly road plan for district. Route Plan of MMU was designed by health officer. It saw9 patient that day. Male patient preferred MMU as it had a doctor. MMU carried 65 drugs-but did not have ACT. If patient requires referral they sent to Dabra or Gwalior. Medical waste is taken back to CH Dabra. It had Washbasin with water and water tank. The MMU is not going to C grade villages which are the most difficult as identified by polio program.

The data provided by district for each block over the months is quite steady 30-40 patients being examined per trip but then this can be so consistent if either there is a target fixed for MMU or same patients repeatedly come for treatment of chronic ailment. This is just a hypothesis of the team and needs more exploration.



Figure 2 At Block Dabra

In Hoshangabad the average time gap for visit to a village by MMU is two months as observed in Kesala block. Even the drug dispensed is for 5 days which may not be of much use in cases of chronic disease or those who need follow up.

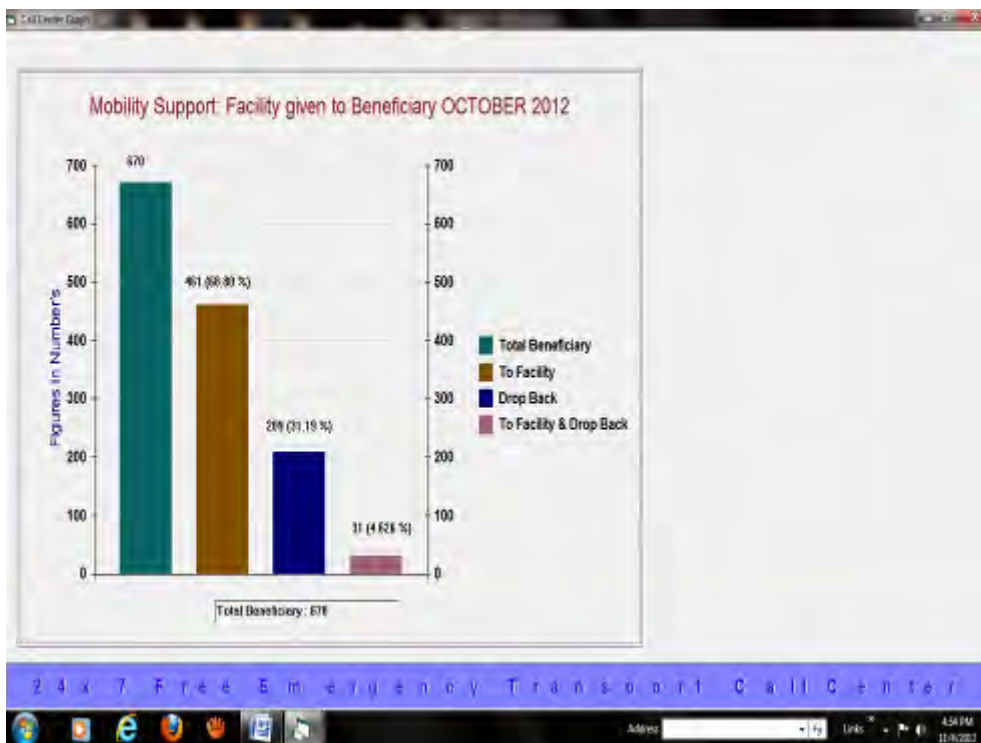
Referral Transport

The call centre for 108 and JE are separate. Community informed that most of them were being brought to facility by 108 as the Janani express call centres are always busy.

The drop backs were more than brought in patients due to same reason as above



Figure 3 Hoshangabad JE bringing pt in mid night



Ayush Services: 11 AYUSH doctors posted at CHC / PHC funded through NRHM. Medicines availability a problem as issued from Centre.

Urban Slums

Civil dispensaries (CD) are operating as OPD. There are a few Urban Field Health Centre (UFHC). However links between CD and UFHC like referrals.

Also there are several pockets in slums that may be low covered or uncovered as a systematic approach to coverage is required. A list of listed and unlisted slums will ensure determination of complete universe that is vulnerable and require services.

III] Human Resources for Health

With increased globalization and economic disparity even within states attracting and retaining human resource for health is remain a major challenge which requires a much responsive and dynamic human resource policy. In last seven years of NRHM, Madhya Pradesh has put major effort to add health workforce with applying various strategies which are increasing number of sanctioned posts, hiring contractual personnel, increasing salary and incentivizing personnel for working in hard to reach areas and high focus districts. Rational deployment was observed in visited districts which are moderately well to provide essential maternal and child health services. Approximately, additional 100 specialists, 400 medical officers, 1000 staff nurses, 4000 ANMs and 100 lab. technicians have been added in last seven years of NRHM. Uptake of services like institutional deliveries are increased from 30 percent (NFHS-2 2005-06) to 76 percent (AHS- 2011-12) however decrease in MMR shows minimal change in last seven years. In both Gwalior and Hoshangabad district, every attempt was made to complete the staff positions at 24x7 facilities to make it functional.

Increase in number & percentage of healthcare providers since the inception of NRHM – Regular and Contractual (baseline vs. current)

Table 12. Progress of HR in last 5 years

Cadre (Regular/ Contractual)	In-position 2005	In-position 2012
Specialists	71	2397
Doctors	203	2487
Staff Nurses	152	4403
ANMs	1443	10634
MPWs		5302
Lab Technicians	34	1265

Number of current sanctioned, in-position and vacancies for the various categories of healthcare providers

Table 13: current status of Human resources in the state

Cadre <i>(Regular/ Contractual)</i>	Sanctioned	In-position	Vacant
Gynecologist	572/33	373/11	22
Anesthetist	295/20	182/08	199/12
Pediatrician/ SNCU	465/85	425/74	42/11
Radiologists	90	94	-4
General Surgeon	508	225	283
Medicine Specialist	589	265	324
Orthopedics	150	257	-107
ENT	78	162	-84
Ophthalmologist	100	190	-90
General Doctors – MOs/ LMO	3790/366	2358/333	1432/33
Dental Surgeon	50 (I)+ 144 (II)	111	
Physiotherapist	0	5	
AYUSH Doctors/ Pharmacist	600/200	550/161	50/39
Staff Nurses	7803/974	4403/526	3400/448
ANMs	10651/4103	10634/4102	17/01
MPWs	7731	5302	2429
Lab Technicians	1430/104	1265/102	165/02
X-ray technician/ Radiographer	677	513	164

Table 14. Numbers posted in 24x7 PHCs and CHCs (FRUs)

Cadre <i>(Regular/ Contractual)</i>	In-position 2012 (NRHM contractual)
Doctors – MOs	333
Staff Nurses	526
ANMs	4102
MPWs	5302
Lab Technicians	1265

Area of Improvements

- The DH Gwalior has 4 gynecologist and on an average performing 10-15 C-Section per month.
- 2CH and 1 CHC cannot be made functional as FRU for want of a gynecologist, and gynecologist in one of the blocks is posted in PHC.

- The LSAS trained doctor at Bhitwar was not confident in giving anesthesia and is requesting for a 15 days refresher as probably not using his skills.
- Contractual ANMs not being provided pay for last 6 months as observed in PHC Barai and Sector sub centre
- The contract of staff has not been renewed after the first appointments.
- No systems of appraisal or increment of the contractual staff.
- The biometric system of attendance is actually becoming problem for field level staff and is also leading to delayed payments of staff salary.
- The permanent sanctioned staff is demotivated due to poor HRH management in terms of nonexistent transfer policy and promotion policy.
- There is a lot of disparity between sanctioned staff and staff in position. Many a time sanctioned staff is not clear. Staffs from other units are attached. Legalities of suspended staff cases continue endlessly.
- Some staff work for twenty four or even more than that continuously. They are not given any help, no facilities. But they continue to function.

Hoshangabad

Hoshangabad district is one of the better performing districts in terms of development and also near to (80 km) Bhopal well connected by road and railways but the manpower is not adequate in numbers. In spite of many efforts since last seven years to fill up the vacant positions it is not fulfilling the need of the district. Discussion with staff working at various facilities revealed many reasons which are common to both regular and contractual but more grievances found from contractual employees. Also, attrition rate is much higher in contractual personnel as compare to other states.

In Hoshangabad district, deployment of available human resource has been done to deliver maternal and child health services but other services are not yet focused. Objectively rational deployment has been done to sustain the delivery points but hilly and forest areas are found scarcity of human resource in all cadre. More than one block is hilly and tribal area which is one of the tiger reserves of the country and this area suffering to deliver services at both facility-based and outreach level. In this area Pachmarhi CHC is located but none of the doctor is in place and fixed day basis a doctor from other facility is visiting. This area has again deprived with required infrastructure due to restriction by forest department for constructing any building. In SDH Itarsi, there are 15 doctors are in place against

Contractual employees are demotivated due to less salary packages without any benefits and compare to other states salary of DPMU is considerably less. Also, there is no structured process of performance appraisal in place for contractual staff under NRHM due to this job responsibilities are poorly understood by both employee and supervisor/ reporting officer.

Performance based incentive in high focus districts is a good strategy but not yet implemented/ regularized to retain human resource but also needs to be assessed for its effectiveness to attract human resource. In Pachmarhi CHC and other facilities in this area are having very less number of staff.

Due less salary, attrition of contractual staff is higher and they are getting absorbed within the state with other donor agencies which are providing technical assistance to the state. In effect, to maintain salary parity with NRHM staffs lesser salary packages are being offered by donor partners also which sequentially affects the quality of experienced professional inputs.

Recommendations:

After generating evidences from the field and real time data analysis, CRM team has come up with several recommendations which are useful for the state. According to the state specific context and health status, the policy makers are suggested to prioritize and formulate the action plan.

- HR policy for employees of all cadre both regular and contractual need to be developed or revised which may be mentioned clearly about salary revision and performance review mechanism along with career trajectory for the medicos and paramedics. This policy will help State to engage their staff for longer term and motivate staff to perform towards their career goal.
- State needs to establish a Human Resource Cell for keeping all the records and made responsible for reviewing performance and timely response to fulfil the need of employee with due emphasis on contractual employees in the districts and public health professionals.
- Since the previous strategies are not effective to attract and retain human resource, before deciding financially and non-financial packages it desired to generate evidences by studying market forces to close the HR gaps in the state.
- To retain trained contractual employees under NRHM, it urgently required to increase the salary packages and other benefits.
- A medium term plan is required to create health infrastructure and emphasis should be given to ensure residential facilities for all the staff members. Leave policy is to be revisited for contractual staff

- Adequate number of ancillary staff to be ensured to improve hospital amenities and cleanliness.
- To retain continuous professional development program for contractual staff may be laid down.
- There is need to create team for monitoring and mentoring staff and also it needs to train the team on each program and documentation and follow-up of each monitoring visits which may be made available on the website to assess the process of monitoring and progress at district & state level.

IV. Reproductive and Child Health Program

MATERNAL HEALTH

Declining trend in Maternal Mortality Rates, Slower rates though!

- The last decrease was of 25 points, much lower than the penultimate decrease of 44 points whereas the national decrease every year is around 42 to 47 points. As per recent AHS data stark differences among districts is observed Hoshngabad has a MMR of 296 whereas Gwalior has 262

MMR	2001-03	2004-06	2007-09
	379	335	269

Rising trend of 3 ANC check up

- Madhya Pradesh shows 3 or more Antenatal coverage of 68.1% as per AHS, whereas it was 60 % in 2009 (CES) 34.2 % in 2007-08. There is high inter district variations Hoshngabad though a high focus district has 92.4 % rates of 3 or more ANC coverage whereas Gwalior has only 60.5%

Very low coverage of full ANC check-up. Quality of Check-up & follow up remains poor in High as well Non high focus districts. BP, HB being done, low rates of ultra sound

- Madhya Pradesh has only 13% mothers with full ANC check-up, Urban has double the number than the Rural population (10.9%). Only 50% coverage by the Government facility
- Both Hoshngabad (17.5%) & Gwalior (15.6%) have lower full ANC check-up around 50 % were taken in Government facilities and more than 75% mothers had got BP checked in both the districts hence there is no substantial differentiation in follow up of better performing and high focus district

- 30.7% had an ultrasound in the state. Gwalior had 57.3% whereas, Hoshngabad has only 39.1%

Observations:

- ANC services were noted in all SHC visits and VHND. All ANMs were doing Hb testing, urine test and BP. At Pethrota, it was seen that HB testing strips were used which were not giving accurate readings. At VHND Amlada kala, the ANM found urine albumin positive but did not take action. On probing she said that BP was normal and there was no pedal edema.

Rising trend of Institutional deliveries, But few (27.2%) stay for 24 hours

- Delivery points Madhya Pradesh: There are 151 L3, 566 L2 and 142 facilities are L1.
- 76.1 percent deliveries take place at institutions in Madhya Pradesh with urban deviation by 18 percent.
- Gwalior and Hoshangabad have more than 85 percent institutional deliveries rates. Though ghjigher rates in urban areas.
- Both Gwalior and Hoshangabad are among few districts with higher rates of private deliveries. Gwalior- 29.5 percent; Hoshangabad- 15.9 percent deliveries take place in Private facilities.
- Higher rates of Birth weight observation in Hoshngabad (88.10%) & Gwalior (79.8%)
- Only 5.5% stay in facilities up to 24 hours in Hoshngabad whereas 34% in Gwalior. Hoshngabad has one of the lowest PNC stay rates
- 23.5% home delivery in Madhya Pradesh, 9% Gwalior, 13% Hoshngabad



Diet being distributed to JSSK beneficiarv at Gwalior

Observations:

- MP has shown remarkable progress in scaling up institutional deliveries over the last 5 years of NRHM. Hospitals providing delivery services have increased from about 335 in 2006 to about 859 at present. **However corresponding reductions in MMR are not observed.** This is mainly because of non-uniform geographic distribution of HR, infrastructure, logistics and quality of services
- While there are four L3, 14 L2 and five L1 delivery points, about two L3, ten L2 are functional as per GOI criteria. The geographic distribution is also not uniform and there is concentration of MCH services in the northern part of the district. Both the DH and

the Civil hospitals are situated closely within 16 Km. There are 2 pockets of the districts the south east and south west which have minimal MCH facilities and travel of more than 2 hours is needed to reach the nearest Cemonc. Therefore it is suggested that CHC Pipariya and CHC Seoni Malwa should be very quickly operationalized for Cemonc services.

- Facility wise HR gap analysis is done in a detailed manner and it is highly appreciated. A systematic mapping of delivery points and rigorous analysis of functionality on all the parameters of HR, LR, NBCC, BMW, and blood availability is being done. The performance of the delivery points on normal deliveries, LSCS, Severe anemia, MDR is also included in the monthly analysis. The list of delivery points is as per Gol criteria.
- Apart from shortage of MOs, specialists, and nurses there is a shortage of support staff like Ayahs, sweepers, clerks, accountants and pharmacists in several facilities visited like Itarsi CH, CHC Babai. AT SHC L1 there was a need for a security staff/watchman for the ANM's security.
- Most of the nurses (about 80%) in all hospitals were SBA trained but not all. A few were trained 3-4 years back (CHC Sukhtawa) and there was a need for refresher. The CRM team did not meet any Bemonc trained MOs.
- In L1 facilities of SHC Kaisla and SHC Ghana, the ANM was conducting deliveries 24/7 but not following the protocols properly. She was giving oxytocin for labor augmentation, but not for AMTSL. It was also observed that the Dai was conducting the deliveries frequently (Kaisla).
- In most hospitals and L1 SHC we found charts with clinical protocols for PPH, AMTSL and Eclampsia and also breast feeding.
- Few designated facilities visited are not conforming with the service deliveries to be provided e.g. PHC Semari Harchand and CHC- Panchmari are designated as L2 facility but the services confined to conducting normal deliveries only.

Low C section rates , 1/3rd in private

- 3.8 % C section rate in Madhya Pradesh with more than 10% rate in Bhopal, Indore, and Jabalpur. Substantially high private coverage Balghat, Damoh, Dindori, Tikamgarh may hint towards lower capacity of public system in these districts.
- Low C section rates in Hoshngabad (2.6%), though higher ANC coverage. Around 1/3rd take place in private facility in Madhya Pradesh, Gwalior & hoshngabad also whereas Gwalior has C section rate of 6.9 %

Observations:

- Against a target of 120 L3 delivery points, it is noted that 89 have all 3 specialist present. 6 require only Gynecologist; 8 require only Anesthetist; and 10 require only pediatrician. Out of 750 identified L2 delivery points, 257 are with 2 or more MOs, 224 are with 1 MO. Out of the 250 planned L1 delivery points only 16 have 2 ANMs, 81 have one ANM and 33 are without ANMs.
- During July 2012, A GO was issued for redeployment of ANMs and MOs and specialists to delivery points as per load. Districts are not allowed for new contractual appointments unless existing staff are rationally posted. As per the GO 31 MOs were redeployed and promoted and about 2700 ANMs were redeployed to improve functionality of high load delivery points.
- Financial incentives (ranging from 9000 to 15000) for specialists and MOs is agreed by the state govt for posting in remote areas. The incentive for nurses is also approved up to Rs 5000.
- To improve quality of services and supervision, there is a structured plan for a team of mentors to visit high focus districts and high load delivery points every quarter with a checklist.

Higher PNC Coverage

- PNC coverage rate 74.2% in Madhya Pradesh for the first home visit & 76.6% within 1 week

JSY- issue of cheques in tribal women

- As per AHS 61.1% avail JSY in MP almost similar in all districts

Observations:

- JSY payment system was significantly streamlined. A/C payee cheques were given to the mothers in the hospital itself. None of the mothers interviewed had a bank account and they all said that they will open bank accounts.
- JSY payments are through account payee cheques , beneficiaries do not have accounts .Opening an account would mean Rs 1000 to be deposited and a lot of papers to be submitted which does not materializes .Thus most tribal women leave cheques behind and number of home deliveries are rising.

4% Abortion rates in MP at 3.1 month, without much inter district variations

- Around 50% performed by skilled health personnel & 44% takes place at institution lower rates of safe abortion at Hoshngabad (41.1%) higher in Gwalior (83.4%)

Observations:

- MTP First trimester services available in all facilities visited (PHC, CHC) and comprehensive abortion care in DH
- All the CHCs and DH and CH Itarsi were providing MTP facilities and MOs were trained on MVA and medical abortion (but the number of MTPs done is small). PHC Semriharchand was not providing MTP facility. It was clear that there was large awareness about medical abortion in the population and woman demanded medical abortion. Woman also took pills from the chemist shops frequently without doctor's advice. The MOs and specialist mentioned that there is a significant reduction of perforation and sepsis cases after the introduction medical abortion in the market. They frequently saw incomplete abortion or irregular bleeding with medical abortion and they managed it easily with MVA.

Emergency Obstetric Care

Observations:

- In CHC Babai, CHC Sukhtawa and CHC Seoni Malwa obstetric complications were being managed well and the MOs described examples of managing PPH and Eclampsia. They were reasonably confident of doses of mag sulph and stabilisation procedure of maintaining airways, IV line and catheter. Records were well maintained about the referrals. Nurses were not able to describe PPH management very well and few were not very confident about AMTSL. Partograph was being maintained for all labour patients.
- There was one instance of a woman (with severe PIH and Breach) referred to DH at night from CH Itarsi (a fully functional Cemonc) with a note from the anaesthetist saying that GA cannot be administered. The DH team gave her spinal and did the CS. It was very much possible to give spinal at Itarsi itself and prevent referral of the patient!!
- The supplies of medicines at the labour room, SHC and VHND were good. The labour rooms were well equipped with bathrooms, wash basins; colour coded waste segregations and overall cleans. In some places privacy was not too good.
- Out of four L3 facilities, only District hospital Hosangabad providing full range of services. There is need to strengthen the remaining facilities to provide L3 services e.g. at Piparia/ Seoni Malwa CHC BSU and Gynecologist is required.

Blood Bank

- Blood Banks were functional at 2 hospitals (DH and CH Itarsi). At CH Itarsi the post of blood transfusion officer was vacant and a technician was managing. The collection was being done by both voluntary camps and replacement by relatives. There were about 120 to 170 collections per month and enough units stored at a time (45 in Itarsi and 72 in DH) of all the blood groups. Components were not available. The testing for HIV, HepB and Hep C was being done.

JSSK & Referral Transport

- Janani express was fully functional with 14 vehicles and three 108 vehicles. Data showed that about 70% of labour patients used JE vehicle. The call centre got 1700 calls per month and monitors the vehicles through GPS also. The call center responded fast to the test calls. There was an instance where the JE driver took Rs 100 from the pregnant woman.
- Mothers were getting free services, diet, transport and drugs. However JSSK package of services were not prominently displayed in many hospitals like the DH, Itarsi CH, CHC Seoni Malwa. There was a problem of drop back facilities because the timing was fixed at 12 to 3 pm only.

Maternal Death Review

- Maternal death review is a weak area. The big problems are that community reporting is almost non-existent in Hoshangabad. The ASHAs and the ANM are not fully aware of the criteria of reporting all woman deaths in the age of 15 -49. The facility reporting is good. The DH staff mentioned that they do monthly review of maternal deaths and ask the block officials to do the community based review. However no such mechanism could be elicited at the block levels.

AREAS FOR IMPROVEMENT: MATERNAL HEALTH

- Compliance to the GO for Redeployment of specialists and MOs has to be ensured. Perhaps there is a need to significantly increase the financial incentives to amounts which are sufficiently attractive as per the market situation.
- Refresher SBA trainings and Bemonc trainings to be fast tracked.

- Mentoring support and QAC visits to high load facilities should start this year and a feedback loop established. All the issues pointed out in comments 5, 6 and 7 can be handled well with mentoring and supportive supervisions and stronger performance monitoring.
- Facility based performance monitoring should be linked up with financial incentives for doctors and nurses.
- The Janani express call centre should call back a random sample of 4-5 clients/ASHA to check about informal payment demands from the driver. The call centre can also use these call to check back about PNC and immunization services.
- Training of ASHA and ANMs on MDR should be started and reporting of maternal deaths should initiate.

Case study from Bemonc CHC Seoni Malwa 29th July 2012

There were massive floods all over the block. Village Bundara kala was flooded and a pregnant woman Priya w/o Jittu was hanging on the roof of the house for many hours. She went into labour and the ASHA called the Janani Express vehicle. The JE was not able to reach and cross the broken bridges and flooded villages. The BMO himself went on the 108 vehicle and could not reach the village. Then they took a boat and with great difficulty and got Priya on the ambulance. Her BP was 180/110, she was having Eclamptic convulsions and in labour. She was taken to the CHC, given magsulph, oxygen, IV fluids and antibiotics. The convulsions were controlled, the baby delivered with meconium aspiration. The mother and the baby were stabilised and sent to Hoshangabad DH for SNCU management.

Dr Kanti Batham, a surgeon is managing the EMOC and NBSU services with support of the BMO Dr Verma. CHC Seoni Malwas should be urgently prioritised for providing Bemonc services because it has a large catchment area of hard to reach underserved population.

Innovation: Human Milk Bank, District Hospital, Hoshangabad

Human Milk Bank has been established in District Hospital Hoshangabad. A great effort out of the way towards building the District Hospital as a Baby Friendly Hospital. The SNCU babies benefit from this facility. The mothers who are unable to feed to their preterm or sick neonates after delivery are benefited by the pasteurised human milk received from mothers who has sufficient breast milk. This milk is only for the sick and preterm neonates

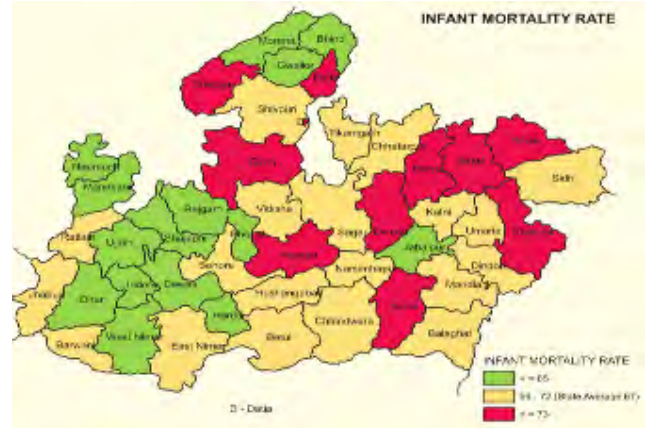
Declining Mortality Rates with very high urban- rural differentials, much concentration in high focus districts.

Declining Child Mortality including NRM and E-NMR in Madhya Pradesh

	2007	2008	2009	2010	2011	AHS 2010	INDIA 2010	Remarks
E-NMR		38	37	34	-		25	<i>Declining trend</i>
NMR	49	48	47	44	-	44	33	
IMR	72	70	67	62	59	67	47	
U5MR		92	89	82	-	89	59	

- Live births per year: 22.22 lakhs
- Under five populations: 1.13 crores
- Around 9% of country births take place in M.P

- Very High Rural Urban Differentials in child mortality.
- Whereas Rural IMR is 67, Urban IMR is 42. Similarly, Rural U5MR is 88 and urban is 54.
- Poor childhood mortality indicators observed in for High focus districts.
- Inter district variation in Child mortality.
- Worst five districts with very high Child mortality are:
 - NMR: Panna(66), Satna(63), Damoh(61), Sagar(58), Raisen(54)
 - IMR: Panna(93), Satna(90), Damoh (80), Guna(79), Raisen(78)
 - U5MR: Panna(140), Satna(130), Sidhi(118), Damoh(117), Umariya(110)



Progress in establishing SNCUs & NBCCs, lag in High focus districts, and poor progress in NBSUs

- The State has planned for SNCUs and is progressing in the direction. However, all high focus districts not saturated with SNCUs. Only 23 out of 40 high focus districts have SNCUs. The State has 12 bedded SNCUs with 55.3 percent inborn admission rates. Newborn care corners to be established in high focus districts. The State requires to undertake focussed efforts towards saturation of all delivery points with NBCCs

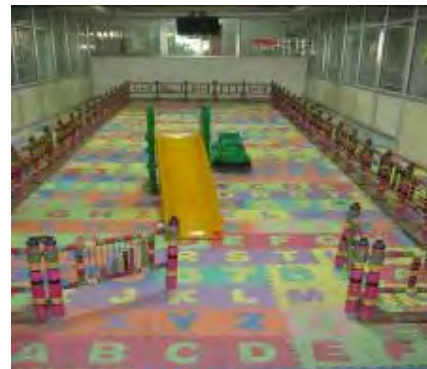


Figure 3. Early intervention clinic at Hoshangabad

Observations:

- SNCU at Hoshangabad is well functional with innovations such as Milk Bank. NBSU also functional at CHC-Bhitarwar which is farthest from district headquarters
- Baby warmers in NBCC are not being used due to electricity issues.
- SNCUs are very efficient – DH at Hosangabad-with innovative initiatives (e.g. Breast Milk Bank).
- Early intervention clinic at District Hospital is another innovation
- Hosangabad DH was accredited as BFHI hospital but the hospital staff was not aware about BHFH criteria.

NRCs planned and established. Outcome and quality of treatment requires monitoring

- The State has NRCs in all high focus districts. There are districts which have more than 4 NRCs and all districts have at least one NRC. Manpower is appropriately deputed at these facilities. However saturation of trainings is required for qualitative outcomes. Only 69 percent Staff Nurses are trained and 79% of Medical officers. Bed occupancy is around 50-60 percent.

Observations:

- NRCs well functional in 2 blocks out of 4 with 100% occupancy in Hoshangabad
- NRCs are releasing children without adequate nutritional rehabilitation as they are bound by day norm and not by improving status of nutrition. NRC is functioning and referrals are received from ICDS. NRC is adhering to NRC functional norms and Follow Up is being completed. There are few cases where they return for NRC services again mainly due to disease contracted from infection. Analysis of growth rate based on age groupings and exit and entry weight is required to give a better understanding of cases that are admitted for rehabilitation.
- Large stocks of F-100 were found to be stocked in the rooms of Cold chain Warehouse is occupying space. It is not clear whether they are being used and if not used then does state have any plans to dispose it of
- The non respondents are very high and when some children with disease are referred to higher centre like DH for treatment they are not continued with the NRC diet regimen(Gwalior)
- No cooking demos being provided to mothers in all places

Improving institutional births and 48hr stay, but lower early breastfeeding rates

- The State Institutional delivery has increased from 46.9% in 2007-09 (DLHS 3) to 76.1% in 2010 (AHS) and 73.1 percent mothers and children get post natal checkup within 24 hours of birth as against 39.4 percent in 2007-09. 65.5 percent deliveries take place at Government Institutions in Madhya Pradesh. High inter-district variations.
- But only 61.5 percent are breastfed within first hour which though has increased over DLHS 3 (42.7 percent) in Madhya Pradesh

Low breastfeeding rates

- 60 percent of children were breastfed with in 1 hour in Gwalior with higher rates in rural areas whereas 78.4% children in Hoshngabad with surprisingly higher rates in urban areas by 5%.
- Both the districts have low rates of exclusively breastfeed children up to 6 months.
- Hoshngabad complementary feeding practices before six months is substantially high in Hoshngabad with more than 60 %children being given water and animal formula

milk. Whereas in Gwalior very high rates of use of animal or formula milk observed before six months, chiefly due to its urban nature.

Poor progress on Childcare Outreach- low Vitamin A, IFA coverage, breastfeeding rates.

- State Vitamin A supplementation is 54.5%, that has increased from 2007-09 when it was only 41.1 percent.
- State IFA coverage is 24.8 percent and 22 districts rate poorer than State average with worse five being, Tikamgarh (12), Sagar (12), Damoh (12), Barwani (13), Bhind (14)
- Hoshangabad has 66 percent Vitamin A coverage, with no rural and urban differentials. 34.9 percent coverage of IFA.
- It is surprising to see very low vitamin coverage rate in Gwalior which is 50.8%.
- 28.6 percent of these newborns are underweight at birth (AHS 2010) for the State. 25 districts have lower early breastfeeding rates than state average, with worse five being Neemuch (37), Ratlam(41), Sagar(43), Mandsaur(45), Dhar(45)

Observations:

- The State has taken initiative of a treatment Strategy for Anemia. 14 districts have been selected where hemoglobin estimation would be undertaken.
- Six baby friendly hospitals have been accredited Baby friendly hospitals.

But better in ORS and ARI care seeking.

- ORS/ORT/HAF use in diarrhea has improved significantly from 30 percent in 2007-09 to 85 percent as reported in AHS 2010. However, 20 districts have poorer rates than State average with worse five being Ujjain(56), Sagar(69), Ratlam(70), Sheopur(71), East Nimar(72)
- Similarly, care seeking for ARI has increased from 68.4 percent to 92.3 per cent. However, 13 districts have poorer rates than State average with worst five being Dindori(73), Madla(84), Seoni(86), Gwalior(87), Datia(89)
- Diarrhea prevalence is higher in Gwalior (18.5%) than Hoshngabad (12.4%). However care seeking is almost equal
- ARI prevalence & care seeking go hand in hand in Hoshngabad where both of these phenomenon are higher

High burden of Malnutrition- Interventions in place, quality requires impetus

- 82.3 % of children (under 5 years) of age with anaemia (NFHS 3)
- 60 % of children (under 5 years) who are underweight (NFHS 3)
- 12.6 % of children (under 5 years) who are severely wasted /SAM (< -3SD) (NFHS 3)
- 48.2 % Children age 6 months and above exclusively breastfed (CES 2009)

JSSK –implemented well in Maternal component, neonatal component requires impetus

Madhya Pradesh has incurred expenditure on maternal health but no expenditure is booked under JSSK in the first quarter 2012-13.

Observations:

JSSK being implemented with provision of free drugs, vehicle, diagnostics, however neonatal component requires planning and implementation.

Family Planning

- The Lap ligation services are also getting affected by Rs 600 account payee cheque payments as informed by field level providers.

FAMILY PLANNING

Madhya Pradesh has 4th highest TFR among the 9. State has shown second best CPR for any modern methods (57%) in AHS 2010-11; however, sterilisation is major contributor (47.6%). Total Unmet Need is 22.4% which is again second best after Rajasthan; however, it's still very high. Women between 15- 19 years who were already mothers or pregnant at the time of survey are 46.4%, Women reporting birth of order 3 & above is 37.4% and Live Births taking place after an interval of 36 months is 37.3%.

Table 15. Family Planning Indicators

State / District	TFR	CPR for Any Modern Method (%)	Total Unmet need (%)
Madhya Pradesh	3.1	57.0	22.4
Gwalior	2.3	54.2	16.2
Hoshangabad	2.7	66.9	18.9

TFR – decreasing trend

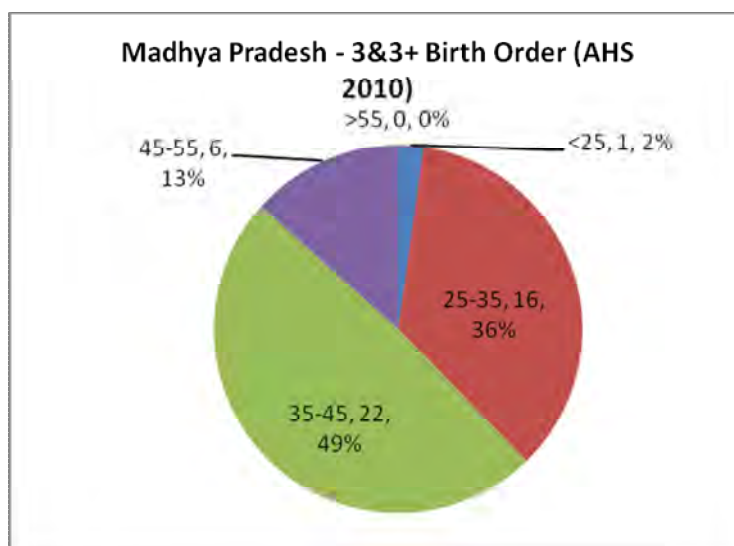
- TFR of the state has shown a decline from 3.3 in 2009 to 3.2 in 2010 (AHS).
- Among 45 districts, Shivpurih as the highest TFR (4.5) and Indore and Bhopal the lowest (2.2). Among the 284 districts only 10 districts are higher than Shivpuri (4.5); this reflects that although MP has relatively low TFR, inter-district variations are very high and there are very poor performing districts.

Couple Protection Rate (CPR) for Any Modern Methods-only marginal increase

- CPR for any modern methods is 57% out of which 47.6% is contributed by sterilization only (AHS 2010), has improved very marginally over DLHS-3 2007-08 (54.8%)
- State has reported good CPR by modern methods and majority of the districts (28) 62% are having CPR for any modern methods between 45-60%
- There are 16 districts (36%) with CPR higher than 60% which is very encouraging. However, as mentioned earlier the major contributor is female sterilization. Further, all the districts have CPR above 30%.

Unmet need for family planning: Increased over 2007-08

Total Unmet Need is 22.4% as per AHS 2010 that has shown increase over DLHS III (2007-08) when it was 18.2 percent. None of the districts of Madhya Pradesh have unmet need more than 35%, which is relatively better among the districts of 9 states; however, there is only one district with unmet need less than 15% (Jabalpur-14.3%). Majority of districts (67%) have reported unmet need less than 25% and with little effort unmet need in these districts may be reduced below 15%. State needs to focus on other FP methods as well and not just sterilisation.



Higher rates of Permanent methods over temporary, laparoscopic; declining IUD performance

- Method wise performance (2011-12):
- State is highly dependent on laparoscopic sterilization (74.83%)

- Percentage of male sterilizations out of total sterilizations has dipped from 2.4% to 1.3%
 - Proportion of Post Partum Sterilization is very low (5.31%), although it has shown a slight improvement in the first 6 months of current financial year to become 16.4% out of total female sterilizations (up from 14%)
- Usage of IUCD is as low as 0.5% in the state and it is one of the reasons for low spacing between live births. All districts except Bhopal (1.5%), Indore (1.2%) and Rewa (1.1%) have reported less than 1% IUCD usage.

Table 16. Method wise performance

Method	2005 -06	2006 -07	2007 -08	2008 -09	2009 -10	2010 -11	2011 -12
Sterilization	3.67	3.68	4.52	4.41	4.35	6.44	5.95
IUD Insertions	4.53	4.62	5.01	4.95	4.11	3.65	2.96

- Sterilization performance has improved significantly (from 3.67 lakhs in 2005-06 to 6.44 lakhs in 2010-11); for 2011-12 it has marginally declined to 5.95 lakhs.
- There is a consistent decline reported in IUD performance (from 4.53 lakhs in 2005-06 to 2.96 lakhs in 2011-12). It has also been shown in AHS 2010 that increase in CPR for nay modern methods is primarily on account of increased sterilization services and not the IUCD.
- Data reported in HMIS shows huge seasonal variation for sterilization performance (86.21% sterilization conducted in last 2 quarters). Further, in 2011-12 the proportion of sterilization in first two quarters has declined to 13.79% from an already low proportion of 17.78% in 2010-11 for the same period.

Table 17. Proportion (%) of Minilap, PPS, Laparoscopic sterilizations and NSVs:

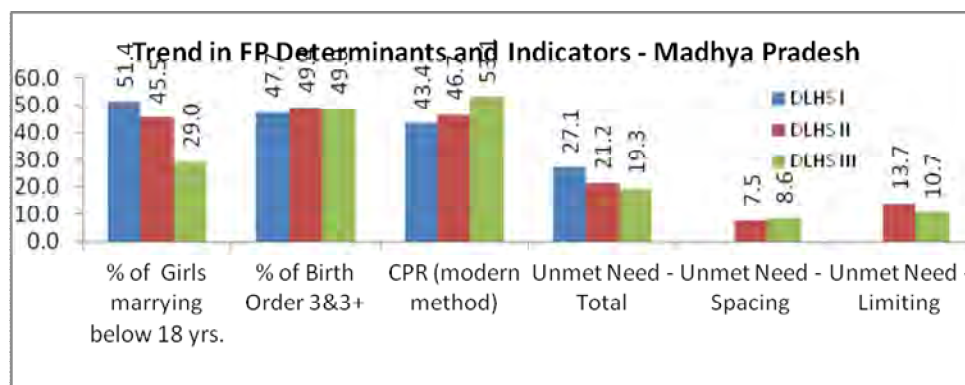
Minilap		PPS		Laparoscopic Sterilisation		NSV	
2010-11	2011-12	2010-11	2011-12	2010-11	2011-12	2010-11	2011-12
11.28	11.95	5.88	5.31	76.22	74.83	6.63	7.92

- Although there is a decline, state is highly dependent on laparoscopic sterilization services (74.83%)
- Proportion of PPS is very low (5.31%) and has further decline.
- There has been a marginal improvement in male sterilization (from 6.63% to 7.92%)

- Scheme is being piloted in 34 out of the 50 districts in the State.
- The Scheme had taken off well in the State;
- Utilization reports have been received from all districts for Quarter, April-June, 2012.
- ASHAs have reported selling condoms in selected districts; though a proportion of ASHAs still reports that they find it difficult to sell the contraceptives. However, they agreed that this scheme helps them find an avenue to strike a conversation with the eligible couples.

Provisional data of Census-2011:

- State's decadal growth rate (20.30) is higher than the national average (17.64%). Every 10 years Madhya Pradesh adds around 1.2 crores persons.



Immunization

Higher rates of BCG & Measles, drop outs in DPT & Polio: *High & Non high focus districts show similar patterns*

- Higher BCG, immunization rates in the states (85%) both Gwalior & Hoshngabad has more than 90% rates. However decrease by 25% for 3rd dose of Polio, DPT. 80.7% receives measles vaccine in the state
- The Cold Chain WH infrastructure was also very impressive. All the ILRs, DFs and WIF/WIC were working properly.
- Sessions are conducted in biweekly immunization fashions. This lead to higher wastage. Micro planning to be conducted. It was estimated that 150 percent wastage is being done.
- Stock outs were observed in some facilities in Gwalior
- DP and ILR were functional. One best practice observed is during load shedding of more than 2 days, all vaccines are migrated to other PHC with electricity.
- Polio coverage was high.
- Yashodas working at some places was observed- Suhagpur CHC, Itarsi.

Best Case: Vaccine Storage Unite at Hoshangabad

Vaccine Cold Chain Store has been established at District Hospital Hoshangabad with support from NIPI. This is an excellent endeavor anmd has facilities like proper equipments, re[pair room, protocol display, proper space and ventilastion, icve lined refrigerators, dry store, documentation in place, maintains buffer stock of 20 percent, proper logistics for packing and loading for delivery, proper management and analysis.



Repair Station



Dry Store

ARSH

- WIFS has been launched but a nodal officer has not been deputed at State Level
- 42 AFHCs are functional at DH level, 69 CHCs, 31 PHCs- total 142 AHFCs functional
- Trained Staff are not posted
- The State faces some constraints as irregular reporting, low coverage, and availability of trained staff.

VJ National Vector Borne Disease Control Programme (NVBDCP)

- Madhya Pradesh reports four Vector Borne Diseases under NVBDCP namely Malaria, Dengue, Chikungunya and Lymphatic Filariasis. Kala-Azar and AES/JE (Acute Encephalitis Syndrome/Japanese Encephalitis) are not reported from the state. Both the districts Gwalior and Hoshingabad do not report Lymphatic Filariasis.
- Hoshangabad district has been included for additional support under World Bank assisted project phase-2.
- All posts sanctioned under WB (1DVBDC, 1DEO, 1DF& LA, 5 MTSs) for Hoshangabad are vacant. In state also 3 State level VBD Consultants, 12 districts level VBD Consultants, 72 MTS (Malaria Technical Supervisor), 40 Contractual MPWs (Multi-purpose Workers) and 6828 ASHAs are vacant.
- **42 posts of DMOs (now designated as DVBD) in state are vacant.** In both the districts, Assistant Surgeon is working as DMO. In Hoshingabad the charge of DMOs has been changed 8 times in 3 years and no officer has completed 1 year period.
- All 5 sanctioned posts of MIs, 3 LTs, 1 /3 of JMI/ SI, 2/26 of SW and 27/153 MPW(M) in Hoshingabad and 1 of AMO, 5/7 of MI, 1 of Pump Mechanic and 47/101 MPW(M) in Gwalior are vacant.

Malaria

- Malaria positive cases (91,851), Pf % (35.28%), Deaths (109) have increased in 2011 as compared to 2010 (87165, 35.67% and 31). However positive Malaria cases have decreased and Pf% have increased in 2012 as compared to 2011 (till October).
- Although positive Malaria cases have decreased in both districts Hoshangabad and Gwalior in 2011 as compared to 2010, but there is increase in Pf % in district Hoshangabad.
- ASHAs are not having or not using RDT kit for diagnosis of Malaria cases, ACT for treatment of Pf cases and PQ for radical treatment of Pv cases. However these are available at district, sub-district and sub-center level.
- Reports of slides prepared by ASHAs/ MPWs are communicated within 3-7days. Negative results are not communicated at all.
- The Microscopes are not working for need of minor repair.
- National Drug Policy for treatment of Malaria is not implemented. Both Pf and Pv cases are treated with Chloroquine only. However, DMO has displayed a copy of policy at all delivery points and supplied to ASHAs.
- Identified SSH for Malaria is not functional in Hoshangabad at SDH Itarsi and Sukhtawa.
- Second round of IRS has been completed in October 2012 in both the districts in. Sufficient availability of Larvivorous fishes in both the districts.

- Wall paintings are displayed at all the health facilities visited.

Dengue and Chikungunya

- Sentinel site for diagnosis of Dengue & Chikungunya is established at Medical College, Gwalior & DRDA Gwalior. MaC Elisa kits are supplied from NIV Pune. Aphaeresis machine is available for platelet separation.
- 12 cases & 1 death due to dengue and 17 suspected & 1 confirm case (on 20.01.2012) of Chikungunya has been reported in 2012 (till October) by Medical College, Gwalior.

Recommendations- NVBDCP

- All vacant staff positions at state, district, and sub-district till ASHA levels need to be urgently filled up as it is affecting program implementation. [42 vacant post of DMO (now designated as DVBD) and 3 State level VBD Consultants, 12 districts level VBD Consultants, 72 MTS (Malaria Technical Supervisor), 40 Contractual MPWs (Multi Purpose Workers) and 6828 ASHAs in state including 1DVBDC, 1DEO, 1DF& LA, 5 MTSs for Hoshangabad district and 5 sanctioned posts of MIs, 3 LTs, 1 /3 of JMI/ SI, 2/26 of SW and 27/153 MPW(M) in Hoshangabad and 1 of AMO, 5/7 of MI, 1 of Pump Mechanic and 47/101 MPW(M) in Gwalior district.]
- Ensure Test Reports and treatment for Malaria within 24 hours.
- Microscopes needs repair should be made functional and non-repeatable should condemned.
- Ensure availability of RDT kits, Tab Primaquine and ACT with ASHAs.
- National Drug policy on Malaria, 2010 should be displayed at all delivery points and available with all ASHAs/ MPWs, concerned Health officials and even Private Practitioner. Ensure awareness of policy and its implementation.
- Presumptive treatment for malaria should not be given. However complete treatment may be given to the suspected cases of Malaria.
- LTs should be trained in malaria microscopy and work load rationalized
- ANMs and ASHAs are required to be trained in malaria.
- Orientation of Health functionaries on surveillance and management of Malaria cases and other VBDs.
- The quality spray for vector control has to be ensured.
- The data entry in electronic application for malaria reporting, the NAMMIS must be ensured regularly and linked with HMIS.
- Incentives to the ASHAs should be given as per norms/ guideline issued by NVBDCP.

Revised National Tuberculosis Control Programme (RNTCP)

- RNTCP implemented from District to block level
- ASHA is the main DOTS provider
- Infrastructure is according to norms
- Achievement of targeted Case Detection Rate and Cure Rate has improved in Gwalior.
- Active involvement of NGOs in programme.
- Moutex test started in Gwalior since two months.
- Vehicle rate (@ Rs. 750/ days 8 hrs) has not been revised since long causes mobility constraint

- There is MOU for transporting to Bhopal maintaining cold chain for MDR- TB cases.

Recommendation

- Vehicle rate needs revision as it causing mobility constraint. The present local rates are Rs1500/day + Diesel.

National Leprosy Elimination Program (NLEP)

- NLEP is implemented in both the Districts.
- Prevalence Rate and New Cases Detection have increased in 2012
- In Gwalior, the posts of 3 NMS retired are vacant and existing 2 NMS are to retire in October 2013.
- No regular post of DLO. Assistant surgeon is looking after the work of DLO.
- Reconstructive surgery can be started by providing instruments and training to 2 Orthopaedic Surgeons from Medical college and 1 from District Hospital, Gwalior
- Physiotherapist is available but no Physiotherapy Unit is available.
- All computer work, faxes, photocopies etc. is done from local market causes wastage of time.
- The regular DLO may be posted. The vacant posts of NMS may be filled up.
- Initiatives may be taken for Reconstructive surgery by providing instruments and training to 2 Orthopaedic Surgeons from Medical College and 1 from District Hospital, Gwalior and Physiotherapy Unit as Physiotherapist is already available in Gwalior.
- The arrangements for computer, fax machine, photocopies may be made to save time and proper utilization of staff.

Integrated Disease Surveillance Programme (IDSP)

- Reporting of S & P unit has been decreased in 2011 & 2012. In similar years the L unit reporting has been increased.
- District IDSP team is not complete as there is no Epidemiologist for analysis and feedback
- Data manager and DEO are maintaining data from available records under one officer in-charge who is engaged in court health services.

Recommendation

- The post of Epidemiologist should be filled-up at earliest.

National Program for Control of Blindness (NPCB)

- IOL Operations are done more than targets during last 5 years in Gwalior.
- Cases were screened for IOL surgery at CHC, Bhitwar, at Gwalior on 5.11.2012

AIDS Control Program

- Total tests done in 2012 are about double of 2011, whereas % of TPR has decreased to 0.43% in 2012 to 0.65% in 2011.

National Deafness Control Program

- All programme activities have decreased in year 2011-12 as compared to previous years in Gwalior district. However Disability Certificate issued and hearing Aids advised have increased in in year 2011-12.

Involvement of AYUSH doctor

- AYUSH doctors are available in both the districts but they need orientation toward National Health Programmes., immunization and to NRHM.
- Using Allopathic drugs because of non-availability of sufficient Ayurvedic and Homeopathic drugs.

Recommendation

- AYUSH doctors may be given orientation training in National Health Programmes.
- Sufficient Ayurvedic and Homeopathic drugs should be available at districts.

IDD: District IDD Survey or screening for Thalassemia not done.

VI] Community Process including ASHA, PRI, VHSC, CBM and NGO

There are 56097 ASHAs in place against the target of 56941. The state is approximately near the required number of ASHAs. The dropout rates of ASHA's are not recorded therefore their attrition rate is not known.



The ASHA trainings in Module 5th were completed for over 75% of ASHAs positioned. Total 42098 ASHAs trained up to 5th module. HBNC training of 1st round started in 33 districts and completed in 12 districts. The HBNC incentives are being started in the state. Total 93% ASHAs equipped with Drug kit. Training for module 6th and 7th are started in one block in Gwalior District whereas first round of

training over for 30 ASHAs in Hoshangabad district.

The ToT of 586 district trainer has trained in module 6th and 7th. Additionally 34 state level trainers are available in the state of MP.

The state is in the process to select ASHA Sahyogi that covered 15-20 ASHAs for mentoring and handholding. These ASHA sahyogi are selected among the ASHAs having 3 years of experience and minimum 12th standard of education. There are 2-3 Sub health centres constitute cluster.

ASHAs are not having or not using RDT kit for diagnosis of Malaria cases, ACT for treatment of Pf cases and PQ for radical treatment of Pv cases. However these are available at district, sub-district and sub-center level. In some villages the caste and class divide is becoming demotivating for ASHAs who are performing better and their incentives are being shared by such non performing upper class ASHAs

The community identifies and look towards ASHA for all kind of help. It was observed that one ASHA has been selected twice for best performing award but the same was not given to them. ASHAs are a highly motivated and need guidance. ASHA are accompanying women for deliveries but there is no rest rooms are available at hospital where they can rest. The state has set up the grievance redressal mechanism to resolve the issues for ASHAs.

There are 52117 VHSNCs have been constituted in the state. The team interacted with PRI member and it was found that the committees were involved in the installation of hand pump, filling pits to avoid water lodging. The VHSNCs funds are not fully utilized. It was observed that the co-ordinations of the committees with PRI were minimal. The VHSNC members have not been found to be actively involved in the functioning of committees. They were also not aware of their roles, infact the impression they were carrying was that there would be remuneration for this position.

It was also worth to note that only 10,000 is received by each VHSNC and if population is higher, and ASHAs are more in numbers then it is a small amount.

Recommendation

- ASHA support structure has to be established and strengthened to develop to provide technical support to the grievance redressal cell should make more functional. ASHA help desk must also be created on fast track.
- Capacity building of the VHSNC members and post training handholding for two years must be done to help them improvise methods and collective efforts to improve social determinants in their village

VII] Promotive Health Care, Action of Social Determinants and Equity Concerns

There are 46207 Swasthya Gram Tadarth Samittees (equivalent to VHSNCs) are constituted in the State.

Some sub centres are attached with aganwadi centre. There is a unique manner of establishing sub centre and Jan Mitra Samadhan Kendras and MIS data entry centre are in the same premises. The Vaccination, malaria, leprosy, blindness control, safe motherhood programs are covered under service guarantee scheme.

Each service under service Guarantee scheme is being provided within fixed time frame. It was also observed by team that Aganwadi workers are identifying malnourished children and sending them to NRCs. Take home rations (THR) available and being distributed every Tuesday. Community informed that the some aganwadis were functioning only on Tuesdays and would distribute few packets of THR.

क्र.सं.	विवरण	प्रकार
1	सुविधाएँ	सुविधाएँ
2	सुविधाएँ	सुविधाएँ
3	सुविधाएँ	सुविधाएँ
4	सुविधाएँ	सुविधाएँ
5	सुविधाएँ	सुविधाएँ
6	सुविधाएँ	सुविधाएँ
7	सुविधाएँ	सुविधाएँ
8	सुविधाएँ	सुविधाएँ
9	सुविधाएँ	सुविधाएँ
10	सुविधाएँ	सुविधाएँ
11	सुविधाएँ	सुविधाएँ
12	सुविधाएँ	सुविधाएँ
13	सुविधाएँ	सुविधाएँ
14	सुविधाएँ	सुविधाएँ
15	सुविधाएँ	सुविधाएँ
16	सुविधाएँ	सुविधाएँ
17	सुविधाएँ	सुविधाएँ
18	सुविधाएँ	सुविधाएँ
19	सुविधाएँ	सुविधाएँ
20	सुविधाएँ	सुविधाएँ

The Ultrasound machines have been installed with silent observer for to prevent sex selective abortion but this may not alone help in legal prosecution of the violators in court of law.

The pace of implementation of school health program is slow in terms of coverage of number of schools as well as number of children. However no implementation of

school program was visible in the field.

Coordination between ICDS and Health departments were seen because of the need of list of children. This is provided by AWW. Whereas Coordination with other departments is nonexistent as there is no such need felt at the field level.

Water and Sanitation is a totally missed opportunity in the field. Social audit is not practiced. UNICEF, UNFPA & HUP PFI are providing technical assistance for MCH and urban health. HMIS data entry is being made and facility based reporting is required.

Recommendation

- There is need to institutionalize Convergence among Department of Health, Department of Women Child Development and public health engineering at District level. The Program Officer and Civil Surgeon / CMHO and corresponding levels below culminating with a monthly meeting between ANM and ICDS Supervisor. Later this can be expanded to include other depts. (e.g. Department of education).
- The MCTS tracking identification number must be made mandatory for an USG scanning and then the pregnancy must be tracked for outcomes.
- Microplan for MMU visit can be modified so that School health Checkups and aganwadis health check up along with monitoring of both schools and aganwadis can be included in the areas visited by MMU.

VIII] Programme Management including monitoring, logistics and issue of integration and institutional capacity

1. **Programme Management Structures:** All the programme management structures (e.g. State Health Society, District Health Society, Rogi Kalyan Samiti etc.) are in place. In Madhya Pradesh the SPMU consultants work under various Directors and Joint directors. The consultants from the development partners are also paired with respective joint directors. The Mission Director has the overall responsibility for NRHM whereas the Director and Joint director NRHM ensure proper functioning of SPMU. Hence, the co-ordination and integration of the department of H& FW is taken care of by the directors. Similarly the DPMU is placed under CMHO and District RCH officer where as the BPMU is placed under BMO.

Mechanism for inter-sectoral convergence like Swasthya & Mahila Baal Vikaas Sthayee samiti of Zila Panchayat was found working. Regular meetings were held wherein representatives of Health, WCD, and PHE meet in PRI leadership.

2. **Vacancy:** The vacancies particularly at State and district level are a matter of grave concern. 71% posts at State level, 78% at the district level and 20% at block level are vacant. Interaction with PMU staff indicated that many more are planning to leave in near future. Reasons given were better job options, and better salary etc. High vacancy in PMU has been observed by previous CRMs too. Continual high vacancy levels indicate deeper systemic problems which the State needs to probe into. Some of the staff is overloaded as they are in –charge of additional posts which are vacant. The motivation level also seems to suffering due to HR issues particularly salary.

3. **Capacity Building:** Though the State provides 1-2 day induction training PMU staff, there is no refresher or follow up training. Orientation training is mostly theoretical –classroom teaching which provides background but is not helpful in solving the practical problems faced by the PMU staff on a day to day basis. Co-ordination between State and district PMU was reported to be functioning well

4. **Planning, Supervision & Monitoring:** District –wise differential planning which NRHM/RCH aspires is yet to be achieved. The DHAPs are template and there is very little scope for innovation by district.

The CRM team was given to understand the supervisory visits are taken up by PMU staff from time to time; however team didn't find any pre-decided schedule, visit reports and action taken reports. The only format for supervision available was for monitoring Village Health and Nutrition Days which were being filled by block level PMU. There was no visit report of the supervisory visits by the district or block officials. The supervision is ad-hoc and not systematic. It is more of state driven initiative and not a part of regular duty.

5. **Delegation of power:** As per the documents shared by the State the financial and administrative powers has been delegated to SPMU/DPMU.

6. **Procurement:** The State has been procuring 80% of the drugs from TNMSC rate contracts as per drug policy 2009. The districts and the facilities have to maintain the stock of all the medicines as per the Essential Drug List. The districts have the authority to make local purchases up to 20% (if required) to ensure availability of drugs.

7. State Public Health Procurement Corporation has been approved by state to handle drug procurement as well as medical equipment. The State has advertised for various posts for district and State drug cells. It is expected that the cells would be established in coming few months. Currently the state is managing with existing regular staff. State drug MIS is working well with extensive online search options in 50 district hospitals 59 civil hospitals

and 333 community health centers. ProMIS is being used at State and district warehouses for national programmes.

State Drug Management Information System (SDMIS) is working well with extensive online search options in 50 district hospitals 59 civil hospitals and 333 community health centres. Approval of a State Public Health Procurement Corporation to handle drug procurement as well as medical equipment.43 district warehouses out of 50 are ready and staffed by a storekeeper and data entry operator, recruitment is ongoing for pharmacists and assistants for these stores.866 extra pharmacists, assistants and data entry operators being recruited to improve the operational efficiency of SDMIS at 50 district hospitals, 59 civil hospitals and 333 community health centres. Areas which require action or strengthening are store keepers at facilities have not received any store keeping training, this needs to be initiated. Shortage of paracetamol in the high fever system due to excess demand and supply capacity constraints. Supply shortfall due to delayed delivery of high turnover drugs indented against the central rate TNMSC rate contract.

8. Supply and Logistics: The State and the districts are striving for uninterrupted supplies of drugs. The team didn't find any major stock outs during its visit. However, to maintain a steady flow is a challenge as it was reported that the suppliers were not able to supply on time because of huge demand and more of local purchase was required. The districts have to write to the State to get approval for local purchases exceeding the 20% limit which takes too long.

9. Infrastructure wing: The construction of infrastructure is undertaken through the agencies of State government. There is also a construction wing under Health department which undertakes construction of maternity wards, SNCU and NRC etc. The Department has a civil wing with engineers (some from Public Works Dept, some regular employees of Health department and some on contract under NRHM) who supervise the construction.

10. Accreditation of private facilities: The accreditation of the private facilities for FP is being done by the District Level Committee. The State is revising the guidelines for accreditation of private facilities for JSY and hence currently there is no MOU with private facility for JSY. The District Level Committees under MTP Act have been constituted but are largely non-functional.

Expenditure on Programme Management

In the year 2011-12, MP has shown an expenditure of Rs. 16.72 crores as against Rs. 21.88 crores planned for in the budget on Programme Management with an adverse variance of 23.6%. Adverse variance of 40.9%, 24.3% and 7.9% indicate the vacancies because of which there is less expenditure on salary. Moreover no expenditure is booked against the mobility budget of Rs.187.80 lakhs.

FMR	Activity	FY 2011-12 (Rs. Lakhs)
-----	----------	------------------------

Code		Approved budget	Reported expenditure	Variance %
A.10	PROGRAMME MANAGEMENT			
A.10.1	Strengthening of SHS/ SPMU (Including HR, Management Cost, Mobility Support, field visits)	184.85	109.24	-40.9
A.10.2	Strengthening of DHS/ DPMU (Including HR, Management Cost, Mobility Support, field visits)	496.56	375.97	-24.3
A.10.3	Strengthening of Block PMU (Including HR, Management Cost, Mobility Support, field visits)	1277.04	1,176.70	-7.9
A.10.4	Strengthening (others)			
A.10.5	Audit Fees	12.00	0.41	-96.6
A.10.6	Concurrent Audit	30.00	9.78	-67.4
A.10.7	Mobility Support to BMO/ MO/ Others	187.80	0.00	-100.0
	Sub-total Programme Management	2188.25	1672.09	-23.6

Similarly in the first six months of the current financial year 2012-13, the expenditure is lower than the budget.

FMR Code	Activity	Annual Budget (Rs. Lakhs)	Expenditure (Apr-Sept 2012)		
			Planned (Rs. lakhs)	Reported (Rs. lakhs)	Variance %
A.10	PROGRAMME MANAGEMENT				
A.10.1	Strengthening of SHS/ SPMU (Including HR, Management Cost, Mobility Support, field visits).	219.34	109.67	83.43	-23.9

A.10.2	Strengthening of DHS/ DPMU (Including HR, Management Cost, Mobility Support, field visits)	1097.31	548.66	218.62	-60.2
A.10.3	Strengthening of Block PMU (Including HR, Management Cost, Mobility Support, field visits)	1464.84	732.42	547.78	-25.2

The State needs to take urgent steps to speed up recruitment of programme management staff so that budget allotted is utilized effectively.

Major Recommendations:

1. State needs to urgently take up a third party institutional assessment including HR particularly for the programme management staff under NRHM. The State also needs to compare the salary being offered by other departments and other states for similar posts. State needs to take urgent steps to fill up the vacant posts and take action to ensure retention.

State needs to come up with HR policy to address all the problems of contractual as well as regular staff.

2. The State needs to look into the orientation and on the job training being provided to the programme management staff as well as personnel engaged in material management and logistics. Store keepers at facilities have not received any store keeping training, which needs to be initiated. The programme managers need to be provided regular refresher training.

3. State should ensure minimum stock levels of all drugs and particularly of vaccines. The team found very low stock levels of OPV vaccine. It would be better to keep the Immunization Division in MoHFW informed of the shortage and delay in supply by the OPV supplier for expediting supplies or by diversion from other Regional stores. Similar action should be taken for other vaccines as well.

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

IX. Knowledge Management including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology

The infrastructure at SIHFW was excellent and the In-House faculty is OK. Number of course (9 nos) is under-utilization. A full-time Director may be able to devote more attention, as the present arrangement is on addl. charge basis for the Jt. DHS. The officers nominated for the training courses should be relieved by their bosses so that last minute cancellation of training program is avoided. Mandatory participation in training/refresher courses for the service providers at pre-decided intervals could be worked out. More autonomy for Dir/SIHFW on lines of NIHFW could be contemplated. TOT courses for ANM and ASHA at SIHFW and DHFWTC would yield better outcomes.

The DHFWTC/GWL covers 14 districts. In year 2011-12, Seventy two training courses covering 1766 trainees were conducted. In 2012-13,401 trainees have participated in 17 batches. The courses were on IMNCI,ARSH,IMMZN,DOT,VHNSC and Induction Program conducted for fresh MOs. Trg. load is 1000 MOs,4000 Supervisors and 350 SNs. Problem of last minute withdrawn of nominated candidates needs to be sorted out with respective CMHO

TAST and other development provide technical support to State NRHM

There was no field visits by faculty post training to assess its utilisation is done. Two Gynecologists, 1 ophthalmologist and 1 ENT specialist are posted in SIHFW and RHFWTC .State must look into this precious human resource utilisation for better health care service delivery in field. Huge infrastructure of both institutes lying unused.

X. Financial Management

OBSERVATIONS:

1. Status of Humans Resource:

All the posts are in place at State level i.e. Director Finance, State Finance Manager and State Account Manager District Accounts Manager. There are 26 post of DAM including Gwalior (post of DAM of Gwalior is vacant since, 2008) 103 post of Block/CHC/PHC Accountant and 9 post of ANM are vacant at the District and Block level in the State.

2. Status of Maintenance of Books of Accounts:

Books of Accounts are properly maintained as per Finance and Accounts Manual at SHS/DHS/CHC/PHC/SC Level. They are maintaining books of account on Tally software and manual and updated till 31st October, 2012. Hence our observations related to the maintenance of books of accounts are based on manual accounts:-

Cash/Bank Book

- Cash book is maintained in Tally ERP9 which is not customized version as well as manual and updated till 31st October, 2012.

- Payment made at DHS to Block DEO/PHC Accountant/Block Accountant of Rs. 91,000/- towards consultancy has not been passed in the manual cash book of RCH but tds entry has been passed dated 12.05.2011.
- Payment made at DHS to MO/PGMO of Rs. 1,93,000/- towards consultancy has not been passed in the manual cash book of RCH but tds entry has been passed dated 12.05.2011.
- Payment made at DHS to Rakish Kumar Mina (CA Firm) of Rs. 41,837/- towards consultancy has not been passed in the manual cash book of RCH but tds entry has been passed dated 19.10.2011.
- Payment made at DHS to Sharda Travels of Rs. 37,715/- towards consultancy but tds entry has been passed in the RCH manual cash book dated 22.06.2012
- Grant Register has not been maintained by the DHS.
- Payment made at DHS to Khandelwal Travel of Rs. 1,83,000/- has not been passed in the manual cash book of Mission Flexible Pool but tds entry has been passed dated 04.06.2012.
- Books of accounts have not been provided by the PHC-Chinaur as the books for 2012-13 were written by the staff.
- Books of accounts were not recorded for the month of October, 2012 at PHC-Antari.

Bank Reconciliation

a) District Health Society

Bank reconciliation has not been prepared by the District for RCH, MFP, and RI for the year, 2012-13 (upto October) the details are given below:

Programme	Balance as per Pass Book as on 31.10.2012	Balance as per cash book as on 31.10.2012	Difference in Rupee
RCH	2,71,15,389.63	83,62,461.00	1,8752,928.63
MFP	1,71,87,716.00	1,00,18,233.00	71,69,483.00
RI	17,53,391.00	18,52,365.00	-98,974.00

b) District Hospital, Morar

RKS and RCH bank account has not been reconciled by the District Hospital Morar. The detail is below:

Programme	Balance as per Pass Book	Balance as per cash book	Difference in Rupee
Mission Flexible Pool			

2012-13 (30.06.2012)	60,46,779.00	13,71,871.00	46,74,908.00
RCH Bank Account			
2012-13 (31.07.2012)	27,15,784.00	107.00	27,15,677.00

c) Civil Hospital, Dabra

RKS and RCH bank account has not been reconciled by the Civil Hospital. The detail is below:

Programme	Balance as per Pass Book	Balance as per cash book	Difference in Rupee
Mission Flexible Pool			
2012-13 (31.08.2012)	7,85,966.00	4,65,519.00	3,20,447.00
RCH Bank Account			
2012-13 (31.10.2012)	2,35,856.00	3,16,551.00	-80,695.00

d) Civil Hospital, Dabra

RCH bank account has not been reconciled on 31.03.2012 by the Civil Hospital. The detail is below:

Programme	Balance as per Pass Book	Balance as per cash book	Difference in Rupee
2012-13 (31.03.2012)	4,42,528.00	11,356.00	4,31,172.00

e) CHC-Bhitarwar:

RKS bank account has not been reconciled by the CHC. The detail is below:

Programme	Balance as per Pass Book	Balance as per cash book	Difference in Rupee
-----------	--------------------------	--------------------------	---------------------

2011-12	4,81,867.00	3,21,113.00	1,60,754.00
2012-13 (30.09.2012)	3,33,263.00	3,06,784.00	26,479.00

f) PHC-Antri

RKS bank account has not been reconciled by the PHC. The detail is below:

Programme	Balance as per Pass Book	Balance as per cash book	Difference in Rupee
2011-12	1,05,914.00	1,00,075.00	5,839.00
2012-13 (30.09.2012)	1,53,196.00	1,42,892.00	10,304.00

i) Reconciliation of Release between State Health Society and District Health Society:

a) RCH Flexible Pool:

There is no reconciliation of releases between State Health Society and District Health Society has been done. The year wise differences have been pointed out from the books of accounts. The detail has been given below

Detail of Releases under RCH Flexible Pool from State to District Health Society, Gwalior			
Year	Fund Received by District from State	Funds released by State to District	Difference in releases
2008-09	8,50,00,000.00	8,50,00,000.00	-
2009-10	5,00,00,000.00	5,00,00,000.00	-
2010-11	9,73,71,000.00	8,66,63,400.00	1,07,07,600.00
2011-12	5,86,46,000.00	5,86,46,000.00	-
2012-13	4,72,85,680.00	4,93,00,000.00	-20,14,320.00
Note: Releases for 2012-13 up to 31st October, 2012			

b) Mission Flexible Pool:

There is no reconciliation of releases between State Health Society and District Health Society has been done. The year wise differences have been pointed out from the books of accounts. The detail has been given below

Detail of Releases under Mission Flexible Pool from State to District Health Society, Gwalior			
Year	Fund Received by District from State	Funds released by State to District	Difference in releases
2008-09	4,25,00,000.00	2,25,00,000.00	2,00,00,000.00
2009-10	2,90,20,000.00	2,90,20,000.00	-
2010-11	4,06,00,000.00	5,27,12,500.00	-1,21,12,500.00
2011-12	60,00,000.00	60,00,000.00	-
2012-13	1,79,45,000.00	1,58,00,000.00	21,45,000.00
Note: Releases for 2012-13 up to 31st October, 2012			

c) Routine Immunization:

There is no reconciliation of releases between State Health Society and District Health Society has been done. The year wise differences have been pointed out from the books of accounts. The detail has been given below:

Detail of Releases under Routine Immunization from State to District Health Society, Gwalior			
Year	Fund Received from State	Funds released by State to District	Difference in releases
2008-09	23,80,000.00	23,80,000.00	-
2009-10	19,00,000.00	19,00,000.00	-
2010-11	1,00,000.00	28,61,903.00	27,61,903.00
2011-12	22,32,000.00	22,30,000.00	2,000.00
2012-13	-	38,83,000.00	38,83,000.00
Note: Releases for 2012-13 up to 31st October, 2012			

ii) Reconciliation of Expenditure between State Health Society and District Health Society:

a) RCH Flexible Pool:

There is no reconciliation of releases between State Health Society and District Health Society has been done. The year wise differences have been pointed out from the books of accounts. The detail has been given below:

Detail of Expenditure under RCH Flexible Pool in the books of accounts as per State and District Health Society, Gwalior

Year	Expenditure as per DHS	Expenditure as per SHS	Difference in Expenditure
2007-08	7,55,12,569.00	7,49,98,912.00	5,13,657.00
2008-09	7,73,86,120.00	7,72,22,166.00	1,63,954.00
2009-10	7,32,16,261.00	7,40,55,343.00	-8,39,082.00
2010-11	7,51,31,925.00	7,19,98,590.00	31,33,335.00
2011-12	6,41,03,334.00	5,82,79,381.00	58,23,953.00
2012-13	2,98,98,259.00	2,93,71,648.00	5,26,611.00

Note: Expenditure for 2012-13 up to 31st October, 2012

b) Mission Flexible Pool:

There is no reconciliation of releases between State Health Society and District Health Society has been done. The year wise differences have been pointed out from the books of accounts. The detail has been given below:

Detail of Expenditure under Mission Flexible Pool in the books of accounts as per State and District Health Society, Gwalior			
Year	Expenditure as per DHS	Expenditure as per SHS	Difference in Expenditure
2007-08	93,56,573.00	97,31,242.00	-3,74,669.00
2008-09	1,04,66,955.00	1,04,66,955.00	-
2009-10	3,92,87,801.00	3,94,19,504.00	-1,31,703.00
2010-11	3,33,46,274.00	3,14,10,422.00	19,35,852.00
2011-12	2,33,27,504.00	2,20,23,380.00	13,04,124.00
2012-13	39,50,441.00	39,09,967.00	40,474.00

Note: Expenditure for 2012-13 up to 31st October, 2012

c) Routine Immunization:

There is no reconciliation of releases between State Health Society and District Health Society has been done. The year wise differences have been pointed out from the books of accounts. The detail has been given below:

Detail of Expenditure under Routine Immunization in the books of accounts as per State and District Health Society, Gwalior			
Year	Expenditure as per DHS	Expenditure as per SHS	Difference in Expenditure
2007-08	19,47,064.00	19,47,064.00	-
2008-09	19,25,628.00	19,95,628.00	-70,000.00
2009-10	21,24,616.00	21,24,616.00	-
2010-11	17,92,954.00	16,40,450.00	1,52,504.00

2011-12	14,48,921.00	13,01,280.00	1,47,641.00
2012-13	3,73,950.00	3,58,898.00	15,052.00
Note: Expenditure for 2012-13 up to 31st October, 2012			

Advance Register

- Advance Register has not maintained at District Health Society and CHC/PHC under any programme.

Vouchers

The vouchers of cash/bank are properly maintained at State, Districts, CHC and PHC level. Vouchers are not serially numbered at SHS, DHS, DH, CHC and PHC.

Journal

- Journal ledger has not been maintained by the District Health Society and Block/CHC/PHC.

Stale Cheques:

There are stale cheques of Rs. 12300/- more than 4 months. Most of them towards payments of JSY beneficiaries have been stood in bank reconciliation of 31st March, 2012 at CHC/Block-Bhitarwar.

3. Delay in Payments of JSY beneficiary:

There are few instances of delay in payment of JSY beneficiary at CHC the detail is given below:

- There are 60 signed cheques were kept with the CHC accountant, Bhitarwar i.e. Cheque no. 250055 of Rs. 1400/- dated 15.10.2012 towards JSY payment.
- There are 50 signed cheques were kept with the Civil Hospital, Dabra, accountant i.e. Cheque no. 318626 of Rs. 1400/- dated 10.10.2012 by the name of Kalawati was laying with accountant.
-

Status of e-transfer/CPSMS:

State Health Society, District Health Society and CHC/PHC have maintained bank account with State Bank of India (SBI). The State Health Society is sending funds to DHS through e-transfer, DHS to Block/CHC/PHC through account payee cheque only. The registration for CPSMS has been completed at DHS and Block level in the State.

5. Status of Tally ERP9:

The State Health Society and District Health Society are using Tally ERP9 but it is not customized version of Tally ERP9 as they have some problem in Customized version of Tally ERP9 at SHS and DHS.

6. Fund Disbursement Procedure

The funds are being released in a flexi pool by the SHS to DHS according to ROP and DHS to Block/CHC/PHC also in a flexible pool in all cases except Untied Fund, Annual Maintenance Grants and RKS. State generally sends the fund a week to DHS when they get the demand from the DHS and 12-15 days takes in fund disbursement from District Health Society to blocks/CHCs/PHCs.

7. Statutory Audit and Concurrent Audit

Statutory Audit of NRHM

The Audit Report, 2011-12 has been finalized by the Auditor for RCH, NRHM and RI but consolidation of NDCPS is yet to be done at the State level. The State will be submitting consolidated Audit Report by 15.11.2012 to Gol. The Statutory Audit Report, 2011-12 of District has been completed and submitted to SHS. The some observations on audit report of District Health Society by the auditor are under:

Advances more than one year:

Particulars	Op.Balance as on 01.04.2011	Balance as on 31.03.2012
CEO Janpad Panchayat	24,699.00	24,699.00
Doctors Association of Gwalior (JSY)	25,000.00	25,000.00
Health and Family Welfare Centre Gwalior	37,80,551.00	37,80,551.00

- Diversion of Fund from RCH to NRHM at Block Ghatigaon

The Block had diverted fund from RCH to NRHM. The detail is below:

Date	Amount
21.12.2011	1,00,000.00
26.12.2011	45,000.00
26.12.2011	50,000.00
26.11.2011	1,00,000.00

Statutory Audit of RKS:

RKS is separate legal entity therefore, Statutory Audit is necessary. RKS at District Hospital Morar, Gwalior has been audited since 2009-10 to 2011-12 and also RKS audit has neither been done at any level i.e. Block/CHC/PHC nor provide any audit report for any year.

Concurrent Audit

The Concurrent Auditors have been appointed for 2012-13 by the SHS and DHS. Second quarter concurrent audit is completed at SHS till July, 2012 but at DHS, Gwalior concurrent audit has not been started by the Auditor for the same district has replied that they have written to Auditor but DHS has produced anything in written. ATR has not been prepared by the State on Concurrent Audit Report, 2011-12 as the State has received Concurrent Audit Report in the month November, 2012.

8. CAG Audit:

The CAG Audit for the year, 2009-10 to 2011-2012 has been completed in the State and the draft Audit Report has been submitted by the Auditor. The observations will be resubmitted on 10.11.2012 by the State to CAG.

9. Delegation of Financial Power:

Delegation of Financial Power from State Health Society to District Health Society and DHS to down the line has been issued.

10. Low/Nil Expenditure during 2012-13

SHS Level (RCH)

General Observation

Out of the approved annual PIP of Rs. 52977.67 lakh (Approved PIP of Rs. 52677.67 and for Committed Liabilities of Rs. 300.00 carried over from the year 2011-12), reported expenditure is Rs. 14649.18 lakh upto 2nd quarter, 2012 under RCH Flexi pool which is only 27.67% of the approved PIP.

Area of Concern

- Low expenditure has been reported by the state under JSSK Maternal Health (1.11%) of the approved PIP.

SHS Level (MFP)

General Observation

Out of the approved annual PIP of Rs. 40354.08 lakh, (Approved PIP of Rs. 32899.08 and for Committed Liabilities of Rs. 7455.00 carried over from the year 2011-12) expenditure reported during the year 2012-13 is Rs. 4,024.95 lakh under Mission Flexi Pool which is only 9.97% of the approved PIP.

Area of Concern

- The State has reported low expenditure under non negotiable activities i.e. ASHA (14.73%), untied funds (12.91%), Annual Maintenance Grants (7.57%), and Corpus Grants to HMS/RKS (8.45%) of the approved PIP.
- The State has reported negligible expenditure under Procurement (1%) and Planning Implementation and Monitoring (1.71%) of the approved PIP.

DHS Level (RCH)

General Observation

Out of the approved annual budget of Rs. 1076.14 lakh, reported expenditure is Rs. 249.74 lakh up to the second quarter of 2012-13 under RCH Flexi pool i.e. only 23.21%.

Area of Concern

- The DHS has reported nil expenditure under Child Health and Urban Health
- The DHS has reported negligible expenditure under JSSK (9.68%) and Family Planning (4.97%) of the approved budget.

DHS Level (MFP)

General Observation

Out of the approved annual PIP of Rs. 349.58 lakh, reported expenditure is Rs. 33.17 lakh up to the second quarter of 2012-13 under RCH Flexi pool i.e. only 9.49%.

Area of Concern

- The DHS has reported nil expenditure under RKS, Strengthening of In-service Training Facilities, up gradation of District Hospital and CHC/PHC, and Monitoring and Evaluation.
- The DHS has reported low expenditure under Asha (3.83%), and Untied Funds (0.29%) and AMG (1.44%).

11. Pending Utilization Certificates:

The pending Utilization Certificate for RCH Flexi Pool and NRHM Flexi Pool the detail of pending UCs has given below:

Programme	2009-10	2010-11	2011-12	Total
				Rs. In Crore

RCH-II	-	-	329.40	329.40
Mission Flexible Pool	19.52	219.86	270.38	509.77

12. Income Tax Issues:

It has been observed that CHC-Block Bhitwar has not followed rules of Income Tax under tax deduction at sources. CHC has deducted TDS on salary of the staff but it is deposited late into bank i.e. TDS of Rs. 5,874 vide cheque no. 249901 dated 22.09.2012 but it is deposited on 10.10.2012.

13. Outstanding State Share Contribution

The State has contributed more than the entitled State Share from 2007-08 to 2012-13. The break up for the same has been given below:

Year	Amounts required on basis of releases	Amount Credited in SHS Bank A/C	Short/ (Excess)
2007-08	108.90	-	108.90
2008-09	124.92	90.00	34.92
2009-10	106.73	133.00	(26.27)
2010-11	138.42	131.99	6.43
2011-12	169.32	129.00	40.32
Total (2007-08 to 2011-12)	648.29	483.99	164.29
2012-13	344.14	86.00	258.14
Total	992.43	569.99	422.43

*State Share for 2012-13 as per ROP

14. Procurements Guidelines

The procurement manual has not been made by the State Health Society. The State is following the procurements guidelines of Government of Madhya Pradesh and the SHS sends procurements guidelines time to time to DHS when it is required.

15. Utilization of State Share

As per Audit Report, 2011-12, the State has utilized funds 44.56 crore out of State Share for RCH.

16. Utilization of Funds under Untied Fund, AMG and RKS

Release under Untied Funds, RKS and Annual Maintenance Grants from DHS to Block/CHC/PHC/SC are being treated as advance in the books of accounts of DHS and subsequently the DHS adjust expenditure against advances through statement of expenditure on monthly basis submitted by the CHC, PHC, and SC to DHS. The utilization trend of DHS-Gwalior for the year, 2010-11, 2011-12 and 2012-13 (up to 31st October, 2012) in the books of accounts of State Health Society has been given below:

Statement Showing Allocation, Release and Expenditure for Untied fund/AMG/RKS Grant District Gwalior												
Activity	2010-11				2011-12				2012-13 (as on 31.10.2012)			
	Allotment	Release	Exps.	Bal	Allotment	Release	Exps.	Bal	Allotment	Release	Exps.	Bal
Untied Fund	525000	525000	314919	210081	475000	475000	291295	183705	216000	216000	8141	207859
AMG	105000	105000	533607	516393	950000	950000	647433	302567	460000	460000	0	460000
RKS	240000	240000	1072350	1327650	250000	250000	981732	1518268	555000	555000	0	555000

Based on the table above and records available, the observations are as under:-

Area of Concern

- The DHS has reported low expenditure under Untied Fund i.e. 60% for 2010-11, 61% for 2011-12 and 3.77% for 2012-13 (up to 31st October, 2012) of the approved budget.
- The DHS has reported nil expenditure under Annual Maintenance Grants for 2012-13 (up to 31st October, 2012) of approved budget.
- Low trend of expenditure has been noted under RKS i.e. 45% for 2010-11, 39% for 2011-12 and nil for 2012-13 (up to 31st October, 2012) of the approved budget.

17. Diversion of Funds

The diversion of funds has been noted for Rs. 40 crore in the books of accounts of State Health Society. The detail of diversion of funds is below:

Date	Particulars	Amount in crore (Rs.)
06.10.2012	Fund of ANM Nursing training is being diverted to Routine Immunization	20.00
06.10.2012	Fund of ANM Nursing training is being diverted to Routine Immunization	10.00
19.10.2012	Fund of ANM Nursing training is being diverted to Routine Immunization	10.00

18. Financial Integration under NRHM:

State has opened Group Bank Account for receiving grants under NRHM including NDCPs from Gol. District Health Society, Gwalior has not yet opened Group Bank Account so far.

19. Utilization of Interest

We have observed that the interest is being used by the State Health Society and District Health Society but it is not possible to quantify therefore, my observation in the case of interest it is part of unspent balance of the programme.

20. Internal Control Mechanism:

- State is being followed procurement guidelines of the State for centralized purchase of Medicines and Equipments.
- At the all level like SHS, DHS, Block, CHC, PHC, Sub Centre and VHSC are joint signatory for fund disbursement to the implementing agencies.
- In the case of Civil Construction always invited quotations/tenders by the State but maximum contract has been given to PWD for the repair or minor civil work.

- Status of Advances- There advance as on 30.09.2012 of Rs. 204.38 crore under RCH, Rs. 334.55 crore under Mission Flexible Pool and Rs. 12.34 crore under RI which is subject to the reconciliation. The State has no district wise detail of advances.
- Payment to the beneficiaries is being made through account payee cheques only.

21. Unspent Balance under RCH-I:

There is no unspent balance under RCH-I as per Audit Report; 2010-11 but there is advances at District level of Rs. 12.27 crore as per compliance report of Concurrent Audit Observations of State Health Society, Madhya Pradesh for the period of April, 2012 to July, 2012.

22. Monitoring and Evaluation methodologies adopted by the State to improve financial management system:

The State generally identifies poor performance of the district on the basis compliance report on auditor's observations and follow up for timely completion of the activities at each level. Surprise visits from the State to DHS to Block if required.

RECOMMENDATIONS

1. All posts of District Accounts Manager and Block Accountant should be filled on priority basis.
2. Advance Register should be maintained for all kind of advances.
3. Bank Reconciliation should be prepared on monthly basis at DHS, Block, PHC and CHC.
4. Unspent balance should be reconciled on monthly basis between State and DHS, DHS and CHC/PHC.
5. Journal Entries must be passed in manually in the books of accounts for bills and SOE.
6. Budget Vs expenditure must be analyzed to know the exact variance of budget and expenditure so that proper steps can be taken to improve the utilization of funds.
7. Income Tax provision for deduction of TDS must be followed by the DHS for statutory requirements.
8. The reason of Low/Nil expenditure may be clarified.

9. JSY payment should be made on time to the JSY beneficiaries.
10. Diversion of funds is not allowed from one programme to another programme as per the GoI.
11. Funds should be released through e-transfer from DHS to Block/CHC/PHC level.
12. Properly implement customized tally, ERP9, accounting software so that FMR can be generated through the customized Tally ERP9.
13. Stale cheques must be reversed from books of accounts.
14. Funds should be disbursed within a week at DHS level.
15. Advance more than a year should be settled at the earliest.
16. Books of accounts of RKS at District Hospital/CHC/PHC level must be audited on time as per guidelines on yearly basis.
17. Outstanding State Share should be deposited in State Health Society bank account at the earliest.
18. Group Bank Account should be opened at the earliest at DHS, Gwalior.
19. Unspent balance under RCH-I should be refunded to GoI at the earliest.
20. Release and Expenditure should be reconciled between State Health Society and District Health Society.