Quarterly Monitoring Report - Haryana

Dates of Visit – 2nd to 5th September 2013

Dr. Madhusudan Yadav
Consultant, NHSRC
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Executive Summary

Jind is one of the High Priority Districts of Haryana. With a population of 1,332,042 it has a sex ratio of 870, which is amongst the lowest in the State. Although almost all its indicators have shown improvement since DLHS III (District Level Health Survey III), there are still many concerns that district faces today. Overall these concerns could be classified in three categories A) systemic issues (for e.g. poor availability of human resources, especially specialists); B) local issues (for e.g. lack of USG (Ultrasonography) facility at all government health facilities) and C) issues due to poor day to day management of services at facility level (overcrowding in wards, non-availability of food for post natal women, poor patient flow management in hospitals etc). In order to better understand the current scenario of service delivery under NRHM (National Rural Health Mission) and other NHPs (National Health Programs) along with mechanisms instituted by district to cater to its public health needs this monitoring visit was undertaken. Some of key observations (and possible suggestions) made, include the following:

1. Low sex ratio remains a concern for the district as well as the State.
2. As of now there are 3 designated L3 centres for a population of 13.32 lacs, but due to various constraints only one of them is providing comprehensive EmOC (Emergency Obstetric Care). Whole burden of EmOC provision is falling on GH Jind (General Hospital Jind). This is leading to overcrowding in the maternity wards at the DH (District Hospital) and compromised quality of post op care for women undergoing LSCS (Lower Section Caesarian Section).
3. District has reported only 2.2 percent LSCS rate for the period of April–June 2013-14, while the normal range varies between 5-10%.
4. In total district has 58 facilities designated as L1, L2 and L3 but only 36 (17SHC, 13 PHC, 5 non-FRU CHC and 1 DH) of them are functional as per the desired criteria.
5. In district Jind currently there is 53% shortage of Medical Officers and 16% shortage of staff nurses.
6. In order to meet its requirement of various categories of human resources the district has focused on:
   A) Incentives for doctors posted in difficult areas
   B) Multi-skilling trainings of non-specialist personnel
   C) Outsourcing/In-sourcing of specialist services
7. Although district is offering incentives for difficult areas it has not been able to ensure availability of a complete package of specialists, i.e. a gynaecologist, paediatrician and an anesthetist, at all the L3 FRUs (First Referral Units). In-sourcing of specialists has worked sporadically, with very few cases having been attended by these specialists.
8. It is pertinent that district takes up the issue of provision of specialists services with more enthusiasm and ensures that the flexibilities of financing mechanism under NRHM is leveraged appropriately to secure these services. Some measures that could be employed for the same could include A) incorporating the financial aspirations of specialist to best possible levels, B) offering a say in decisions pertaining to NBSUs/SNCUs (New Born Stabilization Unit/ Sick Newborn Care Unit) management, C) putting in place a grievance redressal mechanism at district level for all in-sourced doctors, D) making them part of MDR (Maternal Death Review) and IDR (Infant Death Review) committees and E) incorporating measures that makes them believe that they matter to the health facility.
9. It is commendable that most of the training load has been met by the district, but at the same time it is also important that district now focuses on measuring the knowledge retention of those trained and also making sure that the trained person are posted at the right facility.

10. First quarter data from current year [Graph 4] puts the figure for first trimester registration at 47 percent, which is a subject of concern and it reflects on involvement of ANMs (Auxiliary Nurse Midwives) in provision of MCH (Maternal and Child Health) services. A plausible cause could be inadequate quality in VHNDs (Village Health and Nutrition Days) that are being conducted in district [also noticed during the visit] and thus village level registrations are being missed. Although district attributes this to misreporting by ANMs, it is unlikely as all the blocks have uniformly low levels of first trimester registrations. [Graph 5]

11. For deliveries that the system could capture and report there is high percentage [84%] of institutional delivery, but it falls down drastically to 54 percent, if compared against expected deliveries.

12. As far as hotspots of home delivery in district is concerned, analysis of data reveals that 4 blocks [Kalwa, Kaharak Ramji, Safidon and Uchana] are reporting relatively high percentages of home deliveries. It is important that district reaches out to pregnant women in these blocks because, of those who deliver at home, only few have access to SBA (Skilled Birth Attendant) trained person. [Graph 7]

13. District has formed FBMDR (Facility Based Maternal Death Review) committee at the district hospital. This committee meets to review deaths as and when they are reported. For the period of April-June 2013 no maternal death has been reported in Jind [source HMIS]. Last year 3 maternal deaths were reported – 1 due to hypertension, 1 due to PPH and 1 has been classified under other causes.

14. JSSK (Janani Shishu Shuraksha Karyakaram) is being implemented across all the delivery points in the district.
   a. No user fees are being charged for antenatal mothers and postnatal mothers are also exempted till a period of one month. But none of facilities were aware about exemption of user charges for sick newborns till the age of one year and hence user fees were levied on them.
   b. Sufficient supplies of drugs were noted in all the facilities and none of the interviewed beneficiary reported purchasing of medicines from outside. Though during interactions with doctors posted at SNCUs, NBSUs and LR (Labor Room) it was found that sometimes (approximately once in a quarter) it happens that some drugs aren’t available for few days and during those period patients have to purchase the same from outside.
   c. Blood transfusions are provided free of cost as and when needed. There is a blood bank functioning at GH Jind which acts as a nodal centre for provision of L3 care in the district. In addition one BSU (Blood Storage Unit) is also functional at SDH Narwana. For the second quarter of the year 2013-14 a total of 104 obstetric cases were provided blood transfusion (3.7 percent of reported deliveries).
   d. Across the district there is not a single public hospital which is providing the critical diagnostic facility of USG. This is leading to substantial amount of out of pocket expenditure for the pregnant women.
e. At facilities where the delivery load per day is substantial, cooks have been brought into service to prepare food in hospital premises, whereas facilities where deliveries are happening infrequently packed eating material (like biscuits, milk, bread etc) are provided. Quality of food was reported as satisfactory by most of the beneficiaries. Provision of food at GH Jind has been erratic since last two months.
f. District has an optimally functional network of 102 ambulances and most of the beneficiaries that were interviewed reported utilizing the free transport service. As GH Jind is pooling patients across the district hence one of the challenges faced by the hospital is provision of timely drop back services. Average waiting duration for drop-back (at GH Jind) is about 4-5 hours post discharge.
g. About two-third of the women that were interviewed knew about the entitlements under JSSK. But at the same time none of them were aware of all the entitlements of the scheme. Free transport and free delivery along with provision medicines were the components that maximum beneficiaries were aware about.
h. None of the beneficiaries reported that they were asked for informal payments, but few of them did report giving money to staff ‘out of their happiness’. It is important that district puts up specific IEC material requesting patients to refrain from making such payments.

15. JSY incentives are being made as per the laid norms. From this fiscal year district is not paying the ASHAs for escorting the mother to hospitals. Mode of payment is through bearer cheque and according to District Accounts Manager, all the blocks of district have reported that around 20-25% of these cheques are not collected by beneficiaries, although this could not be verified physically during the visit.

16. Numbers of JSY (Janani Shuraksha Yojana) payments made to home delivery cases have reduced compared to previous year, and given the fact that some blocks of Jind still report high percentages of home deliveries, it is important to follow up on these cases too, to ensure that no such beneficiary is left out.

17. Immediate newborn care at the level of PHCs is being provided by on duty staff nurses and in few places by Medical Officers (at PHC where they have been made available). As the nurses posted at most of PHCs are also NSSK (Navjat Shishu Shuraksha Karyakaram) trained they do have knowledge about components of immediate newborn care, but none of those, with whom interactions were taken up during the visit, reported having performed any emergency procedures for e.g. newborn resuscitations [at PHC level] and the current practice is to refer cases where a sick newborn is anticipated [for e.g. cases of preterm deliveries, newborns with low birth weight].

18. At CHC level NBSUs have been established but lack of paediatricians means that none of these NBSUs are providing specialist care. At district level GH Jind has a SNCU, though it hardly meets the criteria of an SNCU. A new SNCU infrastructure is being built up in the hospital, and is expected to be made functional in approximately 45 days. It is critical that this process is expedited.

19. SHCs cater to the maximum load of immunization the district. As per HMIS 2012-13 completely immunized children against expected live birth stood at 71% and after visiting the district two plausible reasons could be drawn for this – A) migratory populations pose a challenge to district as they are difficult to be tracked back and B) there are still few resistant population groups who refuse to get their children vaccinated. It is recommended that
district takes up an evaluation study and understand the extent of impact that such populations have on its immunization program.

20. Family planning services in the district are provided across all levels of health facilities, with difference in service package. Highest percentages of IUCDs (Intrauterine Contraceptive Devices) are being placed at SHC level and this has lead to substantial decrease in load at higher facilities.

21. Women still carry a disproportionate burden of family planning in the district and of the terminal methods provided NSVs (Non-scalpel Vasectomies) account for 3.9% of cases whereas 96% of family planning operations are Mini-laps.

22. As of now PP-IUCD (Post Partum IUCD) component in the district is very weak, but during discussions with Deputy Civil Surgeon it was informed that PP-IUCD has now been stressed upon to the doctors.

23. District has 1002 ASHAs against the requirement of 1054 ASHAs, thus there is a shortfall of 52 ASHAs. Majority of this shortfall is in Safidon and Uchana block and it is advised that district recruits suitable ASHAs in these block as early as possible, because these two blocks also report a comparatively higher proportion of home deliveries.

24. One of the main grievances that ASHAs across most blocks of Jind have reported is that their drug kits aren’t refilled timely and this creates a problem for them in providing village level care for minor illness. Allowing ANMs to indent for refilling of ASHA kits is a positive step in this direction and it needs to be strengthened further.

25. VHSNC have been formed in all villages of the district, but quality of VHNDs conducted in Jind is not up-to satisfactory levels. Most of the VHNDs have ANMs, ASHAs and AWWs (Anganwadi Workers) participating together but it has not succeeded optimally to act as an integrated platform for provision of preventive and curative care at village level. Average participants in these VHNDs range from 2-3 antenatal/postnatal women.

26. DHIS2 is used by the district for uploading data, although district level analysis of the available data was not observed. Data is treated as a ‘liability’ that has to be collected and uploaded, rather than an ‘asset’ which is could be very pivotal in district and block level planning.

27. On an average 146 OPD (Out Patient Department) and 3 IPD (In-patient Department) per 1000 population at district level has been reported from April to July 2013.

The report also briefs about individual facility level finds of those health centers that were visited and it might be useful for district to get a snapshot of current level of the functionalities at these centers, and take remedial actions for betterment of service provision.
1. Introduction

As part of supportive supervision to High Priority Districts of Haryana, a monitoring visit was undertaken from 2\textsuperscript{nd} to 5\textsuperscript{th} September to district Jind. During the visit following activities were undertaken –

- Visit to public health facilities and interactions with postnatal women admitted in maternity wards
- Discussions with DPMU (District Program Management Unit) functionaries
- Discussions with Civil Surgeon and Deputy Civil Surgeon
- Interactions with functionaries of IDSP (Integrated Disease Surveillance Project) and NPCB (National Program for Control of Blindness)

This report details the observations and analysis of findings that emerged out of the visit. It also mentions few suggestions, not as a separate heading but as a part of analysis of a particular component, which district functionaries could consider in order to mitigate the challenges faced by them while ensuring equitable access to healthcare for all.

<table>
<thead>
<tr>
<th>Name of Health facility</th>
<th>Type of Facility</th>
<th>Level (Designated by District)</th>
<th>Current Status of Functionality</th>
</tr>
</thead>
<tbody>
<tr>
<td>GH Jind</td>
<td>DH</td>
<td>✓</td>
<td>24X7; providing L3 care</td>
</tr>
<tr>
<td>GH Narwana</td>
<td>SDH</td>
<td>✓</td>
<td>24X7; providing L2 care</td>
</tr>
<tr>
<td>Safidon</td>
<td>CHC</td>
<td>✓</td>
<td>24X7; providing L2 care</td>
</tr>
<tr>
<td>Dumerkha Khurd</td>
<td>PHC</td>
<td>✓</td>
<td>24X7; providing L1 care</td>
</tr>
<tr>
<td>Kharal</td>
<td>SHC</td>
<td>✓</td>
<td>24X7; providing L1 care</td>
</tr>
</tbody>
</table>

2. District Profile

Jind is amongst the oldest of 21 districts of Haryana. Spread over an area of 2702 sq.kms the district has three sub-divisions: Jind, Narwana and Safidon. Jind sub-division further has two tehsils: Jind and Julana; whereas Narwana and Safidon sub-divisions have one tehsil each, Narwana and Safidon respectively.

On its East and North-East lie the districts of Panipat, Karnal and Kaithal respectively. Its boundary on the North forms the Haryana-Punjab border and on West and South-West it has a common boundary with district Hisar & Fatehabad. Rohtak and Sonipat border the district on South and South-East.\footnote{http://jind.nic.in Accessed on 5/09/2013}
Table 2: Socio-demographic Profile of Jind

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Total area</td>
</tr>
<tr>
<td>2.</td>
<td>Total population (2011 Census)</td>
</tr>
<tr>
<td>3.</td>
<td>Sex Ratio (2011 Census)</td>
</tr>
<tr>
<td>4.</td>
<td>Sex Ratio 0 - 6 years</td>
</tr>
<tr>
<td>5.</td>
<td>% Decadal Growth Rate</td>
</tr>
<tr>
<td>6.</td>
<td>Literacy Rate (Census 2011)</td>
</tr>
<tr>
<td>7.</td>
<td>Number of Health Blocks</td>
</tr>
<tr>
<td>8.</td>
<td>Number of villages</td>
</tr>
</tbody>
</table>

Source – DHAP (District Health Action Plan) Jind 2012-13

Low sex ratio remains a concern for the district as well as the State.

Availability of Health care –
District has 6 health blocks – Kharak Ramji, Kandela, Kalwa, Julana, Uchana, Ujhana, and Safidon. As of now there are 3 designated L3 centres for a population of 13.32 lacs, but due to various constraints only one of them is providing comprehensive EmOC care. Table 3 details the overall availability of public health care infrastructure in the district. Further details about functionality of various facilities are detailed later in the document.

Table 3 - Availability of Health Facilities –

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District Hospital</td>
<td>1</td>
</tr>
<tr>
<td>SDH</td>
<td>1</td>
</tr>
<tr>
<td>Total No. of CHCs</td>
<td>7</td>
</tr>
<tr>
<td>Total No. of PHCs</td>
<td>21</td>
</tr>
<tr>
<td>No. of Sub Centers</td>
<td>162</td>
</tr>
<tr>
<td>24x7 CHCs</td>
<td>7</td>
</tr>
<tr>
<td>24x7 PHCs</td>
<td>21</td>
</tr>
<tr>
<td>Blood Bank</td>
<td>0</td>
</tr>
<tr>
<td>Blood storage Units</td>
<td>1</td>
</tr>
</tbody>
</table>

Source – PRC (Population Resource Center) Monitoring Report
3. Key Health and Service Delivery Indicators

Haryana is amongst the better performing States of India and has IMR of 44 (a reduction of 4 points) latest SRS data. But having said that, sex ratio remains a cause of concern for the state. Table 4 and 5 detail the key parameters of Haryana and Jind respectively.

**Table 4 – State Statistics: Haryana**

<table>
<thead>
<tr>
<th>Population - Census - 2011</th>
<th>Person</th>
<th>25,353,081</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>13,505,130</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>11,847,951</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex Ratio ( No. of Females per1000 males)</th>
<th>Census - 2011</th>
<th>877</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Ratio 0 - 6 years</td>
<td>Census - 2011</td>
<td>830</td>
</tr>
<tr>
<td>MMR ( per 100,000 live births)</td>
<td>SRS - 2007</td>
<td>153</td>
</tr>
<tr>
<td>CBR ( per 1000 population)</td>
<td></td>
<td>21.8</td>
</tr>
<tr>
<td>CDR ( per 1000 population)</td>
<td></td>
<td>6.5</td>
</tr>
<tr>
<td>IMR</td>
<td>SRS - 2012</td>
<td>44</td>
</tr>
</tbody>
</table>

Source – HMIS

Compared to DLHS 3 findings there have been marked improvements in indicators across the spectrum (Table 5). But this has to be taken with a pinch of salt due to compromised quality of data in HMIS.

**Table 5- District Statistics - Jind**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>DLHSIII (2007-08)</th>
<th>HMIS 2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANC Check-up in first trimester</td>
<td>58</td>
<td>60.9</td>
</tr>
<tr>
<td>3 or more ANC Check-up</td>
<td>55.4</td>
<td>81</td>
</tr>
<tr>
<td>Atleast 1 TT received</td>
<td>92.3</td>
<td>54.6</td>
</tr>
<tr>
<td>100 IFA Tablets</td>
<td>17.5</td>
<td>48.7</td>
</tr>
<tr>
<td><strong>Deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutional Delivery</td>
<td>42.1</td>
<td>85</td>
</tr>
<tr>
<td>Home Delivery</td>
<td>56.9</td>
<td>15</td>
</tr>
<tr>
<td>Home Delivery by SBA</td>
<td>6.2</td>
<td>70</td>
</tr>
<tr>
<td><strong>Postnatal care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfed within 1 hour of birth</td>
<td>12.1</td>
<td>82</td>
</tr>
<tr>
<td>PNC within 48 hrs of delivery</td>
<td>42.5</td>
<td>72</td>
</tr>
<tr>
<td><strong>Immunization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCG</td>
<td>92.5</td>
<td>124</td>
</tr>
<tr>
<td>DPT3</td>
<td>66.4</td>
<td>110</td>
</tr>
<tr>
<td>Measles</td>
<td>67.3</td>
<td>117</td>
</tr>
<tr>
<td>Full immunization</td>
<td>55.4</td>
<td>100</td>
</tr>
</tbody>
</table>

Source – HMIS
4. Health Infrastructure

District has six health blocks - K.Ramji, Kandela, Kalwa, Julana, Uchana, Ujhana, and Safidon. As of now there are 3 designated L3 centres for a population of 13.32 lacs, but due to various constraints only one of them is providing comprehensive EmOC care.

**Table 6 – Health Infrastructure in Jind**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Hospital</td>
<td>1</td>
</tr>
<tr>
<td>SDH</td>
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<td>0</td>
</tr>
<tr>
<td>Blood storage Units</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: DPMU Jind

Within district, GH Jind acts as the referral centre and provides L3 care. Out-of-district referrals are usually made to PGIMS Rohtak. Due to suboptimal level of functionality of Narwana SDH and CHC Safidon (both designated L3 centres), populations from these block go to health centers of neighboring districts.

For provision of BEmOC services 21 PHCs and 6 non-FRU CHCs have been designated as L2 centers, but due to lack of essential manpower [esp. Medical Officers] only 13 PHCs are able to function as L2 centers. In rest of the PHCs care is being provided by SNs who are SBA trained and in some cases NSSK trained too.

In total district has 58 facilities designated as L1, L2 and L3 but only 36 (17SHC, 13 PHC, 5 non-FRU CHC and 1 DH) of them are functional as per the desired criteria. As State now discourages deliveries at SHCs, the burden of deliveries and PNC now falls majorly on L2 PHCs, which are not handling any complications and are referring it to FRU-CHC/SDH (Narwana SDH and Safidon CHC). But since these two health facilities are also not providing EmOC care, the whole burden of EmOC provision is falling on GH Jind. This is leading to overcrowding in the maternity wards at the DH, as was seen during the visit. It was also noted that postnatal women who had normal delivery and women who had undergone LSCS were kept in same ward at the GH, leading to high chance of cross infections in women as well as neonates.
### Table 7 - Delivery points

<table>
<thead>
<tr>
<th>Health Facilities</th>
<th>Jind District Total</th>
<th>Jind Designated Delivery Points</th>
<th>Functional as Per Desired Criteria</th>
<th>Percentage Functional</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSC</td>
<td>162</td>
<td>28</td>
<td>17</td>
<td>60</td>
</tr>
<tr>
<td>PHC</td>
<td>21</td>
<td>21</td>
<td>13</td>
<td>61</td>
</tr>
<tr>
<td>CHC Non FRU/PHC</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>83</td>
</tr>
<tr>
<td>CHC/FRU</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SDH</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DH</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>192</td>
<td>58</td>
<td>36</td>
<td>62</td>
</tr>
</tbody>
</table>

Source: DPMU, Jind

### 5. Human Resources for Health

Human resources for health form a critical component of the Health Systems Framework, as suggested by the World Health Organization, and availability of skilled workforce in adequate numbers is a challenge faced by many states in India. At the state level Haryana also faces a shortage in specialists of more than 50% for OBG (Obstetrics and Gynaecology), Anesthetists and Pediatricians. Shortage of manpower is also reflected in other health cadres too.

### Table 8 - Human Resources Status in Haryana

<table>
<thead>
<tr>
<th>HR categories</th>
<th>Current HR Situation Haryana State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sanctioned posts</td>
</tr>
<tr>
<td></td>
<td>Regular</td>
</tr>
<tr>
<td>1st ANM</td>
<td>3103</td>
</tr>
<tr>
<td>SN</td>
<td>1596</td>
</tr>
<tr>
<td>LHV</td>
<td>463</td>
</tr>
<tr>
<td>LT</td>
<td>926</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>913</td>
</tr>
<tr>
<td>MO</td>
<td>2499</td>
</tr>
</tbody>
</table>

#### Specialist

<table>
<thead>
<tr>
<th></th>
<th>Sanctioned posts</th>
<th>In position</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBG</td>
<td>216</td>
<td>8</td>
<td>88</td>
</tr>
<tr>
<td>Anaesthetist</td>
<td>198</td>
<td>3</td>
<td>57</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>177</td>
<td>26</td>
<td>62</td>
</tr>
</tbody>
</table>

Source: State PIP 2013-14

In district Jind currently there is 53% shortage of Medical Officers and 16% shortage of staff nurses. In addition district also has shortage of specialists to provide EmOC and early new born care to sick neonates. Comparatively the shortage is nil for laboratory technicians and 6 percent for ANMs.
Table 9 – Human Resources Status in Jind

<table>
<thead>
<tr>
<th>HR categories</th>
<th>Sanctioned posts</th>
<th>Total Sanctioned</th>
<th>In position</th>
<th>Total Available</th>
<th>Shortfall</th>
<th>% Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regular</td>
<td>Contractual</td>
<td></td>
<td>Regular</td>
<td>Contractual</td>
<td></td>
</tr>
<tr>
<td>ANM</td>
<td>162</td>
<td>165</td>
<td>327</td>
<td>156</td>
<td>150</td>
<td>306</td>
</tr>
<tr>
<td>SN</td>
<td>84</td>
<td>112</td>
<td>196</td>
<td>64</td>
<td>101</td>
<td>165</td>
</tr>
<tr>
<td>LHV</td>
<td>28</td>
<td>0</td>
<td>28</td>
<td>25</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>LT</td>
<td>36</td>
<td>0</td>
<td>36</td>
<td>33</td>
<td>3</td>
<td>36</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>46</td>
<td>0</td>
<td>46</td>
<td>45</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td>MO</td>
<td>115</td>
<td>5</td>
<td>120</td>
<td>52</td>
<td>4</td>
<td>56</td>
</tr>
</tbody>
</table>

What is district doing to optimize its human resources utilization?

In order to meet its requirement of various categories of human resources the district has focused on:

A) Incentives for doctors posted in difficult areas

B) Multi-skilling trainings of non-specialist personnel

C) Outsourcing/In-sourcing of specialist services

Although district is offering incentives for difficult areas it has not been able to ensure availability of a complete package of specialists, i.e. a gynaecologist, paediatrician and an anesthetist, at all the L3 FRUs. In-sourcing of specialists has worked sporadically, with very few cases having been attended by these specialists. It is pertinent that district takes up the issue of provision of specialists services with more enthusiasm and ensures that the flexibilities of financing mechanism under NRHM is leveraged appropriately to secure these services. For e.g at Narwana the SDH lacks a paediatrician but a paediatrician is available in private and already handles many referrals from nearby SHCs. Such scenarios exist in other sub-divisions too, and the Senior Medical Officer/Medical Superintendent should take a lead to in-source such specialists. Some measures that could be
employed for the same could include A) incorporating the financial aspirations of specialist to best possible levels, B) offering a say in decisions pertaining to NBSUs/SNCUs management, C) putting in place a grievance redressal mechanism at district level for all in-sourced doctors, D) making them part of MDR and IDR committees and E) incorporating measures that makes them believe that they matter to the health facility.

In order to improve quality in provision of services by existing manpower, district has taken up trainings pertaining to maternal care, new born care, family planning services, home based newborn care and on components like HMIS. Tables below show the planned training load and the achievement made by the district. It is commendable that most of the training load has been met by the district, but at the same time it is also important that district now focuses on measuring the knowledge retention of those trained and also making sure that the trained person are posted at the right facility. For e.g. An EMOC trained lady medical officer has been posted at CHC Safidon, but she is not able to perform LSCS due to lack of an anaesthetist and instead has to manage the general OPD and casualty. It is important that district identifies such irrationalities and rationalizes utilization of it existing multi-skilled human resources, so that its trained manpower provides the desired inputs in the service delivery. Rational deployment will also serve as a morale booster for rest of the medical officers, as they would be convinced about the training being a mode of enhancing their skill as well as an enabler to put that skill to use.

### Table 10 – Training Status of MO/SN

<table>
<thead>
<tr>
<th>Trainings</th>
<th>Medical Officer/Staff Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012-13</td>
</tr>
<tr>
<td></td>
<td>Planned</td>
</tr>
<tr>
<td>F-IMNCI</td>
<td>2</td>
</tr>
<tr>
<td>RTI/STI</td>
<td>1 (For Medical Officers only)</td>
</tr>
<tr>
<td>MTP+MINILAP</td>
<td>2</td>
</tr>
<tr>
<td>NSSK</td>
<td>1</td>
</tr>
<tr>
<td>HBPNC</td>
<td>2</td>
</tr>
<tr>
<td>Counselling for PPIUCD</td>
<td>0</td>
</tr>
<tr>
<td>BEmOC</td>
<td>2</td>
</tr>
</tbody>
</table>

Source – DTO Jind Reports

### Table 11 - Trainings of ANM

<table>
<thead>
<tr>
<th>Trainings</th>
<th>ANM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012-13</td>
</tr>
<tr>
<td></td>
<td>Planned</td>
</tr>
<tr>
<td>NSSK</td>
<td>NA</td>
</tr>
<tr>
<td>HBPNC</td>
<td>6</td>
</tr>
<tr>
<td>SBA + IMEP</td>
<td>4</td>
</tr>
<tr>
<td>IMNCI+SV</td>
<td>2</td>
</tr>
<tr>
<td>Alt IUD</td>
<td>3</td>
</tr>
<tr>
<td>HMIS</td>
<td>4</td>
</tr>
</tbody>
</table>

Source – DTO Jind Reports
Table 12 - Trainings of SNs

<table>
<thead>
<tr>
<th>Trainings</th>
<th>Exclusively for Staff Nurses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012-13</td>
<td></td>
<td>2013-14</td>
</tr>
<tr>
<td></td>
<td>Planned</td>
<td>Achieved</td>
<td>Planned</td>
</tr>
<tr>
<td>Counselling for PPIUCD</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SBA + IMEP</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

Source – DTO Jind Report

Training of SNs to counsel postnatal mothers for PPIUCD is pending from last year, and district must ensure that these are completed as PPIUCD now forms an important strategy for family planning.

6. Maternal Health

6.1 ANC (Antenatal Care)

For the first quarter of 2012-13 Jind reports capturing 79% [110% for same quarter in 2013-14] of expected deliveries, and this figure rises up to 90 percent if we take into consideration the whole year of 2012-13. Thus we have an impression that most of the pregnant women are identified and registered in the system. That said, it is to be remembered that close to 10 percent or approximately 3164 pregnancies fail to reach the health delivery system and vice versa. Another cause of concern, at least for the period of April – June 2013-14, is a decline in 3ANC percentage and it is advisable that district follows up on conversion of first ANCs into three ANCs for the second quarter of 2013-14.

Graph 2- Total ANC Registration against Expected Delivery

Source- HMIS
**ANC Registrations within first trimester** –

Early registration of pregnancy is emphasized as it helps in availing better care for pregnant woman as well as it gives sufficient time for the health functionary to plan for components of antenatal care, place of delivery and prepare the family [for e.g. getting requisite documents ready for availing benefits under JSY, JSSK etc] for the upcoming birth in the house. First quarter data from current year [Graph 4] puts the figure for first trimester registration at 47 percent, which is a subject of concern and it reflects on involvement of ANMs in provision of MCH services. A plausible cause could be inadequate quality in VHNDs that are being conducted in district [also noticed during the visit] and thus village level registrations are being missed. Although district attributes this to misreporting by ANMs, it is unlikely as all the blocks have uniformly low levels of first trimester registrations. [Graph 5]
6.2 Institutional Deliveries

For deliveries that the system could capture and report there is high percentage [84%] of institutional delivery\(^2\), but it falls down drastically to 54 percent, if compared against expected deliveries. Further if we bring into picture the fact that Jind district manages to register as high as 90 percent of expected pregnancies, and provides 3 ANC to 96 percent of them; then there are three questions that arise – A) why do women choose not to come and deliver at health facilities even after availing 3 ANCs, B) if they are delivering at home then which are blocks with high percentage of home delivery and C) what is availability of skilled attendants for home deliveries.

As mentioned earlier Jind has only one EmOC care facility for a population of 13 lac, and in such a situation it is possible that people choose to go other nearby higher levels of centre [for e.g. GH Tuhana for people in Narwana block] hoping to avoid referrals and avail better quality of care as compared to their nearby PHC/CHC/SDH. As far as hotspots of home delivery in district is concerned, analysis of data reveals that 4 blocks [Kalwa, Kaharak Ramji, Safidon and Uchana] are reporting relatively high percentages of home deliveries. It is important that district reaches out to pregnant women in these blocks because, of those who deliver at home, only few have access to SBA trained attendant. [Graph 7]

\(^2\) HMIS, April 2012-march 2013
Met Need for EmOC –

Management of obstetric complications is a critical requirement in provision of safe delivery services. In Jind district maximum percentage of complications are managed at DH/SDH level [Graph 8], but the concern for district is the fact that GH Jind is the only health facility which conducts LSCS deliveries. This is due to non functionality of other two designated L3 centers [SDH Narwana and CHC Safidon] which has led to disproportionate load of obstetric emergencies on the GH Jind and has also affected the LSCS rates of the district. For e.g. district has reported only 2.2
percent LSCS rate for the period of April-June 2013-14, while the normal range varies between 5-10%.

**Graph 8 – Management of Obstetric Complications**

![Graph 8](image)

*Source – HMIS/DHIS*

**Duration of stay after delivery**

After having interactions with the admitted postnatal women, and various health functionaries it was observed that, for deliveries happening at the DH/SHD/and CHCs duration of stay varies between 24hrs to 48hrs while those being conducted at PHCs report a stay of 6 to 8hours, after which the delivered women/ and relatives insist on going back home.

**6.3 Maternal Death Review**

District has formed FBMDR committee at the district hospital. This committee meets to review deaths as and when they are reported. For the period of April-June 2013 no maternal death has been reported in Jind [source HMIS]. Last year 3 maternal deaths were reported – 1 due to hypertension, 1 due to PPH and 1 has been classified under other causes.

**6.4 Janani-Shishu Suraksha Karyakram (JSSK)**

JSSK is being implemented across all the delivery points in the district, and various components of this program were evaluated during this visit. Informal interviews with beneficiaries on also formed part of this evaluation. Findings of the same are represented in Graph 9.
6.4.A User fee in Out Patient Department (OPD) and In Patient Department (IPD)
As of now no user fees is being charged for antenatal mothers and postnatal mothers are also exempted till a period of one month. But none of facilities were aware about exemption of user charges for sick newborns till the age of one year and hence user fees were levied on them. It was brought to the notice of district officials.

6.4. B. Drugs and Blood
Sufficient supplies of drugs were noted in all the facilities and none of the interviewed beneficiary reported purchasing of medicines from outside. Though during interactions with doctors posted at SNCUs, NBSUs and LR it was found that sometimes (approximately once in a quarter) it happens that some drugs aren’t available for few days and during those period patients have to purchase the same from outside.

Blood transfusions are provided free of cost as and when needed. There is a blood bank functioning at GH Jind which acts as a nodal centre for provision of L3 care in the district. In addition one BSU is also functional at SDH Narwana. For the second quarter of the year 2013-14 a total of 104 obstetric cases were provided blood transfusion (3.7 percent of reported deliveries).

6.4. C. Diagnostics
Across the district there is not a single public hospital which is providing the critical diagnostic facility of USG. This is leading to substantial amount of out of pocket expenditure for the pregnant women. While discussing this concern with Civil Surgeon, it was told that the current rates of 150 per patient are not sufficient to outsource the service. It was suggested to CS that either the district should consider in-sourcing the specialists and hence reduce the cost per patient, or put a proposal to increase per patient cost by INR50, so that cost is not a barrier in provision of this critical diagnostic service.

Other lab examinations were available free of cost for antenatal mothers at all L2 and L3 facilities that were visited.
6.4. D. Diet
Barring GH Jind, other health facilities are providing diet to the admitted postnatal mothers. Provision of diet has been disrupted at GH Jind since last 20-22 days. A discussion was taken up with MS regarding this concern and measures were suggested. At facilities where the delivery load per day is substantial, cooks have been brought into service to prepare food in hospital premises, whereas facilities where deliveries are happening infrequently packed eating material (like biscuits, milk, bread etc) are provided. Quality of food was reported as satisfactory by most of the beneficiaries.

6.4. E. Referral Transport
District has an optimally functional network of 102 ambulances and most of the beneficiaries that were interviewed reported utilizing the free transport service. As GH Jind is pooling patients across the district hence one of the challenges faced by the hospital is provision of timely drop back services. Average waiting duration for drop-back (at GH Jind) is about 4-5 hours post discharge and this can only be reduced if all peripheral facilities share an equitable load of normal deliveries.

6.4. F. Display of entitlements
Various entitlements were found displayed across all the facilities that were visited.

6.4. G. Awareness of community
About two-third of the women that were interviewed knew about the entitlements under JSSK. But at the same time none of them were aware of all the entitlements of the scheme. Free transport and free delivery along with provision medicines were the components that maximum beneficiaries were aware about. ASHAs were found to be the major source of information.

6.4. H. Grievance Redressal Cell
None of beneficiaries reported that they were aware about grievance redressal, and usually it was the on duty SN (Staff Nurse) who was told about any grievance.

6.4. I. Out of pocket expenditure / informal charges
None of the beneficiaries reported that they were asked for informal payments, but few of them did report giving money to staff ‘out of their happiness’. It is important that district puts up specific IEC material requesting patients to refrain from making such payments.

6.5 Janani-Suraksha Yojana (JSY)
JSY incentives are being made as per the laid norms. From this fiscal year district is not paying the ASHAs for escorting the mother to hospitals. Mode of payment is through bearer cheque and according to District Accounts Manager; all the blocks of district have reported that around 20-25% of these cheques are not collected by beneficiaries, although this could not be verified physically during the visit. It is recommended that district follows up with beneficiaries who refuse to collect cheques due to lack of a bank account and guide them in opening new accounts or integrating their other accounts (for e.g. account under MNREGA). Numbers of JSY payments made to home delivery cases have reduced compared to previous year, and given the fact that some blocks of Jind still report high percentages of home deliveries, it is important to follow up on these cases too, to ensure that no such beneficiary is left out.
Table 13 – Status of JSY Payments

<table>
<thead>
<tr>
<th>JSY Incentives</th>
<th>Jind 2013-14</th>
<th>Jind 2012-13 (Till July 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ANC registered</td>
<td>6782</td>
<td>27505</td>
</tr>
<tr>
<td>Number of Women registered under JSY</td>
<td>1785</td>
<td>4428</td>
</tr>
<tr>
<td>% JSY registration to Total ANC Registration</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>Mothers paid JSY incentive for home deliveries</td>
<td>270</td>
<td>47</td>
</tr>
</tbody>
</table>

Source – DAM Office

7 Child Health
7.1 Immediate Newborn Care and Sick New Born Care
Immediate newborn care at the level of PHCs is being provided by on duty staff nurses and in few places by Medical Officers (at PHC where they have been made available). As the nurses posted at most of PHCs are also NSSK trained they do have knowledge about components of immediate newborn care, but none of those, with whom interactions were taken up during the visit, reported having performed any emergency procedures for e.g. newborn resuscitations [at PHC level] and the current practice is to refer cases where a sick newborn is anticipated [for e.g. cases of preterm deliveries, newborns with low birth weight].

At CHC level NBSUs have been established but lack of paediatricians means that none of these NBSUs are providing specialist care. At district level GH Jind has a SNCU, though it hardly meets the criteria of an SNCU. It has been established in a small room and has 2 radiant warmers and phototherapy units, but there is a paediatrician available to provide specialist care, along with SNs who have been trained in F-IMNCI (Facility based Integrated Management of Neonatal and Childhood Illnesses) and NNSK. A new SNCU infrastructure is being built up in the hospital, and is expected to be made functional in approximately 45 days. It is critical that this process is expedited.

Table 14 - Status of different type of new born care facilities in Jind

<table>
<thead>
<tr>
<th>Status</th>
<th>NBCC</th>
<th>NBSU</th>
<th>SNCU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approved</td>
<td>Operational</td>
<td>Approved</td>
</tr>
<tr>
<td>Jind</td>
<td>24</td>
<td>24</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: PIP 2013-14

7.2 Immunization
SHCs cater to the maximum load of immunization the district. Ticker boxes were observed to be used at the SHCs for keeping a track of immunization and missed children are tracked back using it. In-spite of best efforts of ANMs and other health functionaries there still are cases who have missed complete immunization.
Table 155- Immunization session held

<table>
<thead>
<tr>
<th>Immunization Sessions</th>
<th>% of immunization sessions held vs planned</th>
<th>% of immunization sessions where ASHA were present (out of the held sessions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jind</td>
<td>98.6%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Source – DPMU, Jind

As per HMIS 2012-13 completely immunized children against expected live birth stood at 71% and after visiting the district two plausible reasons could be drawn for this – A) migratory populations pose a challenge to district as they are difficult to be tracked back and B) there are still few resistant population groups who refuse to get their children vaccinated. It is recommended that district takes up an evaluation study and understand the extent of impact that such populations have on its immunization program. At institutional level there are post partum centers that provide immunization and PNC services.

8. Family Planning

Family planning services in the district are provided across all levels of health facilities, with difference in service package. As shown in graph below highest percentage of IUCDs are being placed at SHC level and this has lead to substantial decrease in load at higher facilities, especially at GH Jind. NSVs and Minilaps are being performed at SDH/DH.

Graph 10 – Type of Family Planning Service against Level of facility

Source - HMIS

Women still carry a disproportionate burden of family planning in the district and of the terminal methods provided NSVs account for 3.9% of cases whereas 96% of family planning operations are Mini-laps.

As of now PPIUCD component in the district is very weak, but during discussions with Deputy Civil Surgeon it was informed that PPIUCD has now been stressed upon to the doctors in GH Jind and in coming months number of PPIUCDs placements would increase. But it must be noted that only one facility (GH Jind) will be providing this service. It is important for district to operationlize PPIUCD at all its L3 CHCs and SDH.
9. Quality in Health Services

9.1 Infection Control and Bio-Medical Waste Management

This area has both a positive side and a negative side in district Jind. Among the positives following can be included:

A) Needle cutters/destroyers were seen at all nursing units and were used.

B) Knowledge among nursing staff on infection control practices [for e.g. recapping of needles should be avoided] was present.

C) All operative areas were fumigated and other infection control protocols were observed.

But there are challenges as well, especially inBMW management; such as –

A) Poor on-site segregation by posted medical staff

B) General lack of awareness regarding the need and importance of proper BMW management among the staff.

9.2 Information Display

Information pertaining to various health programs of central government as well as state government was found displayed at the health centers visited. Wall paintings were found to be the main method of displaying information/entitlements in the district. But it was observed across all the centers that almost anyone who needed any information [for e.g. location of a OPD; whether doctor was available etc] was asking for it at the registration cabin, in-spite of the same information being displayed on the walls.

10. Community Processes

10.1 ASHA and MAMTA

District has 1002 ASHAs against the requirement of 1054 ASHAs, thus there is a shortfall of 52 ASHAs. Majority of this shortfall is in Safidon and Uchana block and it is advised that district recruits suitable ASHAs in these block as early as possible, because these two blocks also report a comparatively higher proportion of home deliveries.

**Table 16 Block wise ASHAs and ASHAs facilitators against target as on July 2013**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of Block</th>
<th>ASHA Selection</th>
<th>ASHA Facilitator Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Achievement</td>
<td>Target</td>
</tr>
<tr>
<td>1</td>
<td>Julana</td>
<td>156</td>
<td>150</td>
</tr>
<tr>
<td>2</td>
<td>Kharak Ramji</td>
<td>115</td>
<td>110</td>
</tr>
<tr>
<td>3</td>
<td>Kandela</td>
<td>129</td>
<td>129</td>
</tr>
<tr>
<td>4</td>
<td>Safidon</td>
<td>121</td>
<td>105</td>
</tr>
<tr>
<td>5</td>
<td>Uchana</td>
<td>180</td>
<td>164</td>
</tr>
<tr>
<td>6</td>
<td>Ujhana</td>
<td>201</td>
<td>193</td>
</tr>
<tr>
<td>7</td>
<td>Kalwa</td>
<td>152</td>
<td>151</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1054</td>
<td>1002</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: DPMU, Jind
ASHA facilitators in required numbers have been recruited at all the health blocks and they have been acting as the first point of contact for ASHA in case she has any grievance. One of the main grievances that ASHAs across most blocks of Jind have reported is that their drug kits aren’t refilled timely and this creates a problem for them in providing village level care for minor illness. It is important for district to ensure timely supply of medicines for ASHA drug kit so that credibility of ASHA as a first point contact, at village level, for minor illnesses and further referrals is maintained. Allowing ANMs to indent for refilling of ASHA kits is a positive step in this direction and it needs to be strengthened further.

Another concern reported by ASHAs is delay in release of their payments, in case a Senior Medical Officer [who is the signing authority] is not available at a block. For e.g. in Safidon block the payment were delayed by two months due to this reason. Julana block is also reporting the same issue. It is important that district takes a stock of the situation with its Block ASHA Coordinators and put in place an alternate mechanism of clearing ASHA payments [for e.g. by temporarily allowing posted MO (Medical Officer) as a signing authority] so that such delays could be avoided.

10.2 Skill Development
959 ASHAs in the district have been trained in module 1-5, whereas 42 remain untrained. These 42 are recently recruited ASHAs [as told by District ASHA Coordinator]. For HBPNC modules 1-2 a total of 893 ASHAs have been trained, while 108 remain untrained.

10.3 Village Health, Sanitation and Nutrition Committees (VHSNC)
VHSNC have been formed in all villages of the district, but quality of VHNDs conducted in Jind is not up-to satisfactory levels. Most of the VHNDs have ANMs, ASHAs and AWWs participating together but it has not succeeded optimally to act as an integrated platform for provision of preventive and curative care at village level. Average participants in these VHNDs range from 2-3 ANC/PNC women. These conclusions are based on records that were observed in SHC and from discussions that were taken up the District Public Health Nurse. SHCs still remain the point of care for ANC/PNC/FP services as well as for getting basic lab tests done [for e.g. Hb].

11. Disease Control Programme
11.1 National Programme for Control of Blindness (NPCB)
District has set itself a target of 7728 eye surgeries against which there 1264 eye surgeries have been performed so far, of which 98% are IOL surgery. 36 screening camps for +50 populations have been reported during April to June 2013, while no camps school going children have been conducted. No trainings of MPHW, AWW, ASHAs or any other health functionaries have been performed this year.

11.3 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)
In Haryana this programme is being implemented in the districts Mewat, Ambala, Kurukshetra and Yamuna Nagar and hence it was not observed during the current visit.
12 Others

12.1 Information Systems
DHIS2 is used by the district for uploading data, although district level analysis of the available data was not observed. Data is treated as a 'liability' that has to be collected and uploaded, rather than an ‘asset’ which is could be very pivotal in district and block level planning. For e.g. a simple analysis of manpower posted against number of institutional deliveries being conducted (at PHC level) shows that PHCs having MO conducted an average of 50 deliveries for the period of April to July 2013, while PHCs where only SNs are posted conducted an average of 58 deliveries for the same period. If such kind of analysis (which needs more of ‘logic’ rather than statistical skills) is done at district and block level then it is possible that district could tune policies to its advantage rather than blindly following it.

12.2 OPD and IPD
On an average 146 OPD and 3 IPD per 1000 population at district level has been reported from April to July 2013. One probable reason for a less IPD per 1000 population could be availability of only one GH (Jind) where round the clock IPD care is provided in true sense.

13. Key Findings from Facility Visit

Name of Health Facility – General Hospital Jind

Key Observations –

1. Hospital has a well maintained infrastructure. As of now it is a 100 bedded facility (proposed to be expanded as 200 bedded) providing following services:
   a. Emergency and Trauma Care
   b. General Medicine
   c. General Surgery
   d. ENT
   e. Dentistry
   f. Orthopaedics
   g. Ophthalmology
   h. Obstetrics & Gynaecology
   i. Paediatrics

2. Flow of patients to various OPDs is managed satisfactorily except in the General OPD and at the drug dispensing counter. Both these places were found to be crowded, though at drug dispensing counter a queue was maintained.

3. As of now post natal mothers and infants above one month of age are charged an user fees of 5 per visit. It is important that GH abolishes this practice.

4. Although there is a display of room numbers of various OPDs and directions to different wards/departments of the hospital, it is not helpful to patients as many of them can’t read. It
will be helpful to patients if there could be one counter to provide them with such information. Rogi Shayata Kendras in West Bengal are an example of such an initiative.

**Clinical Services –**

1. **Dental Care –**
   a. Average patient load is 150 to 180 patients. Two dental OPDs manage this caseload. Apart from 2 BDS medical officers, there is availability of an endodontist also.
   b. It was noticed that about dental care to jailed detainees/under-trials was also being provided during the OPD hours and this is leading to increase in waiting time for general populace. It is suggested that services to such people be provided after OPD hours.
   c. Range of services provided include from minor procedures to management of traumatic fractures and other facial injuries.
   d. More IEC material needs to be displayed in waiting area of dental OPD. Hospital could also think of distributing pamphlets with printed pictorial messages to patients.

2. **ICTC –**
   a. A common room is provided to HIV counselor, RTI/STI counselor and ART medicines dispenser. A set up like this is grossly inadequate to ensure patient privacy, and effective counseling.
   b. Both the counselors are experienced but there counseling skills could not be adequately judged.

3. **Family Planning –**
   a. Minilap Tubectomy, PPS, NSV/ Conventional Vasectomy, emergency contraception and Spacing methods are available

4. **Safe abortions services are available at the GH.**

5. **Blood bank services –**
   a. GH has a well equipped and 24X7 functional blood bank, which caters to requirement of about 700 units of blood across the whole district. It is manned by a Blood Transfusion MO, LT and staff nurses.
   b. There are 4 freezers of 200 unit capacity, out of which 2 are used to store treated blood and two for untreated blood.
   c. Blood donation camps are the main source of collection of blood. In addition family donation and willing exchange donors are also promoted.
   d. At least 30 units of all blood groups and 2-5 units of rare blood groups are stocked at the blood bank. Stock outs have not been reported yet.

6. **Obstetrics and Gynaecology Services –**
a. GH is a key institute providing EMOC services in the district. As of now it has one gynaecologist, and one EMOC trained MO.

b. Average institutional delivery load is 300 to 350 per month. Current LSCS rate is between 5 – 10 percent, which is normal considering the fact that there are many referrals from across the district.

c. Duty SNs were aware of Eclampsia management protocol, AMTSL (Active Management of Third Stage of Labor) components and were SBA trained. But not all cases had there Partograph filled and referrals based on partographs were not observed.

d. LR is equipped with 3 labor tables and essential equipments + emergency drugs and attached toilet + 24 hr running water supply.

e. Overcrowding of gynae wards was observed and almost all beds had two patients admitted on them.

f. There is non-availability of post-op wards for LSCS cases and this puts them at higher risks of infection.

7. Child Health Services –

a. As of now immediate newborn care is provided in LR by a paediatrician and for intensive care GH is equipped with a makeshift SNCU.

b. Most common reason for admission in SNCU was found to be respiratory distress and sepsis. It was claimed by the MO that sepsis was usually seen in outborn infants but given the poor infection control practices in wards it is possible that nosocomial infections are increasing.

c. Work of new SNCU needs to be expedited as the make-shift SNCU has poor infection control measures in place.

d. Immunization services are provided at PP centre housed in a separate building within the GH campus.

8. JSSK Implementation –

a. No declaration of entitlements was found displayed near/within the maternity ward/LR or in waiting area.

b. There are 2 critical gaps in provision of JSSK – lack of USG facility at GH and Lack of provision of diet (since almost a month). It is recommended that at-least 2 cooks be put in place and provision of diet be restarted at the GH.

c. All beneficiaries that were interviewed had availed 102 ambulance service.

d. Drugs are being provided free. Necessary BTs are also made available without any cost.

e. Given the delivery load and number of LSCS cases it is important that all components of JSSK be made available at GH.
f. As of now the rates approved for outsourcing the USG services are 150 per case, but at this rate it is becoming difficult for the district to hire USG services. It is recommended that State considers that amount be increased to 200/- so that provision of USG services can be ensured.

9. Referral Transport –
   a. District has 16 functional ambulances, of which 2 are ALS.
   b. At GH 3 ambulances are stationed. Drop back facility and referral to higher centers is being provided.
   c. Sometimes a high waiting period of 2-3 hours is reported, in case all ambulances are busy with more emergency cases.
   d. 32 paramedics have been put in place to provide in-vehicle support to patient, in terms of providing medical first-aid.

**Narawana SDH**

This facility caters to a population of 60 thousand. Although it is a huge facility, only 50 beds are functional due to lack of doctors and paramedical staff.

Essentially this facility provides following services –

1. General OPD
2. Dentist
3. Casualty
4. Gynaecology and Obstetrics
5. AYUSH
6. Blood storage
7. Laboratory
8. X-ray

**General OPD –**

1. It is handled by MS of the hospital.
2. Average OPD case load is between 350-380/day.
3. Due to high volume of patients, there is hardly any ‘personalized’ care provided to the patients. This applies to all the general OPDs that were visited.

**Dental Department –**

1. It is manned by a BDS MO. Average case load is around 50 per day.
2. Dental caries and extraction of teeth are the most common cases that are reported and catered to.

3. OPD is well equipped with a functional dental chair and other equipments. Interaction with the duty MO was done to assess the availability of drugs and supplies, which were found to be made adequately available.

Casualty –

1. It is manned by 4 MOs. In case of any of the duty MOs is busy with other assignments (eg. Court evidences etc), then doctors from other departments pitch-in.

2. On an average there are about 500 MLCs handled by this facility per month.

3. It is equipped with necessary equipments and drugs.

Obstetrics and Gynaecology –

1. Maternity services are provided by 1 specialist, 1 MO and 6 SNs. For surgical needs there is a LSAS trained MO to administer anesthesia.

2. Discussions with duty nurses was taken up and it was observed that, A) they are aware of AMTSL, PPH management, Eclampsia management and post partum care, B) they maintain a LR register, one referral register and one birth and death register, C) they are responsible for maintaining Partograph of women undergoing delivery.

3. As of now there are no LSCS being performed at the facility. Discussions with on duty specialist taken up to understand the constraints. Major reason provided by specialist doctor for not performing LSCS was her being affected by Carpel Tunnel Syndrome, and she being advised by her physician not to perform surgeries. It is recommended that District resolve this issue at the earliest, either by rationalization of HR or by outsourcing/in-sourcing the service.

4. Although the facility is a L3 FRU, due to non-willingness of posted specialist, it is unable to function so.

5. Wards were found to be managed well. Food is being provided to admitted women.

6. Immediate newborn care is provided by the existing staff and high risk cases are referred to GH Jind. There is an NBSU available at the facility and in-sourcing of a paediatrician could be considered by the district.

AYUSH

1. There is a homoeopathic physician posted at the facility along with a pharmacist.

2. On an average 50 patients are catered to. There are referrals from the general OPD too, especially for the cases with skin conditions, allergies, ovarian cysts and few other chronic conditions.

Blood Storage Unit –
1. Blood storage is run by 4 LTs, of which 2 are usually posted at BSU and other two help with the general lab work.

2. MS is I/C MO for the BSU. On an average 10 units/month are utilized at the facility. GH Jind is the supplying blood bank for this BSU.

3. Most of the cases catered to are from casualty and maternity. BSU doesn’t cater services to private patients and all such cases go to GH Jind.

4. BSU has 1 freezer, 1 centrifuge and 1 microscope. All these equipments are functional. No shortage of reagents or supplies noted.

5. BMW management is not up-to mark, especially segregation at the point of origin. General awareness about BMW management was found to be lacking.

Laboratory –

1. Health facility has a well functional laboratory. Its utilization is good, but services are available only during OPD hours.

2. There is a facility of ECG and X-ray also. 300 MA machine is used at the facility. No portable X-ray.

3. Male X-ray technician does ECG too, and it was requested to MS that for female patients a SN be made available.

Safidon CHC –

The health facility is housed in a huge infrastructure which is grossly under-utilized due to severe shortage of manpower. It caters to a population of 1,52,912.

Services provided by this health facility are –

1. General OPD
2. Casualty
3. Dental Care
4. Maternity and Immediate Newborn care

General OPD –

1. It is handled by 2 MOs, one of which is a EMOC trained LMO (Lady Medical Officer). Average case load is 300-350 per day. It was observed that duty doctor could hardly give any time to individual patients due to high volume of patients. Even basic examinations (for eg. Palpation of abdomen in case of abdominal pain) were not performed.

2. Crowd flow management was observed to be poor, resulting in crowding of space around the doctor and no privacy for patients.

Dental care –
1. Provided by a dental MO who is usually deputed from other facility.

2. Functional dental chair and adequate supplies for provision of services.

Maternity and Newborn Care

1. Provided by 1 MO (EMOC trained, but who has to manage the general OPD, and casualty too), and 4 SNs.

2. Well equipped and hygienic LR. Adequate supply of regular and emergency medications.

3. Duty SNs found to be trained in SBA and having satisfactory knowledge about delivery and post delivery care. Partographs found filled, but whether they are used for referring is doubtful.

4. No LSCS being performed. Any suspected complicated case is referred to GH Jind. In last two months number of deliveries conducted were 60 (August), 50 other cases were referred) and 67 (July). For the same duration number of referred cases, both who were sent for BTs and finally delivered at Safidon and those who were referred to higher facilities for further management, were 50 (August) and 80 (July).

5. Anemia was the leading cause for patients being referred out.

6. Skills of EMOC trained MO is not being utilized and leading to increased referrals to GH Jind. It is recommended that district considers rationalization of HR to ensure that, A) either LSCS are being performed at this health facility or B) skill of the trained MO is put to use at some other facility.

Dumerkhan Khurd PHC

1. PHC is housed in a well maintained building, and is a 24X7 L2 facility. But all signal functions of L2 are not provided by the facility.

2. It is manned by
   a. 1 MO (BDS) who attends to general OPD.
   b. 3 SNs who are all SBA trained and conduct normal deliveries, perform referrals of high risk cases and provide post partum care for admitted women. Average length of stay of post partum mothers is between 6-8 hours.
   c. In last three months number of deliveries conducted were – 5 (June), 7 (July) and 19 (August).
   d. LR is equipped with one labour table, regular and emergency medicines, equipments for sterilization and functional oxygen cylinders. Though it was reported by on duty SN that oxygen cylinders leak.
   e. 1 LT
   f. 1 Pharmacist
   g. 1 HI
Essentially most of the PHCs in the district are providing normal delivery facility.

**Kharal SHC**

1. The SHC is manned by 2 ANMs (1 ANM is residential) and a MPHW. It serves a population of 9,166 and has 8 ASHAs under it.

2. Overall functioning of the SHC was found to be satisfactory.

3. SHC provides the services of A) OPD (average monthly case load of 120 -150), B) ANC & PNC (and ID for women who prefer to be delivered by the posted ANM), C) Immunization and D) Family Planning services including IUCD.

4. Equipments and supplies required for provision of above services were available with the SHC.

5. **VHND micro-planning is not being done.** Previous records of sessions conducted under VHND showed that on average 4-5 women attended these sessions, and activities of immunization were essentially carried out during these sessions.

6. Home visits are carried out on 3 week days (Monday, Tuesday and Thursday).

7. First Monday of every month is reserved for ASHA meetings and during these meetings ASHAs are A) oriented on ANC/PNC and newborn care, B) Maintenance of records and C) Compilation of total incentive amount.

8. Following registers were being maintained at the SHC –
   a. Survey Register
   b. ANC/Immunization/Birth/Death Register
   c. Eligible couple Register
   d. OPD/ Malaria Register
   e. Stock Register

9. **MCP cards were examined for correctness of entries and they were found to be filled up properly.** But the records of height to weight for the newborns were not maintained.

10. MPHW is currently providing DOTS to 7 TB cases in population covered by SHC.

11. Referrals from SHC are made to GH Tuhana and SDH Narwana.
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