सत्यमेव जयते

Report of the Comptroller and Auditor General of India Performance Audit on Public Health Infrastructure and Management of Health Services

SUPREME AUDIT INSTITUTION OF INDIA

लोकहितार्थ सत्यनिष्ठा

Dedicated to Truth in Public Interest

Government of Haryana

Report No. 2 of the year 2024

Report of the
Comptroller and Auditor General of India

Performance Audit
on
Public Health Infrastructure and Management of Health Services

Government of Haryana

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PREFACE

This Report has been prepared for submission to the Governor of the State of Haryana under Article 151 of the Constitution of India for being laid before the Legislature. The report has been prepared in accordance with the Performance Auditing Guidelines, 2014 and Regulations on Audit and Accounts, 2020 of the Comptroller and Auditor General of India.

The report of the Comptroller and Auditor General of India contains the results of Performance Audit of Public Health Infrastructure and Management of Health Services covering the period from 2016-17 to 2020-21. The data has been updated up to 2021-22, wherever feasible.

The audit has been conducted in conformity with the Auditing Standards issued by the Comptroller and Auditor General of India.

Audit acknowledges the cooperation received from the Health and Family Welfare Department, Haryana at each stage of the audit process along with their field functionaries in conducting the Performance Audit.

Executive Summary

Executive Summary

National Health Policy (NHP), 2017 was adopted to inform, clarify, strengthen and prioritise the role of the Government in shaping health system in all its dimensions. Considering NHP 2017 and experience in COVID-19 pandemic, performance audit on "Public Health Infrastructure and Management of Health Services" was conducted to assess the adequacy of financial resources allocated, availability of health infrastructure, manpower, machinery and equipment in the health institutions as well as efficacy in the management of health services in the State. The performance audit also covers the efficacy of the regulatory framework being enforced by the Government to regulate private health sector, schemes being implemented by Government of India through State Government and overall linkage with the Sustainable Development Goal-3. The audit was conducted for the period 2016-21 but wherever feasible, the data has been updated up to 2022-23 or later.

The Ministry of Health and Family Welfare, Government of India, has issued a set of uniform standards called the Indian Public Health Standards (IPHS) to improve the quality of healthcare delivery in the country and serve as a benchmark for assessing performance of healthcare delivery system. The IPHS norms for District Hospitals (DHs), Sub-Divisional Civil Hospitals (SDCHs), Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub Centres (SCs) prescribe standards for the services, manpower, equipment, drugs, building and other facilities. These include the standards to bring the health institutions to a minimum acceptable functional grade (indicated as essential) with scope for further improvement (indicated as desired).

In addition to IPHS, various standards and guidelines on healthcare services issued by Government of India such as the Maternal and Newborn Health toolkit; Assessor's Guidebook for Quality Assurance; National Quality Assurance Standards for Public Health Facilities; Bio-Medical Waste Management Rules; and Drugs and Cosmetic Rules were used to evaluate the healthcare facilities in Health Institutions.

As far as Ayushman Bharat (AB) is concerned, Audit has included findings related to Health and Wellness Centres and have also considered implementation of AB while making recommendations in various areas of Health Sector.

As per National Family Health Survey (2019-21), health indicators of the State are better than national indicators except sex ratio, death rate and maternal mortality rate. State Government could spend 6.37 *per cent* of its total expenditure and 0.77 *per cent* of GSDP on health services during 2022-23 way below 8 *per cent* of budget and 2.5 *per cent* of GSDP targeted under NHP 2017. Budget estimates were based on the last years' expenditure plus the usual escalation without comprehensive planning.

Estimation, planning and creation of requisite infrastructure facilities are essential for ensuring the provision of optimum level of healthcare facilities. There was inadequate availability of health institutions as compared to the prescribed norms. There was shortfall in the number of CHCs/PHCs/SCs as compared to the population norms recommended in IPHS. State Government had not made district wise plan detailing the status of bed availability in public and private sector health institutions. Moreover, the existing CHCs/PHCs did not have the required number of beds. The sampled health institutions had many shortcomings in building infrastructure and most of the residential accommodation of selected health institutions were not maintained and were in dilapidated condition. There were planning deficiencies and avoidable delays in various construction works due to delay in ensuring encumbrance free site, obtaining requisite administrative approvals, tendering process etc. There were shortfalls in achievement of the targets of up-gradation of Health and Wellness Centres (HWCs) and Ayush Health and Wellness Centres (AHWCs). Instances of lack of proper upkeep and maintenance of the already constructed/available infrastructure were also noticed, which resulted in these being not fully utilised for the intended purposes.

Audit assessed availability of drugs and equipment against essential drugs and equipment listed in IPHS norms. There was shortage of essential drugs and equipment in all test-checked health institutions and there was wide variation in availability across same types of institutions. One of the reasons for the shortage was non-supply, short-supply, and delay in supply of drugs to the warehouses and health institutions and delay in processing of the indents.

There were many issues in procurement at Haryana Medical Services Corporation Ltd. (HMSCL) including purchase of medicine from blacklisted firm, internal control weakness in drug procurement portal, which allowed receipt at Warehouse prior to the date of dispatch entered by the suppliers, not blacklisting the firms which were repeatedly supplying sub-standard drugs, not transferring the interest on advances taken by HMSCL, etc. There were also issues of quality control as there were delays in testing of drugs, not sending drugs for test, not codifying drugs and distributing drugs which were declared Not of Standard Quality. For local purchase, system of sample testing was not enforced.

Analysis of data of Human Resource Management System (HRMS), which contains information of permanent staff deployed in various departments under Government of Haryana revealed that 17,409, i.e., 41.82 *per cent* of the 41,628 sanctioned posts were vacant.

In terms of percentage of vacant posts, Director Medical Education and Research (DMER), which includes sanctioned strength of five medical colleges at Karnal, Faridabad, Sonipat, Agroha and Nuh and University of Health

Sciences, Rohtak, has shortage of doctors, nurses and paramedic staff. DMER had 40.20 *per cent* vacancies in doctors, 23.9 *per cent* in nurses and 62.5 *per cent* in Paramedics. No regular Directors and Medical Superintendents were appointed in any of the Medical Colleges under DMER.

In DGHS, while average vacancies for doctors, nurses and paramedic staff are 35 *per cent*, it ranged from 14.92 *per cent* in Rohtak to 57.48 *per cent* in Yamunanagar. When post wise vacancies are analysed, it makes the status even worse. For instance, shortage of Radiographer/Ultrasound Technician against the sanctioned strength varied from 37.5 *per cent* in Rohtak district to 100 *per cent* in Fatehabad district. Availability of staff nurse against sanctioned strength varied from excess by 0.65 *per cent* in Rohtak to shortage by 51.62 *per cent* in Ambala district. There was skewed distribution of manpower in all the Health Directorates across districts. Compared to IPHS norms, there was an overall excess of Specialists (including specialists engaged under NHM) in case of DHs but there is a wide variation across districts leading to shortage in six DHs and excess in 15 DHs. In case of SDCHs, the overall shortage of Specialists was 63 *per cent* in the State. 35 out of 41 SDCHs had shortage of more than 50 *per cent* in Specialists compared to IPHS norms. In test-checked health institutions, audit had noticed that many health services could not be provided due to non-availability of staff and infrastructure could not be gainfully utilised. The skewed distribution also led to uneven patient load per doctor.

Further, the sanctioned posts were also not as per population as population to doctor ratio ranges from one doctor sanctioned for 2,339 people in Panchkula district to one doctor sanctioned for 9,999 people in Faridabad district. The DHs, SDCHs and CHCs did not have specialist cadre.

The services that a health institution is expected to provide can be broadly classified as out-patient department (OPD), in-patient department (IPD), emergency services, maternity services, support and auxiliary services. Varying level of shortages were found in all DHs/SDCHs in specialist services. The shortage in availability of specialist services in SDCHs was severe as compared to DHs.

The availability of doctors was not ensured as per the patient load in the health institutions. In IPD services, allocation of beds was not done based on specialities in all the test-checked SDCHs, while OT facility was not available in any of the test-checked PHCs/UPHC. Positive isolation room was not available in DH Panipat, SDCH Narnaund, MCH Nalhar (Nuh) and seven out of 12 test-checked CHCs/ UHCs.

Further, the Bed Occupancy Ratio (BOR) of all the test-checked health institutions were below 80 *per cent* except DHs Hisar and Panipat. LAMA rate of SDCHs Adampur, Samalkha and Narnaund were higher as compared to other

institutions which shows that these hospitals could not gain trust of patients. In Emergency services, it was noticed that facility of 24 hours management of emergency services such as accident, first aid, stitching of wounds etc., were available only in seven out 24 test-checked PHCs/UPHCs. ICU service was not available in eight out of 22 DHs in the State. In Maternity services, institutional births in public health facility remained at 57.5 *per cent* during the period 2019-21. Further, there was shortfall in conducting review of maternal deaths and neonatal deaths during 2016-17 to 2020-21. The radiology services were not available in most of the SDCHs.

Several diagnostic services, both radiological and pathological, as required under IPHS norms were being provided in the health institutions. However, no health institution was providing all the diagnostic services as prescribed under IPHS. Among auxiliary and support services, health institutions up to CHC level were performing well in providing few services, while improvement was needed in most of other services. Further, PHCs are required to improve in all these services.

There was shortfall in required number of equipment, consumables, miscellaneous supplies, essential medicines, etc. in Health and Wellness Centres (HWCs). None of the test-checked HWCs had created and maintained the database of all families and individuals in an area served by an HWC. Health Cards and Family Health Folders were also not made. Further, the identification and registration of beneficiaries/ family was not done for Pradhan Mantri Jan Arogya Yojana by any of the test-checked HWCs.

The implementation of test-checked centrally sponsored schemes like NUHM, Family welfare, Nikshay Poshan Yojana etc. in the state of Haryana was not commensurate to the targets set for the respective schemes. There were shortfalls in utilisation of the allotted funds. There were delays in payment of financial assistance/incentive under Family welfare scheme, Janani Suraksha Yojana and Nikshay Poshan Yojana. Further, efforts to increase the awareness amongst the various stakeholders which could result in greater participation and enthusiasm towards the various programmes, was also found inadequate. Monitoring and implementation of various programmes were not effective, which resulted in the available resources being not fully utilised.

While the Legislature has developed a statutory framework for regulation of the medical sector, implementation of the Rules by the Government was not effective. While adopting the CEA Act, it was restricted to clinical establishments having more than fifty beds, and thus, private clinic establishments having less than 50 beds were kept out of the regulatory mechanism. Resultantly, the prescribed minimum standards of facilities and services cannot be ensured in these unregistered clinical establishments. Further, even after four years from the date of the notification of minimum

standards in respect of Medical Diagnostic Laboratories, Health Department is continuing the provisional registration instead of permanent registration. Further, the functioning of other regulatory bodies was also not in full compliance of the respective acts, with issues of non-constitution of requisite councils, lack of regular meetings, irregular inspections, lack of monitoring etc. being noticed. Thus, the mechanism developed by the legislature to regulate the various constituents of medical sector remained ineffective as the Government did not implement the provisions in true spirit and the enforcement remained ad-hoc and perfunctory.

SDGCC had not formulated 7 years' strategic plan and 3 years' action plan for implementation of SDGs. Budget was not allocated target-wise, in absence of which, it is not possible to assess impact of allocation on a particular target. The State adopted 39 NIF (National Indicator Framework) indicators which covered 12 targets in its State Indicator Framework (SIF). The State was able to publish only 10 NIF Indicators covering 8 targets (out of 13 targets of SDG-3) even after lapse of six years out of 15 years' timeframe for achievement of SDGs. Performance in four indicators of SDG-3 was not satisfactory with reference to national targets despite increase in expenditure on health services. Eight steps process to be adopted for localisation of the SDGs in the State was not executed effectively.

Recommendations

In view of the above mentioned findings, Audit recommends the following:

Government may consider increasing budget allocation on health services in line with the guidelines of National Health Policy. The budget estimates should be prepared keeping in view bottom up/systematic approach by obtaining demand assessment from the field offices.

The Government should make a plan for determining the requirements and providing the requisite infrastructural facilities in each district, on the basis of its population, local epidemiology, health-seeking behaviour of the population, contribution of the private sector, the benchmarks set under National Health Policy and IPHS. The Government may look into the issues of delays in start and/or completion of planned infrastructural works, with a view to remove the bottlenecks and ensure speedy completion.

Availability of essential drugs and equipment should be ensured at all health institutions. Online Drug Management Information System (ODMIS) portal should be updated to capture deficiency in availability of essential drugs at health institutions dynamically and consequently help better monitoring and planning of drug availability at the level of health institutions.

Government could also consider making the availability of medicines and equipment at health institutions visible to citizens making the system more

transparent and accountable. Clear cut timelines and responsibilities needs to be defined for processing of the indents. Accountability should be fixed in cases of wrong entry of supply date resulting in undue benefit to the suppliers, non-levy of penalty for non-supply of medicines, procurement of medicines from blacklisted firms, and not blacklisting firms repeatedly supplying sub-standard drugs, continued procurement of drugs from suppliers despite their drugs being tested NSQ and delayed testing or not testing drugs. In case of locally purchased medicines, a system of sample testing (not all cases) like the one adopted by HMSCL should be adopted. Standard Operating Procedure (SOP) for storage of medicines at health institutions should be adopted.

Government should bring out a long-term strategy and policy to reduce variations in doctor-population ratio across districts. In the short term, the existing staff strength should be rationalised across districts and health institutions. While rationalising, it should be ensured that the postings are done in such a way that complimentary healthcare professionals i.e., doctors, nurses, paramedics, technicians and other support staff are posted in each health institution.

Government should consider bringing in sanctioned strength of Health departments including Specialists at par with the IPHS norms and should focus on expediting recruitment process in order to fill vacancies in the sector. Government should plan through State policy for assessment of medical personnel, sanction of posts, recruitment and deployment of doctors, nurses and paramedical staff.

Government should map availability of the infrastructure, services, and human resources against identified benchmark and create a centralised database of infrastructure and services available across government health institutions, to identify gaps, take informed decision with respect to allocation of funds and reduce idle infrastructure. Government should ensure availability of all OPD services, IPD services, emergency services, diagnostic services as prescribed under IPHS norms. Steps should be taken to improve and strengthen auxiliary and support services to improve overall healthcare experience.

Monitoring and implementation mechanisms of various centrally sponsored schemes/programmes need to be reviewed to ensure that distribution of resources (both human and financial) are made as per actual requirements, to avoid instances of shortages or excess. Government may review the data collection mechanisms to ensure availability of a reliable monitoring mechanism. Government may attempt to increase awareness and outreach through various activities, for making the target population aware of the benefits along with removal of fears and/or misconception and increase participation.

Government should extend provisions of CEA to all clinical establishments including both private hospitals and diagnostic laboratories in a phased manner.

Government may adopt the GoI standards notified for the diagnostic labs and make permanent registration mandatory, along with taking up the matter with GoI for resolving the issues related to online portal for permanent registration of Medical Diagnostic Laboratories.

The targeted number of inspections may be carried out to ensure quality of the drugs sold. It may be ensured that all utilities generating bio-medical waste comply with the provisions with regard to authorisation, bar coding, annual returns along with third party inspection. All requisite regulatory bodies may be constituted as per the respective statutory norms, and these bodies may adopt an adequate and effective monitoring mechanism to guarantee conformity with the necessary minimum standards.

The State Government may take steps to adopt more numbers of indicators in Haryana SDG Index Report so as to present a comprehensive picture for measuring and monitoring the performance of the State in achievement of SDG. State strategic plan with well-defined milestones for measuring and monitoring implementation may be developed after due consultations.

Reports prepared by the SDGCC should have information on target-wise actual spending showing performance against the planned budget expenditure thereby assisting in judicious and adequate resource allocations. Further, SDGs Dashboard should be operational and SDG Mission Committee (SDGMC) as well as State Level Coordination Committee (SLCC) should be constituted for ensuring availability of data and creation of a continuous monitoring and reporting framework.

Chapter-I
Introduction

Chapter-1

Introduction

Health and Family Welfare Department, Haryana has adopted the World Health Organisation's (WHO) definition of Health i.e., "Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity." The aim of the Government of Haryana is to provide quality healthcare to all its citizens by constantly upgrading itself in terms of infrastructure, human resources, drugs, equipment etc. The Department's objective is to provide adequate, accessible, equitable, quality healthcare services to all leading to the reduction of out-of-pocket expenditure on health of a common man.

As per Business of the Haryana Government (Allocation) Rules 1974, the Health Department is responsible for all matters related to physical, mental and social well-being of citizens as listed in ***Appendix 1.1***.

1.1 Health services

Health services provided by the hospitals can broadly be divided in the categories *vi .,* Line services, support services and auxiliary services as shown below:

Line services

i. Outdoor patient department
ii. Indoor patient department
iii. Emergency services
iv. Super specialty (OT, ICU)
v. Maternity
vi. Blood bank
vii. Diagnostic services

Support services

i. Oxygen services
ii. Dietary service
iii. Laundry service
iv. Biomedical waste management
v. Ambulance service
vi. Mortuary service

Auxiliary services

i. Patient safety facilities
ii. Patient registration
iii. Grievance / complaint redressal
iv. Stores

Resource Management

i. Building Infrastructure
ii. Human Resource
iii. Drugs and Consumables
iv. Equipment

All public health services depend on the presence of basic infrastructure including availability of human resources. Every public health program - such as immunisation, infectious disease monitoring, cancer and asthma prevention, drinking water quality and injury prevention requires health professionals who are competent in synergising their professional and technical skills in public health and provide organisations with the capacity to assess and respond to community health needs. Public health infrastructure has been referred to as

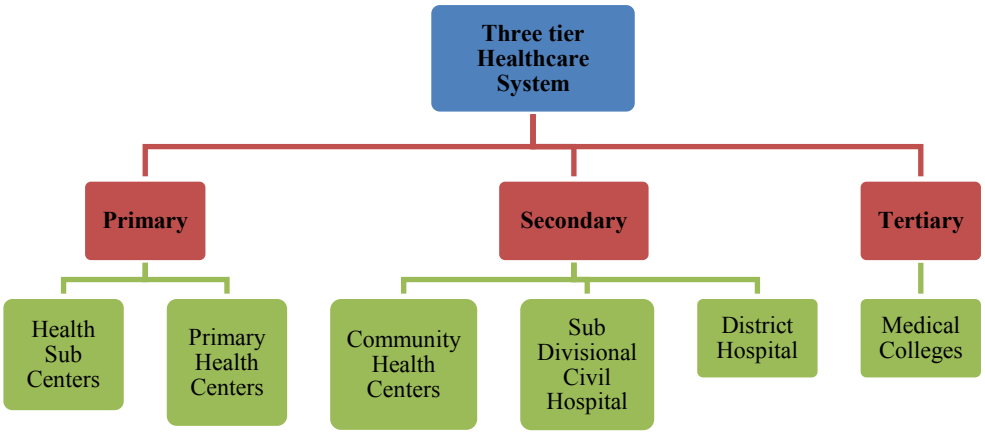
"the nerve centre of the public health system". While creation of strong infrastructure is responsibility of many organisations, public health agencies (health departments) are considered primary players.

The primary objective of National Health Policy, 2017 is to improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public sector. The policy also recognises the pivotal importance of Sustainable Development Goals to ensure healthy lives and promote well-being for all at all ages. At the global level, the Sustainable Development Agenda aims to ensure healthy lives and promote well-being for all at all ages by 2030 as per Sustainable Development Goal (SDG)-3 (Good Health and Well-being).

Indian Public Health Standards (IPHS) are a set of uniform standards envisaged to improve the quality of healthcare delivery in the country. IPHS norms were revised in 2012 and 2022 keeping in view the changing protocols of the existing programmes and introduction of new programmes, especially for Non-Communicable Diseases but the State Government has not adopted IPHS norms.

1.2 Overview of healthcare facilities in the State

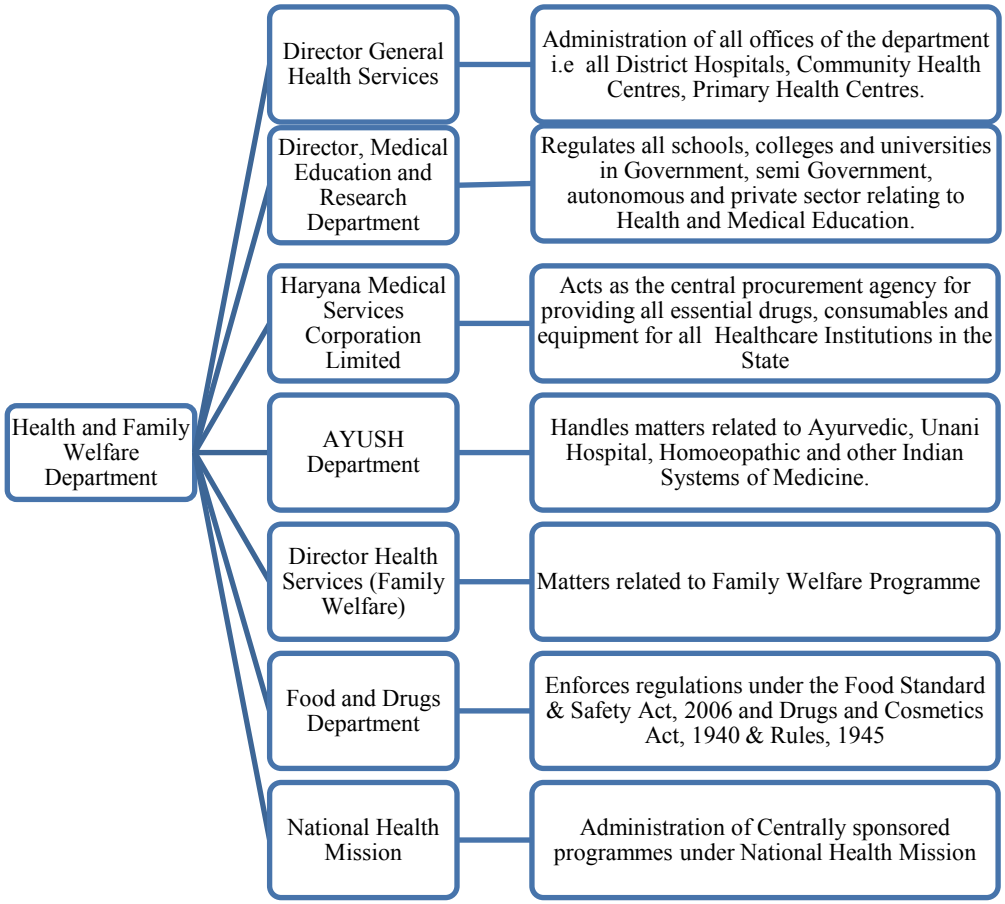
In the State, public healthcare is structured into three levels for providing primary care, secondary care and tertiary care as indicated below:



Health Sub-Centres (HSCs) and Primary Health Centres (PHCs) are primary level healthcare units which provide initial healthcare services to the people. Patients requiring more serious healthcare attention are referred to the second tier of the healthcare system consisting of Community Health Centres (CHCs), Sub-District/ Sub-Divisional Hospitals and District Hospitals, established in each district for providing preventive, promotive and curative healthcare services to the population. A tertiary referral hospital is a hospital that provides tertiary care, which is healthcare from specialists in a large hospital after referral from primary care and secondary care. Tertiary healthcare is provided by the hospitals associated with the Government Medical colleges.

1.3 Organisational Set-Up

Health and Family Welfare Department has seven directorates as described in the organogram.



The heads of health services at the district level are Civil Surgeons (CSs) while the District Hospitals are headed by Principal Medical Officers (PMOs)/Medical Superintendents (MSs)/Senior Medical Officers (SMOs). Community Health Centres (CHCs) and Primary Health Centres (PHCs) are headed by SMOs and MOs in-charge, respectively. As per information provided by DGHS, Haryana, there were 22 Civil Hospitals, 41 Sub Divisional Civil Hospitals, 127 CHCs and 409 PHCs as of February 2024.

Medical Education and Research Department, Haryana under its jurisdiction has one All India Institute of Medical Sciences, Manethi (Rewari), two Universities of Health Sciences[1], one Post Graduate Institute of Medical Sciences[2], five Medical Colleges[3] (functional), three[4] Medical Colleges (under construction),

[1] (i) University of Health Sciences, Rohtak and (ii) University of Health Sciences, Kutail (Karnal).

[2] Post Graduate Institute of Medical Sciences, Rohtak

[3] (i) BPS Government Medical College (GMC) for Women, Khanpur Kalan (Sonepat), (ii) Shahid Hasan Khan Mewati, GMC, Nalhar (Nuh), (iii) Kalpana Chawla GMC, Karnal, (iv) Sh. Atal Bihari Vajpayee, GMC, Chhainsa (Faridabad) and (v) Maharaja Agrasen Medical College, Agroha (Hisar).

[4] GMC: (i) Bhiwani, (ii) Jind and (iii) Narnaul.

two Nursing Colleges[5], three General Nursing and Midwifery (GNM) Training Schools[6] and eight Auxiliary Nurse Midwife (ANM) Training Schools[7].

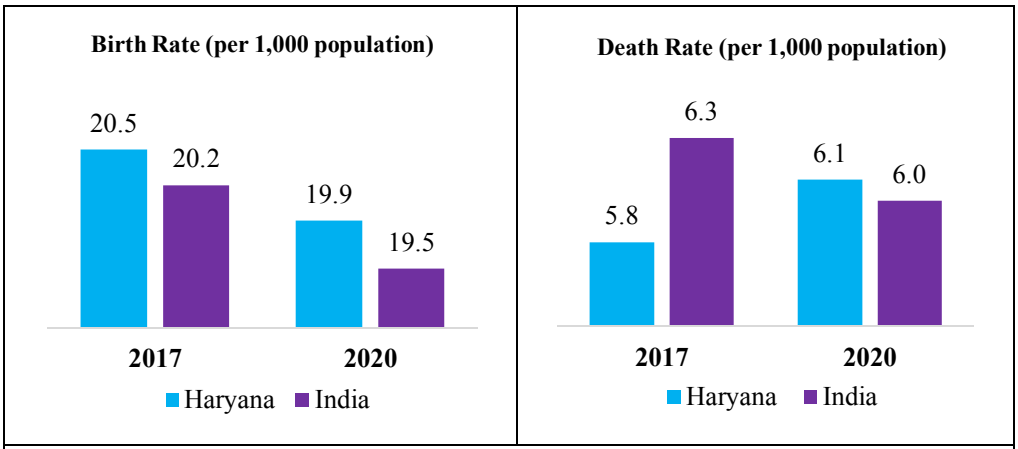
There are four Food/ Drug/ Chemical laboratories under the control of Food and Drug Department, Haryana. The State Government has notified Senior Control Officers as the Licensing Authorities for the retail sale establishments for their respective zones namely Ambala, Hisar, Gurugram, Faridabad, Rohtak, Karnal, Rewari, Sirsa, Sonipat and Kurukshetra. State Drug Controller has been notified as Licensing Authority to grant/renew Drug Manufacturing License (DML) including for Homoeopathic medicines as well as cosmetics.

AYUSH Department has two Ayurveda Colleges, 555 dispensaries, 2 *Panchkarma* Centres, 8 Ayurvedic *Prathmik* Seva *endras*, 3 Ayurvedic Hospitals and 5 Special Therapy Centres. National Health Mission is headed by Mission Director, which has 22 District Health Societies (DHSs) one located in each district of the State. The Mission implements Central Schemes/ Centre-State sharing schemes through DHSs, CHCs and PHCs.

1.4 Status of Health Indicators in the State

The healthcare services in the State can be evaluated based on the achievement against benchmark of health indicators. The status of a few important health indicators of Haryana *vis-a-vis* national average are given below:

Chart 1.1: Health Indicators in the State

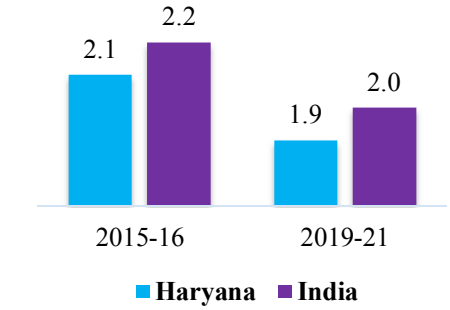


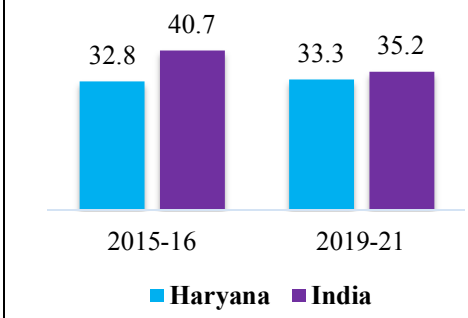
Source: Sample Registration System bulletin

[5] Government Colleges of Nursing at (i) Safidon (Jind) and (ii) Kutail (Karnal).

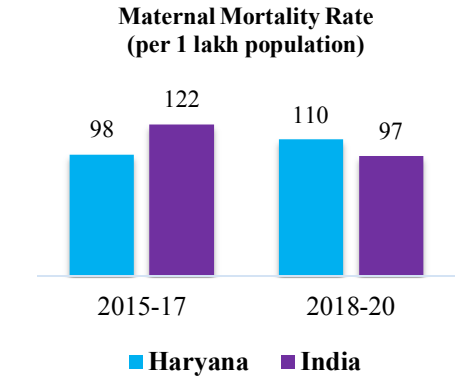
[6] GNM Training Schools at (i) Karnal, (ii) Hisar and (iii) Bhiwani.

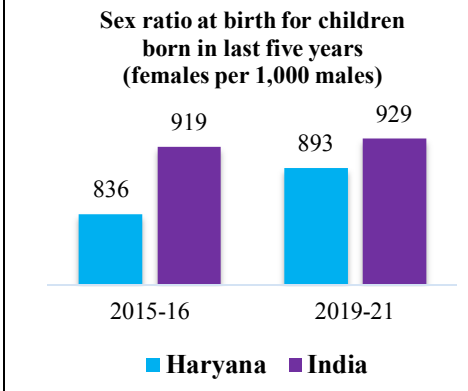
[7] ANM Training Schools at (i) Ambala, (ii) Narnaul, (iii) Rohtak, (iv) Bhiwani, (v) Sirsa, (vi) Gurugram, (vii) Faridabad and (viii) Mandi Khera (Nuh).





Source: NFHS-4 (2015-16) and NFHS-5 (2019-21)





Source: Sample Registration System bulletin for MMR for both (2015-17 and 2018-20) and NFHS-4 (2015-16) NFHS-5 (2019-21) for sex ratio.

It was observed that though the birth rate (per 1,000) in the State had decreased from 20.5 (2017) to 19.9 (2020), it was more than the national average. Death rate in the State increased from 5.8 (2017) to 6.1 (2020) which was above the national average. In case of total fertility rate, it has decreased from 2.1 (2015-16) to 1.9 (children per woman) in 2019-21, which is lower than the national figures. Infant mortality rate increased from 32.8 (2015-16) to 33.3 (2019-21) but was still less than the national infant mortality rate.

Maternal Mortality Rate of the State has increased from 98 (2015-17) to 110 (2018-20) whereas it has decreased for the nation. Sex Ratio at birth for children born in the last five years (females per 1,000 males) in the State increased from 836 (2015-16) to 893 (2019-21) but is still below the national average.

1.4.1 Haryana Health Indicators compared with National Health Indicators

The National Family Health Survey conducted in 2015-16 (NFHS-4) and NFHS-5 conducted in 2019-21 provides information on population, health and nutrition for India and each state/union territory (UT). Some of the important health indicators of State of Haryana are given in ***Table 1.1***.

Table 1.1: Comparison of Health Indicators as given in NFHS-4 and NFHS-5

Indicator	NFHS -4 (2015-16)		NFHS-5 (2019-21)	
	Haryana	India	Haryana	India
Sex ratio of the total population (females per 1,000 males)	876	991	926	1,020
Neonatal mortality rate (NNMR) (per 1,000 live births)	22.1	29.5	21.6	24.9
Under-five mortality rate (U5MR) (per 1,000 live births)	41.1	49.7	38.7	41.9
Mothers who had an antenatal check-up in the first trimester (%)	63.2	58.6	85.2	70.0
Mothers who had at least 4 antenatal care visits (%)	45.1	51.2	60.4	58.1
Mothers whose last birth was protected against neonatal tetanus[8] (%)	92.3	89.0	90.7	92.0
Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	32.5	30.3	51.2	44.1
Mothers who consumed iron folic acid for 180 days or more when they were pregnant (%)	14.3	14.4	32.0	26.0
Registered pregnancies for which the mother received a Mother and Child Protection (MCP) card (%)	92.0	89.3	96.8	95.9
Mothers who received postnatal care from a doctor/nurse/ LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	67.3	62.4	91.3	78.0
Average out-of-pocket expenditure per delivery in a public health facility (₹)	1,569	3,197	1,666	2,916
Children born at home who were taken to a health facility for a check-up within 24 hours of birth (%)	1.4	2.5	3.8	4.2
Children who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	NA	NA	91.0	79.1
Institutional births (%)	80.4	78.9	94.9	88.6
Institutional births in public health facility (%)	52.0	52.1	57.5	61.9
Home births that were conducted by skilled health personnel[9] (%)	5.8	4.3	1.1	3.2
Births attended by skilled health personnel (%)	84.6	81.4	94.4	89.4
Births delivered by caesarean section (%)	11.7	17.2	19.5	21.5
Births in a private health facility that were delivered by caesarean section (%)	25.3	40.9	33.9	47.4
Births in a public health facility that were delivered by caesarean section (%)	8.6	11.9	11.7	14.3

Source: National Family Health Survey-4 &5

NA Data not available under N HS-4

Colour code		Indicates improvement as compared to NFHS-4		Indicates decline in position as compared to NFHS-4

Health indicators (2019-21) of the State are better than national indicators. There has been improvement in Neonatal Mortality Rate (NMR), Under-five Mortality Rate (U5MR), antenatal check-ups, use of iron and folic acid by pregnant women, registered pregnancies for which the mother received a Mother and Child Protection (MCP) card, postnatal care and institutional births in public health facility in Haryana.

There has been decline in mothers whose last birth was protected against neonatal tetanus and increase in average out-of-pocket expenditure per delivery in a public health facility and births delivered by caesarean section in the State.

[8] Includes mothers with two injections during the pregnancy for their last birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time prior to the last birth.

[9] Doctor/nurse/LHV/ANM/midwife/other health personnel.

1.5 Audit Objectives

The new National Health Policy (NHP) adopted in 2017 builds on the progress made in 14 years since the last NHP came in 2002. The context had changed in four major ways. First, although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases. The second important change is the emergence of a robust healthcare industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to healthcare costs, which are presently estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, the new health policy was adopted to respond to these contextual changes. The primary aim of NHP 2017 is to inform, clarify, strengthen and prioritise the role of the Government in shaping health systems in all its dimensions.

Considering the goals laid down in NHP 2017 and experience in COVID-19 pandemic, it has become crucial to assess the adequacy of financial resources, availability of health infrastructure, manpower, machinery and equipment in the health institutions as well as efficacy in the management of health services in the State through existing policy interventions and scope for further improvement. Thus, to ensure timely and systematic corrections, a performance audit on Public Health Infrastructure and Management of Health Services in the state of Haryana was taken up. The objective of the performance audit was to provide a holistic view of the healthcare sector in the State i.e., a macro picture using State level information and data and a micro picture arising from audit findings on maintenance of infrastructure and delivery of healthcare services.

The objectives of the Performance Audit (PA) were to:

- assess the availability of the necessary human resource at all levels e.g. doctors, nurses, paramedics etc.;
- assess the availability of drugs, medicines, equipment and other consumables;
- assess the availability and management of healthcare infrastructure;
- assess the adequacy of the funding for healthcare;
- examine the funding and spending on various schemes of the Government of India;
- examine the adequacy and effectiveness of the regulatory mechanisms for ensuring that quality healthcare services are provided in the public/ private healthcare institutions/ practitioners;
- assess whether State spending on health has improved the health and well-being conditions of the people as per SDG-3.

1.6 Scope of Audit

The audit was conducted for the period 2016-21. However, the information regarding human resources has been incorporated as available on the Human Resource Management System (HRMS) as of October 2022. Budget and expenditure information and number of OPD/IPD cases has been updated upto March 2023. The information in respect of procurement of drugs/medicines/ equipment has been taken upto March 2022. Information related to specialists and specialty-wise OPD services has been incorporated as provided by the department as of April/May 2023. Population data of Census 2011 has been used wherever applicable. Details of health institutions have been considered as of February 2024. The audit sample is described below.

All seven directorates

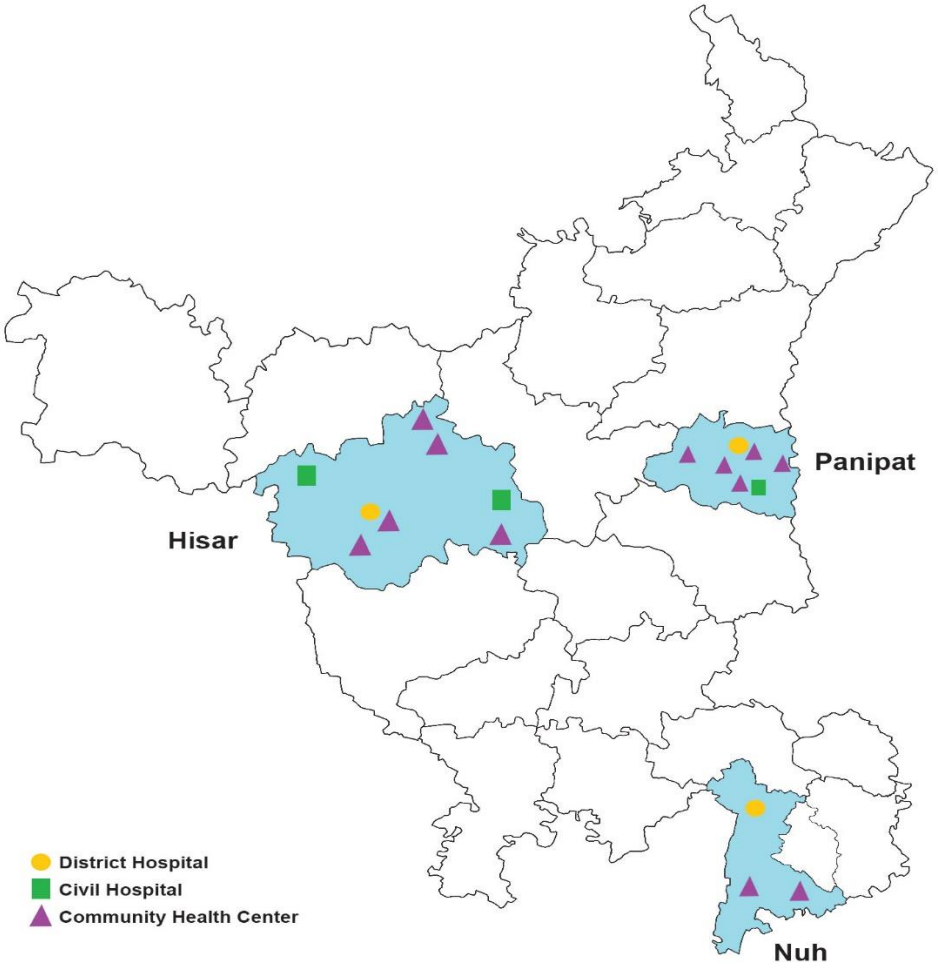
- Director General, Health Services
- Director, Medical Education and Research Department
- Haryana Medical Services Corporation Limited
- Director General, AYUSH Department
- Commissioner, Food and Drug Administration
- Director, Family Welfare
- Mission Director, National Health Mission

Three districts (Panipat, Nuh and Hisar) for field study out of 22 districts selected using Stratified Random Sampling Method

- All three Districts/General Hospitals of the selected districts
- One dedicated TB Hospital, Hisar
- Three out of six Sub Divisional Civil Hospitals
- Ten out of 18 Community Health Centres (CHCs)
- Two out of four Urban Health Centres (UHCs)
- 19 out of 52 Primary Health Centres (PHCs)
- Five out of 10 Urban PHCs 50 *per cent*
- 31 out of 112 Sub-centres
- 24 out of 98 Ayurvedic Dispensaries
- Two Medical Colleges i.e. Agroha and Nalhar (Nuh) of selected districts
- One Government General Nursing and Midwifery (GNM) School of Nursing, Hisar and one Government Auxiliary Nurse Midwifery (ANM) Training School, Mandikhera of the selected districts.

The details of selected Health Institutions in the sampled districts are given in ***Appendix 1.2***. Records regarding Sustainable Development Goal (SDG-3) have been analysed during audit of Sustainable Development Goals Coordination Centre (SDGCC) under Swarna Jayanti Haryana Institute for Fiscal Management (SJHIFM). Moreover, the records pertaining to assistance/grants/ equipment received for COVID-19 have also been scrutinised. Funding by Local Bodies and private sector on healthcare has been excluded. However, the regulatory aspects/information available with the Health Department have been reviewed during the PA.

The Entry Conference and Exit Conference were held on 02 March 2022 and 10 January 2023 respectively with Additional Chief Secretary to Government of Haryana, Health & Family Welfare Department. The responses received from the Department during the Exit Conference have been suitably incorporated in this report. The draft report has been updated on the basis of replies and information obtained from various offices. The latest updated draft report was sent to the State Government in September 2023 for further comments. Their reply was awaited (March 2024). Districts selected for field units in Haryana are depicted on the map below:



1.7 Doctors'/patients' Survey

A survey of 33 doctors (from six selected hospitals), 120 Out-patient department (OPD) patients (10 patients per DH and SDHC; and five patients per CHC) and 39 In-patient department (IPD) patients, selected on random basis, was conducted (January 2022 to June 2022) during the performance audit in order to get feedback from doctors and regarding patients' satisfaction with healthcare facilities/ services. The outcome of the survey has been depicted in ***Appendix 1.3***.

1.8 Audit Criteria

Criteria adopted for the performance audit include:

i. National Health Policy, 2017.

ii. Indian Public Health Standards, 2012.

iii. NHM Assessor's Guidebook for Quality Assurance.

iv. Clinical Establishment Act, 2010 as adopted by Government of Haryana.

v. Food Safety and Standards Act, 2006.

vi. Drugs & Cosmetics Act, 1940.

vii. The Indian Nursing Council Act, 1947.

viii. National Family Health Survey -4 & 5

Other criteria have been mentioned in ***Appendix 1.4***.

1.9 Consideration of Ayushman Bharat in this report

Ayushman Bharat (AB), the flagship health scheme of the Government of India, was launched in September 2018 to achieve Universal Health Coverage as recommended in the National Health Policy, 2017. AB adopts a continuum of care approach, comprising of two inter-related components, which are:

Health and Wellness Centres (HWCs)

- Creation of 1,50,000 HWCs by transforming the existing Sub Centres and Primary Health Centres.
- Aim to deliver Comprehensive Primary Healthcare (CPHC) covering maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

Pradhan Mantri Jan Arogya Yojana (PM-JAY)

- Aims to provide a cover of ₹ 5 lakh per family per year for secondary and tertiary care hospitalisation across public and private empanelled hospitals in India.
- Over 10.74 crore poor and vulnerable entitled families (approximately 50 crore beneficiaries) are eligible for these benefits.
- Provides cashless access to healthcare services for the beneficiary at the point of service, that is, the hospital.
- Benefits of the scheme are portable across the country i.e., a beneficiary can visit any empanelled public or private hospital in India to avail cashless treatment.
- Services include approximately 1,387 procedures covering all costs related to treatment, including but not limited to drugs, supplies, diagnostic services, physician's fees, room charges, surgeon charges, OT and ICU charges etc.
- Public hospitals are reimbursed for healthcare services at par with private hospitals.

Government of Haryana (GoH) had registered State Health Authority (SHA), in August 2018 i.e. Ayushman Bharat Haryana Health Protection Authority (AB-HHPA) under the Haryana Registration and Regulation of Society Act, 2012. SHA is the Governing Body of AB-HHPA which is responsible for implementing PM-JAY in the State of Haryana. In Haryana, 1,498 medical establishments[10] are empanelled with AB-PMJAY as on 24 January 2024.

As per Socio Economic and Caste Census (SECC) 2011, there were 73.50 lakh beneficiaries under 15.52 lakh households. Out of 73.50 lakh beneficiaries, 25.69 lakh beneficiaries under 8.72 lakh households were registered in Haryana State as on March 2021 with Beneficiary Identification System (BIS) under PM-JAY on the basis of their eligibility as per national criteria i.e., SECC database. Thus, total coverage of households and beneficiaries was 56.19 *per cent* and 34.95 *per cent* respectively in the State (as of March 2021). Coverage of beneficiaries across districts varied as detailed in ***Table 1.2***.

[10] Government medical establishments: 511 + Private hospitals: 987

Table 1.2: Coverage of beneficiaries across districts under PM-JAY (as on 31 March 2021)

Sl. No.	Name of District	Total no. of eligible SECC beneficiaries	No. of beneficiaries registered under PM-JAY	*Per cent* of beneficiaries registered under PM-JAY
1	Ambala	3,11,467	1,26,559	40.63
2	Bhiwani	4,14,832	1,66,609	52.32
3	Charkhi Dadri		50,450	
4	Faridabad	5,42,436	92,816	17.11
5	Fatehabad	3,07,809	1,07,162	34.81
6	Gurugram	3,58,601	88,282	24.62
7	Hisar	4,79,947	2,07,705	43.28
8	Jhajjar	1,78,690	76,783	42.97
9	Jind	3,92,029	1,47,283	37.57
10	Kaithal	3,87,709	1,58,236	40.81
11	Karnal	5,59,658	2,15,227	38.46
12	Kurukshetra	3,29,103	1,39,149	42.28
13	Mahendragarh	2,08,158	99,520	47.81
14	Nuh	3,31,005	70,530	21.31
15	Palwal	3,16,105	96,259	30.45
16	Panchkula	1,13,871	36,836	32.35
17	Panipat	3,71,879	1,15,473	31.05
18	Rewari	2,05,191	74,241	36.18
19	Rohtak	3,03,675	78,994	26.01
20	Sirsa	4,02,301	1,31,361	32.65
21	Sonipat	3,84,410	1,16,945	30.42
22	Yamuna Nagar	4,50,846	1,71,972	38.14
Total		**73,49,722**	**25,68,392**	**34.95**

Source: Information provided by Health Department

Poor	Moderate	Good

An all-India Performance Audit of PM-JAY was conducted for the period September 2018 to March 2021, in which Haryana was one of the sampled states. The result of the said audit have been included in the All India Performance Audit Report (Report No. 11 of 2023). In the current report, findings related to Health and Wellness Centres have been included in a separate chapter and audit has also considered implementation of Ayushman Bharat while making recommendations in various areas of the Health sector.

1.10 Audit Findings

Field study for the PA for the period 2016-17 to 2020-21 was conducted from September 2021 to July 2022. The audit observations noticed are given in the succeeding chapters:

Chapter 2:	Human Resources
Chapter 3:	Healthcare Services
Chapter 4:	Availability of Drugs, Medicines, Equipment and Other Consumables
Chapter 5:	Healthcare Infrastructure
Chapter 6:	Financial Management
Chapter 7:	Implementation of Centrally Sponsored Schemes
Chapter 8:	Adequacy and effectiveness of the regulatory mechanisms
Chapter 9:	Sustainable Development Goal – 3

Chapter-2
Human Resources

Chapter 2

Human Resources

For an effective and efficient functioning of a health institution, adequate number of motivated, empowered, trained and skilled human resources is essential. Human resource planning is a must before investing in other components like infrastructure, equipment, drugs etc. The number and type of staff in terms of Specialists, General Duty Medical Officers (GDMOs), nurses, allied health professionals, administrative and support staff etc. has to be ascertained taking into consideration medical requirements of the people to which the health institution caters to.

Availability of manpower and related issues have been discussed in this chapter.

2.1 Human resource availability against sanctioned strength

The Human Resource Management System (HRMS), a module of Integrated Financial Management System (IFMS), contains information of permanent staff deployed in various departments under Government of Haryana. Audit obtained the data dump of HRMS as of October 2022 and analysed the data. HRMS data could provide information about the sanctioned strength and manpower deployed in each Government establishment under Department of Health. Year-wise information of sanctioned strength and persons-in-position was neither available in HRMS nor provided by the concerned Directorates. Audit obtained and analysed the data related to:

i. Director General Health Services (DGHS)

ii. AYUSH

iii. Director Medical Education and Research (DMER)

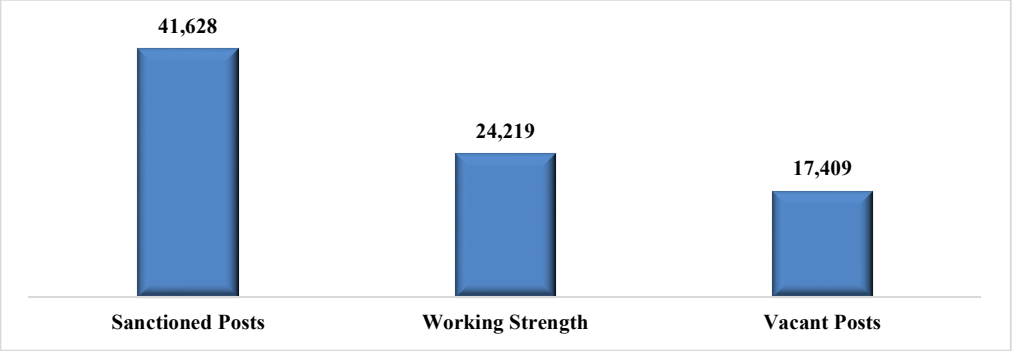
iv. Family Welfare (FAW)

v. Food and Drugs Administration (FDA)

vi. Haryana Medical Services Corporation Limited (HMSCL)

HRMS provides information about sanctioned strength and persons-in-position for all the offices (Directorates, Medical Colleges, District Hospitals (DHs), Community Health Centres (CHCs), Public Health Centres (PHCs), Sub Centres (SCs), Field staff, *etc.*) of the above-mentioned Directorates. The position of sanctioned strength and persons-in-position in the above-mentioned health sector related Directorates in the State taken together as on 31 October 2022 is given in ***Chart 2.1***.

Chart 2.1: Manpower position in Government Health Institutions



Source: Analysis of data from Human Resource Management System (HRMS), Haryana

Thus, there was 41.82 *per cent* vacancies across the Directorates as evident from the graph. Details of manpower in different health Directorates /institutions is given in ***Table 2.1***.

Table 2.1: Manpower position across the different Health Departments (as of October 2022)

Name of the Directorate/ Institution	Sanctioned strength	Share in Total Workforce (in *per cent*)	Working Strength	Vacant Posts	Percentage of Vacant Posts
Director General Health Services (DGHS)	25,307	60.79	15,299	10,008	40
Department of Medical Education and Research (DMER)	10,072	24.20	5,430	4,642	46
Family Welfare (FAW)	3,384	8.13	2,213	1,171	35
AYUSH	2,277	5.47	1,016	1,261	55
Food and Drugs Administration Haryana	583	1.40	257	326	56
Haryana Medical Services Corporation Limited (HMSCL)	5	0.01	4	1	20
Total	**41,628**	**100**	**24,219**	**17,409**	**41.82**

Source: HRMS data
Colour code: Red denotes most shortages; yellow denotes moderate shortages.

DGHS and DMER have major share in the total sanctioned strength. They contribute to 85 *per cent* of the total sanctioned workforce of health sector and DGHS Directorate alone contributes 60.79 *per cent* of the total sanctioned workforce. In terms of percentage of vacant posts, the Directorate of Food and Drugs Administration Haryana and AYUSH have the highest shortage of manpower at 56 and 55 *per cent* respectively.

In addition to permanent staff as mentioned in the table above, contractual staff had also been engaged by all the health departments/institutions for better and efficient delivery of services under the State policy for engaging/outsourcing of services, 2015 and through Haryana Kaushal Rozgar Nigam. Position of the same is given in ***Table 2.2.***

Table 2.2: Manpower position of contractual staff across the different Health Directorate (as of January 2024)

Name of the Directorate/Institution	Working Strength	Main posts filled up through outsourcing
Director General Health Services (DGHS)	10,827	Sweepers, Ward servants, Security men, clerical and other support staff.
National Health Mission (NHM), Haryana	14,468	Total staff including doctors, nurses, paramedics under NHM has been deployed through outsourcing.
Department of Medical Education and Research (DMER)	7,398	Sweepers, Ward servants, clerical and other support staff.
AYUSH	2,234	Doctors, Paramedics and other support staff.
Food and Drugs Administration Haryana	175	Scientific assistants, clerical and other support staff.
Haryana Medical Services Corporation Limited (HMSCL)	106	Security and Multitasking staff.
Total	**35,208**	

Source: Information furnished by departments concerned

As shown in ***Table 2.1***, 17,409 posts were vacant against the regular sanctioned strength in all the health institutions as of October 2022. This gap was filled up by hiring the staff on contractual basis as shown in ***Table 2.2***. For NHM, total staff including doctors, nurses and paramedics is being hired on contractual basis. Directorate-wise shortage of staff and impact on various health services is discussed in following paragraphs.

2.2 Availability of Staff in various posts under Director General Health Services (DGHS)

In DGHS, 10,008 posts, i.e., 39.5 *per cent* of total sanctioned strength of 25,307, were vacant as of October 2022. Category-wise vacancy position is shown in ***Table 2.3***.

Table 2.3: Availability of staff in various Posts under DGHS (as of October 2022)

Category	Sanctioned post	Working strength	Vacant posts	Percentage of vacant posts
Doctors	5,721	4,081	1,640	28.7
Nurses	5,469	3,564	1,905	34.8
Paramedics	9,112	5,387	3,725	40.9
Others[1]	5,005	2,267	2,738	54.7
Total	**25,307**	**15,299**	**10,008**	**39.5**

Source: HRMS data

Vacant posts under the above-mentioned categories ranged from 28.7 *per cent* to 54.7 *per cent*.

DGHS had engaged contractual staff and as per the information provided by DGHS in January 2024, total 10,827 posts have been filled up through

[1] Others include supportive staff such as clerical staff, sweepers, ward servants, drivers, etc.

outsourced staff. However, no post of doctors and nurses have been outsourced. Out of the above 10,827 posts, 75 posts of paramedics have been filled up through outsourcing and 10,752 persons have been deputed in 'Others' category against the vacancy of 2,738 persons.

Shortage in various posts of doctors, nurses and paramedics against the sanctioned strength under DGHS is given in ***Table 2.4***.

Table 2.4: Post-wise vacant posts under DGHS (as of October 2022)

Sr. No.	Post Name	Sanctioned Post	Working Strength	Vacant posts	Percentage of vacant posts
Doctors					
1	Deputy Civil Surgeon	122	69	53	43
2	Senior Medical Officer	367	247	120	33
3	Medical Officer	4,211	2,994	1,217	29
4	Senior Dental Surgeon	33	25	8	24
5	Dental Surgeon	773	547	226	29
6	Other Doctors	215	199	16	7
	Total	**5,721**	**4,081**	**1,640**	**29**
Nurses					
7	Nursing Sister	463	124	339	73
8	Staff Nurse	4,776	3,411	1,365	29
9	Public Health Nurse	176	24	152	86
10	Other Nurses	54	5	49	91
	Total	**5,469**	**3,564**	**1,905**	**35**
Paramedics					
11	Medical Lab Technologist	1,302	633	669	51
12	Pharmacist	1,156	499	657	57
13	Operation Theatre Assistant	465	209	256	55
14	Radiographer/Ultrasound Technician	389	87	302	78
15	Dental Mechanic Cum Assistant	268	120	148	55
16	Ophthalmic Assistant	225	103	122	54
17	E.C.G. Technician	137	29	108	79
18	Multi-Purpose Health Supervisor(F)	594	318	276	46
19	Multi-Purpose Health Supervisor (M)	622	526	96	15
20	Multi-Purpose Health Worker(M)	3,105	2,181	924	30
21	Other Paramedics	849	682	167	20
	Total	**9,112**	**5,387**	**3,725**	**41**
Total		**20,302**	**13,032**	**7,270**	**36**

Source: HRMS data

Colour code: Red denotes most shortages; yellow denotes moderate shortages and green denotes least shortages.

Shortage of manpower in terms of percentage for Medical Lab Technologist, Pharmacist, Nurses, Operation Theatre Assistant, Radiographer/Ultrasound Technician, ECG Technician is very high. Non-availability of manpower can have impact on essential services in health institutions.

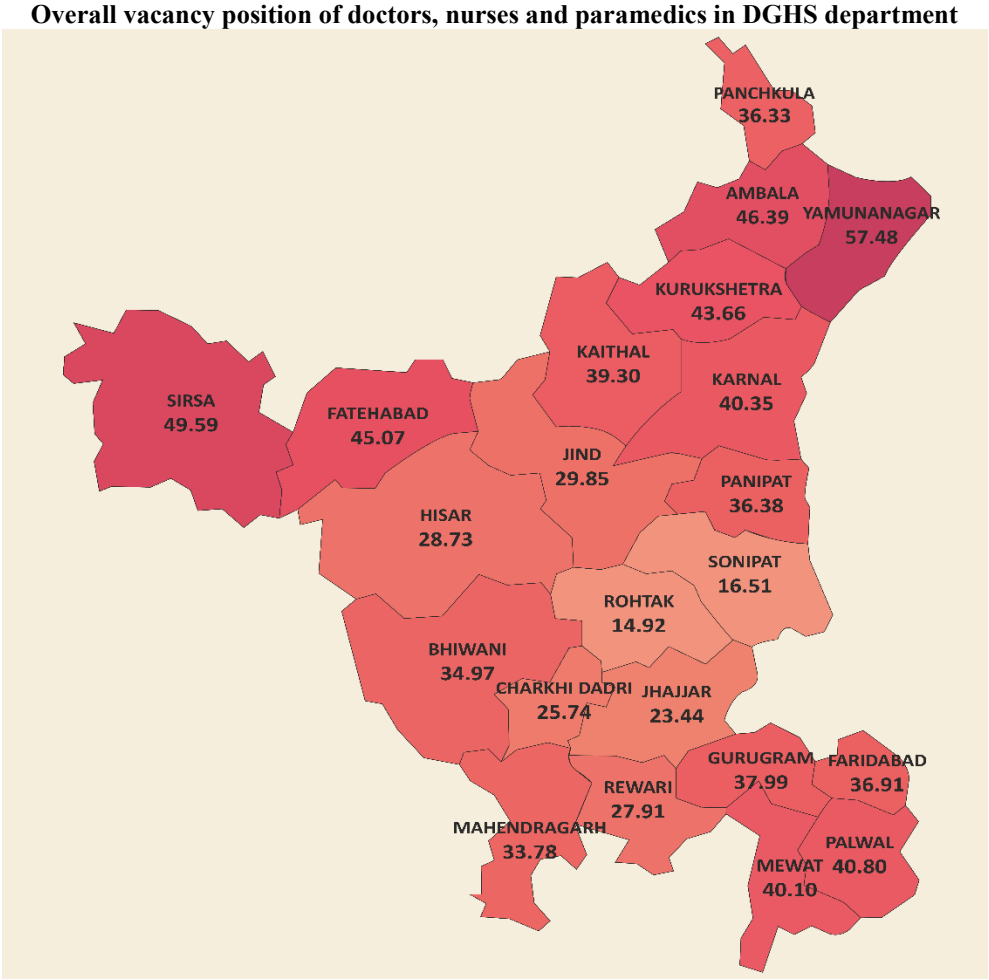
Further, IPHS 2012 norms provide for availability of speciality-wise doctors such as Gynaecologist, Anesthetist, Pediatrician, etc. However, speciality-wise sanctioned posts were not created in DHs and CHCs in the State. Large number of vacancies against sanctioned strength and non-creation of speciality-wise posts of doctors led to non-availability of essential OPD, IPD, and Emergency services as discussed in paragraphs 3.1, 3.2 and 3.3 in this report.

2.2.1 Skewed distribution of available manpower in DGHS

It is important for the Government to deploy available manpower uniformly across the State. However, it was observed that 7,270 posts of doctors, nurses and paramedics (as of October 2022) in DGHS were vacant and the available manpower for these categories was unevenly distributed. The vacancy position varied from as low as 14.92 *per cent* in Rohtak district to 57.48 *per cent* in Yamunanagar district as shown in the map below:

Chart 2.2: Skewed distribution of Manpower across the State under DGHS (as of October 2022)

Overall vacancy position of doctors, nurses and paramedics in DGHS department

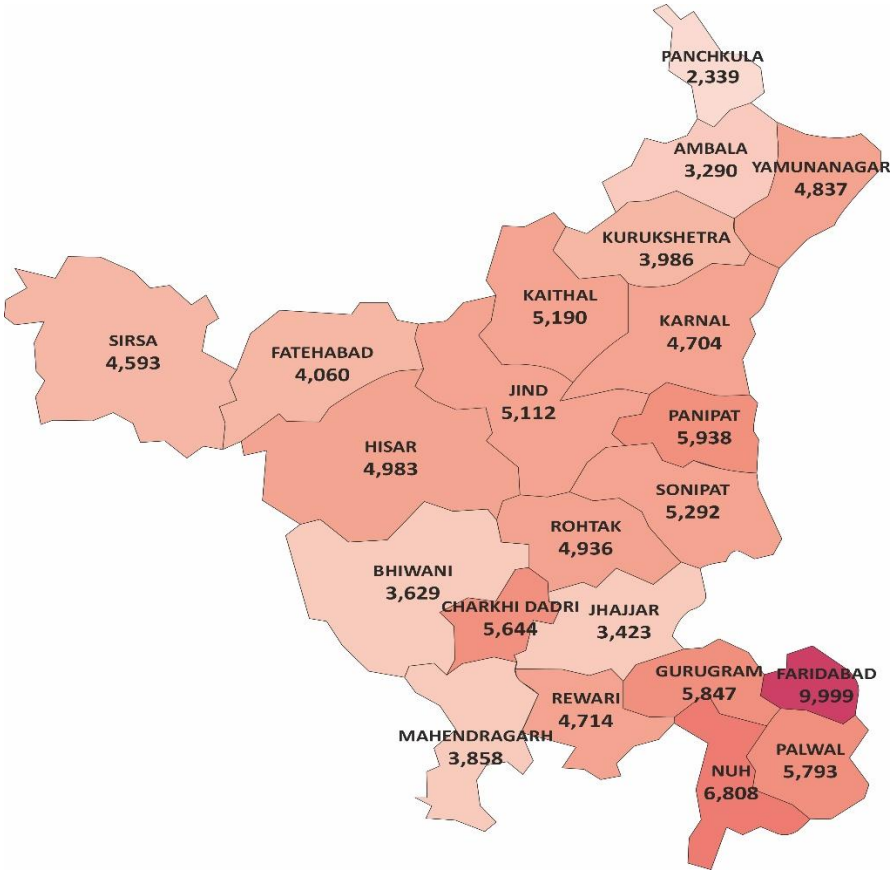


Source: HRMS data
Colour Code: Scaled on light to dark colour. Darker the colour, higher the vacancies.

(i) neven Sanctioned strength of Doctors at District Level

Haryana State has a total of 5,721 sanctioned posts of allopathic doctors under DGHS, i.e. one government doctor for 4,431 persons. It has been observed that sanctioned posts of doctors have no correlation with the population as shown in the map below.

Chart 2.3: Uneven Sanctioned strength of doctors vis- -vis population at district level



Source: HRMS data
Colour Code: Scaled on light to dark colour. Dark colour denotes least sanctioned strength and light colour denotes most sanctioned strength of doctors.

As evident from the map, one doctor is sanctioned for 2,339 persons in Panchkula district whereas one doctor is sanctioned for 9,999 persons in Faridabad district. In 15 districts[2], fewer doctors are sanctioned than the state sanctioned average of one doctor for 4,431 people.

(ii) acancy position of doctors

In DGHS, doctors have several designations like Medical Officer, Senior Medical Officer, Additional Medical Officer, Dental Surgeon, Senior Dental Surgeon, Deputy Civil Surgeon, Civil Surgeon, Principal Medical Officer etc. Overall, DGHS has a total of 4,081 public doctors (Allopathic) available against

[2] (i) Charkhi Dadri, (ii) Faridabad, (iii) Gurugram, (iv) Hisar, (v) Jind, (vi) Kaithal, (vii) Karnal, (viii) Nuh, (ix) Palwal, (x) Panipat, (xi) Rewari, (xii) Rohtak, (xiii) Sirsa, (xiv) Sonipat and (xv) Yamunanagar.

their total sanctioned strength of 5,721 (including Specialist Doctors). Thus, 28.7 *per cent* posts of doctors are lying vacant in the state. District-wise position along with population of districts is shown in ***Table 2.5***.

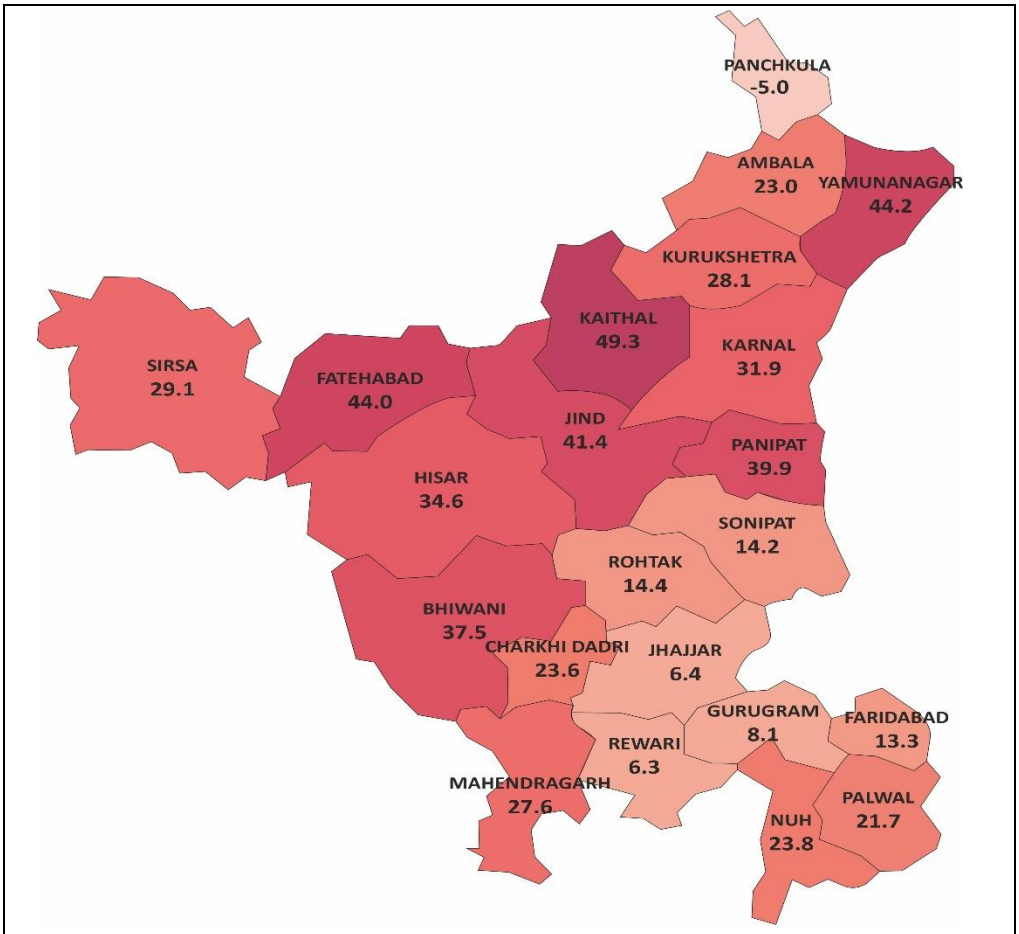
Table 2.5: District wise vacant posts of doctors (including Specialist doctors) (as of October 2022)

District	Population (Census 2011)	Sanctioned Posts	Working Strength	Vacant Posts/Excess	Percentage of Vacant Posts/Excess
Faridabad	18,09,733	181	157	24	13.3
Hisar	17,43,931	350	229	121	34.6
Gurugram	15,14,432	259	238	21	8.1
Karnal	15,05,324	320	218	102	31.9
Sonipat	14,50,001	274	235	39	14.2
Jind	13,34,152	261	153	108	41.4
Sirsa	12,95,189	282	200	82	29.1
Yamuna Nagar	12,14,205	251	140	111	44.2
Panipat	12,05,437	203	122	81	39.9
Bhiwani	11,32,169	312	195	117	37.5
Ambala	11,28,350	343	264	79	23.0
Nuh	10,89,263	160	122	38	23.8
Kaithal	10,74,304	207	105	102	49.3
Rohtak	10,61,204	215	184	31	14.4
Palwal	10,42,708	180	141	39	21.7
Kurukshetra	9,64,655	242	174	68	28.1
Jhajjar	9,58,405	280	262	18	6.4
Fatehabad	9,42,011	232	130	102	44.0
Mahendragarh	9,22,088	239	173	66	27.6
Rewari	9,00,332	191	179	12	6.3
Panchkula	5,61,293	240	252	(-) 12	(-) 5.0
Charkhi Dadri	5,02,276	89	68	21	23.6
P , Deputation Leave Reserve at H		***410***	***140***	***270***	***65.9***
Total	**2,53,51,462**	**5,721**	**4,081**	**1,640**	

Source: HRMS data

Colour code: Red denotes most shortages; yellow denotes moderate shortages, light green denotes least shortages and dark green colour denotes excess of doctors.

Chart 2.4: District wise Vacancy of Doctors (in *per cent*)



Source: HRMS data
Colour Code: Darker the colour, higher the vacancies

Posts of doctors were lying vacant in all the districts except in Panchkula district where 12 doctors are posted in excess of the sanctioned strength. Vacancies at district level range from lowest (12) in Rewari to highest (121) in Hisar.

Percentage of vacancies of doctors in each district has been shown in the map above. In terms of percentage, 6.3 *per cent* to 49.3 *per cent* posts of doctors are vacant in the districts of Haryana. This shows a skewed distribution of available doctors across districts in Haryana.

(iii) Doctor to Population Ratio in Haryana

As per 2011 Census, the population of Haryana state was 2,53,51,462. World Health Organisation (WHO) has recommended one doctor for every 1000 persons. Accordingly, the State should have 25,351 doctors.

But as per Haryana Medical Council records the State has a total of 20,891 registered doctors (public & private) as of June 2022. This indicates availability of one doctor for 1,214 people which is less than WHO recommendation.

Haryana State has a total of 6,006 public doctors (4,081 in DGHS, 1,052 in

Medical Colleges[3], 20 in Family Welfare, 508 in AYUSH[4] and 345 in NHM) in health related departments (as of October 2022). This denotes availability of one public doctor for 4,221 persons in Haryana State.

2.2.2 Availability of Staff Nurse, Radiographer/Technician, etc. under DGHS

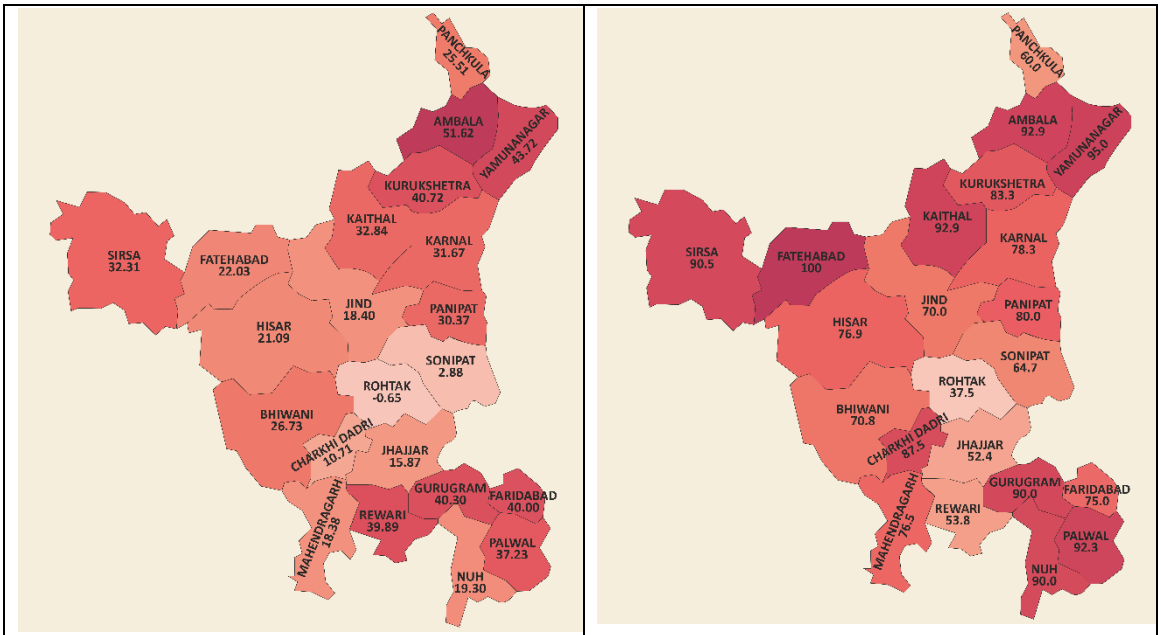
The skewness in availability of manpower categories becomes even more pronounced when the vacancy position is analysed against particular posts. For instance:

i. Availability of staff nurse against sanctioned strength varied from excess by 0.65 *per cent* in Rohtak to shortage by 51.62 *per cent* in Ambala district.

ii. Shortage of Radiographer/Ultrasound Technician against the sanctioned strength varied from 37.5 *per cent* in Rohtak district to 100 *per cent* in Fatehabad district.

The shortage in the above two posts across all the districts is shown in the maps below:

Chart 2.5: District wise Vacancy position in Staff Nurse and Radiographer/Ultrasound Technician (as of October 2022)



Vacancy position in Staff Nurse	Vacancy position in Radiographer/ Ultrasound Technician

Source: HRMS data
Colour Code: Scaled on light to dark colour. Darker the colour higher the vacancies.

Similar skewed distribution was observed in other posts and in other departments including DMER, AYUSH and Family Welfare departments.

[3] 1,050 regular and two on contractual basis.

[4] 372 regular and 136 on contractual basis.

2.2.3 Availability of Staff in DHs

Availability of Staff (regular) against the sanctioned posts in each District Hospital (DH) is depicted in ***Table 2.6***.

Table 2.6: Availability of Staff in various Posts in each District Hospital (DH) (as of October 2022)

Name of DH	Specialists/Doctors			Nurses			Paramedics		
	S	P	%V/E (+)	S	P	%V/E (+)	S	P	%V/E (+)
Ambala	84	52	38	160	76	53	92	31	66
Bhiwani	84	55	35	162	115	29	95	38	60
Charkhi Dadri	51	43	16	44	32	27	46	22	52
Faridabad	68	57	16	102	62	39	62	31	50
Fatehabad	51	39	24	44	38	14	49	23	53
Gurugram	136	119	13	204	105	49	120	49	59
Hisar	68	56	18	104	91	13	64	41	36
Jhajjar	51	40	22	44	41	7	45	31	31
Jind	68	41	40	102	86	16	61	42	31
Kaithal	68	42	38	102	84	18	61	38	38
Karnal	68	54	21	102	92	10	60	39	35
Kurukshetra	68	52	24	102	63	38	64	36	44
Mahendragarh at Narnaul	51	41	20	44	36	18	45	19	58
Mandikhera (Nuh)	51	41	20	44	35	20	45	16	64
Palwal	51	45	12	44	35	20	49	39	20
Panchkula	84	93	(+)11	160	127	21	92	55	40
Panipat	68	39	43	102	85	17	62	33	47
Rewari	68	67	1	102	53	48	60	40	33
Rohtak	51	48	6	44	40	9	53	40	25
Sirsa	68	49	28	102	71	30	65	26	60
Sonipat	68	58	15	102	92	10	61	45	26
Yamuna Nagar	68	41	40	102	70	31	61	25	59
Total	**1,493**	**1,172**	**22**	**2,118**	**1,529**	**28**	**1,412**	**759**	**46**

S=Sanctioned post, P=In position, V=Vacant Posts, E = Excess (+)
Source: HRMS data.
Colour code: Dark pink colour depicts most vacancies whereas light pink colour depicts moderate vacant posts and white colour depicts least/excess manpower.

There was shortage of doctors in 21 DHs with DH Panipat having maximum (43 *per cent*) shortage. On the other hand, DH Panchkula had 11 *per cent* surplus doctors against the sanctioned strength. The shortage of nurses was maximum (53 *per cent*) in DH Ambala and minimum in DH Jhajjar (seven *per cent*). In case of paramedical staff, the maximum shortage was in DH, Ambala (66 *per cent*) and minimum in DH Palwal (20 *per cent*).

The Health Department replied (July 2023) that some vacant posts are filled as per Government polices of outsourcing and contractual engagement. The National Health Mission (NHM) also supports Health Department to provide specialists, MBBS Doctors, Staff Nurses, Lab Technicians (LTs), Multi-purpose Health Worker (Female), etc. to run First Referral Units (FRUs), Labour rooms, Special New-born Care Units (SNCUs) and other health facilities upto Sub Health Centre as per guidelines of Ministry of Health and

Family Welfare. The services of this manpower are utilised in the same health facility and are serving the same patients as served by the regular staff.

Audit does not agree with the Department's assertion as the purpose of manpower engaged under NHM is to provide health services for various vertical programmes such as non-communicable disease, Janani Shishu Suraksha Karyakarm, SNCU, etc. Such manpower is not engaged against the vacant posts of regular staff. As per the Record of Proceedings of NHM Haryana, the support under HR is intended to supplement and support and not to substitute State expenditure. All the support for HR will be to the extent of positions engaged over and above the regular positions as per IPHS norms and case load. NHM aims to strengthen health systems by supplementing and hence it should not be used to substitute regular HR.

2.2.4 Availability of Staff in SDCHs, CHCs and PHCs

Availability of Staff (regular) against the sanctioned posts in SDCHs/CHCs/ PHCs is depicted in ***Table 2.7***.

Table 2.7: Availability of Staff in various Posts in SDCHs/CHCs/PHCs (as of October 2022)

Health Institutions	Specialists/ Doctors			Nurses			Paramedics		
	S	P	%V	S	P	%V	S	P	%V
SDCH	960	664	**31**	1,150	771	**33**	1,022	473	**54**
CHCs	1,142	871	**24**	1,276	742	**42**	1,348	1,144	**15**
PHCs	1,216	814	**33**	810	438	**46**	1,607	759	**53**
Total	**3,318**	**2,349**		**3,236**	**1,951**		**3,977**	**2,376**	

S=Sanctioned post, P=In position, V=Vacant Posts
Source: HRMS data.

As evident from the above table, there was huge shortage of Doctors (33 *per cent*), Nurses (46 *per cent*) and Paramedics (53 *per cent*) in PHCs. The maximum shortage of paramedical staff was 54 *per cent* in SDCHs. The details of manpower of SDCHs, CHCs and PHCs have been appended in ***Appendix 2.1***.

2.2.5 Specialists

As per IPHS 2012 norms, DH should essentially have 34 Specialists[5] (15 Specialty) in 300 bedded hospitals, 20 Specialists[6] (12 Specialty) in 200 bedded

[5] (i) Medicine: 3, (ii) Surgery: 3, (iii) Paediatrics: 4, (iv) OBGY: 4, (v) Anaesthesiology: 3, (vi) Ophthalmology: 2, (vii) Orthopaedics: 2, (viii) Radiology: 2, (ix) ENT: 2, (x) Dentistry: 2, (xi) Dermatologist: 1, (xii) Psychiatrist: 1, (xiii) Pathologist: 3, (xiv) Microbiologist: 1, (xv) Forensic specialist: 1.

[6] (i) Medicine: 2, (ii) Surgery: 2, (iii) Paediatrics: 3, (iv) OBGY: 3, (v) Anaesthesiology: 2, (vi) Ophthalmology: 1, (vii) Orthopaedics: 1, (viii) Radiology: 1, (ix) ENT: 1, (x) Dentistry: 1, (xi) Psychiatrist: 1, (xii) Pathologist: 2.

hospitals (DHs and SDCHs[7]), and 17 Specialists[8] (12 Specialty) in 100 bedded hospitals.

Further, in case of 100 bedded SDCHs, 13 Specialists[9] (13 Specialty) are essential and 11 Specialists[10] (11 Speciality) are required in 50 bedded SDCH hospitals. The Health Department, Haryana, which is responsible for administration of DHs, SDCHs, CHCs and PHCs does not have sanctioned posts for specialists (Doctors) which was confirmed by ACS, Health and Family Welfare Department, Haryana during the exit conference (10 January 2023). Accordingly, none of the DHs, SDCHs, and CHCs had specialty-wise sanctioned posts.

Government of Haryana has a policy for sponsoring Post Graduate studies for Medical Officers. MBBS/BDS doctors recruited under Haryana Civil Medical Services (Medical Officers), after completion of four years of regular satisfactory service with atleast two years rural service/remote and difficult areas service in Health Institutions of Haryana, are eligible for pursuing Post-Graduation courses with full pay.

However, the above incentive has not resulted in availability of required essential specialists in Health Institutions with reference to IPHS norms even after considering Specialists engaged under NHM as discussed below:

(i) District Hospitals

(a) Availability of Specialists against norms

The District Hospitals (DHs) had maximum excess of Specialists in case of 200 bedded DHs when compared against IPHS 2012 norms as given in ***Table 2.8***.

Table 2.8: Availability of Specialists in DHs against IPHS norms (April/ May 2023)

Type of DH	No. of DHs	No. of Specialists required as per IPHS norms	No. of Specialists available	Excess (+)/Shortage (*in per cent*)
300 Bedded	3	102	124	(+) 22
200 Bedded	12	240	347	(+) 45
100 Bedded	7	119	140	(+) 18
Total	**22**	**461**	**611**	(+)**33**

Source: Compiled from information furnished by individual health institutions in April/ May 2023

7 Norms for 200 bedded SDCH are not given in IPHS 2012.

8 (i) Medicine: 2, (ii) Surgery: 2, (iii) Paediatrics: 2, (iv) OBGY: 2, (v) Anaesthesiology: 2, (vi) Ophthalmology: 1, (vii) Orthopaedics: 1, (viii) Radiology: 1, (ix) ENT: 1, (x) Dentistry: 1, (xi) Psychiatrist: 1, (xii) Pathologist: 1.

9 (i) Medicine:1, (ii) Surgery: 1, (iii) Paediatrics: 1, (iv) OBGY: 1, (v) Anaesthesiology: 1, (vi) Ophthalmology: 1, (vii) Orthopaedics: 1, (viii) Radiology: 1, (ix) ENT: 1, (x) Dentistry: 1, (xi) Dermatologist/Venereologist: 1, (xii) Pathologist/ Microbiologist/ Biochemistry: 1, (xiii) Public Health Manager: 1.

10 (i) Medicine: 1, (ii) Surgery: 1, (iii) OBGY: 1, (iv) Paediatrician: 1, (v) Anaesthetist: 1, (vi) ENT: 1, (vii) Ophthalmologist: 1, (viii) Orthopaedics: 1, (ix) Radiologist: 1, (x) Dentistry: 1, (xi) Public Health Manager: 1.

As is evident from the above table, the Specialists were in excess in 300 bedded DHs (22 *per cent*), in 200 bedded DHs (45 *per cent*) and in 100 bedded DHs (18 *per cent*). Overall position of Specialists in the case of DHs was in excess (33 *per cent)* in the State of Haryana. Though the overall position of Specialists in DHs was good, there was uneven distribution across DHs as discussed in sub-para (b).

(b) District-wise availability of Specialists

District-wise availability of Specialists in DHs is given in ***Table 2.9***.

Table 2.9: District wise availability of Specialists in DHs

Sr. No.	Name of District	Specialists		
		Required as per IPHS 2012	Available	Excess (+)/Shortage (*in per cent*)
1.	Charkhi Dadri	17	10	41
2.	Kaithal	20	13	35
3.	Fatehabad	17	12	29
4.	Bhiwani	34	28	18
5.	Jind	20	18	10
6.	Ambala	34	31	9
7.	Nuh	17	17	0
8.	Yamunanagar	20	21	(+) 5
9.	Mahendragarh at Narnaul	17	18	(+) 6
10.	Palwal	17	20	(+) 18
11.	Sirsa	20	24	(+) 20
12.	Panipat	20	27	(+) 35
13.	Faridabad	20	28	(+) 40
14.	Karnal	20	28	(+) 40
15.	Kurukshetra	20	28	(+) 40
16.	Sonipat	20	29	(+) 45
17.	Jhajjar	17	27	(+) 59
18.	Rewari	20	32	(+) 60
19.	Panchkula	34	65	(+) 91
20.	Rohtak	17	36	(+) 112
21.	Hisar	20	45	(+) 125
22.	Gurugram	20	54	(+) 170
	Total	**461**	**611**	**(+) 33**

Source: Compiled from information furnished by individual health institutions in April/May 2023

Colour: Red colour depicts most shortage, Yellow colour depicts least shortage and Green colour depicts no shortage/excess.

It is evident from the above table that the maximum shortage was found in DH Charkhi Dadri i.e., 41 *per cent*. Excess number of specialists were found posted/engaged against IPHS norms in 15 DHs[11].

(c) Specialty/department-wise availability of Specialists

IPHS 2012 norms provide for availability of specialty-wise doctors such as Gynaecologist, Anaesthetists, Paediatrician, etc. in 15 different specialties. As

[11] Sr. No. 08 to 22 of the Table.

per information furnished by the DHs, the availability of Specialists in each specialty is given in ***Table 2.10***.

Table 2.10: Availability of Specialists in DHs (Specialty wise)

Name of Specialty	Required as per IPHS norms	Available	Excess (+)/ Shortage %
Medicine	47	51	(+) 9
Surgery	47	43	9
Paediatrics	62	57	8
Obstetrics & Gynaecology	62	67	(+) 8
Anaesthesiology	47	59	(+) 26
Ophthalmology	25	63	(+) 152
Orthopaedics	25	61	(+) 144
Radiology	25	10	60
ENT	25	40	(+) 60
Dentistry	25	81	(+) 224
Dermatologist	3	2	33
Psychiatrist	22	30	(+) 36
Pathologist	40	45	(+) 13
Microbiologist	3	1	67
Forensic Medicine	3	1	67
Total	**461**	**611**	**(+) 33**

Source: Compiled from information furnished by individual health institutions in April/May 2023.
Colour code: Red colour depicts most shortage, yellow colour depicts moderate/least shortage and green colour depicts excess.

As is evident from the above, there was shortage of Specialists in Surgery, Paediatrics, Radiology, Microbiology, Biochemistry and Forensic Medicine. However, there were some specialities such as Medicine, Obstetrics & Gynaecology (OBGY), Anaesthesiology, Ophthalmology, Orthopaedics, ENT, Dentistry, Psychiatry and Pathology, where Specialists were found in excess as compared to IPHS.

(ii) Sub-divisional Civil Hospital

(a) Availability of Specialists against norms

Details of Specialists posted in SDCHs against the required norms is given in ***Table 2.11***.

Table 2.11: Availability of Specialists in SDCHs against the IPHS norms

Type of SDCH	No. of SDCHs	No. of Specialists required as per IPHS norms	No. of Specialists available	Excess (+)/Shortage (*in per cent*)
200 Bedded	1	20[12]	30	(+) 50
100 Bedded	10	130	66	49
50 Bedded	30	330	83	75
Total	**41**	**480**	**179**	**63**

Source: Compiled from information furnished by individual health institutions in April/May 2023
Colour: Red colour depicts shortage, yellow colour depicts moderate shortage and green colour depicts excess.

[12] Norms for 200 bedded SDCH are not given in IPHS 2012. Norms mentioned in the table are those which were given for DHs in IPHS norms 2012.

The Specialists were in excess (50 *per cent*) in 200 bedded SDCH. Overall, 63 *per cent* shortage of Specialists was found in SDCHs, mainly in 100 bedded and 50 bedded SDCHs. As is evident from the above table, in comparison to DHs, shortages in SDCHs were more severe.

(b) SDCH-wise availability of Specialists

SDCH-wise availability of Specialists is given in ***Table 2.12***.

Table 2.12: Availability of Specialists in SDCHs

Name of District	Name of SDCH	Beds Sanctioned	Beds available	Total doctors posted	No. of Specialists		
					Required as per IPHS 2012	Out of total doctors posted	Excess (+)/ Shortage (in *per cent*)
Ambala	Ambala Cantt	200	200	56	20	30	(+)50
	Naraingarh	100	100	37	13	2	85
Bhiwani	Bawani Khera	50	50	9	11	1	91
	Deverala	50	2	0	11	0	100
	Siwani	50	50	11	11	1	91
	Tosham	50	50	11	11	1	91
Faridabad	Ballabhgarh	50	50	11	11	13[13]	(+)18
Fatehabad	Ratia	50	50	4	11	1	91
	Tohana	100	50	27	13	4	69
Gurgaon	Haily Mandi	50	25	7	11	1	91
	Pataudi	50	50	15	11	5	55
	Sohna	50	50	12	11	5	55
Hisar	Adampur	50	50	12	11	3	73
	Barwala	50	50	8	11	2	82
	Hansi	50	50	12	11	4	64
	Narnaund	100	100	18	13	2	85
Jhajjar	Bahadurgarh	100	100	64	13	23	(+)77
	Beri	50	50	14	11	5	55
	Matanhail	50	50	14	11	1	91
Jind	Narwana	100	100	12	13	4	69
	Safidon	50	50	7	11	2	82
	Uchana	50	50	4	11	1	91
Kaithal	Guhla	50	50	8	11	2	82
	Kalayat	50	31	9	11	0	100
Karnal	Assandh	50	50	24	11	2	82
	Nilokheri	50	36	26	11	4	64
Kurukshetra	Shahabad	100	30	26	13	3	77
Mahendragarh at Narnaul	Kanina	50	30	12	11	1	91
	Mahendragarh	100	25	21	13	12	8
Palwal	Hodal	50	50	10	11	4	64
Panchkula	Kalka	50	55	17	11	5	55
Panipat	Samalkha	100	100	11	13	2	85
Rewari	Kosli	50	50	12	11	4	64
Rohtak	Kalanaur	50	50	11	11	4	64
	Meham	50	50	8	11	2	82
Sirsa	Chautala	50	30	8	11	2	82
	Dabwali	100	100	35	13	7	46
	Ellenabad	50	50	9	11	2	82
Sonipat	Gohana	50	50	12	11	2	82
	Kharkhoda	50	24	13	11	3	73
Yamunanagar	Jagadhari	100	100	27	13	7	46
Total		**2,700**	**2,338**	**664**	**480**	**179**	**63**

Source: Compiled from information furnished by individual health institutions in April/May 2023

Colour: Red colour depicts most shortage, yellow colour depicts moderate shortage and green colour depicts least shortage/excess.

[13] Out of 13 specialists, only two specialists belong to DGHS and remaining 11 were deployed by AIIMS, New Delhi.

Out of 179 Specialists deputed in SDCHs, 78 were deputed in four SDCHs having 375 IPD beds i.e. Ambala Cantt, Ballabhgarh (2 State Government and 11 AIIMS, New Delhi), Bahadurgarh and Mahendragarh. In remaining 37 SDCHs (1,963 available IPD beds) only 101 Specialists were deployed. In SDCH, Deverala (two IPD beds), no doctor was found deputed. Due to shortage of Specialists, the available bed capacity could not be utilised. Further, due to non-availability of Specialists in many specialties, services could not be provided to the patients.

(c) Specialty/department-wise availability of Specialists

The availability of essential Specialists in SDCHs is given in ***Table 2.13***.

Table 2.13: Availability of Specialists in SDCHs (Specialty wise)

Name of Specialty	200 Bedded		100 Bedded		50 Bedded		200 Bedded	100 Bedded	50 Bedded
	Required as per IPHS	Available	Required as per IPHS	Available	Required as per IPHS	Available	Excess (+)/Shortage (in *per cent*)	Excess (+)/Shortage (in *per cent*)	Excess (+)/Shortage (in *per cent*)
Medicine	2	2	10	0	30	1	0	100	97
Surgery	2	5	10	3	30	7	(+)150	70	77
Paediatrics	3	3	10	6	30	10	0	40	67
OBGY	3	1	10	10	30	16	67	0	47
Anaesthesiology	2	3	10	6	30	6	(+)50	40	80
Ophthalmology	1	3	10	6	30	4	(+)200	40	87
Orthopaedics	1	3	10	5	30	4	(+)200	50	87
Radiology	1	2	10	1	30	1	(+)100	90	97
ENT	1	2	10	4	30	1	(+)100	60	97
Dentistry	1	4	10	15	30	28	(+)300	(+)50	7
Dermatologist	NA	NA	10	1	NA	NA	NA	90	NA
Psychiatry	1	1	NA	NA	NA	NA	0	NA	NA
Pathologist/ Microbiologist/ Biochemistry[14]	2	1	10	8	NA	NA	50	20	NA
Public Health Manager	NA	NA	10	1	30	5	NA	90	83
Total	**20**	**30**	**130**	**66**	**330**	**83**	**(+)50**	**49**	**75**

Source: **Compiled from information furnished by individual health institutions in April/May 2023**

NA: **Not applicable.**

Colour: **Red colour depicts most shortage, yellow colour depicts moderate shortage and green colour depicts least shortage/excess.**

It is evident from the above table that in case of 100 bedded and 50 bedded SDCHs, there was shortage in all the specialities except Dentistry as compared to IPHS norms.

(iii) Results of three specialties (Paediatrics, B and Medicine) in DHs and SDCHs

IPHS 2012 norms provide four Paediatrics, four OBGY and three Medicine Specialists for 300 bedded DHs, three Paediatrics, three OBGY and two Medicine for 200 bedded DHs and SDCHs. Further, two Paediatrics, two OBGY and two Medicine Specialists for 100 bedded DHs are recommended. In

[14] In case of 200 bedded SDCH, only Pathologist is required.

case of SDCHs, IPHS 2012 provide for one Paediatric, one OBGY and one Medicine Specialists for 100 and 50 bedded hospitals.

(i) The combined availability of Specialists (District wise) in DHs and SDCHs, both regular and contractual, under Paediatrics is given in ***Table 2.14***.

Table 2.14: Availability of Specialists in Paediatrics Speciality

Name of District	Paediatrics					
	Required as per IPHS	Available	Excess (-)/ Shortage (*in per cent*)	Paediatrics OPD cases during 2022-23	Average OPD cases per Paediatrician	Spark line of OPD cases during the period 2016-17 to 2022-23
Charkhi Dadri	2	0	100	0		
Bhiwani	8	1	88	33,191	33,191	
Mahendragarh at Narnaul	4	1	75	38,320	38,320	
Jind	5	2	60	42,697	21,349	
Kaithal	5	2	60	24,054	12,027	
Fatehabad	4	2	50	15,826	7,913	
Nuh	2	1	50	22,645	22,645	
Panipat	4	2	50	35,783	17,892	
Hisar	7	4	43	24,904	6,226	
Jhajjar	5	3	40	46,990	15,663	
Ambala	8	5	38	51,820	10,364	
Sirsa	6	4	33	30,875	7,719	
Karnal	5	4	20	34,366	8,592	
Sonipat	5	4	20	51,880	12,970	
Faridabad	4	4	0	94,651	23,663	
Rewari	4	4	0	24,656	6,164	
Rohtak	4	4	0	50,394	12,599	
Yamunanagar	4	4	0	61,846	15,462	
Kurukshetra	6	7	-17	19,983	2,855	
Gurugram	4	5	-25	89,002	17,800	
Palwal	3	4	-33	40,571	10,143	
Panchkula	5	9	-80	69,117	7,680	
Total	**104**	**76**	**27**	**9,03,571**	**11,889**	

Source: **Compiled from information furnished by individual health institutions in April/May 2023**

Colour: **Red colour depicts most shortage, yellow colour depicts moderate shortage and green colour depicts least shortage/excess.**

Paediatrics Specialists were not deployed in various DHs corresponding to the number of patients. In Bhiwani and Mahendragarh the OPD load was very high for one Paediatrics Specialist in each DH. On the other hand, at DHs of Kurukshetra, Rewari and Panchkula the OPD load for Paediatrics Specialists was very less. No Paediatrics Specialist was found deployed at DH, Charkhi Dadri. Due to non-availability of specialists, impact on the services in selected Health institutions are discussed in Paragraph 3.5.3.

(ii) The combined availability of OBGY Specialists (District wise) in DHs and SDCHs, both regular and contractual, is given in ***Table 2.15***.

Table 2.15: Availability of Specialists in OBGY specialty

Name of District	Obstetrics & Gynaecology (OBGY)					
	Required as per IPHS	Available	Excess (-)/ Shortage (*in per cent*)	OBGY OPD cases during 2022-23	Average OPD cases per OBGY	Spark line of OPD cases during the period 2016-17 to 2022-23
Kaithal	5	0	100	52,365		
Kurukshetra	4	1	75	27,086	27,086	
Mahendragarh at Narnaul	4	1	75	62,004	62,004	
Jind	6	2	67	91,994	45,997	
Bhiwani	8	3	63	51,076	17,025	
Charkhi Dadri	2	1	50	31,794	31,794	
Fatehabad	4	2	50	40,527	20,264	
Sirsa	6	3	50	72,246	24,082	
Hisar	7	5	29	51,726	10,345	
Rewari	4	3	25	37,152	12,384	
Karnal	5	4	20	72,619	18,155	
Ambala	8	8	0	1,42,199	17,775	
Jhajjar	5	5	0	77,404	15,481	
Panipat	4	4	0	70,195	17,549	
Rohtak	4	4	0	60,346	15,087	
Sonipat	5	5	0	69,038	13,808	
Yamunanagar	4	4	0	90,337	22,584	
Panchkula	5	6	-20	1,50,151	25,025	
Palwal	3	4	-33	40,770	10,193	
Nuh	2	4	-100	21,430	5,358	
Faridabad	4	10	-150	64,867	6,487	
Gurugram	6	15	-150	1,27,615	8,508	
Total	**105**	**94**	**10**	**15,04,941**	**16,010**	

Source: Compiled from information furnished by individual health institutions in April/May 2023

Colour: Red colour depicts most shortage, yellow colour depicts moderate shortage and green colour depicts least shortage/excess.

It can be seen that no OBGY Specialist was posted in district Kaithal despite having 52,365 OPD cases in 2022-23. Further in seven districts only 13 OBGY Specialists were deputed against the requirement of 34. In these seven districts, total OBGY OPD cases in one year were 3.77 lakh[15]. As such, it can be observed that in eight districts (including Kaithal) the OPDs for OBGY were being partially handled by the non-specialist doctors. Due to shortage/ non-availability of Specialists, impact on the services in selected Health Institutions are discussed in Paragraph 3.5.2 (iii).

(iii) The combined availability of Medicine Specialists (District wise) in DHs and SDCHs, both regular and contractual, is given in ***Table 2.16***.

[15] (i) Kurukshetra, (ii) Mahendragarh at Narnaul, (iii) Jind, (iv) Bhiwani, (v) Charkhi Dadri, (vi) Fatehabad and (vii) Sirsa.

Table 2.16: Availability of Specialists in Medicine specialty

Name of District	Medicine					
	Required as per IPHS	Available	Excess (-)/ Shortage (*in per cent*)	Medicine OPD cases during 2022-23	Average OPD cases per MD	Spark line of OPD cases during the period 2016-17 to 2022-23
Fatehabad	4	0	100	20,745		
Mahendragarh at Narnaul	4	0	100	1,39,032		
Palwal	3	0	100	1,02,882		
Yamunanagar	3	0	100	1,45,091		
Jind	5	1	80	2,68,608	2,68,608	
Sirsa	5	1	80	1,65,320	1,65,320	
Rewari	3	1	67	71,696	71,696	
Bhiwani	7	3	57	2,02,027	67,342	
Charkhi Dadri	2	1	50	62,251	62,251	
Kaithal	4	2	50	1,86,493	93,247	
Hisar	6	4	33	1,81,742	45,436	
Karnal	4	3	25	2,23,301	74,434	
Rohtak	4	3	25	1,49,899	49,966	
Jhajjar	5	4	20	1,28,405	32,101	
Ambala	6	5	17	3,38,432	67,686	
Faridabad	3	3	0	2,06,265	68,755	
Kurukshetra	3	3	0	2,15,482	71,827	
Nuh	2	2	0	49,256	24,628	
Panipat	3	3	0	1,47,710	49,237	
Sonipat	4	4	0	1,33,471	33,368	
Gurugram	5	6	-20	1,47,375	24,563	
Panchkula	4	5	-25	1,36,140	27,228	
Total	**89**	**54**	**39**	**34,21,623**	**63,363**	

Source: **Compiled from information furnished by individual health institutions in April-May 2023**

Colour: **Red colour depicts most shortage, yellow colour depicts moderate shortage and green colour depicts least shortage/excess.**

There was no Medicine Specialist in districts Fatehabad, Mahendragarh and Yamunanagar. As such, in these three districts, 3.05 lakh OPD cases during 2022-23 were handled by non-specialist doctors. In Palwal Physician/ Medicine Specialist was available in DH Palwal from 25 August 2022 to 09 March 2023 and in Jind and Sirsa two Medicine Specialists were deputed against the requirement of 10. As such the Medicine OPDs were partially hold by Medicine Specialists.

During the exit conference (January 2023), the ACS, Health and Family Welfare Department, Government of Haryana, while agreeing to the audit observations, stated that the exercise for rationalisation of manpower and creation of specialist cadre is under process and would be completed soon. Final action was awaited (December 2023).

The distribution of the above Specialists across the districts has been mapped as shown in ***Chart 2.6***.

Chart 2.6 (i): Excess (-)/Shortage (in *per cent*) of Specialists in Paediatric specialty

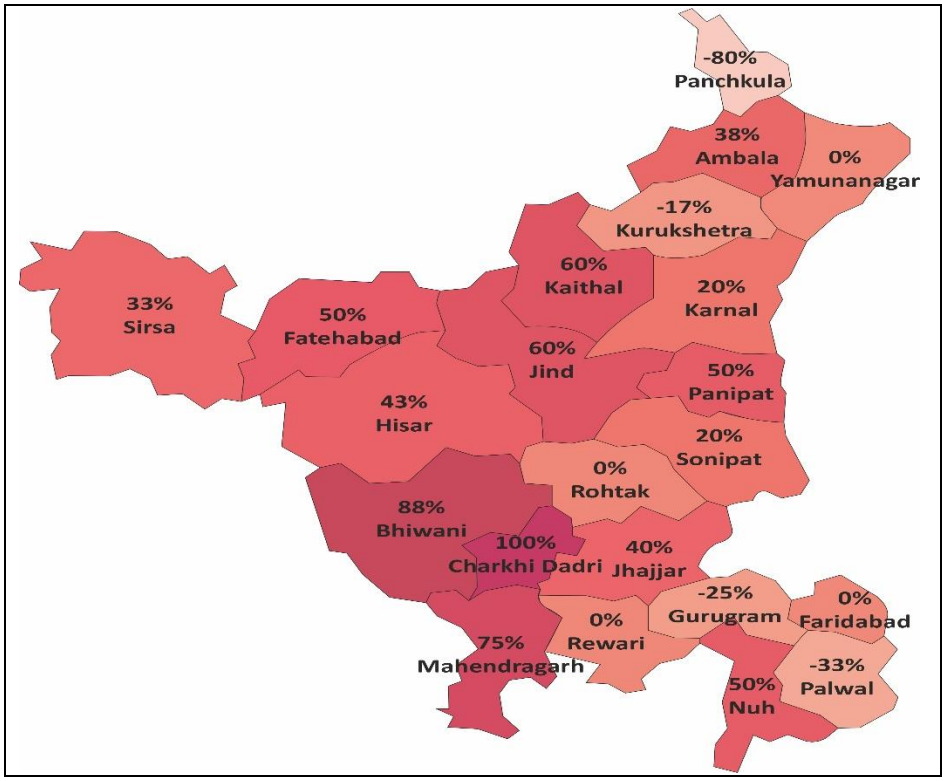


Chart 2.6 (ii): Excess (-)/Shortage (in *per cent*) of Specialists in OBGY specialty (District wise)

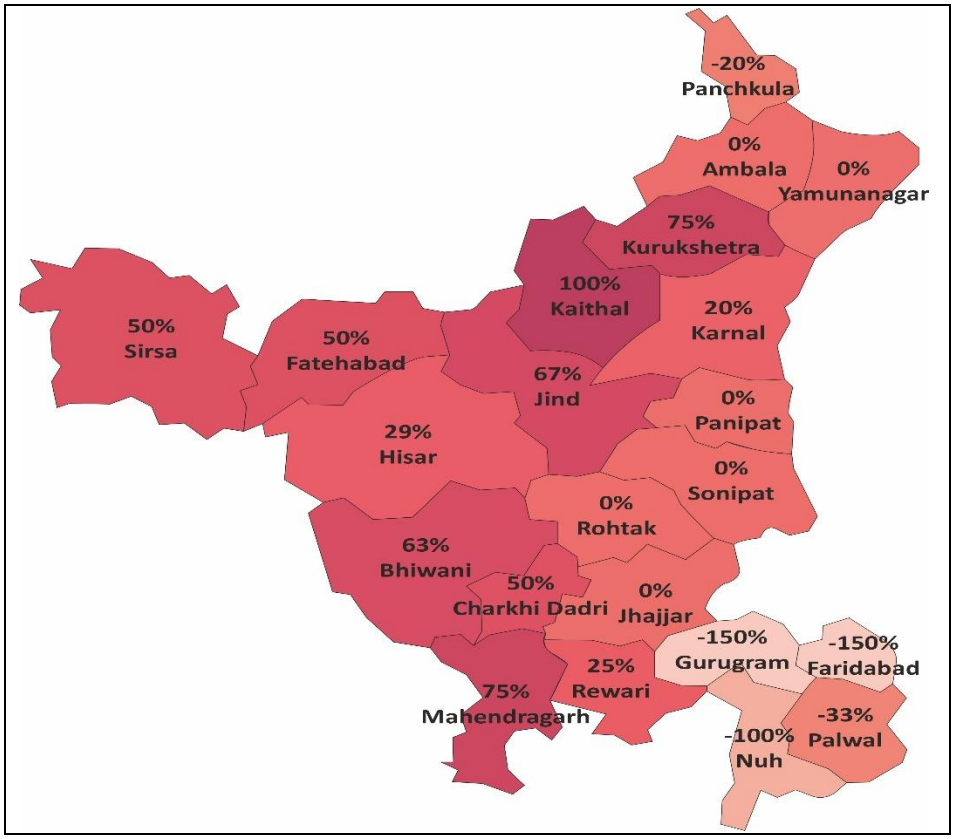
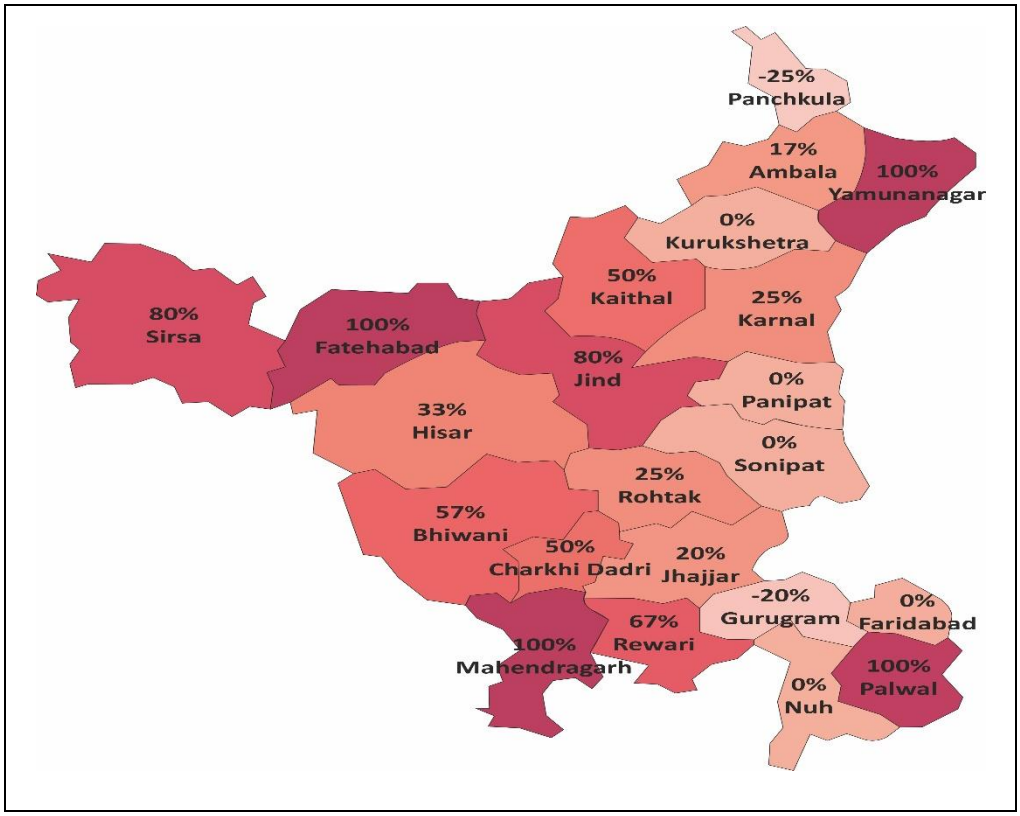


Chart 2.6 (iii): Excess (-)/Shortage (in *per cent*) of Specialists in Medicine specialty (District wise)



Source: **Compiled from information furnished by individual health institutions in April/May 2023**

Colour: **Scaled on light to dark colour. Darker the colour higher the shortages**

(iv) Specialty/Department-wise distribution of Specialists in CHCs

As per IPHS 2012 norms, a CHC should have a Physician/Family Medicine Specialist, Surgeon, Obstetrician & Gynaecologist, Paediatrician, Anaesthesiologist and MO Dental.

The details of availability of Specialists and Dental in 126 CHCs in the State of Haryana is given in ***Table 2.17***.

Table 2.17: Availability of Specialists in CHCs (as on 12 May 2023)

Sr. No.	Name of Specialty	Requirement per CHC as per IPHS	Total Requirement as per IPHS 2012	Availability (in number of CHCs)	Shortage (in *per cent)*
1	General Surgeon	1	126	1	99
2	Physician	1	126	3	98
3	Obstetrician & Gynaecologist	1	126	4	97
4	Paediatrician	1	126	1	99
5	Anaesthetist	1	126	1	99
6	MO Dental	1	126	85	33

Source: Compiled from information furnished by individual health institutions in April-May 2023.

Colour: Red colour depicts most shortage and orange colour depicts least shortage.

Thus, in case of CHCs, there was huge shortage of Specialists in all specialties except Dental.

Due to shortage of specialists, impact on specialties in selected DHs, SDCHs and CHCs are discussed in 3.1.1, 3.1.5, 3.2.5, 3.2.6, 3.2.7, 3.3.4 and 3.6.1.

2.3 Human Resources under Directorate of Medical Education and Research (DMER)

DMER which includes sanctioned strength of five medical colleges and Pt. BD Sharma University of Health Sciences, Rohtak has the second highest sanctioned strength of 10,072 after DGHS. Position of manpower in DMER is given in ***Table 2.18***.

Table 2.18: Manpower position under DMER (as of October 2022)

Medical College/Office Name	Sanctioned Posts	Working Strength	Vacant Posts	Percentage of Vacant Posts
Pandit Bhagwat Dayal Sharma University of Health Sciences, Rohtak	4,872	2,838	2,034	41.7
Bhagat Phool Singh GMC* for Women, Khanpur Kalan, Sonipat	1,621	1,132	489	30.2
Shaheed Hasan Khan Mewati GMC, Nalhar, Nuh	1,059	372	687	64.9
Shri Atal Bihari Vajpayee GMC, Faridabad	967	195	772	79.8
Kalpana Chawla GMC, Karnal	954	467	487	51.0
Maharaja Agrasen Medical College, Agroha	494	329	165	33.4
Directorate of Medical Education and Research, Haryana, (Headquarter Office Panchkula)	105	97	8	7.6
Total	**10,072**	**5,430**	**4,642**	

Source: HRMS data

***GMC: Government Medical College.**

As shown in the table above, shortage of manpower exists in all the five medical colleges and in PBD Sharma UHS, Rohtak. Shri Atal Bihari Vajpayee GMC, Faridabad has the highest shortage of manpower followed by Shaheed Hasan Khan Mewati GMC, Nuh.

Category-wise position of manpower in DMER is given in ***Table 2.19***.

Table 2.19: Category wise position of Manpower under DMER (as of October 2022)

Category	Sanctioned Posts	Working Strength	Vacant Posts	Percentage of Vacant Posts
Doctors	1,757	1050	707	40.2
Nurses	2,651	2,018	633	23.9
Paramedics	2,149	806	1,343	62.5
Other	3,515	1,556	1,959	55.7
Total	**10,072**	**5,430**	**4,642**	

Source: HRMS data

As shown in the table above, there was shortage of 40.2 *per cent* doctors, 23.9 *per cent* nurses and 62.5 *per cent* paramedic staff in the five Medical Colleges and PBD Sharma UHS, Rohtak.

Shortage of manpower for some of the specific posts in DMER is given in ***Table 2.20***.

Table 2.20: Manpower position of some specific posts in DMER as of October 2022

Sr. No.	Post Name	Sanctioned Post	Working Strength	Vacant Posts	Percentage of vacant posts
1	Professors/Sr. Professors	256	242	14	5.5
2	Associate professors	216	133	83	38.4
3	Assistant Professors	691	391	300	43.4
4	Other Doctors	594	284	310	52.2
	Total	**1,757**	**1,050**	**707**	
1	Staff Nurse	2,184	1,679	505	23.1
2	Nursing Sister	383	284	99	25.8
3	Assistant Nursing Superintendent	44	22	22	50.0
4	Other Nurses	40	33	7	17.5
	Total	**2,651**	**2,018**	**633**	
1	Lab Technician & Laboratory Technician	351	198	153	43.6
2	Lab Attendant	205	38	167	81.5
3	Operation Theatre Attendant/ Assistant	168	90	78	46.4
4	Technical Assistant	141	19	122	86.5
5	Radiographer & Radiographic Tech.	88	52	36	40.9
6	Operation Theatre Technician	80	55	25	31.3
7	Other paramedics	1,116	354	762	68.3
	Total	**2,149**	**806**	**1,343**	

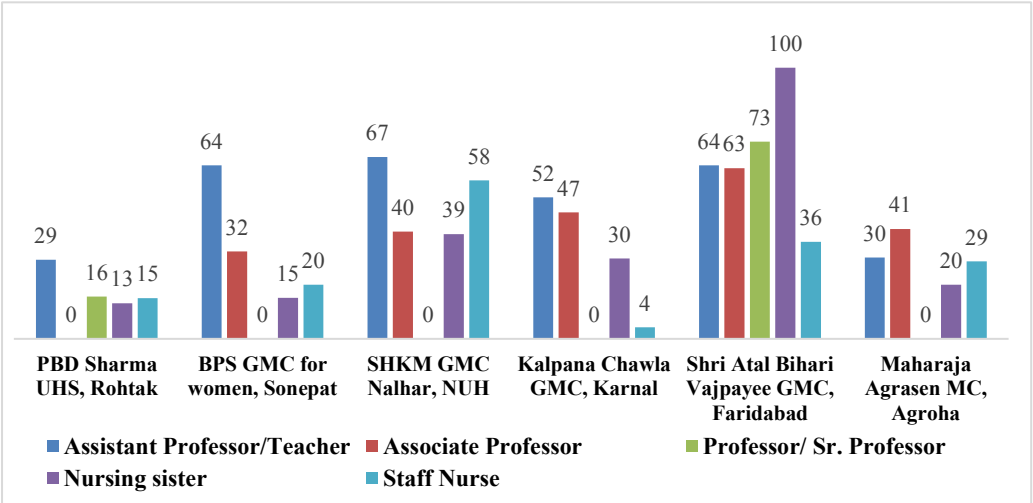
Source: HRMS

Colour code: Red denotes most vacancies; yellow denotes moderate vacancies and green denotes least vacancies.

To fill the gap of manpower in medical colleges and the University of Health Sciences, the Department hired staff on contractual basis. As of January 2024, two posts of doctors i.e. one Associate Professor (MCH Nalhar) and one Research Scientist (BPS Sonepat) have been filled up on contract basis. Further, 431 posts of nurses and 560 posts of paramedics have been filled up through outsourcing. Even after deploying outsourced staff, 705 posts of doctors, 202 posts of nurses and 783 posts of paramedics were vacant.

Post wise vacancy in the five Medical Colleges and PBD Sharma UHS, Rohtak as of October 2022 is given in ***Chart 2.7***.

Chart 2.7: Shortfall of staff in Medical Colleges under DMER (In *per cent*) as of October 2022



Source: HRMS data

As seen from the chart:

i. In PBD Sharma UHS, Rohtak, 29 *per cent* Assistant Professors, 16 *per cent* Professors/Sr. Professors and 15 *per cent* Staff Nurses posts were vacant.

ii. In BPS GMC, Sonipat, 64 *per cent* Assistant Professors, 32 *per cent* Associate Professors and 20 *per cent* Staff Nurses posts were vacant.

iii. In SHKM GMC, Nalhar 67 *per cent* Assistant professors, 40 *per cent* Associate Professors and 58 *per cent* Staff Nurses posts were vacant.

iv. In Kalpana Chawla GMC, Karnal, 52 *per cent* Assistant professors, 47 *per cent* Associate Professors and 30 *per cent* Nursing Sisters' posts were vacant.

v. In Shri Atal Bihari Vajpayee GMC, Faridabad 64 *per cent* Assistant Professors, 63 *per cent* Associate Professors and 73 *per cent* Professors posts were Vacant.

vi. In Maharaja Agrasen MC, Agroha 30 *per cent* Assistant Professors, 41 *per cent* Associate Professors and 29 *per cent* Staff Nurses posts were vacant.

Further, regular Directors and Medical Superintendents were not appointed in any of the Medical Colleges under DMER except Pt. B.D. Sharma, University of Health Sciences, Rohtak. These categories play a major role in providing public health infrastructure and management of health services.

Director, Kalpana Chawla GMC, Karnal replied (January 2023) that the institute has made its best efforts to fill up the vacant posts and request had been sent to Government for granting permission to advertise the posts. It was also intimated that most of the posts of Group C are promotional posts and are required to be filled up through promotion.

2.4 Human Resources under Family Welfare Department

The Family Welfare Department constitutes 8 *per cent* of the total workforce of Health Institutions under Government of Haryana with total sanctioned strength of 3,384. Against which, 2,213 posts were filled and 1,171 posts were vacant. As such, 34.6 *per cent* of posts were vacant in the department. Position of manpower in each category as of October 2022 is given in ***Table 2.21***.

Table 2.21: Position of manpower under Family Welfare Department

Category	Sanctioned Posts	Working Strength	Vacant posts	Percentage of Vacant Posts
Doctors	51	20	31	60.8
Nurses	18	2	16	88.9
Paramedics	2,833	2,020	813	28.7
Other	482	171	311	64.5
Total	**3,384**	**2,213**	**1,171**	**34.6**

Source: HRMS data

As shown above, 28.7 *per cent* to 88.9 *per cent* posts were lying vacant under different categories in Family Welfare Department. It has shortage of 60.8 *per cent* Doctors, 88.9 *per cent* Nurses and 28.7 *per cent* Paramedical staff. No contractual staff has been deployed in the department.

Shortage of manpower in some specific posts under Family Welfare Department is given in ***Table 2.22***.

Table 2.22: Shortage of manpower in some specific posts

Post Name	Sanctioned Posts	Working Strength	Vacant Posts	Percentage of Vacant Posts
MPHW(F)	2,774	1,993	781	28
Clerk	109	38	71	65
Driver	82	21	61	74
Assistant	64	49	15	23
Deputy Civil Surgeon	38	4	34	89
Class IV	38	10	28	74
Peon	31	11	20	65
Statistical Assistant	29	15	14	48
Junior Auditor	21	2	19	90
Refrigerator Mechanic	20	6	14	70
Deputy Superintendent	18	2	16	89
Statistical Investigator	17	2	15	88
District Public Health Nursing Officer	12	0	12	100

Source: HRMS data

Colour code: Red denotes most vacancies; yellow denotes moderate vacancies and green denotes least vacancies.

As shown in the above table, percentage of vacant posts for different types of posts ranged from 23 *per cent* to 100 *per cent.*

2.5 Human Resources under AYUSH

Sanctioned strength for AYUSH Department is 2,277 which is 5.5 *per cent* of the total sanctioned strength of Health Institutions under Government of Haryana. It was observed that 1,261 (55 *per cent*) posts were vacant in this department as far as regular employees are concerned. Shortage had been observed in many key posts which has been discussed in succeeding paragraphs. Category-wise position of manpower is given in ***Table 2.23***.

Table 2.23: Manpower position under AYUSH as of October 2022

Category	Sanctioned Posts	Working Strength	Vacant Posts	Percentage of Vacant Posts
Doctor	750	372	378	50.4
Nurse	27	2	25	92.6
Paramedics	1,208	480	728	60.3
Other	292	162	130	44.5
Total	**2,277**	**1,016**	**1,261**	

Source: HRMS data

The department has shortage of 50.4 *per cent* Doctors, 92.6 *per cent* Nurses and 60.3 *per cent* Paramedical staff. There was shortage of 44.5 *per cent* staff in "other" category also which includes posts of Clerks, Accountants, Assistants, Sweepers, Ward-boys etc.

Shortage of manpower for some key posts in AYUSH Department is depicted in ***Table 2.24***.

Table 2.24: Position of manpower in some key posts under AYUSH Department (as of October 2022)

Post Name	Sanctioned Posts	Working Strength	Vacant Posts	Percentage of Vacant Posts
Pharmacist Ayurvedic	548	383	165	30
Ayurvedic Medical Officer	546	304	242	44
Trained Dai	484	36	448	93
Lecturer	37	15	22	59
MPHW(F)	34	0	34	100
Homeopathic Medical Officer	33	3	30	91
Dispenser Homoeopathic	29	17	12	41
Reader	28	13	15	54
Professor	28	13	15	54
District Ayurvedic Officer	22	13	9	41
Ayush Yog Coach	22	0	22	100

Source: HRMS data
Colour code: Red denotes most vacancies; yellow denotes moderate vacancies and green denotes least vacancies.

As shown in the table above, 30 *per cent* to 100 *per cent* posts were vacant in some key posts. Skewed distribution of posts in AYUSH Department at District level is shown in ***Table 2.25***.

Table 2.25: District wise skewed distribution of AMOs under AYUSH Department as of October 2022

District Name	Population as per 2011 census	Total posts				Ayurvedic Medical Officer			
		Sanctioned Post	Working Strength	Vacant post	Vacant post Percentage	Sanctioned Post	Working Strength	Vacant post	Vacant post Percentage
Faridabad	18,09,733	30	14	16	53	8	6	2	25
Hisar	17,43,931	164	67	97	59	53	21	32	60
Gurugram	15,14,432	68	35	33	49	13	12	1	8
Karnal	15,05,324	97	47	50	52	28	17	11	39
Sonipat	14,50,001	92	53	39	42	27	18	9	33
Jind	13,34,152	116	50	66	57	36	12	24	67
Sirsa	12,95,189	117	49	68	58	40	21	19	48
Yamunanagar	12,14,205	66	33	33	50	18	10	8	44
Panipat	12,05,437	64	27	37	58	19	4	15	79
Bhiwani	11,32,169	104	65	39	38	25	23	2	8
Ambala	11,28,350	108	39	69	64	18	13	5	28
Nuh	10,89,263	77	24	53	69	16	6	10	63
Kaithal	10,74,304	86	42	44	51	26	14	12	46
Rohtak	10,61,204	99	72	27	27	32	27	5	16
Palwal	10,42,708	72	25	47	65	15	8	7	47
Kurukshetra	9,64,655	229	113	116	51	20	17	3	15
Jhajjar	9,58,405	100	42	58	58	30	16	14	47
Fatehabad	9,42,011	62	26	36	58	19	9	10	53
Mahendragarh	9,22,088	237	56	181	76	39	13	26	67
Rewari	9,00,332	63	31	32	51	18	16	2	11
Panchkula	5,61,293	131	82	49	37	19	14	5	26
Charkhi dadri	5,02,276	95	24	71	75	27	7	20	74
Total	**2,53,51,462**	**2,277**	**1,016**	**1,261**	**55**	**546**	**304**	**242**	**44**

Source: HRMS data
Colour code: Red denotes most vacancies; yellow denotes moderate vacancies and green denotes least vacancies.

The table given above shows that posts have been sanctioned unevenly at district level. The range of total posts sanctioned for districts varies from lowest (30) in

Faridabad to highest (237) in Mahendragarh. Panchkula has the lowest population of 5.61 lakh and 131 posts are sanctioned for it whereas for Faridabad which has the highest population of 18.09 lakh, only 30 posts are sanctioned. It shows that posts have not been sanctioned by considering the population of the district.

Further, the available manpower in the Department has not been distributed uniformly. The range of vacant posts in the districts lies between 16 and 181 in absolute figures and in terms of percentage 27 *per cent* to 76 *per cent* posts are vacant at district level.

Total 44 *per cent* posts of Ayurvedic Medical Officer (AMO) were lying vacant in the State. At district level, the lowest 8 *per cent* (Gurugram) to the highest 79 *per cent* (Panipat) posts were vacant for AMOs. In terms of absolute numbers also, there exists a huge variation in the vacant posts of AMOs as in Gurugram district only one post of AMO was vacant whereas in Hisar district 32 posts of AMOs were lying vacant.

In addition to regular employees, as of January 2024, AYUSH Department has deployed 2,234 contractual staff also which takes the total deployed manpower to be more than the sanctioned strength. It shows that the sufficient manpower was deployed against the sanctioned strength but out of 2,234 contractual staff, 916 were Yog Sahayaks and 1021 were Sweepers, Water Carriers etc.

AYUSH Department replied (January 2023) that requisitions had been sent to Haryana Public Service Commission (HPSC) and Haryana Staff Selection Commission (HSSC) for recruitment of District Ayurvedic Officer, Ayurvedic Medical Officer, Homeopathic Medical Officer, Ayurvedic Pharmacist, Homeopathic Pharmacist, Ayush Yog Coach and MPHW.

2.6 Availability of Staff under National Health Mission (NHM)

National Health Mission Haryana provides quality healthcare, specially to the vulnerable groups by facilitating their access to quality primary healthcare. Position of manpower under NHM is given in ***Table 2.26.***

Table 2.26: Availability of staff in various Posts under NHM (as of January 2024)

Category	Approved strength	Working strength	Vacant posts	Percentage of vacant posts
Doctors	648	345	303	47
Nurses	2,764	2,324	440	16
Paramedics	8,385	6,823	1,562	19
Other	5,989	4,976	1,013	17
Total	**17,786**	**14,468**	**3,318**	

Source: Information furnished by NHM, Haryana as of January 2024.

Above table shows that 47 *per cent* posts of doctors were vacant in NHM, Haryana.

2.7 Human Resources under Food and Drugs Administration Department (FDA)

Total sanctioned strength of FDA, Haryana is 583. It was observed that 56 *per cent*, i.e., 326 posts were lying vacant in FDA. Shortage of manpower for some of the posts in FDA are shown in ***Table 2.27***.

Table 2.27: Manpower position under FDA including contractual staff (as of October 2022)

Post Name	Sanctioned Posts	Working Strength	Vacant Posts	Percentage of vacant posts
Drug Control Officer (DCO)	46	12	34	74
Assistant	46	19	27	59
Food Safety Officer (FSO)	45	12	33	73
Chemist	29	12	17	59
Laboratory Technician	29	19	10	34
Deputy Superintendent	27	3	24	89
Laboratory Attendant	25	6	19	76
Reader	23	0	23	100
Designated Officer	22	5	17	77
Analyst	11	3	8	73

Source: HRMS data
Colour code: Red denotes most vacancies; yellow denotes moderate vacancies and green denotes least vacancies.

Percentage of shortage for the above-mentioned posts ranged from 34 *per cent* to 100 *per cent*.

As of January 2024, 175 contractual[16] staff has also been hired by FDA but most of the staff was related to clerical and multitasking posts.

The Department stated (December 2022 and January 2023) that selection of 26 DCOs was finalised in 2020 but the matter is under litigation. Further, requisition for the post of Chemist and Laboratory Attendant had already been sent to HSSC during the year 2022. The post of Reader was sanctioned by the Government in 2018 but preparation of service rules is under process. The posts of Assistants, Deputy Superintendents and Designated Officers were to be filled up by promotion, but due to non-availability of suitable candidates, these posts remained vacant.

2.8 Shortage of drivers/Emergency Medical Team (EMT) for Ambulance Services

The revised guidelines of NHM Haryana issued in May 2019 for implementation of Referral Transport Scheme stipulate that:

(i) three drivers should be posted for each Advance Life Support (ALS) Ambulance/Basic Life Support Ambulance (BLS)/Neonate and Patient

[16] 175 posts of Group C & D staff had been filled up on contractual basis by FDA, which included mainly (i) Clerical staff: 66, (ii) Multitasking staff: 80, (iii) Drivers: 8 and (iv) Scientific assistants: 11.

Transport Ambulance (PTA). One driver should be posted for Kilkari Ambulance.

(ii) three EMTs should be posted for each ALS/BLS/Neonate ambulance. Even if the available EMTs are less than the norms, the number of operational ALS/BLS/Neonate ambulances may be reduced for ensuring three EMTs are posted for each ambulance. The preference should be given firstly to ALS ambulance, secondly to BLS and then to Neonate ambulance.

Details of shortage of drivers/EMTs on ambulances in the test-checked districts as of April 2022 (Panipat) and June 2022 (Nuh and Hisar) is given in ***Table 2.28***.

Table 2.28: Shortage of manpower for Ambulance and Emergency Medical Team

Name of District	Number of Ambulances	Drivers			Emergency Medical Team (EMT)		
		Required	Available	Shortage (In *per cent*)	Required	Available	Shortage (In *per cent*)
Panipat	28	84	57	32	84	25	70
Nuh (Mewat)	30	90	66	27	90	34	62
Hisar	27	81	65	20	81	35	57
Total	**85**	**255**	**188**	**26**	**255**	**94**	**63**

Source: Information furnished by test-checked Districts
Colour code: Red denotes most vacancies; yellow denotes moderate vacancies and green denotes least vacancies.

As per revised guidelines, 255 drivers (85 ambulances X 3 drivers) should have been posted on these ambulances against which only 188 drivers were posted. Against required 255 EMTs (85 ambulances X 3 EMTs), only 94 EMTs were available.

Civil Surgeon, Panipat replied (January 2022) that additional 27 drivers (included in the table above) had been posted on ambulances in January 2022 from Director, State Transport Haryana. In the case of EMT, it would be recruited after receipt of sanction and guidelines from National Health Mission, Haryana. The reply was not tenable as there was still shortage of 27 drivers in Panipat district. No reply received from the other two districts.

NHM replied (January 2023) that there was a requirement of 244 Drivers and 156 EMTs as stated by the Department. Out of 244 drivers, 168 drivers were available; while out of 156 EMTs, 95 EMTs were available in these districts. Indent for 614 drivers had already been placed on Haryana Kaushal Rozgar Nigam Limited (HKRNL) portal and till date 240 drivers in all districts had been provided by HKRNL, out of which, nine drivers in Panipat, 12 drivers in Nuh and 17 drivers in Hisar had already been provided. The reply was not tenable as the requirement of drivers assessed by NHM was not as per norms. Further, even after approval of the State Government for recruiting manpower through HKRNL, there was still shortage of drivers in NHM.

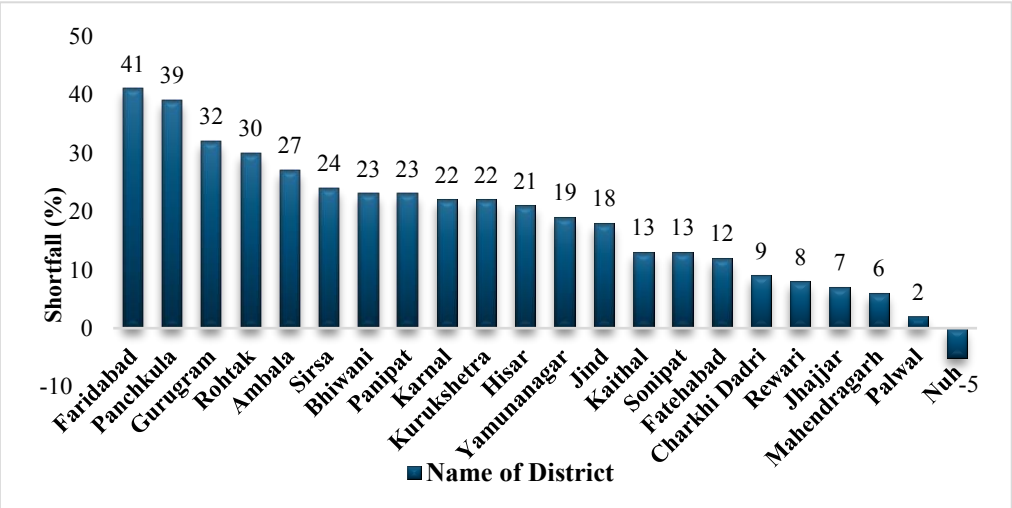
2.9 Availability of Accredited Social Health Activists (ASHAs)

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist, Accredited Social Health Activist (ASHA). Her roles and responsibilities in the society is to create awareness and to provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health and family welfare services. She also counsels women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunisation, contraception, prevention of common infections including Reproductive Tract Infection/ Sexually Transmitted Infection (RTIs/STIs) and care of the young child. As per roles and responsibilities, ASHAs facilitate in Ante Natal Check-up (ANC), Post Natal Check-up (PNC) and escort/accompany pregnant women and children requiring treatment/ admission to the nearest PHC/CHC/FRU. Further, they also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy, Iron Folic Acid Tablet (IFA), Chloroquine, Disposable Delivery Kits, Oral Pills and Condoms, etc.

As per guidelines issued on ASHA by the Central Government in 2005, one ASHA is required per one thousand population. As per population (2,53,51,462) of Haryana in 2011, there is requirement of 25,351 ASHAs against which there was availability of 20,405 (shortfall of 20 *per cent*) ASHAs in Haryana as of October 2022.

District wise shortfall (in percentage) in availability of ASHAs is as under:

Chart 2.8: District wise shortfall (in *per cent*) in availability of ASHAs as per IPHS norms



Source: Information furnished by Department.

From the above table, it is evident that the availability of ASHAs in all districts is uneven. The shortage of ASHAs was ranging between two *per cent* in district Palwal to 41 *per cent* in district Faridabad.

Further, Oral Contraceptive (OC) pills (13,770) and condoms (38,82,720) expired in various health institutions during the period 2016-21. As per NFHS 5 (2020-21), mothers who had at least four antenatal care visits was 60.4 *per cent* in Haryana. Mothers who consumed iron folic acid for 180 days or more when they were pregnant was 32 *per cent*. ASHAs facilitate delivery of health services and also create awareness and popularise health services and family planning methods. Therefore, it cannot be denied that if required number of ASHAs were available, the expiry of OC pills and condoms could have been reduced, if not avoided completely. Health indicators especially related to child and maternal health could have also been improved.

Information regarding availability of number of ASHAs per Sub Centre (SC) along with the name of village was sought from National Health Mission, Haryana. But the Department (October 2022) intimated that the number of ASHA according to SCs and population is not required at NHM HQ, therefore, this data was not available. The reply was not tenable because an 'ASHA portal & Mobile App' has been developed by NHM, Haryana which is being implemented through android mobile phones supplied to the ASHAs. The main purpose of the mobile app is to cover real-time data for such activities e.g., Village Health Nutrition Day celebration, Village Health Sanitation & Nutrition Committee meetings, maintaining Village Health Register/Line-listing of Households etc., which are currently not authenticated through existing databases in the health system and all these are also required to be linked in such a manner that without confirmation/ validation of any of these activities, the incentive claims should not be approved for release of incentive payments. So, in the absence of real time availability of number of ASHAs and village-wise population, the purpose of the app application along with android phones may not be effective.

During the exit conference (January 2023), the ACS, Health and Family Welfare Department, Government of Haryana directed NHM to maintain data related to deployment of human resources at all levels for better monitoring and deployment of ASHAs.

2.10 Shortage of staff and its impact on delivery of health services in test-checked districts

The number of sanctioned/ filled posts of Medical Officers/Nursing Sister/ Officers/Paramedical Staff in the test-checked districts is given in ***Table 2.29***.

Table 2.29: Position of manpower in test checked Districts (as of October 2022)

Name of District	Name of Institution	Doctors			Nurses			Paramedical Staff		
		Sanctioned	Filled	Excess (+)/ Shortfall (*in per cent*)	Sanctioned	Filled	Excess (+)/ Shortfall (*in per cent*)	Sanctioned	Filled	Excess (+)/ Shortfall (*in per cent*)
Nuh	DH Mandi Khera	51	41	20	44	35	20	45	16	64
	CHCs	18	19	(+)6	20	15	25	22	15	32
	PHCs	15	10	33	10	5	50	20	6	70
Panipat	DH Panipat	68	39	43	102	85	17	62	33	47
	SDCH Samalkha	14	11	21	20	16	20	18	18	0
	CHCs	36	25	31	40	18	55	41	51	(+)24
	PHCs	18	8	56	12	2	83	24	9	63
Hisar	DH, Hisar	68	56	18	104	91	13	64	41	36
	SDCH Adampur	14	12	14	20	14	30	18	8	56
	SDCH Narnaund	51	18	65	44	18	59	48	13	73
	CHCs[17]	41	22	46	50	41	18	52	46	12
	PHCs	27	18	33	18	13	28	36	26	28

Source: HRMS Data

Colour code: Red denotes most vacancies; yellow denotes moderate vacancies and green denotes least vacancies/excess.

It is evident from the above table that more shortage in case of Medical Officers was seen in district Panipat and Hisar as compared to district Nuh. Further, more shortage in case of paramedical staff was seen in district Nuh as compared to districts Panipat and Hisar.

It is pertinent to mention that as per IPHS 2012 norms, a PHC should have a Medical Officer. It was, however, noticed that no Medical Officer was posted in PHC Mangal Khan and Puthi Samain, Hisar.

During the exit conference (January 2023), the ACS, Health and Family Welfare Department while agreeing to the audit observations stated that the exercise for rationalisation of manpower and creation of specialist cadre is under process and would be completed soon.

Due to shortage of staff, the delivery of health services in the test-checked health institutions was hampered as several such cases have been highlighted in this report as detailed in ***Table 2.30***.

Table 2.30: Details of services hampered due to shortage of staff

Sr. No.	Impacted Service	Para reference
1.	Non-availability of specialty OPD services in test-checked health institutions due non-availability of Specialists	3.1.1, 3.1.2 & 3.1.3
2.	Number of OPD cases per doctor were uneven in selected health institutions	3.1.5
3	Non-availability of Major/Minor surgeries in test-checked health institutions due to shortage of surgeons	3.2.4
4.	Operation theatres were not functional in some test-checked health institutions	3.2.6
5.	Emergency services were not available in some of the test-checked health institutions	3.3.1, 3.3.2 & 3.3.3
6.	Maternity services were not available in some test-checked health institutions due to shortage of required staff.	3.5.2 (iii)

[17] During field study, CHC-cum-SDCH, Barwala was considered as CHC, Barwala.

Sr. No.	Impacted Service	Para reference
7.	Ventilators supplied in health institutions were not put to use due to shortage of skilled manpower	4.4.2
8.	Out of total upgraded Health & Wellness Centres, some HWCs were not operational due to shortage of staff	5.6.2
9.	Out of total AYUSH Health & Wellness Centres, some were not operational or providing partial services due to shortage of staff	5.7
10.	Infrastructure not put to use appropriately in test checked health institutions	5.9

2.11 Availability of manpower in upgraded AYUSH Health and Wellness Centres

As per the AYUSH HWCs operational guidelines issued in May 2020, there should be an appropriate trained primary health care team, comprising of multi-purpose workers, ASHAs, auxiliary nurse midwife (ANM) led by a community health officer (a qualified AYUSH physician). A qualified/certified Yoga instructor would be deployed at all HWCs on a part time basis to provide continuous and customised Yoga training to the community at HWC and various other identified public places.

The availability of manpower against requirement in 346 upgraded AYUSH HWCs in the State is depicted in ***Table 2.31***.

Table 2.31: Availability of manpower against requirement in upgraded AHWCs

No. of HWCs upgraded upto November 2021	No. of HWCs having Yoga instructor	No. of ASHAs to be deployed 5 per HWCs	No. of ASHAs deployed in actual in HWCs	No. of ANMs to be deployed 2 per HWCs	No. of ANMs deployed in actual in HWCs
346	0	1,730	1,363	692	484

Source: Information furnished by AYUSH, Haryana.

It was intimated (November 2021) by the department that out of 346 AHWCs upgraded, none of the HWCs has a yoga instructor. The above table also shows shortage of ASHAs and ANMs in the upgraded AHWCs as against the sanctioned posts of 1,730 ASHAs and 692 ANMs, only 1,363 posts (79 *per cent*) and 484 posts (70 *per cent*) respectively were filled. Further, out of these upgraded AHWCs, in 51 HWCs of Hisar and Jind districts, no ASHA/ANMs were deployed.

It was further intimated (November 2021) that the process for recruitment of yoga instructors was delayed due to stay imposed by the Hon'ble High Court. Further, the deployment of ASHAs and ANMs was to be done by the Health Department because these primary health care workers were under the control of Civil Surgeons at district level.

Further, in the test-checked districts, against the requirement of 55 Community Health Officers (CHOs)/Ayush Medical Officers (AMOs), only 50 CHOs/ AMOs were deployed. It was further intimated by District Ayurvedic Officers (DAOs) of the respective test-checked districts that as a stop gap arrangement, four CHOs/AMOs in district Panipat had been assigned with additional charge of four nearby AHWCs, where the post of CHOs/AMOs were vacant. Similarly,

in Nuh district, four CHOs/AMOs had been assigned with additional charge of four nearby SCs. In the existing arrangement, the adverse impact on patient health care could not be ruled out as the CHOs were not attending the OPDs regularly on all working days, due to additional attachments.

On being pointed out by audit, the Department stated (January 2023) that file was under process for appointment of regular AYUSH doctors. Now, the Government of Haryana had approved the posts of full time Yog *Sahayak* to be appointed at Yog and *yayamshalas*. It was further stated that ANMs and ASHAs were under the administrative control of the Health Department and instructions had been issued to the Civil Surgeons concerned for the deputation of ANMs and ASHAs.

2.12 Recruitment of manpower

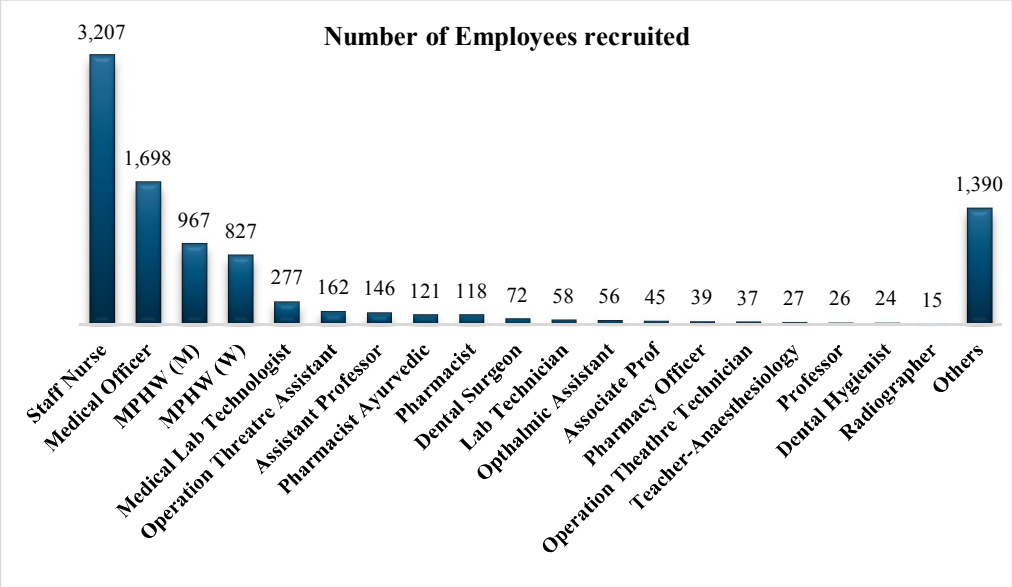
Analysis of HRMS data revealed that out of total 24,219 employees under health sector related directorates, 9,312 employees (38.4 *per cent*) were recruited during the period April 2016 to December 2022. Details of year-wise recruitment are given in ***Table 2.32***.

Table 2.32: Manpower recruited during the period 2016-17 to 2022-23

Year	Doctors	Nurses	Paramedics	Others	Total
2016-17	70	56	8	4	**138**
2017-18	353	1,057	213	322	**1,945**
2018-19	132	98	1,012	288	**1,530**
2019-20	131	2	475	204	**812**
2020-21	703	416	16	123	**1258**
2021-22	47	188	117	21	**373**
2022-23 (upto Dec 2022)	682	1,390	967	217	**3,256**
Total	**2,118**	**3,207**	**2,808**	**1,179**	**9,312**

Source: HRMS data.

Chart 2.9: Category-wise number of Employees recruited



Source: HRMS data.

It is evident from the above table and chart that out of 9,312 persons recruited during the period 2016-17 to 2022-23 (up to December 2022), 3,256 persons had been recruited during 2022-23 only. This constituted almost 35 *per cent* of the manpower recruited during the period 2016-17 to 2022-23 which shows that the pace of recruitment has increased. Apart from the above, out of the total recruitment, 34 *per cent* and 18 *per cent* were nurses and medical officers respectively.

2.13 Conclusion

Government has not created sanctioned posts in the Health sector considering IPHS norms as the benchmark. Specialist cadre has not been created under Health Department. Further, there is shortage in available manpower against the sanctioned strength as well, adversely affecting health services. This shortage is quite high in several key posts such as doctors, staff nurses, radiographers/ ultrasound technicians, pharmacists, etc., which play a very important role in delivering comprehensive healthcare to the beneficiaries. Moreover, available manpower has not been distributed uniformly across the districts and this trend has been witnessed across all the departments and in most of the crucial posts as well. Though the overall availability of Specialists in DHs is good, there is a wide variation across districts leading to shortage in many DHs. The SDCHs have very few Specialists when compared to IPHS norms.

2.14 Recommendations

1. **Government should consider bringing in sanctioned strength of Health departments including Specialists at par with the IPHS norms.**

2. **Government should focus on expediting recruitment process in order to fill vacancies in the sector.**

3. **In the short term, the existing staff should be rationalised across districts and health institutions. While rationalising, it should be ensured that the postings are done in such a way that complimentary healthcare professionals i.e., doctors, nurses, paramedics, technicians and other support staff are posted in each health institution. Availability of infrastructure and other crucial components should be considered during such rationalisation. Government should bring out a long-term strategy and policy to reduce variations in doctor-population ratio across districts.**

4. **Government should plan through State policy for assessment of medical personnel, sanction of posts, recruitment and deployment of doctors, nurses and paramedical staff.**

Chapter-3
Healthcare Services

Chapter-3

Healthcare Services

IPHS norms 2012 provide that services that a health institution is expected to provide can be grouped as Essential (Minimum Assured Services) and Desirable (which should be aspired to be achieved). The services include Out - Patient Department (OPD), indoor and Emergency Services. Audit findings related to various health services have been described in the succeeding paragraphs.

3.1 OPD Services

3.1.1 Availability of OPD services in hospitals

As per IPHS 2012 norms, the OPD services of Ear Nose Throat (ENT), General Medicine, Paediatrics, General Surgery, Ophthalmology, Dental, Obstetrics and Gynaecology and Orthopaedics are essential for District Hospital (DH) and Sub Divisional Civil Hospital (SDCH). Psychiatry is essential OPD service for DHs and desirable for 100 bedded SDCHs.

Details of availability of OPD (Specialist) services in all the DHs and SDCHs as on May 2023 are as given in ***Table 3.1***.

Table 3.1: Availability of OPD (Specialist) services in hospitals

Specialty Services (OPD)	DHs	SDCHs
	Available (out of total 22 DHs)	Available (out of total 41 SDCHs)
ENT	20	5
General Medicine	18	2
Paediatrics	20	15
General Surgery	18	7
Ophthalmology	21	7
Dental	22	34
Obstetrics & Gynaecology	20	20
Psychiatry	17	NA
Orthopaedics	22	8

Source: Information furnished by DHs/SDCHs
NA= Not applicable, as per IPHS 2012 norms, Psychiatry service is desirable for 100 bedded SDCH.
Colour code: Green colour depicts availability of service in maximum number of hospitals; yellow colour depicts availability of service in moderate number of hospitals; and red colour depicts availability of service in least number of hospitals.

The OPD services were adversely affected due to non-availability of Specialists in various health institutions. The details of OPD (Specialist) services in DHs have been given in ***Appendix 3.1 (i)***. Due to non-availability of Specialists in DHs of Charkhi Dadri, Jhajjar, Narnaul and Yamuna Nagar, out of nine requisite specialties, three or more OPD (Specialist) services were not available. All the OPD (Specialist) services were available in SDCH, Ambala Cantt and Ballabhgarh. Further, all the OPD services were also available in SDCH, Bahadurgarh except for General Medicine. The rest of the SDCHs had availability of OPD (Specialist) services ranging from one to five services only. The details of OPD (Specialist) services in SDCHs have been given in ***Appendix 3.1 (ii).***

Further, in case of the test-checked MCHs, all the OPD (Specialist) services were available in both the MCHs, Agroha and Nalhar except Radiology services in MCH Nalhar.

3.1.2 Availability of OPD services in CHCs

As per IPHS 2012 norms, General Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics, Dental and AYUSH Services, Emergency Services, Laboratory Services and National Health Programmes should be available in CHCs.

The availability of OPD services (General) in all the CHCs is given in ***Table 3.2***.

Table 3.2: Availability of OPD services (General) in CHCs (126)

Name of Service	No. of CHCs	Available in no. of CHCs	Not available in no. of CHCs	Shortage (in *per cent*)
General Medicine	126	89	37	29
Surgery	126	18	108	86
Obstetrics and Gynaecology	126	67	59	47
Paediatrics	126	27	99	79
Dental	126	115	11	9
AYUSH	126	82	44	35
Emergency	126	92	34	27
Laboratory	126	116	10	8

Source: Information furnished by CHCs as of May 2023.
Colour code: Green colour= Least Shortage; Yellow colour= Moderate Shortage and Red Colour= Most Shortage.

Out of eight requisite OPD (Specialist) services, less than four services were available in most of the CHCs due to non-availability of Specialists. The details of availability of OPD services in CHCs are given in ***Appendix 3.1 (iii)***.

3.1.3 Availability of OPD services in PHCs

There is no mention of specific OPD services in PHCs in IPHS 2012 norms. OPD services were available in all the test-checked PHCs.

As per IPHS 2012 norms, outpatient room should have separate areas for consultation and examination with sufficient privacy. However, separate areas for consultation and examination in outpatient room were not available in PHC Rair Kalan (Panipat), Ladwa (Hisar), Nagina and Singar (Nuh). Further, in PHCs Atta and Mandi, dental equipment were provided but dental surgeons were not available since 2019 and 2020 respectively.

Dental equipment not in use at PHC Mandi (17 March 2022)

Dental equipment not in use at PHC Atta (30 March 2022)

3.1.4 Availability of infrastructure for AYUSH services in CHCs and PHCs

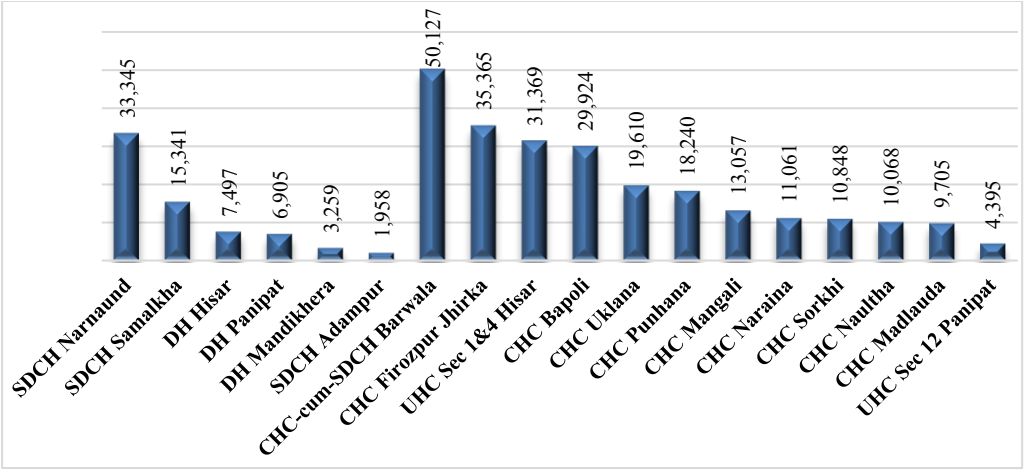
As per IPHS 2012 norms, CHCs and PHCs should have AYUSH doctor, necessary infrastructure such as consultation room for AYUSH doctor and AYUSH drug dispensing area should be made available.

Ayush services were not available in three[1] out of 12 CHCs/ UHCs. Further, out of test-checked 24 PHCs/UPHCs, only five PHCs (Kaimri, Agroha, Singar, Nagina, Siwah) had Ayush services.

3.1.5 Average OPD cases per doctor per annum against available OPD services

During the period 2016-17 to 2022-23, the number of OPD cases in DHs[2] (36.05 lakh), SDCHs (21.01 lakh) and CHCs (39.73 lakh) for the test-checked districts are given in ***Appendix 3.2***. Further, in the test-checked hospitals and CHCs, the average OPD cases per doctor per annum was highest (50,127) in CHC-cum-SDCH Barwala and lowest (1,958) in SDCH Adampur.

Chart 3.1: Average OPD cases per doctor per annum during 2016-17 to 2020-21



Source: Information furnished by the test-checked Health Institutions

[1] CHC- (i) Barwala, (ii) Madlauda and (iii) Naraina

[2] The details of OPD cases of DH, Panipat for the period 2016-17 to 2018-19 were not available with the DH.

It was noticed that in SDCH Narnaund (100 bedded) against the sanctioned strength of 51 only 18 doctors including one Specialist (Dental) were posted. In CHC-cum-SDCH Barwala[3] (50 bedded) against the sanctioned strength of 14 only eight doctors including two specialists (Dental and OBGY) were posted. During 2016-17 to 2022-23 in SDCH, Narnaund total OPD cases were 4.16 lakh and in CHC-cum-SDCH Barwala were 5.09 lakh. Despite having such large number of OPD cases per doctor per annum, specialists were not posted in these two SDCHs.

In the third test-checked SDCH, Adampur (50 bedded) in the same district (Hisar) the OPDs during the same period were only 1.43 lakh. However, against the sanctioned strength of 14 doctors, 12 doctors were deputed in SDCH, Adampur, though Specialist was only one (Paediatrics).

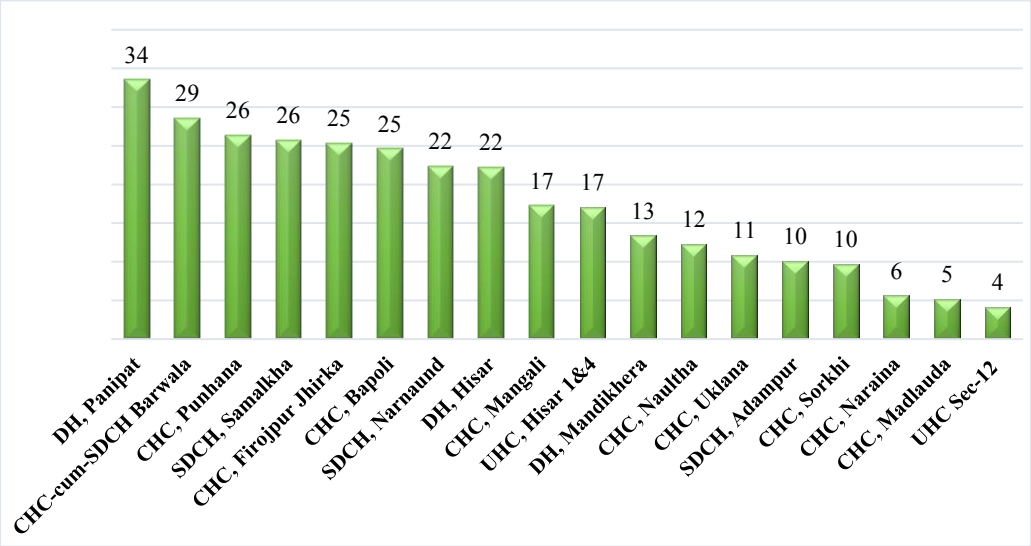
This shows that availability of doctors was not ensured as per the patient load in the health institutions.

3.1.6 Availability of registration counters and average daily patient load per counter

As per NHM Assessor's guidebook for quality assurance in health institutions, the number of registration counters should be such that per hour 12 to 20 patients can be registered. Further, as per IPHS 2012 norms facilities such as adequate waiting area with seating arrangements, electronic display for patient calling, etc should be there.

Average number of patients per hour per counter in the test-checked DHs, SDCHs and CHCs during 2020-21 is depicted in **Chart 3.2**.

Chart 3.2: Average number of patients per hour per counter during 2020-21



Source: Information furnished by the test-checked Health Institutions

[3] Upgraded as SDCH, Barwala in June 2017 but still working as CHC.

As can be seen from the above chart, the counters for registration were not sufficient in DH Panipat, DH Hisar, SDCH Samalkha, SDCH Narnaund, CHC-cum-SDCH Barwala, CHC Punhana, CHC Firojpur Jhirka and CHC Bapoli having a large number of OPDs. The result of high patient load was visible in long queues in the hospitals as depicted in the photographs below:

OPD patients waiting at registration counters in DH Panipat (April 2022)	**Long queues of OPD patients at registration counters in DH Hisar (June 2022)**

On being pointed out by Audit, the Department stated (February 2023) that registration of patients visiting healthcare facilities is decentralised in District Hospitals. There are separate registration facilities for OPD, Emergency and Maternity services. Separate counters are there for males, females, geriatric (senior citizens) and disabled persons for OPD registration. Further speciality-wise decentralisation will be planned as per availability of manpower, logistics and space.

3.1.7 Availability of seating arrangement, toilet facility and patient calling system (Digitalisation)

As per IPHS 2012 norms, waiting area with adequate seating arrangement shall be provided. Main entrance, general waiting and subsidiary waiting spaces are required adjacent to each consultation and treatment room in all the clinics. Fluorescent fire exit plan should be displayed at each floor; Safety, hazard and caution signs should be displayed prominently at relevant places. Health institutions should have patient calling system with electronic display. The status of provision of the above features in the test-checked DHs/CHCs/PHCs is given in ***Table 3.3***.

Table 3.3: Availability of seating arrangement, toilet facility etc.

Name of service	Hospitals	CHC	PHC
	Total =6	Total=12	Total=24
Display of fluorescent fire exit sign	4	4	2
Enquiry/ May I help desk with staff fluent in local language	5	8	8
Directional signage for Emergency, Departments and Utilities	6	7	14
Display of safety, hazard and caution signs prominently at relevant places	5	8	7
Important contacts like higher medical centres, blood banks, fire department, police and ambulance services were displayed	5	9	13
Mandatory information (under RTI Act, PNDT Act, etc.) was displayed	4	9	15
Adequate seating facility	6	10	24
Patient Calling System (Digitalisation)	0	0	0
Separate toilets for male and female	6	12	12

Source: Data furnished by the test-checked health institutions during January to June 2022
Note: Colour grading has been done on colour scale with green colour depicting most number of health institutions, yellow colour moderate while red colour depicts least number of health institutions having the above facilities

From the above, it can be seen that there was no display of fluorescent fire exit sign in 22 out of 24 PHCs and patient calling system was not available in any of the test-checked health institutions. Moreover, the mandatory information (under RTI Act, PNDT Act, etc.) was not displayed in two hospitals (DH Hisar and SDCH Narnaund), three CHCs (Uklana, Naultha and UCHC Sector 1 and 4, Hisar) and nine PHC[4]s.

3.1.8 Patient satisfaction survey

As per NHM Assessor's guidebook, OPD patient satisfaction survey has to be done on monthly basis. It was observed that OPD patient satisfaction survey was not conducted in DH Mandikhera, MCH Agroha, MCH Nalhar, SDCH Samalkha and SDCH Narnaund.

Audit conducted a survey of doctors and patients selected on random basis during performance audit to get feedback from doctors and patients' satisfaction. The results are given in ***Appendix 1.3***.

For OPD services, 120 patients[5] were surveyed during January 2022 to June 2022 in selected health institutions (DHs/SDCHs/CHCs). The results are summarised below:

i. 29 *per cent* patients said that Enquiry/May I Help desk was not available with competent staff.

ii. According to 14 *per cent* patients, seating arrangements were not adequate at registration/OPD counter.

[4] PHC: (i) Daulatpur, (ii) Talwandi Rukka, (iii) Biwan, (iv) Siwah, (v) Atta, (vi) Israna, (vii) Mandi (viii) UPHC Rajeev Colony, Panipat and (ix) UPHC Raj Nagar, Panipat.

[5] 10 patients per DH and SDHC; five patients per CHC

iii. 26 *per cent* patients said that number of registration counters were not adequate in health institutions.

iv. 48 *per cent* patients informed that patient calling system was not satisfactory.

v. 31 *per cent* said that all prescribed medicines were not made available by hospital pharmacy.

vi. 27 *per cent* (pathological tests) and 54 *per cent* (radiology tests) patients said that all the tests recommended by doctors were not done by the hospital.

vii. 13 *per cent* patient objected that complaint box was not available in the test-checked health institutions.

The survey indicates that patient calling system, information display and availability of tests need improvement across the hospitals.

3.2 IPD Services

Indoor Patients Department (IPD) refers to the areas of the hospital where patients are accommodated after being admitted, based on doctor's/specialist's assessment, from the Out-Patient Department, Emergency Services and Ambulatory Care. In-patients require a higher level of care through nursing services, availability of drugs/diagnostic facilities, observation by doctors, etc.

3.2.1 Availability of IPD beds in DH/SDCH

As per IPHS 2012 norms for District Hospitals (DHs), the IPD bed shall be categorised as General Medicine ward, Paediatrics ward, General Surgery ward, Ophthalmology ward, Accident and trauma ward, etc. Availability of IPD beds in the test-checked DHs is given in ***Table 3.4***.

Table 3.4: Availability of IPD beds in test checked DHs/SDCHs (January to June 2022)

Sr. No.	Name of Ward	Requirement of Beds in DH as per IPHS	DH Hisar	DH Panipat	DH Mandikhera	SDCH Narnaund	SDCH Adampur	SDCH Samalkha
1	General Medicine	30	24	6	12	50	24	20
2	General Surgery	30	21	30	8	0	0	0
3	Ophthalmology	5	0	6	8	0	0	0
4	Accident & trauma	10	0	7	10	0	0	20
5	Paediatrics	10	12	30	10	0	4	0
6	Others		143	121	52	0	22	10
Total			**200**	**200**	**100**	**50**	**50**	**50**

Source: Data furnished by the test-checked health institutions

Note: Colour grading has been done on colour scale with green colour depicting satisfactory number of beds, yellow depicts average while red colour depicts non-availability or very less availability of beds in DHs and blue depicts the status of IPD beds in SDCHs

As per IPHS 2012 norms for Sub Divisional Civil Hospitals (SDCHs), allocation of beds for different specialities may be done as per local need. In all

the three test-checked SDCHs, i.e., SDCH Samalkha, SDCH Adampur and SDCH Narnaund allocation of beds was not done based on specialities.

3.2.2 Availability of six beds in PHCs with Maternal and Child Healthcare

Primary Health Centre is the cornerstone of rural health services- a first port of call in rural areas for the sick who directly report or are referred from Sub-Centres for curative, preventive and promotive healthcare.

As per IPHS 2012 norms for PHCs, a typical PHC covers a population of 30,000 in plain areas with six indoor/observation beds. Intra-natal care: (24-hour delivery services both normal and assisted) should be available at PHCs. Availability of beds, labour service and Operation theatre (optional) to facilitate conduct of selected surgical procedures (e.g., vasectomy, tubectomy, hydrocelectomy etc.) in the test-checked PHCs is given in ***Table 3.5***.

Table 3.5: Availability of Labour service with beds and OT in the test-checked PHCs/UPHCs

Name of District	Number of PHCs/UPHCs test-checked	Number of PHCs with availability of six beds	Number of PHCs with availability of Labour service	Number of PHCs with availability of OT for vasectomy, tubectomy, etc.
Hisar	11	5	6	0
Panipat	9	0	3	0
Nuh	4	4	4	0

Source: Information furnished by the test-checked PHCs/UPHCs (January to June 2022).

It is evident from the above table that:

- Six[6] out of eleven PHCs/UPHC in Hisar and all the test-checked PHCs/ UPHCs in Panipat did not have six beds as per norms.
- Five[7] out of eleven PHCs/UPHC in Hisar and six[8] PHCs/UPHCs in Panipat did not have facility for labour service as per norms.
- OT facility was not available in any of the test checked PHCs/UPHCs.

3.2.3 Availability of Isolation wards

As per IPHS 2012 and NHM Assessor's guidebook, the clinics for infectious and communicable diseases should be located in isolation, preferably, in remote corner and provided with independent access. An isolation room should be available in DHs, SDCHs and CHCs. Ordinarily, negative air pressure isolation

[6] PHC- (i) Ladwa, (ii) Hasangarh, (iii) Daulatpur, (iv) Agroha, UPHC- (v) Patel Nagar (Hisar) and (vi) Char Qutab Gate (Hansi)

[7] PHC- (i) Daulatpur, (ii) Agroha, (iii) Ladwa, UPHC-(iv) Patel Nagar (Hisar) and (v) Char Qutab (Hansi)

[8] PHC- (i) Atta, (ii) Rair Kalan, (iii) Israna, (iv) Patti-Kalyana, UPHC-(v) Hari Singh Colony (Panipat) and (vi) Rajeev Colony (Panipat)

rooms are used as prevention rooms, while positive air pressure isolation rooms are used for protection. For patients who test positive for airborne illnesses, negative pressure isolation prevents contaminants from escaping the room.

Availability of isolation rooms in the test-checked Medical Colleges Hospitals (MCHs), DHs and SDCHs is given in ***Table 3.6***.

Table 3.6: Availability of positive and negative isolation rooms (as of January to June 2022)

Name of hospital	Positive isolation room	Negative isolation room
DH, Panipat	N A	N A
SDCH, Samalkha	A	A
DH, Mandikhera	A	A
DH, Hisar	A	N A
SDCH, Adampur	A	A
SDCH, Narnaund	N A	N A
MCH, Agroha	A	N A
MCH Nalhar	N A	N A

Colour code: Green colour/A= Available; Pink colour/NA=Not availabe
Source: Information furnished by the test-checked MCHs/DHs/SDCHs

Isolation wards were not available in DH Panipat; MCH Nalhar and SDCH Narnaund. Only at DH Mandikhera, SDCH Samalkha and SDCH Adampur both types of isolation wards were available. Positive isolation room was not available in seven[9] out of 12 test-checked CHCs/ UHCs and negative isolation room was available only in CHC Madlauda and CHC Punhana.

3.2.4 Availability of surgeries

As per NHM Assessor's guidebook, 2013 and IPHS 2012 norms for DH/SDCH, surgeries related to General surgery, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, ENT services and Orthopaedics should be available at District Hospital. Further, CHCs should be able to provide routine and emergency care in surgery. This includes dressings, incision and drainage, surgery for hernia, hydrocele, appendicitis, haemorrhoids, fistula and stitching of injuries. It should also be able to handle emergencies like intestinal obstruction, haemorrhage, etc. and putting splints/plaster cast.

Availability of specific surgical procedures in the test-checked health institutions is given in ***Table 3.7***.

[9] CHC- (i) Naultha, (ii) Naraina, (iii) Firozpur Jhirkha, (iv) Sorkhi, (v) Mangali, UHC- (vi) Sector 1&4 (Hisar) and (vii) Sector 12 (Panipat)

Table 3.7: Availability of Surgical Procedures in the test-checked Health Institutions (as of January to June 2022)

Name of procedure (as per IPHS)	Hisar				Panipat			Nuh	
	DH, Hisar	SDCH, Adampur	SDCH, Narnaund	CHCs/ UHC (05)	DH Panipat	SDCH Samalkha	CHCs/ UHC (05)	DH Mandi-khera	CHCs (02)
Hernia	A	A	NA	NA	A	NA	03 NA*	A	01 NA**
Hydrocele	A	A	NA	NA	A	NA	03 NA*	A	01 NA**
Appendicitis	A	A	NA	NA	A	NA	03 NA*	A	01 NA**
Haemorrhoids	A	A	NA	NA	A	NA	03 NA*	A	01 NA**
Fistula	A	A	NA	NA	A	NA	03 NA*	A	01 NA**
Intestinal Obstruction	A	A	NA	NA	A	NA	NA	A	01 NA**
Haemorrhage	A	A	NA	NA	A	NA	NA	A	01 NA**
Nasal packing	A	A	NA	4 NA#	A	NA	NA	A	01 NA**
Tracheostomy	A	A	NA	NA	NA	NA	NA	A	01 NA**
Foreign body removal	A	A	NA	NA	A	NA	NA	A	01 NA**
Fracture reduction	A	A	NA	NA	A	NA	NA	A	01 NA**
Putting splints/ plaster cast	A	A	NA	NA	A	NA	NA	A	01 NA**

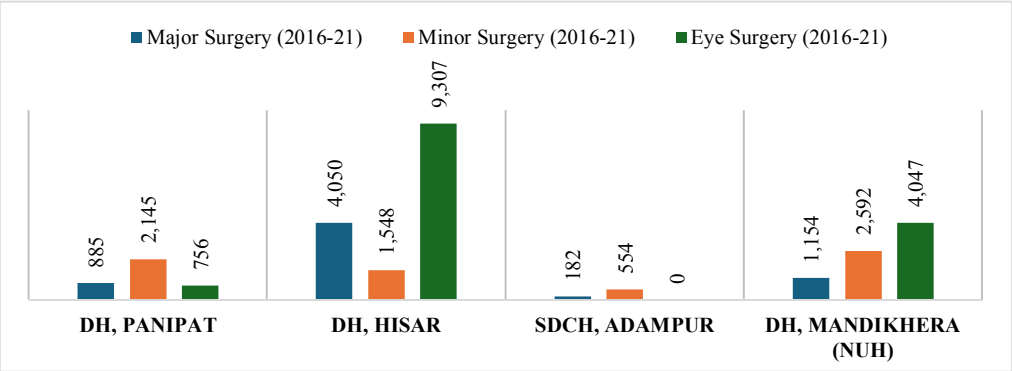
Colour code: Green colour/A= Available; Pink colour/NA=Not availabe
*** Available in CHC Madlauda and UHC Sec-12 Panipat, **Available in CHC Punhana, Available in CHC Mangali.**
Source: Information furnished by the test-checked Health Institutions

As evident from the above, all surgical procedures were available in DH Hisar, DH Mandikhera, SDCH Adampur and DH Panipat (except Tracheostomy). No surgical procedures were available in SDCH Narnaund and SDCH Samalkha.

(i) Availability of major, minor and Ear, Nose and Throat (ENT) surgeries

As per NHM Assessor's guidebook, 2013, surgeries related to General surgery, Obstetrics & Gynaecology, Paediatrics, Opthalmology, ENT services and Orthopaedics should be available at District Hospital. In CHCs, surgeries related to General surgery services, Obstetrics and Gynaecology services and accident and emergency services should be available.

Chart 3.3: Major, Minor and Eye surgeries performed in DH/SDCH during 2016-17 to 2020-21



Source: Information furnished by selected DHs/ SDCHs

Major, Minor and ENT surgeries were available in four out of six selected DH/SDCH. No surgery was performed in SDCH Samalkha and Narnaund and in any of the test checked CHCs during the period 2016-21 due to non-availability of surgeons at these SDCHs/CHCs as discussed in paragraph 2.2.5 (ii)(b) and (iv) in Chapter 2. The number of surgeries performed were maximum in DH Hisar.

3.2.5 Surgery load per surgeon

Audit analysed surgeries conducted per surgeon available in DHs and SDCHs and observed huge variations across hospitals during 2016-17 to 2020-21 as given in ***Table 3.8***.

Table 3.8: Average number of surgeries per surgeon

Name of Hospital	Year	General		ENT		Ortho		EYE	
		No. of surgeons	Avg. No. of Surgeries	No. of surgeons	Avg. No. of Surgeries	No. of surgeons	Avg. No. of Surgeries	No. of surgeons	Avg. No. of Surgeries
DH Panipat	2016-17	4	165	2	28	1	21	1	70
	2017-18	5	58	2	33	1	31	2	20
	2018-19	3	179	1	52	1	31	2	128
	2019-20	2	92	1	154	2	19	2	83
	2020-21	2	40	1	7	2	414	2	113
DH, Hisar	2016-17	2	201	2	223	2	90	2	1,093
	2017-18	3	140	2	236	2	100	2	1,015
	2018-19	5	163	2	186	3	85	2	1,121
	2019-20	5	138	2	195	3	106	2	991
	2020-21	5	54	2	137	4	24	3	290
SDCH, Adampur	2016-17	0	0	0	0	0	0	0	0
	2017-18	0	0	0	0	0	0	0	0
	2018-19	0	0	0	0	0	0	0	0
	2019-20	1	249	0	0	0	0	0	0
	2020-21	1	487	0	0	0	0	0	0
DH, Mandikhera (Nuh)	2016-17	1	272	0	0	2	215	3	555
	2017-18	2	117	0	0	2	427	2	777
	2018-19	1	49	2	18	3	317	1	557
	2019-20	1	44	2	20	2	355	1	189
	2020-21	3	9	2	7	2	264	1	83

Source: Data furnished by health institutions
Colour code: Green colour depicts good number of surgeries, yellow depicts moderate and red depicts either no surgeries or very few.

As can be seen from above table, number of surgeries as well as surgeries per surgeon were maximum in Hisar. Number of surgeries per surgeon has by and large shown a declining trend.

3.2.6 Operation Theatre

As per IPHS 2012 norms and NHM Assessor's guidebook for quality assurance for hospitals, the Operation Theatre (OT) should have convenient relationship with surgical ward, ICU, radiology, pathology, blood bank and Central Sterile Supply Department (CSSD). It should have access without any physical barrier etc.

The availability of various elements of quality OT service are given in ***Table 3.9***.

Table 3.9: Availability of OT services in the test-checked DHs/SDCHs

Description	DH, Panipat	SDCH, Samalkha	DH, Mandikhera	DH Hisar	SDCH Adampur	SDCH Narnaund
OT have convenient relationship with surgical ward, intensive care unit, radiology, pathology, blood bank and CSSD.	No	No	No	Yes	Yes	Yes
Access to facility is provided without any physical barrier and is friendly to people with disabilities.	Yes	No	Yes	Yes	Yes	Yes
OT have piped suction and medical gases, electric supply, heating, air-conditioning, ventilation.	Yes	Yes	Yes	Yes	Yes	Yes
Patient's records and clinical information is maintained.	Yes	No	Yes	Yes	Yes	Yes
Has defined and established grievance redressal system in place.	No	No	Yes	Yes	Yes	Yes
All equipments are covered under AMC including preventive maintenance.	No	No	Yes	Yes	Yes	Yes
The facility has established procedure for internal and external calibration of measuring equipment	Yes	No	Yes	No	Yes	Yes

Source: Information furnished by the test-checked DHs/SDCHs (as of January to June 2022)
Colour code: Green colour/Yes= Available; Red colour//No=Not available

From the above, it was observed that convenient relationship with surgical ward, intensive care unit, radiology, pathology, blood bank and CSSD do not exist in DH Panipat and DH Mandikhera. OTs had piped suction and medical gases, electric supply, heating, air-conditioning and ventilation in all the test-checked hospitals. It was also noticed that OT existed in SDCH Samalkha but due to non-posting of surgeon and specialists the OT was not utilised as evident from the photograph below. However, data collected in April-May, 2023 showed that two specialists (one Dental and one OBGY) were posted as depicted in paragraph 2.2.5 (ii) (b) (Table 2.12) of Chapter 2.

Non-functional OT at SDCH Samalkha (as on 06 March 2022)

3.2.7 Evaluation of IPD services through Outcome Indicators

The IPD services can be evaluated through Outcome Indicators viz. Bed Occupancy Rate[10] (BOR), Bed Turnover Rate[11] (BTR), Discharge Rate[12] (DR), Referral Out Rate[13] (ROR), Average Length of Stay[14] (ALOS), Left Against Medical Advice[15] (LAMA) Rate and Absconding Rate[16]. The IPD cases of DHs[17] (2,82,855), SDCHs (2,07,339) and CHCs (1,41,157) for the test-checked districts during the period 2016-23 are given in ***Appendix 3.3***. The performance of the IPD services through Outcome Indicators in the test-checked DH/SDCH/MCH is given in ***Table 3.10***.

Table 3.10: Outcome indicators of IPD services (2016-21)

Name of District	Name of Hospital	Average Bed Occupancy Rate (%)	Average Bed Turnover rate (%)	Discharge Rate (%)	Average Referral out rate (%)	Average length of stay (No. of Days)	LAMA rate (%)	Absconding rate (%)
Hisar	DH, Hisar	82.14	60.20	72.20	3.48	1.39	10.64	6.46
	SDCH, Adampur	8.92	1.60	0.63	17.00	2.00	33.00	0.00
	SDCH, Narnaund	42.40	17.23	86.48	4.26	7.00	25.79	1.00
Panipat	DH Panipat	129.29	103.93	75.25	13.67	2.11	5.37	4.48
	SDCH, Samalkha	27.02	57.65	29.40	10.20	1.87	85.00	0.80
Nuh	DH, Mandikhera	59.88	24.01	97.05	8.78	2.50	0.44	0.33
	MCH, Nalhar	74.65	24.26	68.09	9.81	6.45	12.13	4.07

Source: Information furnished by the test-checked Health Institutions
Colour code: Green colour depicts good performance, yellow- moderate and red depicts poor performance

It may be observed that:

- BOR of all the test-checked health institutions was below 80 *per cent* except for DH Hisar and DH Panipat. Average bed occupancy rate of 129 *per cent* at DH Panipat shows inadequate number of beds against requirement.
- Average Bed Turnover Rate of DH, Panipat was 104 *per cent* during the period which shows the pressure on beds. Average Bed Turnover Rate of SDCH Adampur, SDCH Narnaund, DH Mandikhera and MCH,

[10] The Bed Occupancy Rate (BOR) is an indicator of the productivity of the hospital services and is a measure of verifying whether the available infrastructure and processes are adequate for delivery of health services.

[11] The Bed Turnover Rate (BTR) is a measure of the utilization of the available bed capacity and serves as an indicator of the efficiency of the hospital.

[12] Discharge Rate (DR) measures the number of patients leaving a hospital after receiving due healthcare. High DR denotes that the hospital is providing healthcare facilities to the patients efficiently.

[13] Referral Out Rate (ROR) to higher centres denotes that the facilities for treatments were not available in the hospitals.

[14] The Average Length of Stay (ALOS) as the name suggests represents the time the patient is retained in the hospital.

[15] Leave Against Medical Advice (LAMA) is an act whereby a patient takes his/her discharge contrary to the recommendation or will of the attending physician.

[16] Absconding Rate denotes leaving the hospital premises unexpectedly, without the knowledge of clinical staff.

[17] The IPD cases of DH, Panipat for the period 2016-17 to 2018-19 were not available with the DH.

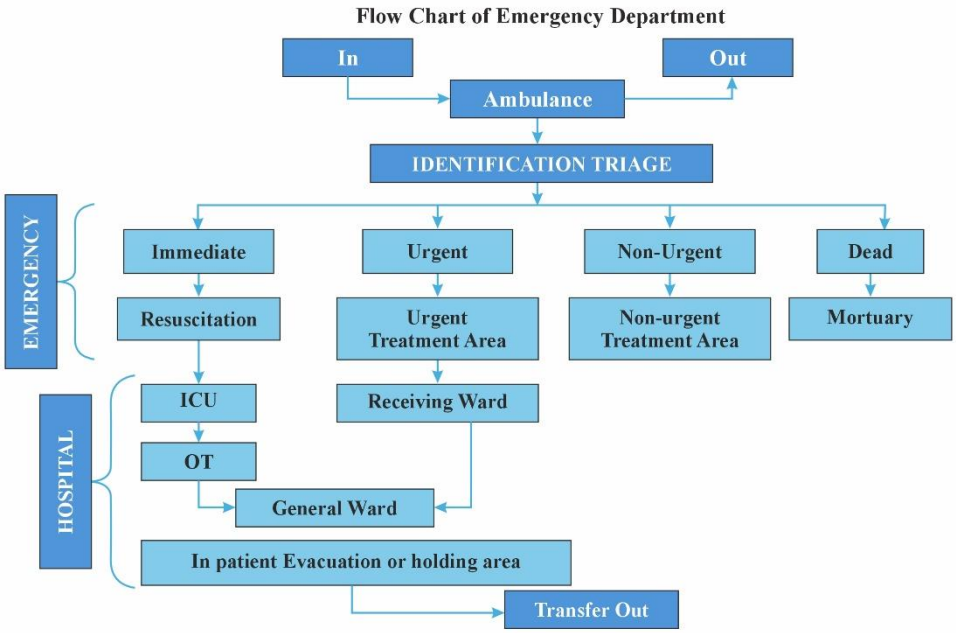
Nalhar was quite low as compared to other institutions.

- Discharge rate of SDCH Adampur and SDCH Samalkha were 0.63 *per cent* and 29.40 *per cent* respectively. Low discharge rate show that these health institutions are not providing healthcare facilities to the patients efficiently.
- High absconding rate in DH, Hisar, DH Panipat and MCH, Nalhar shows that proper security services were not provided as per norms.
- High LAMA rate of SDCH Adampur, SDCH Samalkha and SDCH Narnaund shows that these hospitals could not gain trust of patients because of non-availability of specialist doctors and equipment as discussed in paragraph 2.2.5(ii)(b) of chapter 2 and paragraph 4.4.1 of chapter 4 respectively.
- Bed occupancy rate of MCH, Agroha was 87.06 *per cent* during 2016-21 while average Referral Out Rate, LAMA Rate and Absconding Rate was not maintained by the hospital. However, LAMA rate for emergency ward was 5.71 *per cent* (2018-19), 5.57 *per cent* (2019-20) and 8.39 *per cent* (2020-21). No record with respect to LAMA cases in emergency services was maintained for the years 2016-17 and 2017-18.

3.3 Emergency services

Emergency Department is the first point of contact for any critically ill patient, needing immediate medical attention. Due to the unforeseen nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries. Flow chart of Emergency Department is given in ***Chart 3.4.***

Chart 3.4: Flow chart of Emergency Department



3.3.1 Availability of emergency services

As per IPHS norms 2012 for DHs/SDCHs, 24x7 operational emergency with dedicated emergency room shall be available with adequate manpower. Emergency shall have dedicated triage, resuscitation and observation area. Separate provision for examination of rape/ sexual assault victim should be made available in the emergency as per guidelines of the Supreme Court.

Emergency should have mobile X-ray/laboratory, side labs/plaster room/and minor OT facilities. Besides, separate emergency beds may be provided. Sufficient separate waiting areas and public amenities for patients and relatives should be located in such a way that it does not disturb functioning of emergency services.

Further, IPHS norms provide that one emergency OT should be available in DHs/ SDCHs. Besides this, separate emergency OT should be available for obstetrics and gynaecology in DHs. Moreover, procedures under emergency surgeries required for assault injuries/bowel injuries/head injuries/stab injuries/multiple injuries/perforation/intestinal obstruction should be available. Facility of emergency laboratory services should be available.

As per NHM Assessor's guidebook 2013, the hospital should provide orthopaedic services by ensuring availability of emergency orthopaedic procedures. Further, there should be an established procedure for admission of patients and emergency department should be aware of admission criteria to critical care units like ICU, SNCU and Burn ward. Emergency protocols should be defined and implemented for head injury, snake bite, poisoning, drawing etc. The facility should have disaster management plan in place.

As per information supplied by concerned DHs and SDCHs regarding availability of emergency services, it was found that the emergency services were available in all the DHs and SDCHs except in SDCH, Haily Mandi and Kalayat as detailed in ***Appendix 3.4 (i) and (ii).*** Further, the component-wise status of emergency services in the test-checked hospitals is given in ***Table 3.11***.

Table 3.11: Availability of emergency services in the test-checked hospitals (as of January to June 2022)

Particulars	Panipat		Hisar				Nuh	
	DH Panipat	SDCH Samalkha	MCH Agroha	DH Hisar	SDCH Adampur	SDCH Narnaund	MCH Nalhar	DH Mandikhera
Availability and functioning of Emergency OT	Y	N	Y	Y	N	N	Y	N
Availability of infrastructure hospital emergency ward	Y	Y	Y	N	Y	N	Y	Y
Availability of infrastructure relating to trauma ward such as bed capacity, machinery & equipment etc.	Y	N	Y	N	Y	N	Y	Y
Availability of triage procedure to sort patients	Y	Y	Y	Y	Y	N	Y	Y
Availability of surgical facilities for emergency appendectomy	N	N	Y	Y	N	N	Y	Y
Availability to diagnose and to treat for Hypoglycemia, Ketosis and Coma	Y	N	Y	Y	Y	N	Y	Y

Particulars	Panipat		Hisar				Nuh	
	DH Panipat	SDCH Samalkha	MCH Agroha	DH Hisar	SDCH Adampur	SDCH Narnaund	MCH Nalhar	DH Mandikhera
Availability of assault injuries/bowel injuries/head injuries/stab injuries/multiple injuries/perforation/intestinal obstruction	N	N	Y	Y	N	N	Y	Y
Availability of emergency laboratory services	Y	N	Y	N	N	N	Y	Y
Availability of blood bank in close proximity to emergency department	N	N	Y	Y	N	N	Y	Y
Availability of mobile X-ray/ laboratory, side labs/plaster room in accident and emergency service	N	N	Y	N	N	N	Y	N
Availability of Emergency Operation Theatre for Maternity, Orthopaedic Emergency, Burns and plastic and Neurosurgery cases round the clock	N	N	Y	N	N	Y	Y	(Only for Maternity & Orthopaedic Emergency)
Availability of facilities for accidents and emergency services including poisoning and trauma care	Y	Y	Y	Y	Y	N	Y	(No trauma care)
Availability of separate provision in emergency ward for examination of rape/sexual assault victim	Y	N	Y	Y	Y	Y	Y	N
Availability of sufficient separate waiting areas and public amenities in emergency ward for patients and relatives.	Y	Y	Y	Y	Y	Y	Y	N
Availability of emergency protocols in emergency ward.	Y	N	Y	Y	Y	N	Y	N
Availability of disaster management plan in emergency ward.	Y	Y	Y	Y	Y	N	N	N

Source: Information furnished by the test-checked Health Institutions
Colour code: Green colour/Y= Available; Red colour/N=Not available and pink colour depicts partial availability of services.

3.3.2 Availability of routine and emergency care in CHCs

As per IPHS 2012 norms for CHCs, CHCs should provide care of routine and emergency cases in medicine. Specific mention is made of handling of emergencies like dengue haemorrhagic fever, cerebral malaria and others like dog & snake bite cases, poisoning, congestive heart failure, left ventricular failure, pneumonia, meningoencephalitis, acute respiratory conditions, status epilepticus, burns, shock, acute dehydration etc. Further, essential and emergency obstetric care including surgical interventions like caesarean sections and other medical interventions should be available.

The availability of care of routine and emergency cases in surgery in CHCs is given in ***Table 3.12***.

Table 3.12: Availability of routine and emergency cases in medicine in CHCs (as of January to June 2022)

Name of Routine and Emergency care service	Panipat	Nuh	Hisar
	No. of test-checked CHCs/ UHCs (5)	No. of test-checked CHCs (2)	No. of test-checked CHCs/ UHCs (5)
Dengue Haemorrhagic Fever	2	0	4
Cerebral Malaria	2	0	4
Dog & snake bite cases	2	1	4
Poisoning	1	1	4
Congestive Heart Failure	1	0	4
Left Ventricular Failure	1	0	4
Pneumonias	1	0	4
Meningoencephalitis	1	0	4
Acute respiratory conditions	1	0	4
Status Epilepticus	1	0	4
Burns	1	0	4
Shock	1	0	4
Acute dehydration	1	0	4
Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions	0	1	1

Source: Information furnished by the test-checked CHCs/UHCs
Colour code: Green colour depicts performance by good number of CHCs/UHCs and red colour depicts performance by less number or nil number of CHCs/UHCs

It was observed that:

- Most of the routine and emergency care services were available in CHCs at Barwala, Sorkhi, Uklana, Madlauda and UHC Sector 1&4 Hisar but not available in CHCs at Mangali, Bapoli, Naultha, Firozpur Jhirka and UHC Sector 12 Panipat.
- At CHC Naraina, only dengue haemorrhagic fever, cerebral malaria and dog & snake bite routine and emergency care services were available.
- Only dog & snake bite and poisoning routine and emergency care services were available in CHC Punhana.
- Obstetric care including surgical interventions like caesarean sections and other medical interventions was available only in CHC Sorkhi (Hisar) and CHC Punhana (Nuh).

3.3.3 Management of Emergency cases in PHCs

As per IPHS 2012 norms for PHCs, 24 hours emergency services such as appropriate management of injuries and accident, first aid, stitching of wounds, incision and drainage of abscess, stabilisation of the condition of the patient before referral, dog bite/snake bite/scorpion bite cases and other emergency conditions should be provided in PHCs. These services are to be provided primarily by the nursing staff. However, in case of need, Medical Officer may be available to attend to emergencies on call basis. Intra-natal care: 24-hour delivery services both normal and assisted including appropriate and prompt referral for cases needing specialist care should be ensured.

The availability of emergency services in the test-checked PHCs is given in ***Table 3.13***.

Table 3.13: Availability of Emergency Services in PHCs (as of January to June 2022)

Name of District	Number of test-checked PHCs/ UPHCs	24 hours Management of selected emergency services	Emergency on call basis, 24-hour normal delivery services and referral
Panipat	9	1	2
Hisar	11	6	6
Nuh	4	0	4

Source: Information furnished by the test-checked PHCs/UPHCs.

Facility of 24 hours management of selected emergency services such as accident, first aid, stitching of wounds etc. were available only in seven[18] out 24 test-checked PHCs/UPHCs.

24 x7 emergency, referral and normal delivery services were available in 12[19] out of 24 PHCs/UPHCs.

This could be attributed to shortage/non -availability of doctors and nurses at PHC level as depicted in ***Appendix 2.1 (iii)***.

3.3.4 Non availability of Intensive Care Unit (ICU)

As per IPHS 2012 norms for District Hospitals, in ICU, critically ill patients requiring highly skilled life-saving medical aid and nursing care are concentrated. The unit should not have less than four beds nor more than 12 beds. Number of beds may be restricted to five *per cent* of the total bed strength initially but should be expanded to 10 *per cent* gradually. Out of these, they can be equally divided among ICU and High Dependency Wards (HDU). As per NHM Assessor's guidebook, the hospital should also provide intensive care service as part of curative services. The ICU facilities are desirable in SDCH.

The ICU service was not available in eight[20] out of 22 DHs. Out of 41 SDCHs, ICU service was available only in six[21] SDCHs. The details of availability of ICU service in DHs and SDCHs are given in ***Appendix 3.4 (i) and (ii)***. Further, in the test-checked hospitals only DH Panipat had ICU services. Details of ICU facilities in DH Panipat are detailed in ***Table 3.14***.

[18] PHC- (i) Mandi, (ii) Kaimri, (iii) Talwandi Rukha, (iv) Puthi Samain, (v) Hasangarh, (vi) Agroha and (vii) Dhansu

[19] PHC- (i) Mandi, (ii) Siwah, (iii) Talwandi Rukha, (iv) Puthi Samain, (v) Hasangarh, (vi) Agroha, (vii) Dhansu, (viii) Kaimri, (ix) Jamalgarh, (x) Biwan, (xi) Nagina and (xii) Singar

[20] DH- (i) Gurugram, (ii) Hisar, (iii) Jhajjar, (iv) Jind, (v) Kaithal, (vi) Narnaul, (vii) Mandikhera (Nuh) and (viii) Yamuna Nagar.

[21] SDCH- (i) Ambala Cantt, (ii) Ratia, (iii) Bahadurgarh, (iv) Matanhail, (v) Uchana and (vi) Mahendragarh.

Table 3.14: Availability of ICU services in DH Panipat (as of January 2022)

Particulars	Availability
Availability of various types of ICU services as prescribed by national standards	Available
Functional in-patient beds in ICU	16 (12 ICU + 4 HDU)
Percentage of patients admitted in ICU who were monitored for fluid/electrolyte charting	Fluid: 100 *per cent* Electrolyte: NIL
Percentage of patients admitted in ICU who were monitored for intake and output charting	100 *per cent*
Percentage of patients admitted in ICU who were monitored for cardiac care monitoring	100 *per cent*
Availability of ICU ventilators	Available
Facilities for curative services in ICU	Available
Facilities for diagnostic services in ICU	Not available
User charges displayed in local and simple language and communicated to patients effectively	No
Availability of adequate space and waiting area for ICU as per requirement	Not available
Nutritional assessment of patient done as required and directed by doctor	Not done

ABG, Portable -ray, ECO investigation was not available.

Source: Information furnished by DH, Panipat.

3.3.5 Emergency cases referred to other hospitals

Details of cases referred to other hospitals from DHs/SDCHs is given in ***Table 3.15***.

Table 3.15: Emergency cases referred to other hospitals from the test-checked DHs/SDHCs

Year	DH, Panipat	SDCH, Samalkha	DH, Mandikhera	DH, Hisar	SDCH, Adampur	SDCH, Narnaund
	(In *per cent*)					
2016-17	10	2	1	5	37	9
2017-18	9	2	1	5	27	14
2018-19	7	2	1	5	24	14
2019-20	4	2	1	4	20	13
2020-21	5	1	1	3	20	12

Source: Information furnished by the test-checked DHs/SDCHs.

As evident from the above table, the number of emergency cases referred to other hospitals was more in SDCHs Adampur and Narnaund. This could have been due to non-availability of specialists as discussed in paragraph 2.2.5 of Chapter 2.

3.4 Emergency Response and Health System Preparedness Package

Coronavirus disease 2019 (COVID-19) is a contagious disease caused by a virus, the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). The disease had spread worldwide, leading to the COVID-19 pandemic. Symptoms of COVID-19 are variable, but often include fever, cough, headache, fatigue, breathing difficulties, loss of smell and loss of taste.

Audit reviewed the Emergency Response to COVID-19 by the Department for lessons learnt for future preparedness.

3.4.1 Fund utilisation under COVID-19

The Government of India provided funds under Emergency COVID Response Package (ECRP) to the State in order to support preparedness and prevention related activities due to COVID-19 outbreak. The receipt and expenditure under ECRP is given in ***Table 3.16***.

Table 3.16: Utilisation of funds under COVID-19

(₹ in crore)

Year	Name of Scheme	GoI Share			State Share			Total		
		R	E	CB	R	E	CB	R	E	CB
2019-20	**COVID-19**	37.11	37.11	0	24.74	24.74	0	61.85	61.85	0
2020-21	**COVID-19**	187.71	97.69	90.02	0	0	0	187.71	97.69	90.02
	COVID-19 Vaccination	5.71	0.56	5.15	0	0	0	5.71	0.56	5.15
Total		**230.53**	**135.36**	**95.17**	**24.74**	**24.74**	**0**	**255.27**	**160.10**	**95.17**

Source –Information furnished by NHM, Haryana
Note: R: Receipt, E: Expenditure, CB: Closing Balance

It is evident from the above table that:

i. GoI and State Government had released ₹ 37.11 crore and ₹ 24.74 crore as ECRP for the year 2019-20, which was received by NHM, Haryana. Further, ₹ 193.42 crore was released by GoI for the year 2020-21.

ii. Expenditure of ₹ 160.10 crore was incurred out of total ₹ 255.27 crore received by NHM, Haryana during the period 2019-21 for COVID-19.

iii. The amount was spent for diagnostics including sample transport, drugs and supplies, temporary human resource, etc. as shown in ***Table 3.17***.

Table 3.17: Category-wise expenditure incurred under COVID 19 during 2019-21

(₹ in lakh)

Sr. No.	Type of expenditure	Expenditure incurred
1	Diagnostics including sample transport	2,372.21
2	Drugs and supplies including PPE and masks	7,416.89
3	Equipment/facilities for patient care including support for ventilators etc.	1,180.25
4	Temporary HR including incentives for Community Health Volunteers	3,160.71
5	Mobility Support	398.83
6	IT systems including hardware and software etc.	179.41
7	Information, Education and Communication/ Behavioral Change Communication	192.96
8	Training	25.58
9	Miscellaneous (which could not be accounted for in above items of expenditure)	1,027.44
10	COVID Vaccination	56.27
	Total	**16,010.55**

Source: Information furnished by NHM, Haryana

Funds amounting to ₹ 99.90 crore were transferred to HMSCL, Panchkula during FY 2020-21 for procurement of COVID-19 items. Funds received and utilised under COVID-19 in the test-checked districts is given in ***Table 3.18***.

Table 3.18: Fund utilisation in the test-checked Districts under COVID 19

(₹ in lakh)

District	2019-20		2020-21	
	Receipt	Expenditure	Receipt	Expenditure
Hisar	2.00	1.23	474.69	372.56
Panipat	1.00	0.69	435.68	318.43
Nuh	0.00	0.00	129.70	168.51
Total	**3.00**	**1.92**	**1,040.07**	**859.50**

Source: Information furnished by District Health Societies

Funds amounting to ₹ 10.43 crore (₹ 3 lakh in 2019-20 and ₹ 10.40 crore in 2020-21) were released to three selected District Health Societies (DHS) by NHM, Haryana during the period 2019-21. Out of ₹ 10.43 crore, the DHS incurred an expenditure of ₹ 8.61 crore (₹ 1.92 lakh in 2019-20 and ₹ 8.59 crore in 2020-21) for COVID-19 management.

The Director, Finance & Accounts, NHM stated (January 2023) that budget of ₹ 292.19 crore was received from Government of India from FY 2020-21 to 2022-23 for Covid-19 ECRP-I and same had been fully utilised. Further, budget of ₹ 5.71 crore was received from Government of India for Covid vaccination. Of this, ₹ 3.70 crore had been utilised till November 2022, leaving an unspent balance of ₹ 2.01 crore.

3.5 Maternity services

Maternal Mortality Rate (MMR) (per one lakh population) and Infant Mortality Rate (IMR) (per 1,000 live births) are important indicators for evaluating the quality of maternity services available. As per the Sample Registration System Report by Registrar General of India, MMR for Haryana was 110 during 2018-20, compared to the 97 at the national level. Further, as per National Family Health Survey-5, IMR was 33.3 for Haryana, compared to the 35.2 at the national level during the year 2019-21.

Antenatal care[22](ANC), Intra-partum care or delivery care[23] (IPC) and Postnatal care[24] (PNC) are important components of facility based maternity services.

Norms for provisioning of various maternal health services for different levels of hospitals and CHCs have been specified in Maternal and Neonatal Health Toolkit 2013 (MNH Toolkit), Guidelines for Antenatal Care and Skilled Attendance at Birth, 2010 and IPHS 2012 norms prescribed by the GoI for delivery of quality maternal health services.

[22] ANC is the systemic supervision of women during pregnancy to monitor the progress of fetal growth and to ascertain the well-being of the mother and the fetus.

[23] IPC care is the interventions for safe delivery in labour room and operation theatre.

[24] PNC includes medical care of the mother and newborn after delivery of the child especially during the 48 hours post-delivery, which are considered critical.

3.5.1 Achievement in maternity services

ANC involves general and abdominal examination and laboratory investigations to monitor pregnancies, management of complications, such as Reproductive Tract Infection (RTI)/Sexually Transmitted Infection (STI) and comprehensive abortion care. Antenatal Care and Skilled Attendance at Birth, Guidelines (2010), stipulate that every pregnant woman should undergo general and abdominal examinations during each ANC visit.

It should be ensured that every pregnant woman makes at least four visits for ANC. 1st visit: within 12 weeks preferably as soon as pregnancy is suspected, 2nd visit: between 14 and 26 weeks, 3rd visit: between 28 and 34 weeks, 4th visit: between 36 weeks and term.

Further, all pregnant women need to be given one tablet of Iron Folic Acid (IFA: 100 mg elemental iron and 0.5 mg folic acid) every day for at least 180 days, starting after the first trimester, at 14-16 weeks of gestation. IFA dose is necessary to prevent anaemia (prophylactic dose) and this dosage regimen is to be repeated for three months post-partum. Further, as per IPHS immunisation programme as prescribed in IPHS 2012 norms, Tetanus Toxoid (TT), TT-1 should be administered early in pregnancy and TT-2 after 4 weeks of TT-1.

Percentage of pregnant women registered and ANC, TT, and IFA tablets provided in the State of Haryana as per NFHS-5 is given in ***Table 3.19***.

Table 3.19: Indicators of Antenatal Care, TT administration and IFA tablets in the State

(In *per cent*)

Indicators	2015-16	2019-21
ANC received in the first trimester	63.2	85.2
Pregnant women receiving at least four ANC	45.1	60.4
TT administration	92.3	90.7
IFA (180 days)	14.3	32

Source: NFHS-5 survey report.

Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow-moderate and red colour depicting poor performance.

It is evident from the above table that while there is progress in most indicators during the period 2015-16 to 2019-21, delivery of IFA tablets remained only at 32 *per cent* of pregnant women. Further, only 85.2 *per cent* of pregnant women received ANC during their first trimester during 2019-21, while 60.4 *per cent* of pregnant women received four required ANCs during their pregnancy period.

With regard to lesser delivery of IFAs, the Director, Finance & Accounts, NHM replied (January 2023) that to ensure uninterrupted supply of IFA (Red) and Calcium tablets for pregnant women, these drugs have already been added in the State Essential Drug List (EDL). Also, there was an issue of erratic supply of drugs in previous years. The issue had now been sorted and enough IFA, Calcium and Vitamin D3 tablets were available in warehouses. Budget is also sanctioned to districts under Janani Shishu Suraksha Karyakaram (JSSK) for

procurement of drugs through local purchase in case of any stock out in warehouses/ emergency condition.

3.5.2 Status of Institutional Deliveries

IPHS 2012 norms of CHCs/PHCs provide that each CHC/PHC should have a fully equipped and operational labour room. Percentage of Institutional births and Home births by Skilled health personnel as per NFHS-5 in the State is given in ***Table 3.20***.

Table 3.20: Institutional births and Home births by Skilled Health Personnel as per NFHS-5 in the State

(In *per cent*)

Indicators	2015-16	2019-21
Institutional births	80.4	94.9
Home birth by skilled health personnel	5.8	1.1

Source: NFHS-5 survey report.

Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; light green- moderate and red colour depicting poor performance.

Thus, institutional births have increased from 80.4 *per cent* during the period 2015-16 to 94.9 *per cent* during the period 2019-21. However, institutional births in public health facility remained at 57.5 *per cent* during the period 2019-21. The facilities for institutional deliveries in the test-checked health institutions have been discussed in succeeding paragraphs.

(i) Labour room facilities in CHCs/PHCs

Availability of labour room facility in the test-checked CHCs/UHCs/PHCs/ UPHCs as of January to June 2022 is given in ***Table 3.21***.

Table 3.21: Availability of Labour Room in the test-checked CHCs/UCHs/PHCs/UPHCs

Type of Health Institutions	Total Number of HIs	Availability of Labour Room in no. of HIs
CHCs/ UHCs	12	12
PHCs/ UPHCs	24	14

Source: Information furnished by the test-checked health institutions

Labour rooms were available in all the selected CHCs/UHCs. Labour room was available in UHC Sector 12, Panipat, but was not functional since 2014. Out of 24 test-checked PHCs/UPHCs, labour room was available only in 14 PHCs/UPHCs. Further, labour room available in PHC, Atta was not functional. This may have been due to not posting necessary staff including OBGY specialist and staff nurse.

(ii) Pathological investigations

ANC Guidelines 2010 prescribe conducting six[25] pathological investigations, depending upon the condition of pregnancy during ANC visits to identify pregnancy related complications. Availability of pathological investigations for pregnant women in the test-checked health institutions is given in ***Table 3.22***.

Table 3.22: Availability of pathological investigations for pregnant women in the test-checked Health Institutions (as of January to June 2022)

Name of test	DHs (03)	SDHCs (03)	CHCs/UHCs (12)
Blood group including Rh factor	3	3	12
Venereal disease research laboratory (VDRL)/Rapid Plasma Reagin (RPR)	3	3	11
HIV testing	3	3	12
Rapid Malaria test	3	2	3
Blood Sugar testing	3	3	12
Hepatitis B surface Antigen (HBsAg)	3	3	11

Source: Information furnished by the test-checked Health Institutions
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow-moderate and red colour depicting poor performance.

Audit observed that all pathological investigations related to pregnancy were conducted in all the test-checked hospitals of these three districts except Rapid Malaria Test in SDCH Adampur.

Further, it was observed that out of the six prescribed pathological investigations, Blood group including Rh factor, HIV testing and Blood Sugar testing were available in all the test-checked CHCs/UHCs. Further, VDRL/RPR test was not available in CHC, Firozpur Jhirka and HBsAg test was not available in UHC, Sec 12 (Panipat). Rapid Malaria test was not available in nine[26] CHCs/UHCs out of 12 test-checked CHCs/UHCs.

The Director, NHM stated (January 2023) that tests related to HIV and Hepatitis B Surface Antigen were being conducted in the test-checked CHCs/UHCs of district Hisar while VDRL/RPR test was being carried out in CHC, Firojpur Jhirka (Nuh). In district Panipat, all the health institutes were giving services towards all the six pathological tests. Further, instead of rapid malaria test, slide method testing facility was available in UHC, Panipat. The reply is not tenable as during field visits of health institutes, all the pathological investigations were not found available.

[25] (i) Blood group including Rh factor, (ii) Venereal disease research laboratory (VDRL)/Rapid Plasma Reagin (RPR), (iii) HIV testing, (iv) Rapid Malaria test, (v) Blood Sugar testing and (vi) Hepatitis B surface Antigen (HBsAg).

[26] CHC-(i) Mangali, (ii) Sorkhi, (iii) Uklana, (iv) Barwala, (v) Bapoli, (vi) Madlauda, (vii) Naraina, UHC-(viii) Sector 1&4 (Hisar) and (ix) Sector 12 (Panipat)

(iii) Caesarean deliveries (C-Section)

MNH Toolkit designated all FRU-CHCs/SDCHs/DHs as Centres for providing surgical (C-Section) services with the provision of specialised human resources (a gynaecologist/obstetrician and anaesthetist) and equipped operation theatre to provide Emergency Obstetric Care (EmOC) to pregnant women. The Janani Shishu Suraksha Karyakram (JSSK) entitles all pregnant women to C-Section services with a provision for free drugs, consumables, diagnostics, etc.

The statement showing C-section deliveries as per NFHS-5 in the State of Haryana is given in ***Table 3.23***.

Table 3.23: Status of Caesarean deliveries (C-Section) in the State

(In *per cent*)

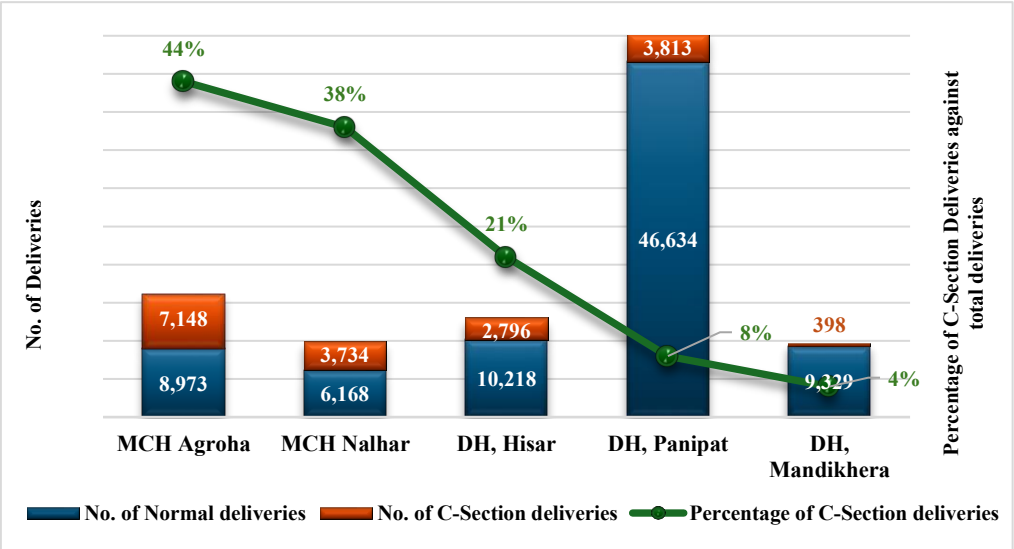
Indicators	2015-16	2019-21
C-section deliveries	11.7	19.5
Private health facility C-section deliveries	25.3	33.9
Public health facility C-section deliveries	8.6	11.7

Source: NFHS-5 survey report.

It is evident from the above table that C-section deliveries have increased from 11.7 *per cent* in 2015-16 to 19.5 *per cent* in 2019-21 in the State of Haryana. But the increase in rate of C-section deliveries was seen to be more at private health facilities (33.9 *per cent*) as compared to public health facilities (11.7 *per cent*). Further, WHO suggests that Caesarean sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons. At population level, Caesarean section rates higher than 10 *per cent* are not associated with reductions in maternal and newborn mortality rates.

Number of C-section deliveries conducted in the test-checked two MCHs and three DHs during 2016-17 to 2020-21 is given in **Chart 3.5**.

Chart 3.5: Number and Percentage of C-Section deliveries conducted in the test-checked MCHs/DHs



Source: Information furnished by the test-checked MCHs/DHs

It was observed that:

- C-section deliveries were not conducted at SDCH Samalkha, SDCH Adampur (only 2 C-section deliveries during 2019-20) and SDCH Narnaund during the period 2016-21 due to non-availability of manpower and non-functional operation theatre. Further, C-section deliveries in all the test-checked CHCs were not conducted during the period 2016-21 due to non-availability of manpower and equipment. This may have led to patients resorting to private facilities thereby increasing their out-of-pocket expenditure.
- There was an increasing trend of C-section deliveries in DH, Mandikhera and DH, Hisar. For instance, in DH, Mandikhera, C-section deliveries increased from six cases in 2016-17 to 194 cases in 2020-21; while in DH, Hisar, C-section deliveries increased from 326 cases in 2016-17 to 833 cases in 2020-21.
- During the period 2016-21, average percentage of C-section deliveries in the two colleges MCH, Agroha and MCH, Nalhar was 44 *per cent* and 38 *per cent,* respectively. It ranged between 30.5 *per cent* to 45.84 *per cent* in MCH, Nalhar, while 33.48 *per cent* to 49.48 *per cent* in MCH, Agroha during the period 2016-21. The matter was brought to the notice of the colleges. They replied that high risk cases were transferred to the hospital from the nearby healthcare institutions**,** so these parameters were on the higher side.

3.5.3 Special Newborn Care Unit/ Newborn Stabilisation Unit

As per MNH Toolkit, twelve bedded Special Newborn Care Unit (SNCU) is essential to treat critically ill new-borns in a district hospital. Twelve bedded SNCU was available in all the three test-checked District Hospitals.

Total admission, referral rate, Leave Against Medical Advice (LAMA) rate, absconding rate and neonatal death rate in the three test-checked DHs is given in ***Table 3.24***.

Table 3.24: Evaluation of SNCU services in the test-checked DHs through Outcome Indicators

Year	DH, Mandikhera					DH, Hisar					DH, Panipat				
	Total Admission	Referral Rate	LAMA rate	Absconding rate	Neonatal Death Rate	Total Admission	Referral Rate	LAMA rate	Absconding rate	Neonatal Death Rate	Total Admission	Referral Rate	LAMA rate	Absconding rate	Neonatal Death Rate
2016-17	543	9.02	5.16	0	15.84	Information not available					911	24.48	12.18	0	3.18
2017-18	633	9.16	6.95	0	13.11	1,159	23.99	8.20	0	2.59	1,070	21.31	15.05	0	2.80
2018-19	372	26.08	12.90	0	4.03	1,054	23.24	6.36	0	3.32	1,236	28.16	11.17	0	2.35
2019-20	490	22.04	9.18	0	2.04	1,342	20.57	6.26	0	2.24	1,225	20.82	6.69	0	1.96
2020-21	512	23.63	7.81	0	6.84	1,241	18.05	2.42	0	2.34	1,042	18.52	10.65	0	2.40
Total	**2,550**	**16.98**	**8.04**	**0**	**8.98**	**4,796**	**21.33**	**5.75**	**0**	**2.59**	**5,484**	**22.74**	**11.00**	**0**	**2.50**

Source: Information furnished by the test-checked DHs.
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow-moderate and red colour depicting poor performance.

It is evident from the above table that:

i. In DH, Mandikhera, total number of 2,550 cases were admitted in SNCU during the period 2016-21. The rate of referral cases ranged between 9.02 *per cent* and 26.08 *per cent*, LAMA rate ranged between 5.16 *per cent* and 12.90 *per cent* and neonatal death rate was upto 15.84 *per cent*.

ii. In DH Hisar, total number of 4,796 cases were admitted in SNCU during the period 2017-21. The rate of referral cases ranged between 18.05 *per cent* and 23.99 *per cent*, LAMA rate ranged between 2.42 *per cent* and 8.20 *per cent* and neonatal death rate was upto 3.32 *per cent*.

iii. In DH, Panipat, total number of 5,484 cases were admitted in SNCU during the period 2016-21. The rate of referral cases ranged between 18.52 *per cent* and 28.16 *per cent*, LAMA rate ranged between 6.69 *per cent* and 15.05 *per cent* and neonatal death rate was upto 3.18 *per cent*.

The Director, NHM stated (January 2023) that during the period 2016-22, the referral rate had decreased by 7.5 points and the LAMA rate had decreased by 2.32 points in district Panipat. Death rate in SNCU has also declined. In district Hisar, the referral rate had decreased by 5.94 points and the LAMA rate had decreased by 3.6 points. Death rate in SNCU had also declined by 2.38 points. Death rate of Nuh district had declined remarkably.

The reply was not tenable as referral rate in district Panipat and Hisar, was still above 18 *per cent* during the year 2020-21; while the LAMA rate was still above 10 *per cent* in district Panipat. Further, in district Nuh, referral rate and LAMA rate had increased during the period 2016-21.

3.5.4 Administration of birth doses to new-borns

As per IPHS 2012 norms, "a fully immunised infant is one who has received Bacillus Calmette-Guerin (BCG), three doses of Oral Polio Vaccine (OPV), three doses of Hepatitis B and Measles before one year of age". The schedule of vaccination at birth of an infant is as follows: **Hepatitis B**: at birth for institutional delivery, preferably within 24 hrs. of delivery, **OPV**: at birth for institutional deliveries within 15 days and **Vitamin 'K'**: given as a single dose soon after birth.

The details of achievement in administration of birth doses to new-borns in the three test-checked districts is given in ***Table 3.25***.

Table 3.25: Achievement (%) of birth doses given to new born during 2020-21

Name of District	Year	Total live births	Achievement (%)		
			Vitamin 'K'	OPV	Hepatitis B
Panipat	2020-21	22,491	75	98	78
Nuh	2020-21	51,821	28	85	40
Hisar	2020-21	32,977	65	90	70

Source: Data from Health Management Information System.
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow-moderate and red colour depicting poor performance.

It can be seen from the above that the percentage of doses of Vitamin K and Hepatitis B which were supposed to be given soon after birth and within 24 hours of delivery respectively was only 28 *per cent* and 40 *per cent* in Nuh district where most live births were recorded among the three test-checked districts. However, percentage of OPV doses in all the three test-checked district was satisfactory.

3.5.5 Discharge within 48 hours of delivery in post-natal care

The 12th Five Year Plan aimed to bring all women during pregnancy and childbirth into the institutional fold so that delivery care services of good quality can be provided to them at the time of delivery at zero expense as envisioned under the Janani Shishu Suraksha Karyakram (JSSK) programme. The programme entitles all pregnant women to absolutely free institutional delivery including C-section with a provision for free drugs, diagnostics, diet, blood and transport from home to facility, between facilities and drop back home. Further, there should be adequate number of beds in postnatal care ward to ensure 48 hours of stay after delivery.

Details related to women discharged within 48 hours from health facilities in the three test-checked districts is given in ***Table 3.26***.

Table 3.26: Total no. of women discharged within 48 hours after delivery during 2020-21

Name of District	Total no. of institutional deliveries	Total no. of women discharged within 48 hours	Percentage
Panipat	22,347	15,445	69.11
Nuh	39,749	37,548	94.46
Hisar	33,014	21,864	66.23

Source: Data from Health Management Information System.
Note: Colour grading has been done on colour scale with yellow colour depicting moderate performance while red colour depicting poor performance.

The Department stated (January 2023) that due to local behaviour, people do not prefer to stay long in the hospital. In DH, Panipat, patients were discharged within 48 hours as average number of deliveries are 800 to 900 per month and number of beds available are only 52, including C-section beds. To increase the bed strength at DH Panipat, sanction has been accorded for a specialised Maternal and Child Health (MCH) wing at DH Panipat. The work for the same has been initiated by PWD (B&R).

The reply is not tenable because as depicted in para 2.2.3 and 2.2.4 of chapter 2, there was shortage of doctors and nurses across health institutions. Had adequate medical support been available, women were likely to have preferred spending the first 48 hours of their postpartum in health institutions.

3.5.6 Maternity care outcomes

With a view to gauge the quality of maternity care provided by the test-checked hospitals, Audit ascertained the outcomes in terms of still birth, referral, LAMA, Absconding rate and neonatal deaths pertaining to 2016-21.

(i) Still Births

The stillbirth rate is a key indicator of quality of care during pregnancy and childbirth, which is defined by WHO as: 'Stillbirth and/or intrauterine fetal death is an unfavourable pregnancy outcome and is defined as complete expulsion or extraction of the baby from its mother with no signs of life'. Details of rate of stillbirth/ intrauterine death (IUD) in the test-checked two MCHs/three DHs/three SDHCs is given in ***Table 3.27***.

Table 3.27: Still birth rate in test-checked MCHs/DHs/SDHCs (in *per cent*)

Year	DH Panipat	SDCH Samalkha	DH Hisar	SDCH Adampur	SDCH Narnaund	DH Mandikhera	MCH Nalhar	MCH Agroha
2016-17	0.07	0	4.02	0.75	0.65	3.14	12.19	6.41
2017-18	0.09	0	3.08	0.45	0.66	2.29	11.20	6.17
2018-19	0.16	0	2.62	0.32	0.00	3.32	12.09	5.61
2019-20	0.03	0	2.37	1.14	0.39	3.89	9.16	3.50
2020-21	0.10	0	3.20	0.51	0.68	6.58	10.49	3.52

Source: Information furnished by the test-checked MCHs/DHs/SDCHs.
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicts moderate performance and red colour depicting poor performance.

As evident from the above table, still birth rate was higher in MCH Nalhar while DH Panipat had the least still birth rate during the period 2016-21. There was no case of still birth in SDCH, Samalkha during 2016-21.

The MCHs replied that as high-risk cases were transferred to MCHs from the nearby healthcare institutions, so these parameters were on the higher side. The Department stated (February 2023) that instructions had been issued to the health institutions concerned to take remedial action to remove the deficiencies/ observations.

(ii) ther indicators

Performance of the test-checked DHs/SDCHs on certain outcome indicators such as average Referral Out Rate (ROR), average Leave Against Medical Advice (LAMA) and Absconding Rate (AR) for the period 2016-17 to 2020-21 is given in ***Table 3.28***.

Table 3.28: ROR/LAMA/AR in the test-checked DHs/SDCHs

Name of Hospital	Total IPD in Maternity	ROR		LAMA		Absconding	
		Cases	Rate	Cases	Rate	Cases	Rate
DH Panipat	1,02,231	3,009	2.94	167	0.16	1,983	1.94
SDCH Samalkha	5,558	478	8.60	1,058	19.03	0	0
DH Mandikhera	13,493	1,255	9.3	981	7.27	577	4.28
DH Hisar	42,303	4,406	10.42	2,901	6.86	359	0.85
SDCH Adampur	9,862	3,074	**31.17**	606	6.14	0	0
SDCH Narnaund	5,374	545	10.14	4,105	76.39	0	0

Source: Information furnished by the test-checked DHs/SDCHs
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicts moderate performance and red colour depicting poor performance.

It can be seen that the facilities at SDCHs were very poor. At SDCH Adampur 31.17 *per cent* patients were referred to other hospitals and 6.14 *per cent* patients left against medical advice. At the SDCH, Narnaund, the LAMA rate was very high. This may have been due to shortage/non availability of specialists as discussed in para 2.2.5(ii) of chapter 2 and shortage of drugs and equipment as discussed in para 4.1 and 4.4.1 of chapter 4.

(iii) Death Review

As per IPHS 2012 norms, all mortality that occurs in the hospital shall be reviewed on fortnightly basis. Further, as per Child Death Review guidelines (2014) issued by MoH&FW, GoI, detailed investigation should be conducted in all cases of child deaths. The Facility Based Neonatal & Post-Neonatal Death Review Forms (Forms 4a and 4b) should be filled for the child death (depending on the age category) by the Duty Medical Officer (DMO). The treating Medical Officer (doctor) (under whose care the child was primarily admitted in the hospital) has to assign the medical cause of death and has to add any other information regarding social factors and delays associated with the death.

Details of maternal and neonatal death reviews conducted in the test-checked MCHs/DHs/SDCHs during 2016-21 are given in ***Table 3.29***.

Table 3.29: Maternal Death Review/ Neonatal Death Review conducted in the test-checked MCHs/DHs/SDCHs

Name of District	Maternal Death			Neonatal Death		
	No. of Maternal deaths	No. of Maternal death reviews conducted	Shortfall (%)	No. of Neonatal deaths	No. of Neonatal death reviews conducted	Shortfall (%)
DH Panipat	10	10	0	137	0	100
SDCH, Samalkha	0	0	0	0	0	0
DH Hisar	0	0	0	396	396	0
SDCH, Adampur	1	1	0	18	18	0
SDCH, Narnaund	0	0	0	0	0	0
DH Mandikhera	8	8	0	229	229	0
MCH Nalhar, Nuh	169	122	28	1,911	0	100
MCH Agroha	16	16	0	276	72	74

Source: Information furnished by the test-checked MCHs/DHs/SDHCs
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow depicts moderate and red colour depicting poor performance.

Neonatal deaths were not reviewed at MCH Nalhar and DH Panipat. In MCH Agroha only 26 *per cent* neonatal deaths were reviewed. 28 *per cent* maternal deaths were also not reviewed at MCH Nalhar.

The Director, NHM stated (January 2023) that as per GoI guidelines, the Child Death Review (CDR) program is being implemented across the districts and the Facility Based Review Committee was also being formed for conducting the child death review which occurred in District hospitals (>500 deliveries/year). As per the physical report received from district Panipat, 19 and 48 Facility Based Child Death Reviews (FBCDR) have been conducted in 2020-21 and 2021-22 respectively. Further, in district Nuh, as per GoI guidelines, the programme has been implemented across districts but not in the medical colleges. As per guidelines, CDR-Community and Facility based review is being carried out in DH as well as in CHC and is incentive-based.

(iv) Monthly Satisfaction Survey and orm III register in Maternity ing

As per NHM Assessor's guidebook, the facility should establish a system for patient satisfaction survey and the survey should be done on monthly basis.

As per Comprehensive Abortion Care (CAC) Training and Service Guidelines 2018, it is mandatory to fill and record information for abortion cases, performed by any technique, in the Form III – Admission Register for case records.

Out of the eight test-checked hospitals/MCHs, SDCH, Narnaund and DH, Nuh did not conduct the monthly satisfaction survey in maternity wing during the period 2016-17 to 2020-21.

Further, it was found that a register in 'Form III Admission Register' (for case records for recording therein the details of the admissions of women for the termination of their pregnancies) was maintained in the maternity wing of all the test-checked hospitals except DH, Mandikhera; SDCH, Samalkha and SDCH, Narnaund.

The Director, NHM stated (January 2023) that instructions had been issued to all delivery health facilities to conduct the patient satisfaction survey.

3.6 Diagnostic services

Efficient and effective diagnostic services, both radiological and pathological, are amongst the most essential healthcare facilities for delivering quality treatment to the public based on accurate diagnosis. Audit observed that many of the significant radiology and pathology tests were not performed in the test-checked health institutions due to lack of required equipment and skilled manpower. Significant audit findings are discussed in the succeeding paragraphs:

3.6.1 Availability of Imaging (Radiology) Diagnostic Services

Radiology, also called diagnostic imaging, is a series of different tests that take pictures or images of various parts of the body. IPHS 2012 prescribe radiology services for the district hospitals (X-ray, Ultrasonography, CT scan, etc.) and X-ray (chest, skull, spine, abdomen, bones, dental). It also prescribes diagnostic services under cardiac investigation, ENT, Radiology, Endoscopy, Respiratory and Ophthalmology in DHs and SDCHs.

As of May 2023, imaging services were available in all the DHs except DH, Fatehabad. However, in case of SDCHs, the imaging services were not available in 17 SDCHs out of 41 SDCHs. The details have been given in ***Appendix 3.4 (i) and (ii)***. Further, the availability of diagnostic services under various categories was checked in the test-checked DHs and SDCHs during audit (April-June 2022) and the status of availability is given in ***Table 3.30***.

Table 3.30: Availability of Imaging (Radiology) services in the test-checked DHs/SDCHs

Name of Service	Name of Test/Diagnostic Service	DH Panipat	DH Mandikhera	DH Hisar	SDCH Adampur	SDCH Narnaund	SDCH Samalkha
Radiology	-ray for chest, Skull, Spine, Abdomen, bones	Yes	Yes	Yes	No	No	No
	Dental -ray	Yes	Yes	Yes	No	No	No
	Ultrasonography	Yes	Yes	Yes	No	No	No
	CT scan	Yes	No	Yes	Not required as per IPHS norms		
	Barium Swallow, Barium meal, Barium enema, IVP	No	No	No			
	MMR (Chest)	No	No	No			
	HSG	No	No	No			
Cardiac Investigation	ECG	Yes	Yes	Yes	No	Yes	Yes
	Stress tests	No	No	No	Not required as per IPHS norms		
	ECHO	No	No	Yes			
ENT	Audiometry	Yes	No	Yes	No	No	No
	Endoscopy for ENT	No	No	Yes	Not required as per IPHS norms		
Ophthalmology	Refraction by using Snellen s chart	Yes	Yes	Yes	No	No	No
	Retinoscopy	Yes	Yes	Yes	No	No	No
	Ophthalmoscopy	Yes	Yes	Yes	No	No	No
Endoscopy	Laparoscopic (diagnostic)	Yes	No	Yes	No	No	No
	Oesophagus	No	No	Yes	Not required as per IPHS norms		
	Stomach	No	No	Yes			
	Colonoscopy	No	No	No			
	Bronchoscopy	No	Yes	No			
	Arthroscopy	No	Yes	No			
	Hysteroscopy	No	No	No			
Respiratory	Pulmonary function tests	No	No	No	No	No	No

Source: Information furnished by the test-checked DHs/SDCHs
Colour code: Green colour depicts availability, red colour depicts non availability and yellow colour depicts that the services are not required as per IPHS norms.

In all the three test-checked SDCHs available diagnostic services were negligible. The DHs were deficient in diagnostic services. In-house ultrasonography was available in DH Panipat and DH Hisar and it was outsourced in DH, Mandikhera. CT Scan facility was available in DH Panipat in PPP Mode and was outsourced in DH Hisar. But this facility was not available in DH Mandikhera.

Facility for stress tests, barium swallow, barium meal, barium enema, IVP, MMR (chest), HSG, Colonoscopy, Hysteroscopy and pulmonary function tests were not available in any of the test-checked district hospitals. It was noticed that maximum services were available at MCH Nalhar and MCH Agroha.

3.6.2 Availability of Imaging (Radiology) Diagnostic Services in test-checked MCHs

For availability of diagnostic radiology services in MCHs, there are no norms prescribed under IPHS 2012. However, information regarding the availability of diagnostic services in the test-checked MCHs was gathered and the same has been compared with IPHS norms for 500 bedded district hospital, details of which are given in ***Table 3.31***.

Table 3.31: Availability of Imaging (Radiology) services in test-checked MCHs

Sr. No.	Type of Diagnostic Services	Availability in MCH Agroha	Availability in MCH Nalhar
1	Cardiac[27](3)	3	3
2	Ophthalmology[28](3)	3	3
3	ENT[29](2)	2	2
4	Radiology[30](7)	6	2
5	Endoscopy[31](7)	7	4
6	Respiratory[32](1)	0	0

Source: Information furnished by the test-checked MCHs during January to June 2022
Colour code: Green colour depicts full availability, red colour depicts non availability and yellow colour depicts moderate availability of services.

It was observed that under radiology category: barium swallow, barium meal, barium enema, IVP; MMR (Chest); HSG; dental X-ray and ultrasonography; under Endoscopy category: Bronchoscopy, Arthroscopy, Hysteroscopy; and under Respiratory: Pulmonary Function Test (PFT) tests were not available in MCH, Nalhar. However, in MCH, Agroha, all diagnostic radiology services were available except MMR (Chest) under Radiology category and PFT under Respiratory category.

27 (i) ECG, (ii) Stress Test and (iii) ECHO

28 (i) Refraction by using Snellen's chart, (ii) Retinoscopy and (iii) Ophthalmoscopy

29 (i) Audiometry and (ii) Endoscopy for ENT

30 (i) X ray for chest, skull, spine, abdomen, bones; (ii) Barium swallow, Barium meal, Barium enema, IVP; (iii) MMR(Chest); (iv) HSG; (v) Dental X-ray; (vi) ultrasonography and (vii) CT scan

31 (i) Oesophagus, (ii) stomach, (iii) colonoscopy, (iv) Bronchoscopy, (v) Arthroscopy, (vi) Laparoscopy (Diagnostic) and (vii) Hysteroscopy

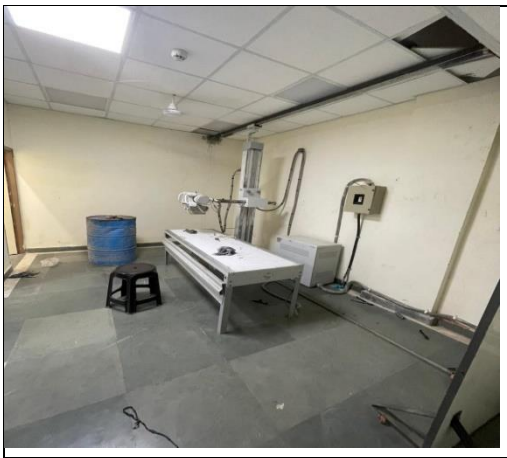
32 Pulmonary function test.

3.6.3 Availability of Imaging (Radiology) Diagnostic Services in test-checked CHCs

IPHS 2012 norms provide that X-ray for chest, skull, spine, abdomen, bones; dental X-ray and Ultrasonography (USG) (desirable) facilities should be available in a CHC under imaging services. Further, ECG which is a cardiac investigation service should be provided in a CHC.

It was observed that only ECG services were available in six[33] out of 12 test-checked CHCs/UHCs. Other imaging facilities were not available in all the CHCs/UHCs.

X-ray room and machine were available in CHC Uklana and Barwala since 2020 and in UHC Hisar (Sector 1&4) since 2014 but it was not being used due to non-deployment of radiographer. In CHC Punhana, X-ray machine was kept in the storeroom as shown in the picture.

	
-ray machine not in use in SDCH Samalkha (06 March 2022)	**-ray machine kept in storeroom in CHC Punhana (21 June 2022)**

3.6.4 Non-registration of imaging equipment (like -ray, CT scan, MRI) from authorities

As per Section (3) of Atomic Energy (Radiation and Protection) Rules, 2004 (1), No person shall, without a license - (a) establish a radiation installation for siting, design, construction, commissioning, operation; and (b) decommission a radiation installation. (2) No person shall handle any radioactive material or operate any radiation generating equipment except in accordance with the terms and conditions of a license.

During the course of audit, details related to installation, functioning and license for x-ray machine was checked in DHs/SDCHs/CHC as given in ***Table 3.32***.

[33] CHC- (i) Madlauda, (ii) Naraina, (iii) Mangali, (iv) Uklana, (v) Barwala and (vii) Punhana.

Table 3.32: Status of imaging equipment in test-checked Health Institutions

Name of Health Institution	-ray machine		
	Installed	Functional	License exists
DH, Hisar	Yes	Yes	Yes
DH, Panipat	Yes	Yes	Yes
DH, Mandikhera	Yes	Yes	Yes
SDCH, Adampur	Yes	Yes	Yes
SDCH, Narnaund	Yes	No	No
SDCH, Samalkha	Yes	No	No
CHC, Barwala	Yes	No	No

Source: Information furnished by the test-checked Health Institutions during January to June 2022

Colour code: Green colour depicts availability and red colour depicts non availability

Audit observed that out of the health institutions where X-ray machine was available, SDCH Samalkha, Narnaund and CHC Barwala had not obtained license to install and operate the X-ray machine. Further, X-ray machine was found installed in SDCH, Samalkha but it was not functional as shown in the picture in the previous paragraph. X-ray machine was in condemned condition in SDCH, Narnaund and X-ray technician was not available since 2016. Thus, non-functioning of these x-ray machines may have led to patients resorting to private facilities thereby increasing their out-of-pocket expenditure.

3.6.5 Thermoluminescent dosimeters (TLD) & pocket dosimeters for radiation protection

TLD badges are used to detect radiation at levels that can be harmful to humans. All the staff working in the X-ray room have to wear monitoring equipment such as TLD badges, pocket dosimeters etc. as per AERB guidelines on personnel monitoring of radiation workers in radiation facilities (June 2020). As per Atomic Energy (Radiation Protection) Rules, 2004 and Atomic Energy Regulatory Board (AERB) Safety Codes, monitoring equipment shall be provided to radiation workers and dose records shall be maintained. In case of any institution violating the prescribed regulatory requirements, AERB is empowered to suspend/modify/withdraw the licence/registration issued to the X-ray installation or seal the X-ray installation(s) in accordance with Rules 10 and 31 of the Atomic Energy (Radiation Protection) Rules, 2004, respectively.

Availability of TLD badges and Pocket dosimeters in the test-checked DHs is given in ***Table 3.33***.

Table 3.33: Availability of TLD badges and Pocket dosimeters in test-checked DHs

Name of Health Institution	TLD badges	Pocket dosimeters
DH, Hisar	Yes	No
DH, Panipat	Yes	No
DH, Mandikhera	No	No

Source: Information furnished by the test-checked DHs during January to June 2022

Colour code: Green colour depicts availability and red colour depicts non availability.

Only DH Panipat and DH Hisar had TLD badges, but pocket dosimeters were not available in any of these hospitals. Due to non-availability of these safety equipment, the safety of technicians was compromised.

3.6.6 Pathology services

Pathology services are the backbone of any hospital for extending evidence-based healthcare to the public. As in the case of radiology services, availability of essential equipment, reagents and human resources are the main drivers for the delivery of quality pathology services through laboratories.

Pathology service was available in all DHs except DH, Kaithal, and pathology service was not available in 17 SDCHs, out of 41 SDCHs. The details are given in ***Appendix 3.4 (i) and (ii).*** Audit observations related to these services have been discussed in the succeeding paragraphs:

(i) Availability of Pathology Diagnostic services in test-checked Hospitals

IPHS 2012 norms prescribe 72 types and 39 types of pathological investigations in the categories of clinical pathology, pathology, microbiology, serology and biochemistry to be carried out in the DHs and SDCHs, respectively. Audit observed that the pathology services in the test-checked hospitals were provided through in-house laboratories. Availability of pathology services offered by the test-checked MCHs/DHs is given in ***Table 3.34***.

Table 3.34: Availability of pathology services in test-checked MCHs/DHs

Name of Health Institution	Clinical pathology[34] (29)	Pathology[35] (8)	Microbiology[36] (7)	Serology[37] (7)	Biochemistry[38] (21)
MCH Agroha	28	7	7	7	15
MCH Nalhar	27	8	6	5	17
DH Hisar	24	4	3	4	11
DH Panipat	23	2	6	5	11
DH Mandikhera	20	5	0	5	12

Source: Information furnished by the test-checked MCHs/DHs during January to June 2022
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow-moderate and red colour depicting poor performance.

Against required 39 types of pathological investigations in SDCHs, availability of pathological investigations offered under various categories by the test-

[34] Clinical Pathology (DH): Haematology, Immunoglobin profile (IGM, IGG, IGE, IGA), Fibrinogen Degradation product, Urine Analysis, Stool Analysis, Semen Analysis, CSF Analysis Aspirated fluids etc.

[35] Pathology (DH): PAP smear, Sputum, Haematology, Histopathology

[36] Microbiology (DH): KOH study for fungus, Smear for AFB & KLB, supply of different media for peripheral laboratories, Culture and sensitivity for blood, sputum, pus, urine etc.

[37] Serology (DH): RPR card test for syphilis, Pregnancy test ELISA for Beta HCG, Leptospirosis, WIDAL test, DCT/ ICT with titre etc.

[38] Biochemistry (DH): Blood sugar, Glucose, Glycosylated haemoglobin, Blood urea, blood cholesterol, serum bilirubin, Icteric index, Serum calcium, Serum Phosphorous, Serum Magnesium, Iodometry titration etc.

checked SDCHs is given in ***Table 3.35***.

Table 3.35: Availability of pathology services in test-checked SDCHs

Name of Health Institution	Clinical pathology[39] (24)	Pathology[40] (1)	Microbiology[41] (4)	Serology[42] (4)	Biochemistry[43] (6)
SDCH Samalkha	14	1	0	4	4
SDCH Adampur	8	0	2	3	1
SDCH Narnaund	15	0	1	4	4

Source: Information furnished by the test-checked SDCHs during January to June 2022
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow-moderate and red colour depicting poor performance

It is evident from the above tables that most of the pathology services prescribed for DHs in IPHS 2012 norms were available in the test-checked MCHs. In the case of DHs, the maximum number of shortfall was seen in DH, Mandikhera, which was way below the tests available in DH, Panipat and DH, Hisar. In the case of SDCHs, SDCH, Adampur has maximum number of shortfall in availability of pathology services.

(ii) Availability of Pathology Diagnostic services in test-checked CHCs

IPHS 2012 prescribes 29 types of pathological investigations in the categories of clinical pathology (18)[44], pathology (1)[45], microbiology (2)[46], serology (3)[47] and biochemistry (5)[48] to be carried out in the CHCs.

Availability of pathology services offered by the test-checked CHCs is given in ***Table 3.36***.

39 Clinical Pathology (SDCH): Haematology, Urine Analysis, Stool Analysis, Semen Analysis, CSF Analysis, Aspirated Fluids etc.

40 Pathology (SDCH): Sputum

41 Microbiology (SDCH): KOH study for fungus, Smear for AFB & KLB, Gram Stain for Meningococci, Gram Stain for Throat Swab and sputum etc.

42 Serology (SDCH): RPR card test for syphilis, Pregnancy test (Urine gravindex), WIDAL test, Rapid test for HIV, HBs Ag, HCV etc.

43 Biochemistry (SDCH): Blood sugar, Blood urea, blood cholesterol, Lipid Profile, LFT, KFT, CSF for protein, sugar, Stocking of OT test for residual chlorine in water

44 Clinical Pathology (CHC): Haematology, Urine Analysis, Stool Analysis etc.

45 Pathology (CHC): Sputum

46 Microbiology (CHC): Smear for AFB & KLB; Grams stain for throat swab, sputum etc.,

47 Serology (CHC): VDRL, Pregnancy test, WIDAL test etc

48 Biochemistry (CHC): Blood sugar, Blood urea, LFT, Kidney function test, Lipid profile

Table 3.36: Availability of Pathology diagnostic services in test-checked CHCs

District	Name of CHC	Clinical pathology (18)	Pathology (1)	Microbiology (2)	Serology (3)	Biochemistry (5)
Panipat	Madlauda	10	1	1 (Available-Grams stain for throat swab, sputum)	2	1 (Available-Blood Sugar)
	Naultha	1	0	0	2 (Not available-Pregnancy test)	0
	Naraina	8	0	0	3	1(Available-Blood Sugar)
	Bapoli	2	0	0	1 (Available-VDRL)	1 (Available-Blood Sugar)
	UHC Sector-12	0	0	0	0	0
Hisar	Mangali	14	0	1 (Available- Smear for AFB & KLB)	3	4 (Not available-Kidney function test)
	Sorkhi	9	0	0	2 (Not available-Pregnancy test)	1 (Available-Blood Sugar)
	Uklana	8	0	0	2 (Not available-Pregnancy test)	1 (Available-Blood Sugar)
	Barwala	6	1	0	3	1 (Available-Blood Sugar)
	UHC sector 1 & 4 Hisar	7	1	0	3	1 (Available-Blood Sugar)
Nuh	Firozpur Jhirka	10	0	0	3	1 (Available-Blood Sugar)
	Punhana	12	1	2	3	5

Source: Information furnished by the test-checked CHCs during January 2022 to June 2022.
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow depicting moderate and red colour depicting poor performance.

In the test-checked CHCs/ UHCs, it was observed that:

i. There was shortfall in availability of Clinical pathology diagnostic services ranging from 22 *per cent* (Mangali) to 100 *per cent* (UHC Sector 12, Panipat).

ii. Sputum diagnostic service was available only in CHCs Madlauda, Barwala, Punhana and UHC Sector 1&4 Hisar.

iii. Both Microbiology (Smear for AFB & KLB; and Grams stain for throat swab, sputum, etc.) investigations were available in CHC Punhana. Grams stain for throat swab, sputum investigation and Smear for AFB & KLB investigation was available in CHC Madlauda and CHC Mangali respectively. In the rest of the CHCs/UHCs, no microbiology investigations were available.

iv. All the serology investigations were available in Naraina, Mangali, Barwala, Firozpur Jhirka, UHC Sector 1&4 Hisar and Punhana, whereas only pregnancy tests were not available in CHC Naultha, Sorkhi and Uklana. Only VDRL test was available in CHC Bapoli. None of the serology investigations were available in UHC Sector-12 Panipat.

v. All five Biochemistry tests were available in CHC Punhana. Out of the five Biochemistry investigations, only kidney function test was not available in CHC Mangali. Further, only one test namely, blood sugar

test was available in eight[49] out of 12 CHCs/UHCs. None of the Biochemistry investigations were available in CHC Naultha and UHC Sector-12 Panipat.

3.6.7 Waiting Time and Turn-around Time

Time taken in receiving samples from the patients for investigations i.e., Waiting Time (WT) and time taken in getting the investigation done and reporting the results to the patients i.e., Turn-Around Time (TAT), reflect the overall efficiency of the diagnostic services, in terms of patient satisfaction.

Audit observed that the doctors prescribed the tests/investigations over the patients' prescription slip. The patients were registered in the pathology/ radiology departments for the procedures based on the recommendations given by the doctors. Further, it was found that none of the test-checked hospitals maintained the records pertaining to TAT and WT. So, in the absence of the requisite record, TAT and WT could not be ascertained.

3.7 Availability of services in Health and Wellness Centres

As per Comprehensive Primary Healthcare guidelines, the availability of diagnostic services, essential medicines, medicines which can be indented by MLHP, clinical materials, tools and equipment, linens, consumables, miscellaneous supplies, furniture & fixtures, lab diagnostic materials and reagents for screening should be ensured to deliver comprehensive primary healthcare services by converting existing SCs and PHCs into HWCs.

The availability (%) of equipment, consumables, etc. in the selected HWCs i.e. (19) has been shown in ***Table 3.37***.

[49] CHC-(i) Madlauda, (ii) Naraina, (iii) Bapoli, (iv) Sorkhi, (v) Uklana, (vi) Barwala, (vii) Firozpur Jhirka and UHC Sec 1&4 Hisar.

Table 3.37: Availability of essential services in the selected HWCs (April-June 2022)

Name of District	Name of HWC	Diagnostic Services (PHC: 22/ SC: 08)	Essential Medicines (91)	Medicines indented by MLHP (43)	Clinical Material, Tools, and Equipment (65)	Linens, Consumables, and misc. items (37)	Furniture and Fixtures (7)	Lab -Diagnostic Materials and Reagents for Screening (19)
Panipat	Naultha (CHC)	68	51	35	95	92	86	95
	Sewah (PHC)	68	64	60	88	86	100	58
	Rair Kalan (PHC)	45	51	28	30	46	71	53
	Atta (PHC)	50	37	26	65	57	86	84
	Pattikalyana (PHC)	68	40	23	74	65	100	68
	Israna (PHC)	41	63	35	36	65	86	47
	Mandi (PHC)	36	60	37	79	84	100	53
	Rajnagar (UPHC)	59	63	23	71	65	100	89
	Hari Singh Colony (UPHC)	64	55	23	18	62	57	58
	Rajeev Colony (UPHC)	64	52	23	18	54	100	68
	HWC Bandh (SC)	62	37	30	50	57	86	47
	HWC Balana (SC)	62	48	26	44	41	86	32
Nuh	Singar (PHC)	50	35	16	64	81	57	68
	Nagina (PHC)	32	43	33	89	84	86	32
	Biwan (PHC)	50	62	35	70	81	100	89
	Jamalgarh (PHC)	55	33	26	85	81	86	79
Hisar	Patel Nagar (UPHC)	36	59	49	45	59	86	95
	Siwani Bolan (SC)	50	35	40	18	14	86	32
	Char Qutub gate Hansi (UPHC)	64	59	23	45	59	86	89

Source: Information furnished by the selected HWCs.
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow depicting moderate and red colour depicting poor performance

It is evident from the above table that five[50] HWCs had less than 50 *per cent* diagnostic services. In case of essential medicines, the availability was ranging between 33 *per cent* and 64 *per cent*. Further, in case of clinical material, tools and equipment, the availability was ranging between 18 *per cent* and 95 *per cent*. The status was satisfactory in case of furniture and fixtures.

HWCs have been conceptualised to provide Comprehensive Primary Healthcare (CPHC), which ensures the highest possible level of health and well-being at all ages, through a set of preventives, promotive, curative and rehabilitative services. Thus, in absence of the above essential services, the aim for which HWCs were created could not be achieved.

NHM replied (January 2023) that a corpus fund of ₹ 6.81 crore (approx.) was provided to HMSCL to ensure the availability of essential diagnostics at HWCs. Further, recurring funds of ₹ 30,000 per SC: HWC and ₹ 50,000 per PHC: HWC were provided for ensuring availability of essential diagnostics.

3.7.1 Database of family and individuals was not created by HWCs

As per operational guidelines for Comprehensive Primary Healthcare (2018) of Ministry of Health & Family Welfare, GoI, one of the objectives of HWCs was

[50] PHC-(i) Rair Kalan, (ii) Israna, (iii) Mandi, (iv) Nagina and (v) UPHC Patel Nagar (Hisar).

to create and maintain the database of all families and individuals. Health Cards and Family Health Folders were to be maintained for all service users fall under jurisdiction of respective HWC. The family health folders were to be kept at the HWC or nearby PHC in physical form and/or digital form. The objective was to ensure that every family should be aware of their entitlement to healthcare through both HWC and the Pradhan Mantri Jan Arogya Yojana or equivalent health schemes of State/Central Government.

However, as of April-June 2022, none of the selected HWCs had created and maintained the database of all families and individuals. Moreover, Health Cards and Family Health Folders were also not maintained. Further, the identification and registration of beneficiaries/ families was not done for PMJAY scheme by any of the selected HWCs.

In none of the selected districts, supervisory visit was made by district, block and PHC level officers/ officials during the year 2020-21 to monitor the progress/ working of HWCs except for district Hisar.

NHM replied (January 2023) that Haryana has 1,284 CHOs and their training regarding maintenance of family database has been completed and every HWC has now started maintaining the database.

3.7.2 Availability of services in AHWCs of test-checked districts

As per AYUSH Health and Wellness Centre's operational guidelines, essential requirements to serve as a AHWC are Infrastructure strengthening, laboratory services, IT networking, creating awareness among the masses through IEC activities and establishment of herbal gardens.

The availability of services in AHWCs of the selected districts have been depicted in ***Table 3.38***.

Table 3.38: Availability of services in AHWCs in selected Districts

Name of District	Selected for upgradation	Infrastructure	Herbal Plants	Equipment	Diagnostic Equipment	IEC
Hisar	35	18	26	31	33	30
Panipat	15	15	15	3	3	15
Nuh	11	5	10	11	11	9

Source: Information furnished by DAOs of the test-checked districts. (Hisar: June-July 2022, Panipat: November 2021 and Nuh: June 2022)
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow depicting moderate and red colour depicting poor performance

Thus, out of total 61 AHWCs selected for upgradation in the test-checked districts, infrastructure has been upgraded in 38 AHWCs, herbal plants have been planted in 51 AHWCs, equipment and diagnostic equipment have been supplied in 45 and 47 AHWCs respectively and IEC activities were carried out in 54 AHWCs. Diagnostic lab items provided in these AHWCs diagnostic labs could not be utilised due to non-deployment of trained staff i.e., ASHA/ANMs.

This has resulted into unfruitful expenditure. Further, the following discrepancies were also found during physical verification in the selected AHWCs:

i. As per the Operational Guidelines, HWC team is to be equipped with laptop, tablets, and smart phones to serve a range of functions such as population enumeration, record delivery of services, enable quality follow up, etc. However, no laptops etc. were provided to 15 AHWCs (Panipat).

ii. There was no electricity connection in one[51] AHWC and water connection was not available in six[52] AHWCs. R.O. units for drinking water were supplied by HLL lifecare Ltd. but have not been installed in five[53] AHWCs.

iii. The toilet in AHWC, Adyana was being used as a storeroom.

iv. AHWCs Madanheri (Hisar) was not in use as the constructed building of AHWC was situated in a low-lying area and there was water-logging in the constructed building, apart from non-availability of equipment and furniture. Despite showing completion in December 2020, AHWC Madanheri was running in a private building.

v. The building of AHWC, Kalirawan was constructed recently. However, toilets were not in use due to the tiles being broken/displaced and whitewash was not done in the building. Fans were also not found in working condition.

vi. In AHWC Badyan Rangran, doors of toilets were not found functional, and all other doors were also in damaged condition. The boundary wall was also found damaged.

vii. In HWC, Choudriwali, light fittings were not proper. Toilets were available but functional doors and water facilities were not available in the toilets. Basic furniture such as chairs was not available in the AHWC.

The DG, AYUSH replied (January 2023) that request for water connection had been made to the Sarpanch of Gram Panchayat concerned. Request for electricity connection has been made to the electricity department.

3.8 Auxiliary and Support services

Auxiliary and support services which are required to be provided by personnel other than health professionals include services related to ambulance, dietary, laundry,

[51] AHWC Madanher

[52] AHWC- (i) Adyana, (ii) Madanheri , (iii) Badyan Rangran, (iv) Tokas Patan, (v) Chirod and (vi) Nara

[53] AHWC- (i) Kurana, (ii) Badyan Rangran, (iii) Tokas Patan, (iv) Chirod and (v) Nara

waste management including biomedical waste, security, water supply, power supply, patient safety measures etc. These services are important for effective functioning of hospitals. Significant audit findings in the test-checked health institutes for these services have been discussed in the succeeding paragraphs.

3.8.1 Ambulance services

As per IPHS 2012 norms, DHs are required to have three running ambulances with well-equipped Basic Life Support (BLS). It is desirable to have one Advanced Life Support (ALS) ambulance. There should be a dedicated parking space separately for ambulances near emergency. There were a total of 622 ambulances (157 Advance Life Support, 166 Basic Life Support ambulances, 262 Patient Transport ambulances, 31 Kilkari/back to home ambulances and 6 Neonatal Ambulances) as of November 2022 which were managed by decentralised control rooms. The ambulance services were available in all the DHs and SDCHs except SDCH, Devrala and Haily Mandi. The details have been given in ***Appendix 3.4 (i) and (ii).*** Further the availability of ambulance services in the selected DHs/SDCHs/CHCs is given in ***Table 3.39***.

Table 3.39: Availability of ambulance services in selected Health Institutions

Health institutions (No.)	Required No. of ambulances available as per norms	Availability of ambulance services 24 7	Availability of demarcated parking space
DHs (3)	3	3	2
SDCHs (3)	3	3	3
CHCs/ UHCs (12)	NA	10	11

Source: Information furnished by the selected health institutions during January to June 2022

UHC Sector-12 Panipat and CHC, Firozpur Jhirkha did not have 24x7 ambulance service.

3.8.2 Referral Transport (RT) Application for Ambulance Service

Referral Transport Scheme under NHM, also called "Haryana Ambulance Services" is functional in all the districts of Haryana. The scheme is made operational through Referral Transport (RT) Application portal and branded as "Haryana Ambulance Services" with toll free number 108. As per the data made available from RT Application portal made available by NHM Haryana, 483 Ambulances were functional in 2020-21.

Free transportation services are provided in case of emergency if the patient is taken to Government Hospital. All transportation from home/site to a private health facility in case of emergency within the district is charged at ₹ 7 per Km for BLS Ambulances and ₹ 15 per Km for ALS Ambulances/ Neonatal Care Ambulances.

Analysis of data for the period 2016-17 to 2020-21 revealed the following:

(i) Absence of validation controls

Analysis of data related to 23,74,212 field trips made during 2016-17 to 2020-21

revealed that in the cases mentioned in ***Table 3.40,*** invalid date of 'Ambulance reached patient' and invalid date of 'Ambulance reached facility' i.e. health institutions were captured.

Table 3.40: Cases of wrong date captured on RT Application

Sr. No.	No. of cases of wrong date captured of 'Ambulance reached patient'	No. of cases of wrong date captured of "Ambulance reached health institute"	Type of wrong date captured
1	37,557	75,772	Null, 30-12-1899, 01-01-1900, year 2047, 2048, 2672

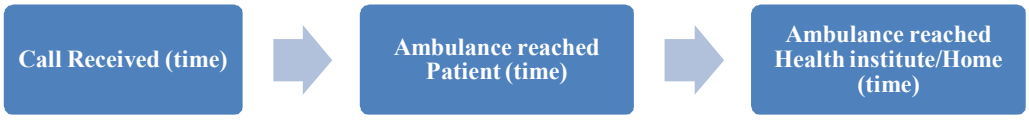
Source: Audit analysis of data from RT Application.

Thus, it is clear from the above discrepancies that validation controls for these fields were absent.

The Director, NHM stated (January 2023) that all the call entries which are not closed, default NULL value is stored for the "Ambulance reached patient" and "Ambulance reached facility". For this, communication has been issued to the districts to close all the calls which are not closed yet.

(ii) Missing Input Controls

In respect of time stamps captured in the RT application, the sequence of events is as per diagram shown below:



On analysis of data, it was observed that the data was inconsistent in the cases given in ***Table 3.41***.

Table 3.41: Missing Input Controls

Inconsistency	Number of trips
Ambulance reached patient (time) < Call received (time)	898
Ambulance reached health institute (time) < Call received time	936
Ambulance reached health institute (time) < Ambulance reached patient (time)	457
Call Received time = Ambulance Reached Patient (time)	2,89,295*
Call Received time = Ambulance Reached health institute (time)	88,798
Ambulance reached patient (time) = Ambulance Reached health institute	96,605

Source: Audit analysis of data from RT Application.
***Out of 2,89,295 trips 67,977 trips are neither "Referral" nor "Back to home" type (where Ambulance takes the patient from Health facility) where likelihood of ambulance and patient being at the same place is high. Distance covered by ambulance in these trips ranges from 1 to 1,000 Kms.**

It shows that input controls for these three date fields viz. call received, ambulance reached patient and ambulance reached health institute are missing in the system and it does not restrict the user from entering inconsistent data.

NHM replied (January 2023) that all the validations have been re-checked and additional checks have been imposed on the above validations and the same discrepancies would not be repeated for future call entries.

(iii) Response time

Response time is the duration between call received time and the time when the ambulance reached the patient. As per Referral Transport (RT) Scheme (initiated in 2009 under National Health Mission) guidelines, response time should be less than 15 minutes. Response time as calculated by the available data provided by RT application is as depicted in ***Table 3.42***.

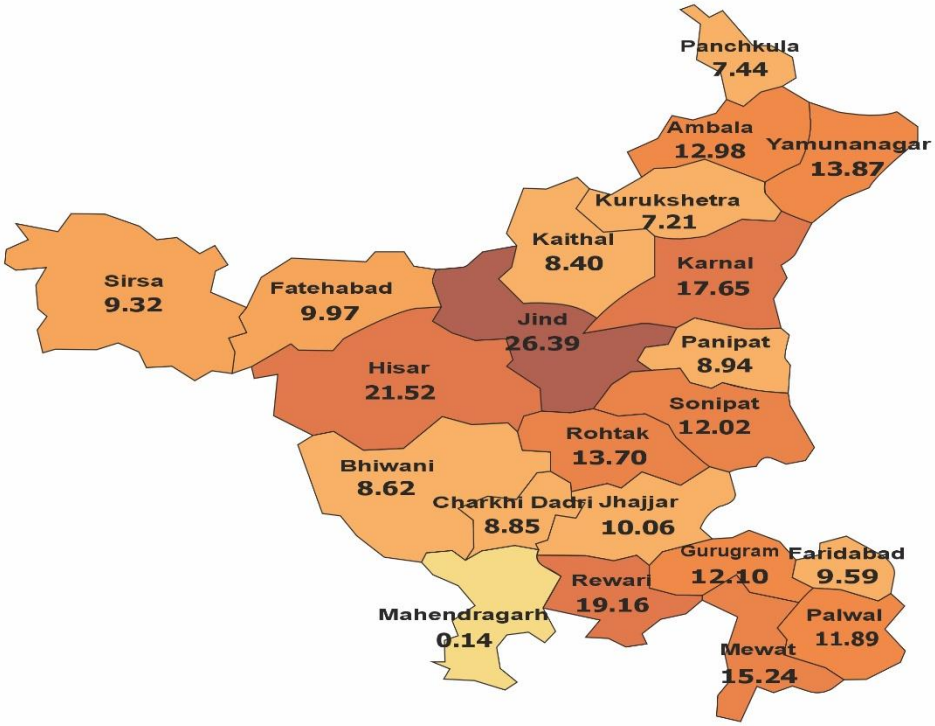
Table 3.42: Response time

Sr. No.	Response time Range (in Minutes)	No. of cases	Percentage of cases
1	0-15	16,27,114	70.79
2	15-30	4,80,128	20.89
3	30-60	1,48,365	6.46
4	60-120	31,990	1.39
5	120-240	3,336	0.15
6	240-360	220	0.01
7	More than 360	6,321	0.28
8	Less than 0 (in negative)	898	0.04
Total		**22,98,372**	

Source: Audit analysis of data from RT Application.

As shown above, in 6,70,360 (29.17 *per cent*) cases the response time was more than 15 minutes whereas in 41,867 cases ambulance reached the patients after one hour of receiving their calls. The average response time across districts is given in ***Chart 3.6***.

Chart 3.6: Average Response time across districts



In Mahendragarh district, ambulances made 75,368 trips with average response time of 0.14 minute (8.4 seconds). In 74,294 cases of Mahendragarh district, response time was 0 as call received time and ambulance reached patient time have been entered as same. Thus, the data was not reliable and as a result the Mission could not monitor response time effectively.

The Director, NHM replied (January 2023) that the response time may vary from district to district. The State average response time is 12.76 minutes. The reply is not tenable as the response time was more than 12.76 minutes in more than 30 *per cent* cases. Further, there were also 898 cases where response time was less than zero. Thus, the data captured was unreliable.

(iv) Huge ariation in Cost of fuel per m. of Ambulances

The RT application captures kilometres driven by each ambulance and cost of fuel consumed. It was found that the cost of fuel per Km (₹/Km) varied significantly as shown in ***Table 3.43***.

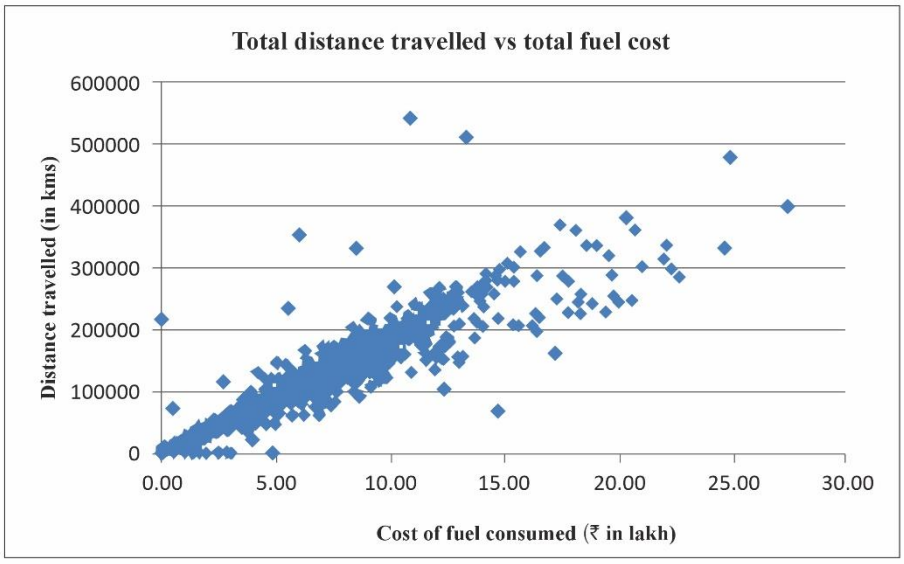
Table 3.43: Variation in cost of fuel per KM

Fuel Cost per Km (₹/km)	Number of ambulances					
	2016-17	2017-18	2018-19	2019-20	2020-21	Total
< 7	409	355	396	444	351	1,955
7-15	25	37	92	72	124	350
15-25	1	1	2	4	2	10
Above 25	6	10	18	7	5	46

Source: Audit analysis of data from RT Application.

The total distance travelled and the corresponding expenditure on fuel in respect of 817 ambulances for the period 2016-17 to 2020-21 has been plotted in **Chart 3.7**.

Chart 3.7: Total distance travelled vs total fuel cost



It is evident from the above chart that the cost of fuel consumed (in ₹) and distance covered by an ambulance shows wide variation.

- In case of 10 ambulances (points touching or near X-axis) distance covered was from 42 km to 209 km for which these ambulances consumed fuel costing ₹ 1,04,907 to ₹ 4,85,371 with cost of fuel more than ₹ 750 per km.
- 15 ambulances (points on Y-axis) consumed no fuel. However, they were shown to have covered a distance from 4 km to 2,18,983 km.
- Further, it was also observed that for 66 ambulances, the cost of fuel per Km increased abruptly from the cost of fuel per km in previous years.

The Director, NHM replied (January 2023) that the application captures the initial meter reading and final meter reading of each call. If in any case, the final meter reading is not updated, then the average cost of fuel may increase. The reply is not tenable as to monitor the mileage, proper entries are to be made in the RT application.

(v) Non-maintenance of record

Helpline (108) i.e. toll-free number does not have the feature of recording the 'call in wait' when the line is busy, and it does not capture the telephone number from which the call was made while the line was busy so that the person could be contacted.

Further, patients to whom ambulances could not be provided, due to any other reason, were not recorded either on the portal or manually. Details of only those cases, where ambulance was provided, were recorded on the RT application. In absence of this feature/data, patients to whom service of ambulances were not provided, could not be ascertained.

NHM replied (January 2023) that the RT application captures the name-wise patient details to whom ambulance service was provided. All validations have been re-checked and the application captures call details of each, and every service provided to the patients during transportation through ambulances. The fact remains the same that the details of patients to whom service of ambulance were not provided have not been maintained by the Mission.

3.8.3 Oxygen services

As per IPHS 2012 norms, Double–Outlet Oxygen Concentrator, one each for the labour room & OT should be available in a DH. Equipment for Eclampsia Room i.e., Oxygen Supply (Central) should be available. Special Newborn Care Unit (SNCU) should have oxygen reservoir & silicone round cushion masks – sizes 0 & 00 (1 set for each bed (essential) + 2). Double Outlet Oxygen Concentrator 1 for every 3 beds (essential) should be available in SNCU.

Oxygen service was available in all the DHs and SDCHs except SDCH, Uchana and Kalayat. The details have been given in ***Appendix 3.4 (i) and (ii).*** The

availability of oxygen services in the selected health institutions is given in ***Table 3.44***.

Table 3.44: Availability of oxygen services in selected DHs/SDCHs

Name of service	District Hospital			SDCH		
	Hisar	Mandikhera	Panipat	Adampur	Narnaund	Samalkha
Whether the requirement of oxygen in the hospital was assessed and infrastructure created accordingly?	Y	N	Y	Y	Y	Y
Whether the standard operating procedure for oxygen was available and was being followed?	Y	N	Y	Y	Y	Y
Whether agreements were executed for the supply of uninterrupted oxygen?	Y	N	N	Y	N	N
Whether Centralised oxygen supply system was installed in the hospital?	Y	Y	Y	Y	Y	Y
If the Centralised oxygen supply system was not installed whether adequacy of required oxygen cylinders was assessed?	Y	N	N	Y	N	N
In all such cases, whether required buffer stock was assessed and maintained all the time?	Y	N	N	Y	Y	Y
Whether records of serviceability and availability of oxygen cylinders were maintained as per guidelines?	N	N	Y	Y	Y	Y
Whether required number of oxygen Supply (Central) are available in Eclampsia Room?	Y	Y	Y	Y	Y	Y
Whether oxygen reservoir is available for each bed at Special New-born Care Unit?	Y	Y	Y	Y	Y	N
Whether the health institution have Double Outlet Oxygen Concentrator at Special New-born Care Unit?	Y	N	N	Y	Y	Y

Source: Information furnished by the test-checked DHs/SDCHs during January to June 2022

Colour Code:		**Yes**		**No**

It was observed that:

i. Requirement of oxygen was assessed, and infrastructure was created accordingly and standard operating procedure for oxygen was available and followed in all the selected hospitals except DH Mandikhera.

ii. Centralised oxygen supply system was installed and required number of Oxygen Supply (Central) was available in Eclampsia Room of all the selected hospitals.

iii. Agreement for the supply of uninterrupted oxygen was not executed by any of the selected hospitals except DH Hisar and SDCH Adampur.

iv. Required buffer stock was not assessed and maintained by DH Mandikhera and DH Panipat.

v. Records of serviceability and availability of oxygen cylinders were not maintained as per guidelines by DH Hisar and DH Mandikhera.

vi. Oxygen reservoir was not available for each bed at Special New-born Care Unit in SDCH Samalkha.

vii. Double Outlet Oxygen Concentrator at Special New-born Care Unit were not available in DH Mandikhera and DH Panipat.

3.8.4 Dietary services

As per IPHS 2012 norms for district and sub district hospitals, the dietary service of a hospital is an important therapeutic tool. Standard D 6 of NHM Assessor's guidebook, provides that "Dietary services are to be available as per service provision and nutritional requirement of the patients". Apart from normal diet, diabetic, semi-solid and liquid diets should be available, and the food should be distributed in a covered container. Quality and quantity of diet should be checked by competent person on regular basis.

Dietary service was available in all DHs except DH, Yamuna Nagar. In case of SDCHs, the dietary service was available in 27 SDCHs, out of 41 SDCHs. The details of availability of dietary services are given in ***Appendix 3.4 (i) and (ii).*** Further, availability/non-availability of dietary services in the test-checked DHs/SDCHs is given in ***Table 3.45***.

Table 3.45: Dietary services in the selected MCHs/DHs/SDCHs

Particulars	DH Panipat	SDCH Samalkha	DH Hisar	SDCH Adampur	SDCH Narnaund	DH Mandikhera	MCH Nalhar	MCH Agroha
Availability of dietary service	A	A	A	A	A	A	A	A
If available, in-house/ outsourced	Outsourced	Outsourced	Outsourced	Outsourced	Outsourced	Outsourced	Outsourced	In-house
Availability of Kitchen	NA	NA	A	A	A	NA	NA	A
Availability of standard procedures for preparation, handling, storage and distribution of clean, hygienic and nutritious diet to the indoor patients as per their caloric requirement	NA	NA	A	NA	A	NA	A	A
Availability of policy and procedure for regular quality checking of raw material, kitchen sanitation, cooked food etc.	NA	NA	NA	NA	NA	NA	NA	NA
Availability of Quality testing of diet supplied in health facilities	NA	NA	NA	NA	NA	NA	NA	NA
Evaluation of dietary services in health facilities	NA	NA	NA	NA	A	NA	A	NA
Dietetic research on menu planning, preserving nutritional values, storage of food items, modern methods of cooking, etc. was conducted to improve the dietary services in the hospitals	NA	NA	NA	NA	NA	NA	NA	NA

Source: Information furnished by the test-checked/DHs/SDCHs during January to June 2022
Colour code: Green colour depicts available (A=Available), pink colour depicts non-availibility (NA= Not Available)

It is evident from the above table that:

i. Dietary services were available in all the selected health institutions.

ii. Kitchen for dietary services was available in MCH Agroha, DH Hisar, and two SDCHs, Narnaund and Adampur.

iii. Policy and procedure for regular quality checking of raw material, kitchen sanitation, cooked food etc. was not available in any of the selected health institutions.

3.8.5 Blood Bank

As per IPHS 2012 norms, blood bank shall be in close proximity to the pathology department and at an accessible distance to the operation theatre department, intensive care units and emergency and accident department. Blood bank should follow all existing guidelines and fulfil all requirements as per the

various Acts pertaining to setting up of the Blood Bank. Separate reporting room for doctors should be there.

The blood bank service was available in all DHs except DH, Panipat. Out of 41 SDCHs, the blood bank was available only in 12 SDCHs. The details of availability of blood bank have been given in ***Appendix 3.4 (i) and (ii)***. Further, the availability of blood bank facilities in the test-checked DHs is given in ***Table 3.46***.

Table 3.46: Availability of Blood Bank facilities in selected DHs

Sr. No.	Name of service	DH, Hisar	DH, Mandikhera
1	Blood bank available in hospital.	Yes	Yes
2	License for Blood bank or authorisation for Blood storage facility taken.	Yes	Not renewed since December 2017
3	Blood bank is in close proximity to pathology department and at an accessible distance to operation theatre department, intensive care units and emergency and accident department or not.	Yes	Yes
4	Availability of Separate Reporting Room for doctors.	Yes	Yes
5	Blood bank validate the test results from external labs on regular basis.	Yes	Yes
6	Schedule of charges displayed at the entrance of department.	Yes	Yes
7	Availability of blood group displayed prominently in the blood bank.	Yes	Yes
8	Blood bank adhering to NACO guidelines and drug and cosmetic act strictly.	Yes	Yes
9	Blood bank practicing first in first out policy for reduction of waste.	Yes	Yes
10	Measures taken to prevent expiry of blood or blood components.	Yes	Yes
11	Refrigerator for storing blood available and record of temperature maintained in different storage units checked regularly	Yes	Yes
12	Availability of mechanism to provide blood if certain blood group is not available at the blood bank.	No	Yes
13	Availability of records of the donor and receiver maintained in the blood bank.	Yes	Yes

Source: Information furnished by the test-checked DHs during January to June 2022
Note: Colour code- green indicates: availability, red indicates: non-availability

Blood bank facility was available at DH Hisar and DH Mandikhera. Both these hospitals had acquired license for blood bank. But the license was not renewed by the DH, Mandikhera since December 2017. Further, the blood banks, in these two test-checked hospitals, were in close proximity to the pathology department, had separate reporting room for doctors, were validating the test results from external labs on a regular basis, had refrigerator for storing blood and record of temperature maintained in different storage units was checked regularly and records of the donor and receiver were maintained.

Government of Haryana had announced to establish a blood bank in November 2018 for DH Panipat, Accordingly, the Medical Superintendent, Office of Civil Surgeon, Panipat proposed that the blood bank running under the control of Red Cross (which was approximately 800 metre away from DH) may be shifted to the DH, Panipat. Principal Medical Officer (PMO), Civil Hospital Panipat intimated (January 2023) that the infrastructure was complete, and all the equipment had been installed and were functional. An MD Pathology and pathologist had also been deputed. The facility had also applied for license of blood bank. But the fact remains that even after a period of more than four years, the blood bank could not be made operational in DH, Panipat.

3.8.6 Laundry services

As per IPHS 2012 norms hospital laundry should be provided with necessary facilities for segregated collection, drying, pressing and storage of soiled and cleaned linens. The service may be outsourced.

As per Kayakalp guidelines[54], the provision of clean linen is a fundamental requirement for patient care. Incorrect procedures for handling or processing of hospital linen[55] may lead to infection risk both to staff and patients who subsequently use it. Kayakalp guidelines also recommend to have six sets of linen[56]. Further, there should be a system to check the cleanliness and quantity of the linen received from laundry.

Laundry service was available in all DHs and in 37 out of 41 SDCHs. The details of availability of laundry service are given in ***Appendix 3.4 (i) and (ii)***. Further, availability of laundry service in the test-checked health institutions is given in ***Table 3.47***.

Table 3.47: Laundry services in the selected DHs/SDCHs/CHCs

Particulars	DH Hisar	DH Mandikhera	DH Panipat	SDCH Adampur	SDCH Narnaund	SDCH Samalkha	Hisar CHCs (5)	Panipat CHCs (5)	Nuh CHCs (2)
Availability of required linen sets	A	A	A	A	A	A	A 3	A 4	2
Availability of system of changing the patient/OT linen at the prescribed intervals to maintain hygiene	A	A	A	A	A	A	A 4	5	A 1
Availability of system to check the quality of cleanliness of the linen received from laundry	A	NA	A	A	A	NA	A 4	A 4	A 1
Availability of date wise and patient wise records against each entry of linen issued from linen stock	A	NA	A	A	A	A	A 4	A 2	A 1
Availability of system for periodic physical verification of linen inventory	A	NA	A	A	A	A	A 5	A 4	A 1
Follow up of procedure for sluicing of soiled and infected linen	A	A	A	A	A	A	A 4	A 3	NA 2
Maintenance of norms for washing and drying of the linens	A	NA	A	A	A	A	5	A 4	A 1

Source: Information furnished by the test-checked DHs/SDCHs/CHCs during January to June 2022

A=Available, NA= Not Available

It was observed that -

- Required linen sets were not available in CHC Barwala, UHC Sector-1&4 Hisar and Sector 12, Panipat.
- System of changing the patient/OT linen at the prescribed intervals to maintain hygiene was not maintained by CHC Firozpur Jhirka and UHC Sector-1&4 Hisar.

[54] Issued by Ministry of Health and Family Welfare, Government of India on 15th May, 2015

[55] The term 'hospital linen' includes all textiles used in the hospital including mattresses, pillow covers, blankets, bed sheets, towels, screens, curtains, doctors' coats, theatre clothes and table clothes.

[56] (i) One already in use (on bed), (ii) One ready to use (in sub store), (iii) One in transit-route to laundry or to the ward, (iv) One in washing cycle in laundry and (v) Two in stock (in central store)

- System to check the quality of cleanliness of the linen received from laundry was not available in DH Mandikhera, SDCH Samalkha, CHC Sorkhi, Naultha and Firozpur Jhirka.
- Date-wise and patient-wise record against each entry of linen issued from linen stock was not maintained in DH Mandikhera, CHC Sorkhi, Bapoli, Madlauda, Naultha and Firozpur Jhirka.
- System for periodic physical verification of linen inventory was not available in DH Mandikhera, Naultha and Firozpur Jhirka.
- Follow-up procedure for sluicing of soiled and infected linen was not done in CHC Sorkhi, Nautlha, Naraina, Punahna and Firozpur Jhirka.
- Norms for washing and drying of linen were not followed in DH Mandikhera, CHC Naraina and Firozpur Jhirka.
- During joint inspection of SDCH Samalkha, it was observed that the washing of linen was being carried out in the toilet as shown in the picture.

Laundry activities carried out in toilet at SDCH Samalkha (06 March 2022)

Further in case of Medical Colleges, MCH, Agroha, there was shortage of different types of linen such as bedspreads, patna towel, pillows, pillow covers, hospital worker OT coats, macintosh sheet, etc.

In MCH, Nalhar, there was shortage of different types of linen such as patna towel, doctor's overcoat, patient's house coat (for female), patients pyjama (for male) shirt, over shoes pairs, pillows, pillow covers, mattress (foam adult) and macintosh sheet. Bedspreads, tablecloths, paediatrics mattress, perineal sheets for OT, leggings, mortuary sheet and mats (nylon) were not available.

Thus, in both the MCHs, linen was not available as per the guidelines. Director, MCH, Agroha replied that mackintosh is used in place of bedspreads. OT gown, perennial sheets for OT and abdominal sheets for OT were stitched by their tailor as per load/requirement. However, no such record regarding availability of stitched OT gown, perennial sheets for OT and abdominal sheets for OT in

central store (during 2016-21) was made available to Audit for verification. As per record submitted by the MCH, only unstitched green cloth was issued. MCH, Nalhar stated that demand for requirement of linen had been placed with HMSCL.

3.8.7 Bio-medical waste management

As per rule 4 (r) of Bio-Medical Waste Management Rules, 2016, it shall be the duty of every occupier[57] to establish a system to review and monitor the activities related to bio-medical waste management. The status of compliance with the Rules have been given in ***Appendix 3.4 (i) and (ii)***. Further compliance with the Rules was reviewed in the test-checked health institutions as detailed in ***Table 3.48***.

Table 3.48: Bio Medical Waste Management services in selected Health Institutions

Name of Service	Panipat			Nuh			Hisar		
	No of hospitals (2)	No of CHCs/ UHCs (5)	No of PHCs/ UPHC (9)	No of hospitals (1)	No of CHCs (2)	No of PHCs (4)	No of hospitals (3)	No. of CHCs/ UHC (5)	PHCs/ UPHC (11)
Authorisation for generating bio-medical waste was obtained by the hospital from State Environment Protection and Pollution Control Board	2	5	8	1	1	2	3	4	8
Availability of Waste Management Committee under the Chairmanship of head of hospital	2	5	4	1	1	2	2	4	4
Waste Management Committee met regularly to review the performance of the hospital as regards waste disposal	2	5	4	1	1	2	2	4	4
Availability of proper system for disposal of bio-medical liquid waste	2	4	4	1	2	2	2	4	5
Plastics bags which contained bio-medical waste had been labelled as per guidelines i.e., symbols for biohazard and cytotoxic	2	5	9	1	2	4	3	5	11
The hospital and healthcare authorities had ensured that personal protective equipment was provided to waste handlers	2	4	8	1	2	3	3	5	10
Availability of barcode system, for bags or containers containing biomedical waste that were to be sent out of the premises, was ensured by the hospital	1	5	9	1	2	2	3	4	10
Periodic medical check-up and immunisation of staff were carried out.	2	4	8	1	2	4	3	5	8

Source: Information furnished by the test-checked Health Institutions during January to June 2022

Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow-moderate and red colour depicting poor performance

[57] "occupier" means a person having administrative control over the institution and the premises generating bio- medical waste, which includes a hospital, nursing home, clinic, dispensary, veterinary institution, animal house, pathological laboratory, blood bank, healthcare facility and clinical establishment, irrespective of their system of medicine and by whatever name they are called.

It is evident from the above table that-

i. Authorisation for generating bio-medical waste was obtained by all the selected hospitals, CHCs/UHCs and PHCs/ UPHCs except CHC Sorkhi, Firozpur Jhirka and six[58] PHCs.

ii. Waste management committee was available and met regularly to review the performance of the hospital as regards waste disposal in all the selected hospitals, CHCs/UHCs and PHCs/ UPHCs except SDCH Narnaund, CHC Sorkhi, Punhana and 14[59] PHCs/UPHCs.

iii. Proper system for disposal of bio-medical liquid waste was available in all the selected hospitals, CHCs/UHCs and PHCs/ UPHCs except SDCH Narnaund, CHC Madlauda, UHC Sector 1&4 Hisar and 13[60] PHCs/UPHCs.

iv. Plastics bags which contained bio-medical waste had been labelled as per guidelines i.e., symbols for bio-hazard and cytotoxic by all the selected health institutions.

v. The hospital and healthcare authorities had ensured that personal protective equipment was provided to waste handlers in all the selected health institutions except CHC Madlauda, PHC Daulatpur, Nagina and Pattikalyana.

vi. Barcode system for bags or containers containing biomedical waste was ensured by all the selected health institutions except DH Panipat, UHC Sector 1&4 Hisar, PHC Daultpur, Biwan and Nagina.

vii. Periodic medical check-up and immunisation of staff was carried out by all the selected health institutions except CHC Naraina and PHC Pattikalyana (Panipat), Agroha (Hisar), UPHC Char Qutub Gate and Patel Nagar.

3.8.8 Effluent Treatment Plant (ETP) for treatment and disposal of liquid waste in hospital

Bio-Medical Waste Management Rules, 2016 prescribe that every institution shall ensure segregation of liquid chemical waste at source and ensure pre-treatment or neutralisation prior to mixing with other effluents generated from healthcare institutions, ensure treatment, disposal of liquid waste in accordance with the Water (Prevention and Control of Pollution) Act, 1974 and effluent treatment plant for liquid waste. Sludge from effluent treatment plant shall be given to common bio-medical waste treatment facility for incineration or to hazardous waste treatment, storage and disposal facility for disposal.

[58] PHC Ladwa, Puthi Mangal Khan, Puthi Samain, Biwan, Singar and Atta.

[59] PHC, Dhansu, Hasangarh, Ladwa, Puthi Mangal Khan, Puthi Samain, Biwan, Singar, Atta, Pattikalyana, Israna, Mandi, UPHC Hari Singh Colony, Char Qutab Gate and Patel Nagar.

[60] PHC Agroha, Dhansu, Daultpur, Talwandi Rukka, Biwan, Nagina, Siwah, Rair Kalan, Atta, Israna, UPHC Hari Singh Colony, Char Qutab Gate and Patel Nagar.

Effluent treatment plant (ETP) for disposal of liquid waste was not available in any of the selected MCHs/DHs/SDCHs except MCH, Agroha.

3.8.9 Mortuary Services

As per IPHS 2012 norms, Mortuary provides facilities for keeping of dead bodies and conducting autopsy. The NHM Assessor's guidebook also provide standards for mortuary services. Mortuary services were available in all DHs and in 17 out of 41 SDCHs. The details have been given in ***Appendix 3.4 (i) and (ii)***. Compliance of NHM Assessor's guidebook was assessed in respect of mortuary services in the three test-checked DHs.

The availability of mortuary services in DH Panipat, Hisar and Mandikhera is given in ***Table 3.49***.

Table 3.49: Mortuary Services in the selected DHs

Particular	DH Panipat	DH Hisar	DH Mandikhera
Availability of mortuary facility in the hospital 24x7	A	A	A
Stainless steel autopsy table with sink, a sink with running water for specimen washing and cleaning and cupboard for keeping instruments in post-mortem room	NA (Request sent to HMSCL for supply)	A	NA
Availability of separate room for body storage provided with at least 2 deep freezers for preserving the body	A	NA (1 Freezer working)	NA
Availability of facility for pathological postmortem	A	NA	NA
System to categorise the dead bodies before preservation	A	NA	NA
System to provide identification tag/wrist band for each stored dead body	A	A	NA
System for storage of unclaimed body for fixed duration	A	A	NA
Facility of high-level disinfection by boiling or chemical treatment was done as per protocol at mortuary	A	A	NA

Source: Information furnished by the test-checked DHs during January to June 2022
Colour code: Green colour depicts available (A=Available), pink colour depicts non-availability (NA= Not Available)

It was observed that:

i. All the above selected district hospitals had 24x7 mortuary facility but system to provide identification tag/wrist band for each stored dead body and facility for high level disinfection by boiling or chemical treatment was not available in DH Mandikhera.

ii. Stainless steel autopsy table with sink was available only in DH Hisar.

iii. Facility of separate room for body storage provided with at least two deep freezers for preserving the body and facility for pathological postmortem was available only in DH Panipat and one freezer was available in DH, Hisar.

iv. Mortuary van was not available and death certificate did not accompany dead bodies sent to the mortuary in either of the selected DHs.

v. System to categorise the dead bodies before preservation was not available in DH Hisar and DH Mandikhera.

3.8.10 Water supply

As per Kayakalp guidelines, availability of adequate water, sanitation and hygiene services are essential components for providing basic healthcare services in the healthcare institutions. The water requirement in the hospital with bed strength not exceeding 100 is 340 litres/bed/day and for hospitals having more than 100 beds the requirement escalates to around 400 litres/bed/ day. Moreover, physical testing for hardness, total dissolved solids (TDS) and other parameters (at least once in a year on samples obtained directly from the source e.g., well water and bore water) and microbiological testing (every three months and additionally when the source is changed/major repairs are done) are to be conducted.

All overhead tanks need to be manually cleaned at least at an interval of six months. The date of water tank cleaning needs to be written on the water tank for ready visibility and easy remembrance for next schedule of cleaning.

Adequacy of water supply at the test-checked DHs/SDCHs/CHCs is given in ***Table 3.50***.

Table 3.50: Water Supply in the selected Health Institutions

Name of District	Name of health institute	Assessment of water requirement per bed per day after excluding requirements for firefighting, Horticulture and steam	Biological/ Physical testing of water samples and maintenance of record	Maintenance of record related to water consumption, purification, complaints on water supply disruption/ downtime	Regularly Cleaning of Overhead water tank at prescribed interval	AMC of water purifiers
Hisar	DH, Hisar	Yes	Yes	Yes	Yes	No
	SDCH, Adampur	No	Yes	Yes	Yes	Yes
	SDCH, Narnaund	Yes	No	Yes	Yes	Yes
	CHC, Mangali	Yes	No	No	Yes	Yes
	CHC, Sorkhi	No	No	No	Yes	No
	CHC, Uklana	Yes	No	No	Yes	No
	CHC, Barwala	Yes	Yes	No	Yes	Yes
	UHC, Hisar 1 &4	No	No	Yes	Yes	No
Panipat	DH Panipat	Yes	Yes	Yes	Yes	Yes
	SDCH Samalkha	No	No	No	No	No
	CHC, Naultha	Yes	Yes	Yes	Yes	Yes
	CHC, Bapoli	No	Yes	No	Yes	No
	CHC, Madlauda	Yes	Yes	Yes	Yes	Yes
	CHC, Naraina	No	No	No	Yes	No
	UHC, Sec 12	Yes	Yes	No	Yes	Yes
Nuh	DH, Mandikhera	No	No	No	No	No
	CHC, Firojpur Jhirka	No	No	No	Yes	No
	CHC, Punhana	No	No	No	Yes	No
PHCs/UPHCs (24)		**Yes (7)**	**Yes (10)**	**Yes (5)**	**Yes (24)**	**Yes (7)**

Source: Information furnished by the test-checked Health institutions during January to June 2022

Colour code: Green colour depicts availability (Yes) and red colour depicts not availability (NA)

It was observed that:

i. Out of 42 selected health institutions**,** only 16[61] health institutions made the assessment of water requirement per bed per day.

ii. 18[62] out of 42 selected health institutions carried out biological testing/ physical testing of water samples.

iii. Records related to water consumption, purification and complaints on water supply disruption was maintained in 12[63] health institutions out of 42 selected health institutions of three districts. So, in the absence of physical testing/biological testing of water samples and non-maintenance of above records, the quality of water supply could not be assessed.

iv. Water tanks were regularly cleaned by all the selected health institutions except DH Mandikhera and SDCH Samalkha.

v. Out of the selected health institutions**,** annual maintenance contract of water purifier was carried out in 15[64] health institutions**.**

3.8.11 Power supply

As per IPHS 2012 norms, 24-hour uninterrupted power supply should be available in all health institutions. Back-up generator facility should also be available**.** Generator of 75 KV in Civil Hospital, 40/50 KV in sub division/sub district hospital and generator of 5 KV in CHCs should be maintained. Further, AMC should be taken for all equipment which needs special care. Preventive maintenance should be done to avoid break down and reduce down time of all essential & other equipment.

Availability of power supply in the test-checked health institutions is given in ***Table 3.51***.

[61] (i) DH Hisar, (ii) SDCH Narnaund, CHC-(iii) Sorkhi, (iv) Barwala, (v) Naultha, (vi) Madlauda, (vii) UHC Sec-12 Panipat, PHC-(viii) Dhansu, (ix) Hasangarh, (x) Daulatpur, (xi) Ladwa, (xii) Kaimri, (xiii) Puthi Mangal Khan, (xiv) Puthi Samain, (xv) Siwah and (xvi) Mandi.

[62] DH-(i) Hisar, (ii) Panipat, (iii) SDCH Adampur, CHC-(iv) Barwala, (v) Naultha, (vi) Madlauda, (vii) Bapoli, (viii) UHC Sec-12 Panipat, PHC-(ix) Ladwa, (x) Kaimri, (xi) Puthi Mangal Khan, (xii) Puthi Samain, (xiii) Mandi, (xiv) Israna, (xv) Siwah, (xvi) Rair Kalan, UPHC-(xvii) Rajeev Colony and (xviii) Hari Singh Colony.

[63] (i) DH Panipat, (ii) DH Hisar, (iii) SDCH Adampur,(iv) SDCH Narnaund, (v) UHC (Sec 1&4) Hisar, (vi) CHC Naultha, (vii) CHC Madlauda, (viii) Puthi Samain, (ix) PHC Siwah, (x) Rair Kalan, (xi) Raj Nagar and (xii) Hari Singh Colony

[64] (i) DH Panipat, (ii) SDCH Adampur,(iii) SDCH Narnaund, (iv) CHCs Mangali, (v) Barwala, (vi) Naultha, (vii) Madlauda, (viii) UHC (Sec-12) Panipat, (ix) PHCs Agroha, (x) Kaimiri, (xi) Puthi Samain, (xii) Puthi Mangal Khan, (xiii) Talwandi Rukka, (xiv) Siwah and (xiv) UPHC Raj Nagar

Table 3.51: Power supply in the selected Health Institutions

Name of District	Name of health facility	Availability of 24-hour uninterrupted stabilised power supply	Installation of Generator back-up and inverters	AMC of backup facility like generators and inverters
Hisar	DH Hisar	Available	Available	Available
	SDCH Adampur	Available	Available	Not Available
	SDCH Narnaund	Available	Not Available	Not Available
Panipat	DH Panipat	Available	Available	Not Available
	SDCH Samalkha	Available	Available	Not Available
Nuh	DH Mandikhera	Available	Available	Available
Hisar	CHC/UHCs (5)	5	Available 2	Available 2
	PHC/ UPHCs (11)	11	Available 4	Available 4
Panipat	CHCs/ UHCs (5)	5	Available 1	0
	PHCs/ UPHCs (9)	9	Available 1	Available 1
Nuh	CHCs (2)	2	Available 1	0
	PHCs (4)	4	0	0

Source: Information furnished by the selected Health Institutions during January to June 2022

Colour code: Green code depicts available, red colour depicts not available and yellow colour depicts available in some of the health institutions.

It was observed that 24-hour uninterrupted stabilised power supply with backup of generator was available in all the selected DHs but AMC of backup facility like generators and inverters was not available in any of the selected hospitals except DH Hisar and DH Mandikhera.

Uninterrupted stabilised power supply was available in all the test-checked CHCs/PHCs/UHCs/UPHCs but backup of generator or inverter was found installed only in four CHCs/UHCs (CHC Uklana, Sorkhi, Naultha, Punhana) and five PHCs/UPHCs (PHC Agroha, Dhansu, Israna UPHC Char Qutub Gate, and Patel Nagar) out of the selected 12 CHCs/UHCs and 24 PHCs/UPHCs, whereas AMC of back-up facility like generators and inverters was available only in two CHCs (Uklana, Sorkhi) and Five PHCs. (Agroha, Dhansu, Israna, UPHC Char Qutab Gate Hansi, and Patel Nagar).

3.8.12 Patient registration, grievance/ compliant redressal

As per IPHS 2012 norms, online registration should be available in district hospitals. Patient Satisfaction Survey was to be conducted quarterly. Each District hospital should display prominently a Citizen's Charter indicating the services available, user fee charges, if any, and a grievance redressal system. Citizen's Charter should be in local language. There should be provision of complaints/ suggestion box along with mechanism to redress the complaints.

Further, NHM Assessor's Guidelines provide that adequate registration counters should be available as per patient load. Unique identification number should be given to each patient during the process of registration.

Availability of patient registration, grievance/ complaint redressal facilities in the test-checked health institutions is given in ***Table 3.52***.

Table 3.52: Availability of services related to patient registration, grievance/complaint redressal

Particulars	DHs (3)	SDCHs (3)	CHCs/UHCs (12)	PHCs/UPHCs (24)
Availability of adequate registration counters	2	3	9	11
Availability of Online Registration System	0	0	0	0
Patient Satisfaction Survey (OPD)	2	2	4	12
Legibility of prescription slips	3	2	12	23
Availability of Citizen charter at OPD	2	3	9	18
Providing unique ID at the time of registration	3	2	6	12
Availability of Grievance Redressal Cell or Complaint cell to register patients' grievances regarding quality of supplied food to them	2	3	8	9
Availability of mechanism for receipt of complaints and whether suggestion boxes had been placed at appropriate places	2	3	9	14
Formation of Grievance Redressal Committee and redressal of complaints in a timely manner	2	3	7	NA

Source: Information furnished by the test-checked Health Institutions during January to June 2022

Colour code: Green code depicts available in most/all, red colour depicts available in least and yellow colour depicts available in moderate number of the health institutions.

NA= Not applicable

It was observed that:

- Adequate registration counters were not available in DH Hisar, CHC Barwala, UPHC Sector 1-4, Bapoli and 13[65] PHCs/UPHCs.
- Online registration system was not available in any of the test-checked health institutions, whereas legible prescription slips were given to patients in all these health institutions except in SDCH Samalkha, PHC Atta.
- Patient Satisfaction Survey of OPD was not conducted in DH Mandikhera, SDCH Narnaund and any of the selected CHCs/UHCs except CHCs Barwala, Ukalana, Naultha and UHC Sector 12 Panipat. Further, the survey was conducted by 12[66] PHCs/UPHCs out of 24 selected PHCs/UPHCs.
- Unique IDs at the time of registration were provided in all the test-checked hospitals except SDCH Adampur. Out of the selected CHCs/ PHCs, six[67] CHCs and 12[68] PHCs/UPHCs provided unique IDs at the time of registration.

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65 PHC-(i) Daulatpur, (ii) Ladwa, (iii) Atta, (iv) Israna, (v) Rair Kalan, (vi) Patti Kalyana, (vii) Jamalgarh, (viii) Biwan, (ix) Nagina, UPHC-(x) Patel Nagar, (xi) Char Qutub Gate Hansi, (xii) Hari Singh Colony and (xiii) Rajeev Colony

66 PHC-(i) Kamari, (ii) Talwandi Rukka, (iii) Puthi Mangal Khan, (iv) Puthi Samain, (v) Hassagarh, (vi) Ladwa, (vii) Agroha, (viii) Dhansu, (ix) Mandi, (x) Siwah, UPHC (xi) Raj Nagar and (xii) Rajeev Colony.

67 CHC-(i) Barwala, (ii) Mangali, (iii) Sorkhi, (iv) Uklana, (v) Madlauda and (vi) Naultha.

68 PHC-(i) Kaimri, (ii) Ladwa, (iii) Agroha, (iv) Dhansu, (v) Talwandi Rukka, (vi) Puthi Mangal Khan, (vii) Puthi Samain, (viii) Hasangarh, (ix) Rair Kalan, (x) Siwah, (xi) Jamalgarh and (xii) UPHC Raj Nagar.

- Grievance redressal cell or complaint cell to register complaints related to quality of supplied food to the patients was available in eight[69] CHCs, nine[70] PHCs and all the test-checked hospitals except in DH Mandikhera and SDCH Narnaund.
- Mechanism of receipt of complaint and suggestion boxes were placed at appropriate place in 14[71] PHCs/UPHCs and all the test-checked hospitals and CHCs except in DH Mandikhera, CHCs Barwala, Naultha and Firozpur Jhirka.
- Grievance Redressal Committee was formed in all the test-checked hospitals and CHCs except in DH Mandikhera, CHCs Sorkhi, Uklana, Barwala, Firozpur Jhirka and UPHC Sector 1&4.

Further, the following shortcomings were observed in patient registration system/ complaint redressal facilities of the two test-checked colleges:

- No unique ID system was available for OPD patients in MCH, Agroha
- Monthly patient satisfaction survey for in-patient and out-patient had not been conducted to improve healthcare services in both the institutions**.**
- Citizen's Charter including patient rights and responsibilities was not displayed at OPD and entrance in both the institutions.
- Online Registration System was not available in both the MCHs.
- Grievance Redressal Committee was formed from the year 2019-2020 but no register for grievance was maintained by the hospital during the year 2016-2019 in MCH, Agroha whereas no committee was formed and no register for complaints/grievances had been maintained during 2016–21 in MCH, Nalhar, Nuh.
- No enquiry official was available at the reception counter in OPD and physical survey and outpatient survey revealed that no proper drinking water facility was available in outpatient registration area in MCH, Nalhar.

3.8.13 Infection Control Management

As per Kayakalp guidelines, hospitals need to designate personnel from the Infection Control Committee to conduct the activities of monitoring of cleanliness to ensure proper cleanliness and supervision of housekeeping activities. Health institutions need to have effective pest control plans for ensuring a pest and animal free environment.

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[69] CHC-(i) Barwala, (ii) Sorkhi, (iii) Mangali, (iv) Madlauda, (v) Naultha, (vi) Firozpur Jhirka, (vii) Punhana and (viii) UHC Sector-12

[70] PHC-(i) Agroha, (ii) Dhansu, (iii) Kaimri, (iv) Talwandi Rukka, (v) Puthi Mangal Khan, (vi) Puthi Samain, (vii) Siwah, (viii) Jamalgarh and (ix) UPHC Raj Nagar.

[71] PHC-(i) Agroha, (ii) Hasangarh, (iii) Daulatpur, (iv) Ladwa, (v) Kaimri, (vi) Talwandi Rukka, (vii) Puthi Mangal Khan, (viii) Dhansu, (ix) Siwah, (x) Pattikalyana, (xi) Mandi, (xii) Jamalgarh, UPHC-(xiii) Raj Nagar and (xiv) Hari Singh Colony.

Availability of infection control services in the test-checked hospitals is given in ***Table 3.53***.

Table 3.53: Availability of services related to Infection control in test-checked Health Institutions

Particulars	Medical Colleges		District Panipat		District Hisar			Nuh District
	Agroha	Nalhar	DH Panipat	SDCH Samalkha	DH, Hisar	SDCH Adampur	SDCH Narnaund	DH Mandikhera
Checklist for Hygiene and infection control	Y	Y	Y	Y	Y	Y	Y	Y
Hospital Infection Control Committee (HICC)	Y	Y	Y	Y	Y	Y	N	Y
Conducting meeting of HICC	Y	N	Y	Y	Y	Y	N	Y
Pest control	Y	N	Y	Y	Y	Y	N	N
Rodent control	N	N	N	N	Y	N	N	N
Availability of anti-termite treatment	Y	N	N	N	Y	Y	N	N
Installation of cattle trap	N	N	Y	Y	Y	Y	N	N
Procedures for disinfection and sterilisation								
i. Boiling	Y	N	N	N	Y	N	Y	Y
ii. High level disinfection	Y	Y	N	N	Y	N	N	N
iii. Chemical sterilisation	Y	Y	Y	Y	Y	N	Y	Y
iv. Autoclaving	Y	Y	Y	Y	Y	Y	Y	Y

Source: Information furnished by the test-checked Health Institutions during January to June 2022

Colour code: Green colour depicts available (Y=Available), pink colour depicts non-availability (N= Not Available)

It was observed that:

- All the selected MCHs/DHs/SDCHs had checklists for hygiene and infection control. All the selected MCHs/DHs/SDCHs had hospital infection control committee (HICC) except in SDCH Narnaund and meetings were conducted by HICC in all the selected health institutions except in SDCH Narnaund and MCH Nalhar (Nuh).
- Pest control was not done by MCH Nalhar, SDCH Narnaund and DH Mandikhera. Moreover, rodent control was being done only by DH Hisar.
- Anti-termite treatment was available in MCH Agroha, DH Hisar and SDCH Adampur and cattle trap was not installed in four[72] MCHs/DHs/SDCHs.
- Out of the four[73] procedures for disinfection and sterilisation, chemical sterilisation and autoclaving procedures were available in all the test-checked MCHs/DHs/SDCHs except chemical sterilisation procedure in SDCH Adampur.
- Boiling procedure was not available in any of the test-checked MCHs/DHs/SDCHs except MCH Agroha, DH Hisar, DH Mandikhera and SDCH Narnaund. High level Disinfection (HLD) procedure was available in both the MCHs and DH Hisar.

[72] (i) MCH Agroha, (ii) MCH Nalhar, (iii) DH Mandikhera and (iv) SDCH Narnaund

[73] (i) Boiling, (ii) High level disinfection, (iii) Chemical sterilisation and (iv) Autoclaving

3.8.14 Patient safety

(i) Availability of patient safety services in test-checked health institutions

IPHS 2012 norms for DHs provide that Hospital Management Policy should emphasise on hospital buildings with earthquake proof, flood proof and fire protection features.

As per paragraph 4.5 of National Disaster Management (NDM) Guidelines (Hospital Safety), 2016 each hospital should have safety and security management protocols to describe the processes designated to eliminate or reduce hazards in the physical environment and to manage staff activities, to reduce the risk of injuries to individuals and loss of property.

Surprise mock drills should be conducted at regular intervals. After each drill, the efficacy of the Disaster Plan and the competence of the staff should be evaluated, followed by necessary changes in the Plan and training of the staff.

Availability of patient safety services in the test-checked health institutions is given in ***Table 3.54***.

Table 3.54: Availability of services related to patient safety

Name of service	Hospitals						CHC/UHC											
	Hisar	Adampur	Narnaund	Mandikhera	Panipat	Samalkha	Barwala	Mangali	Sorkhi	Uklana	Sector 1-4 Hisar	Bapoli	Madlauda	Naraina	Naultha	Sector-12 Panipat	Firo pur Jhirka	Punhana
SOP is being followed in patient safety	Y	Y	Y	Y	Y	Y	All CHCs should have a Disaster Management Plan in line with the District Disaster management Plan.											
Disaster management plan formulated for patient safety	Y	Y	Y	N	Y	Y												
Formation disaster management committee	Y	Y	Y	N	Y	Y												
Facility assigned a space or ward to manage additional patient load in the event of a disaster	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	Y	Y	N	Y	N	N
Follow a periodic plan to evaluate and manage disasters and mass casualty incidents	Y	Y	Y	N	Y	Y	Y	N	N	N	N	Y	Y	N	N	N	N	N
Standard Operating Procedure for all concerned departments to act in an event of a disaster	Y	Y	N	N	Y	Y	Y	N	N	N	N	N	N	N	N	Y	N	N
Facility connected to network of referral facilities that will be necessary in a disaster	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y
Provisions of detection, fire prevention, planning for isolation of fire and transfer of occupants to a place of comparative safety or evacuation of the occupants to achieve ultimate safety were in place	Y	Y	N	N	Y	Y	Y	Y	N	N	N	N	Y	N	N	Y	Y	N
No Objection Certificates required to be obtained from the Fire Department	N	N	N	N	Y	N	N	N	N	N	N	Y	Y	Y	N	N	N	Y
Illuminated signage for fire exit was available	Y	Y	N	N	Y	Y	N	N	N	N	Y	N	N	Y	N	Y	N	Y
Availability of underground static water tank which should remain full at all times to meet any contingency had been constructed and utilised for the said purpose	Y	Y	N	N	Y	Y	N	Y	N	N	N	Y	N	Y	N	Y	N	N
Fire alarms and hose reel had been installed to detect the fire and meet any contingency	N	N	N	N	N	N	Not Applicable											
Excise permit to store spirit	N	N	N	N	N	N												

Source: Information furnished by the test-checked Health Institutions during January to June 2022

Colour code: Green colour depicts available (Y=Available), red colour depicts non-availability (N= Not Available)

Disaster management plan for patient safety was formulated, disaster management committee was formed and periodic plan to evaluate and manage disasters and mass casualty incidents was formed in all the selected DHs/SDCHs except in DH Mandikhera.

In the test-checked DHs/SDCHs, requisite SOPs; provisions of detection, fire prevention, planning for isolation of fire and transfer of occupants to a place of comparative safety or evacuation of the occupants to achieve ultimate safety; were not in place. Illuminated signage for fire exit was not available and underground static water tank had not been constructed in DH Mandikhera and SDCH Narnaund.

No fire alarms and hose reel had been installed to detect fire and meet any contingency and no excise permit to store spirit was taken by any of the test-checked DHs/SDCHs.

Out of the test-checked CHCs/UHCs, only CHCs Barwala, Bapoli and Madlauda follow a periodic plan to evaluate and manage disasters and mass casualty incidents.

(ii) Availability of patient safety services in MCH Agroha, Hisar and MCH Nalhar, Nuh

MCH Agroha neither had any disaster plan nor had it conducted any mock drill during 2016-2021. In the absence of any disaster plan it would be difficult to handle the situation in case of any disaster. It was also noticed that though fire extinguishers had been placed sufficiently in the hospital building and were maintained properly, no fire exit plan or fire exit had been marked in the hospital. No fire hydrant, smoke detector and fire alarm were installed in the old hospital building.

In MCH Nalhar, it was observed that the hospital had no disaster plan for patient safety.

The MCH Agroha replied (May 2022) that fire safety provisions would be made in the old building.

(iii) Availability of fire-fighting e uipment

As per IPHS 2012 norms, fire-fighting equipment should be available, maintained and be readily available when there is a problem.

Availability of fire-fighting equipment in the test-checked health institutions is given in ***Table 3.55***.

Table 3.55: Availability of Fire-fighting equipment in test-checked Health Institutions

Name of District	Name of health institution	Fire hydrant	Smoke detector	Fire extinguisher	Sand buckets
Hisar	SDCH, Adampur	Not available	Not available	Available	Available
	SDCH, Narnaund	Not available	Not available	Available	Not available
	DH, Hisar	Available	Not available	Available	Available
	MCH, Agroha	Available in new building	Available in new building	Available	Available
Panipat	DH, Panipat	Available	Available	Available	Available
	SDCH, Samalkha	Available	Available	Available	Not available
Nuh	DH, Mandikhera	Not available	Not available	Available	Not available
	MCH, Nalhar	Available	Available	Available	Available
Hisar	CHC, Mangali	Not applicable		Available	Not Available
	CHC, Sorkhi			Not Available	Not Available
	CHC, Uklana			Not Available	Not Available
	CHC Barwala			Available	Available
	UHC Hisar (Sec 1 & 4)			Available	Available
Panipat	CHC Bapoli			Available	Not Available
	CHC Madlauda			Available	Not Available
	CHC Naraina			Available	Not Available
	CHC Naultha			Not available	Not Available
	UHC, Sec. 12			Available	Not Available
Nuh	CHC, Firozpur Jhirka			Available	Available
	CHC, Punhana			Available	Not Available
PHCs/ UPHCs (24)				**Available (12)**	**Available (4)**

Source: Information furnished by the test-checked Health Institutions during January to June 2022

Colour code: Green colour depicts available, pink colour depicts not available.

It was observed that:

- Out of selected six DHs/ SDCHs, three[74] hospitals had no fire hydrants. Fire hydrants were not found functional in SDCH, Samalkha even after a lapse of three years since the hospital had shifted to the newly constructed building. Smoke detectors were available in MCH Agroha, MCH Nalhar, DH Panipat and SDCH Samalkha. However, smoke detectors in DH Panipat, and SDCH Samalkha were found non-functional. No fire hydrants and smoke detectors were installed in the old hospital building of MCH Agroha.

- Fire extinguishers were available in all the selected MHs/SDCHs/CHCs except for CHC Sorkhi, CHC Uklana and CHC Naultha. Out of the 24 test-checked PHCs/UPHCs, 12[75] PHCs/UPHCs had no fire extinguishers.

- Among all MCHs/DHs/SDCHs, sand buckets were available only in MCH Agroha, Nalhar, DH Hisar, DH Panipat and SDCH Adampur. Sand buckets were available only in CHC Barwala, Firozpur Jhirka and UHC Hisar (Sector-1 & 4) among all CHCs. Moreover, sand buckets were available only in four[76] PHCs/UPHCs

[74] (i) DH Mandikhera, (ii) SDCH Adampur and (iii) SDCH Narnaund.

[75] PHC-(i) Atta, (ii) Mandi, (iii) Israna, (iv) Rair Kalan, (v) Pattikalyana, (vi) Hasangarh, (vii) Daultpur, (viii) Ladwa, (ix) Agroha, (x) Singar, UPHC- (xi) Char Qutub Gate Hansi and (xii) Patel Nagar.

[76] PHC- (i) Siwah, (ii) Jamalgarh, UPHC-(iii) Rajiv Colony and (iv) Raj Nagar

3.9 Internal Audit

With a view to improve the overall quality of work and reduce errors/ irregularities, there should be an internal audit system in all Government Departments.

Scrutiny of records/ information provided by the departments revealed that there was no internal audit system in place in five[77] out of eight Directorates/ Society/ Corporation of the Health and Family Welfare Department and DMER. The internal audit system existed in NHM but internal audit of office of Mission Director, NHM Panchkula was not conducted.

The Food and Drug Department stated (February 2022) that the internal audit could not be conducted due to shortage of staff. The Department of AYUSH (June 2022) stated that the case of hiring of Sr. Audit Officer from the Institute of Public Auditors of Northwest Chapter, Chandigarh is under process. The DGHS, Panchkula stated (January 2023) that due to the non-sanctioning of particular staff for this purpose, internal audit was not conducted.

3.10 Conclusion

There was wide variation in availability of Specialist OPD services across DHs and SDCHs, which was the result of inadequate availability and skewed distribution of Specialist Doctors in Health Department. In the test-checked health institutions, audit observed that availability of doctors was not ensured as per the patient load. In IPD services, specialty wise beds were not allocated. OT facility was not available in any of the selected PHCs/UPHCs. Positive isolation room was not available in DH Panipat, SDCH Narnaund, MCH Nalhar (Nuh) and seven out of 12 selected CHCs/ UHCs.

Further, the Bed Occupancy Ratio (BOR) of all the test-checked health institutions were below 80 *per cent* except DHs Hisar and Panipat. LAMA rate of SDCHs Adampur, Samalkha and Narnaund were higher as compared to other institution which shows that these hospitals could not gain trust of patients. In Emergency services, it was noticed that facility of 24 hours Management of emergency services such as accident, first aid, stitching of wounds etc., were available only in seven out 24 selected PHCs/UPHCs. None of the test-checked hospitals had ICU services except DH, Panipat. In Maternity services, institutional births in public health facility remained at 57.5 *per cent* during the period 2019-21. Further, there was shortfall in conducting review of maternal deaths and neonatal deaths during 2016-17 to 2020-21. Most of the radiology services were not available in selected SDCHs.

[77] (i) Director General, Health Services, Haryana Panchkula (ii) Director, Malaria, Panchkula, (iii) Director, Medical Education and Research (iv) Director General, Ayush Department, Haryana, Panchkula (v) Commissioner, Food and Drug Administration, Panchkula

In the test-checked health institutions, several diagnostic services, both radiological and pathological, as required under IPHS norms were being conducted in the health institutions. However, no health institution was conducting all the diagnostic services prescribed under IPHS. Among auxiliary and support services, health institutions up to CHC level were performing well in providing few services, while improvement was needed in most of the other services. Further, PHCs are required to improve in all these services.

There was shortfall in required number of equipment, consumables, miscellaneous supplies, essential medicines, etc. in the test-checked Health and Wellness Centres (HWCs). None of the selected HWCs had created and maintained the database of all families and individuals in an area served by an HWC. Health Cards and Family Health Folders were also not made. Further, the identification and registration of beneficiaries/ family was not done for PMJAY scheme by any of the selected HWCs.

3.11 Recommendations

1. **Government should ensure that all OPD services, IPD services, emergency services, diagnostic services as prescribed under IPHS norms for different health institutions are made available to the beneficiaries.**
2. **Government should take steps to improve and strengthen auxiliary and support services so that overall healthcare experience is improved.**
3. **Government should ensure that doctors and other manpower are provided according to the patient load on health institutions.**
4. **The health institutions should be instructed to comply with safety norms.**

Chapter-4

Availability of Drugs, Medicines, Equipment and Other Consumables

Chapter-4

Availability of Drugs, Medicines, Equipment and Other Consumables

Availability of drugs, medicines, equipment and other consumables constitute vital components for delivering comprehensive health services. The Government had set up Haryana Medical Services Corporation Limited (HMSCL) in April 2014 as a centralised agency with the objective to procure and manage drugs, medicines, equipment & instruments at fair and reasonable prices for various Government medical institutions. HMSCL was to procure all essential drugs, medicines and equipment & instruments, hospital supplies, reagents & spares and execute AMC/CMC[1] through open competitive bidding through e-procurement portal following the provisions of Haryana Drug Purchase Policy issued by Government of Haryana in May 2018.

HMSCL operates "Online Drug Inventory and Supply Chain Management System" (ODISCM). Field units make online demand for medicines through this system. HMSCL procures medicines on the basis of demand. The HMSCL provided data of ODISCM to Audit in November 2021 for the period 2016-2022 (upto November 2021).

Further, the Health Department of Haryana launched Mukhya Mantri Mufat Ilaz Yojana (MMIY) in January 2014 to provide free treatment to all citizens of the State. The vision of the scheme was to provide affordable, accessible and equitable quality health services by covering major components of healthcare and to reduce out-of-pocket expenditure. Accordingly, Government of Haryana issued guidelines (January 2017) for procurement of medicines and equipment under MMIY for health institutions.

Audit findings on various components of drug management- availability of drugs, their storage, dispensation to patients and procurement in the health institutions are discussed in the succeeding paragraphs:

4.1 Availability of essential and critical drugs, medicines & consumables

As per IPHS 2012 norms, 493 drugs, lab reagents, consumables and disposables under 20 different categories should be available in a District hospital. Availability of drugs, lab reagents, consumables and disposables under 20 categories in the test-checked DHs and MCHs is given in ***Table 4.1***.

[1] AMC- Annual Maintenance Contract, CMC- Comprehensive Maintenance Contract.

Table 4.1: Availability of Drugs, Lab Reagents, Consumables and Disposables in test-checked MCHs/DHs

Sr. No.	Categories	Number required as per IPHS 2012	Availability in test-checked MCHs/DHs				
			DH, Panipat	DH, Mandikhera	DH, Hisar	MCH, Nalhar	MCH, Agroha
1	Analgesic/Antipyretics/Anti Inflammatory	**11**	8	5	6	4	11
2	Antibodies & Chemotherapeutics	**76**	18	25	49	3	31
3	Anti-Diarrhoeal	**6**	2	3	2	1	3
4	Dressing Material/Antiseptic Ointment Lotion	**24**	12	14	24	5	15
5	Infusion Fluids	**14**	11	11	14	5	14
6	Eye and ENT	**25**	6	7	11	3	6
7	Antihistamines/Anti-Allergic	**12**	7	8	6	4	8
8	Drugs acting on Digestive System	**20**	9	9	19	6	6
9	Drugs related to Haemopoietic system	**4**	1	3	4	1	4
10	Drugs acting on Cardiac vascular system	**26**	15	12	21	10	15
11	Drugs acting on Central/ peripheral Nervous system	**40**	21	19	23	12	22
12	Drugs acting on Respiratory System	**16**	9	6	11	5	13
13	Skin Ointment/Lotion etc.	**23**	5	3	14	3	6
14	Drugs acting on Uro-Genital system	**5**	5	5	4	3	5
15	Drugs used in obstetrics and Gynaecology	**35**	8	6	35	11	17
16	Hormonal Preparation	**14**	2	6	10	1	6
17	Vitamins	**24**	7	11	13	8	15
18	Other Drugs and Material & Misc. Items	**83**	37	35	69	16	45
19	Emergency lifesaving drugs for SNCU	**12**	9	12	12	4	11
20	Other Essential Medicines & Supplies for SNCU	**23**	19	16	23	23	15
	Total	**493**	**211**	**216**	**370**	**128**	**268**

Source: Information furnished by test-checked Health Institutions during April 2022 to June 2022

Colour Code: Red denotes most shortages, green denotes least shortages and yellow denotes moderate shortages

The State Government has formulated a list of 1,027 drugs[2] essentially required at Government medical establishments. The State norms were much higher than IPHS 2012 norms but it was noticed that shortages were significant even when compared with the IPHS norms.

It is evident from the above table that the availability of drugs, consumables and disposables was poor in MCH, Nalhar (26 *per cent*) as compared to other test-checked MCH and DHs. Reasons for shortage were not furnished to audit. Further, the availability in DH Panipat and DH Mandikhera was also below 50 *per cent*.

It has been mentioned in the IPHS norms that the list of the drugs given as norms is not exhaustive and exclusive but has been provided for delivery of minimum assured services. Non-availability of critical essential drugs such as infusion fluids, drugs acting on cardiac vascular system, central/ peripheral nervous system and respiratory system, emergency lifesaving drugs for SNCU, etc. was indicative of non-availability of minimum assured medical services in the MCH, Nalhar.

[2] Government Hospitals – All the 1,027 drugs, CHCs – 1,023 drugs, PHCs-461 drugs and SCs-144 drugs

As per IPHS 2012 norms, a total number of 430 drugs, consumables and disposables under 19 categories should be available in a SDCH. Availability of drugs, consumables and disposables in the test-checked SDCHs is given in ***Table 4.2***.

Table 4.2: Availability of Drugs, Lab Reagents, Consumables and Disposables in test-checked SDCHs

Sr. No.	Category	Number required as per IPHS 2012	Availability in test-checked SDCHs		
			Samalkha	Adampur	Narnaund
1	Analgesic/Antipyretics/Anti Inflammatory	**8**	5	5	6
2	Antibodies & Chemotherapeutics	**71**	12	42	14
3	Anti Diarrhoeal	**5**	2	3	3
4	Dressing Material/Antiseptic Ointment Lotion	**24**	9	17	11
5	Infusion Fluids	**14**	10	11	8
6	Eye and ENT	**23**	3	5	5
7	Antihistamines/Anti- Allergic	**10**	6	8	7
8	Drugs acting on Digestive System	**20**	9	8	9
9	Drugs related to Haemopoietic system	**4**	1	2	4
10	Drugs acting on Cardiac vascular system	**26**	10	20	11
11	Drugs acting on Central/peripheral Nervous system	**40**	13	22	10
12	Drugs acting on Respiratory System	**15**	8	8	6
13	Skin Ointment/Lotion etc	**18**	3	7	3
14	Drugs acting on Uro-Genital system	**5**	1	5	1
15	Drugs acting on Uterus and female genital tracts	**14**	3	6	4
16	Hormonal Preparation	**14**	4	5	2
17	Vitamins	**21**	6	11	7
18	Other Drugs and Material & Misc Items	**73**	14	38	32
19	Drug Kit for Sick Newborn & Child Care	**25**	12	20	14
Total		**430**	**131**	**243**	**157**

Source: Information furnished by test-checked SDCHs during April 2022 to June 2022
Red denotes most shortages, green denotes least shortages and yellow denotes moderate shortages

It is evident from the above table that the availability of drugs, consumables and disposables is poor in SDCH Samalkha (30 *per cent*) as compared to availability in SDCHs Adampur and Narnaund. Further, the availability in SDCH Samalkha and SDCH Narnaund is below 50 *per cent*.

The reasons for lower availability of essential drugs at medical institutions include delayed supply/non-supply of drugs by HMSCL to health institutions as discussed in **paragraph 4.5.5 (iii)** alongwith under-utilisation of budget.

The budget provision *vis a vis* expenditure for drugs/medicines during the period 2016-17 to 2021-22 is given in ***Table 4.3***.

Table 4.3: Budget provision *vis a vis* expenditure for drugs/medicines during the period 2016-17 to 2021-22

(₹ in crore)

Name of Department/ Mission	Budget Provision	Expenditure incurred	Savings (+)/ excess (-)	Savings/Excess (in *per cent*)
DGHS	550.20	551.19	(-) 0.99	(-)0.18
DMER	338.33	315.62	(+) 22.71	6.71
National Health Mission	168.97	90.86	(+) 78.11	46.23

Source: Information furnished by DGHS, DMER & NHM.

As evident from the above table, the budget was underutilised by 6.71 *per cent* in DMER and 46.23 *per cent* in NHM during the period 2016-22. Had the available budget been utilised properly, the above stated shortages in drugs and consumables could have been avoided to some extent.

During the exit conference (January 2023), the ACS to Government of Haryana, Health and Family Welfare Department stated that the matter would be looked into and necessary steps would be taken for making available the medicines/drugs at all health institutions.

4.2 Availability of AYUSH essential medicines

Ministry of AYUSH, GoI had prescribed 277 essential drugs for Ayurveda, Unani, Siddha and Homeopathy in the National List of Essential AYUSH medicines in March 2013. The list was revised in January 2022 by reducing the number of essential drugs to 201. Audit compared availability of AYUSH medicines with revised list of essential AYUSH medicines in the test-checked districts during the period 2016-21. The position is shown in ***Table 4.4*** alongside.

Table 4.4: Availability of AYUSH Essential Medicines in test-checked Districts

Name of District	Number of Ayurvedic Drugs in EDL	Average Availability of Ayurvedic Drugs during 2016-21
Panipat	201	55
Nuh		100
Hisar		64

Source: Information furnished by test-checked Districts during April 2022 to June 2022. Colour code: Red denotes most shortages, green denotes least shortages and yellow denotes moderate shortages

As seen from the table, the availability of Ayurvedic medicines was ranging from 27 *per cent* in Panipat district to 50 *per cent* in Nuh district. It was also seen that against the budget provision of ₹ 27.59 crore[3] (for drugs/medicines, equipment, others) for the period 2016-17 to 2020-21, an expenditure of ₹ 16.47 crore was incurred thereby leaving a saving of ₹ 11.12 crore (40 *per cent*). Thus, despite availability of sufficient funds, the Department did not provide essential medicines to the patients, due to which patients would have had to buy essential drugs from the market increasing their out-of-pocket expenditure.

The Director General, AYUSH, Haryana replied (January 2023) that AYUSH medicines had been procured for AYUSH institutions as per demand received from District Ayurvedic Officers. The reply is not tenable as all EDs prescribed by the Ministry of AYUSH should have been made available in health institutions.

[3] Provision for procurement of Medicines and Equipment had not been made separately. Therefore, budget provision for Medicines and Equipment cannot be bifurcated.

4.3 Availability of critical drugs and medicines for COVID-19

As per instructions of DGHS, all warehouses should maintain stock of essential drugs/ medicines for six months and all health institutions should maintain EDL for three months. Further the State Government had approved (March 2022) a list of 51 COVID-19 medicines for health institutions. Availability status[4] of COVID-19 medicines in the test-checked health institutions is given in ***Table 4.5***.

Table 4.5: Availability of COVID 19 drugs in test-checked Health Institutions

Type of Health institutions	Name of Health Facility	No. of Medicines approved for Covid 19	No. of Medicines available
DHs	DH, Hisar	51	51
	DH, Mandikhera		36
	DH, Panipat		30
SDCHs	SDCH, Adampur		24
	SDCH, Narnaund		28
	SDCH, Samalkha		14
CHCs	CHC, Mangali		23
	CHC, Uklana		18
	CHC, Sorkhi		26
	CHC, Barwala		17
	CHC, Firojpur Jhirkha		15
	CHC, Punhana		13
	CHC, Bapoli		13
	CHC, Naultha		5
	CHC, Naraina		15
	CHC, Matlauda		18
PHCs	PHC, Agroha		15
	PHC, Dhansu		14
	PHC, Hasangarh		12
	PHC, Daulatpur		12
	PHC, Kaimiri		12
	PHC, Ladwa		12
	PHC, Talwandi Rukka		16
	PHC, Puthimangal Khan		26
	PHC, Puthisaimai		17
	PHC, Biwan		14
	PHC, Nagina		19
	PHC, Jamalgarh		20
	PHC, Singar		19
	PHC, Sewah		25
	PHC, Rairkalan		18
	PHC, Atta		18
	PHC, Pattikalyana		12
	PHC, Israna		23
	PHC, Mandi		33

Source: Information furnished by DGHS- during April 2022 to June 2022. No norms were fixed for availability of medicines in respect of UHCs/UPHCs for Covid-19.

Colour code: Green colour depicts availability of satisfactory number of COVID medicines, yellow depicts moderate availability and red depicts availability of lesser number of medicines.

Analysis of data/ information supplied by the test-checked health institutions revealed that against the required number of 51 COVID-19 medicines, all the medicines were available only in DH, Hisar, between 50 and 75 *per cent* were available in two DHs, one SDCH and one CHC and two PHCs, between 25 *per*

[4] Panipat: as of April 2022 and Hisar & Nuh: as of June 2022.

cent and 50 *per cent* were found available in 22 test-checked health institutions and in six health institutions, the availability of medicines was found to be less than 25 *per cent*.

4.4 Equipment

4.4.1 Availability of Equipment in selected SDCHs/DHs

Under IPHS 2012 norms, equipment norms are worked out keeping in mind the assured service recommended for various grades of district hospitals. The equipment required are worked out under 25 different categories. During the course of audit, availability of 332 essential equipment listed under 15 different categories of IPHS 2012 norms for DHs and three categories[5] selected from NHM Assessor's Guidebook for Quality Assurance in District Hospitals which are required in DHs were checked in the test-checked DHs and the findings have been given in ***Table 4.6***.

Table 4.6: Availability of Equipment in test-checked DHs

Sr. No.	Type	Number of essential equipment as per IPHS 2012	Availability in test-checked DHs		
			Panipat	Hisar	Nuh
1	Imaging equipment	**4**	3	4	3
2	X-ray room accessories	**7**	5	4	4
3	Cardiopulmonary equipment	**13**	12	10	9
4	Labour ward, Neo Natal and Special New-born Care Unit (SNCU) Equipment	**27**	17	17	8
5	Special New-born Care Unit equipment	**11**	7	9	7
6	Disinfection of Special New-born Care Unit equipment	**11**	5	7	5
7	Immunisation Equipment	**13**	12	11	12
8	Ear Nose Throat Equipment	**16**	6	15	8
9	Eye Equipment	**24**	15	17	17
10	Dental Equipment	**42**	27	10	24
11	Laboratory Equipment	**50**	28	38	37
12	Endoscopy Equipment	**3**	1	1	1
13	Anaesthesia Equipment	**15**	9	10	14
14	Postmortem Equipment	**8**	4	4	6
15	Operation Theatre Equipment	**21**	8	11	11
16	ICU Equipment	**34**	23	0*	0*
17	Emergency services Equipment	**14**	14	13	9
18	IPD Equipment	**19**	18	19	18
Total		**332**	**214**	**200**	**193**

Source: Information furnished by test-checked DHs during April 2022 to June 2022
Red denotes most shortages; green denotes least shortages and yellow denotes moderate shortages.
*** ICU services were not available in DHs Hisar and Nuh.**

It can be observed from the table that the overall availability of equipment was 64 *per cent* in DH Panipat, 60 *per cent* DH Hisar and 58 *per cent* in DH Nuh. Thus, the availability of equipment was poor in DH Nuh compared to DH Panipat and DH Hisar.

[5] (i) ICU equipment, (ii) Emergency services equipment and (iii) IPD equipment.

SDCHs

Similarly, IPHS 2012 norms recommend essential and desirable equipment for sub-divisional hospitals under different categories, out of which essential equipment under 14 different categories were scrutinised in the test-checked districts. The number of essential equipment available in test-checked three SDCHs in the selected categories is given in ***Table 4.7***.

Table 4.7: Availability of Equipment in test-checked SDCHs

Sr. No.	Type	Essential for 100 bedded hospital	Availability in 100 bedded hospitals		Essential for 50 bedded hospital	Availability in Adampur (50 bedded hospital)
			Samalkha	Narnaund		
1	**Imaging Equipment**	**5**	1	1	**3**	1
2	**-ray room**	**6**	2	0	**6**	5
3	**Cardiopulmonary Equipment**	**11**	4	8	**8**	5
4	**Labour ward & Neo Natal Equipment**	**20**	11	15	**17**	17
5	**Immunisation Equipment**	**13**	13	13	**13**	13
6	**ENT Equipment**	**17**	0	0	**17**	0
7	**Eye Equipment**	**9**	0	0	**22**	0
8	**Dental Equipment**	**4**	4	4	**4**	4
9	**Operation Theatre Equipment**	**17**	5	4	**18**	7
10	**Laboratory Equipment**	**32**	11	9	**27**	17
11	**Surgical Equipment**	**29**	3	13	**27**	9
12	**Endoscopy Equipment**	**3**	0	0	**1**	0
13	**Anaesthesia Equipment**	**14**	2	0	**15**	10
14	**Postmortem Equipment**	**10**	0	0	**10**	0
Total		**190**	**56**	**67**	**188**	**88**

Source: Information furnished by the test-checked SDCHs during April 2022 to June 2022
Red denotes most shortages; green denotes least shortages and yellow denotes moderate shortages.

Availability of equipment in the three test-checked SDCHs was 29 *per cent* in SDCH, Samalkha; 35 *per cent* in SDCH, Narnaund and 47 *per cent* in SDCH, Adampur.

The budget provision *vis-a-vis* expenditure incurred for procurement of equipment during the period 2016-22 is given in ***Table 4.8***.

Table 4.8: Budget provision vis- -vis expenditure on procurement of equipment during 2016-22

(₹ in crore)

Name of Department/ Mission	Budget Provision	Expenditure incurred	Savings	Savings (in *per cent*)
DGHS	309.00	288.53	20.47	6.62
DMER[6]	171.36	143.98	27.38	15.98
National Health Mission	63.06	23.93	39.13	62.05

Source: Information furnished by DGHS, DMER and NHM.

[6] Expenditure in respect of four Medical Colleges and PGIMER, Rohtak on procurement of equipment. In respect of Medical College, Agroha which receives Grant-in-Aid from the Government, GIA is not given Head wise. However, expenditure incurred on procurement of equipment by the college during the period 2016-22 was ₹ 11.08 crore.

As evident from the above table, there was underutilisation of budget by 6.62 *per cent* in DGHS, 15.98 *per cent* in DMER and 62.05 *per cent* in NHM for procurement of equipment during the period 2016-22. The above stated shortage of equipment, in the test-checked hospitals, could have been avoided by proper utilisation of budget.

Thus, availability of essential drugs and equipment varied vastly across test-checked health institutions as seen from Paras 4.1 to 4.4. For instance, out of 493 essential drugs as per IPHS 2012, MCH, Nalhar had only 128 essential drugs while DH Hisar had 370. Though HMSCL has created a Drugs Procurement Management Units portal, which captures supply of drugs to the warehouse and health institutions, it does not have the facility to check the status of availability of essential drugs at health institutions dynamically and consequently does not allow better monitoring and planning of drug availability.

4.4.2 Availability of Ventilators

Details related to ventilators received under PM-CARES and distributed to various health institutions under COVID-19 in the State of Haryana are given in ***Table 4.9***.

Table 4.9: Ventilators received in the State under PM-CARES in Hospitals

Make of ventilator	No. of ventilators received	No. of ventilators distributed
BEL	71	71
AgvA Healthcare	125	125
yna Medtech Private Limited	125	125
Total	**321**	**321**

Source: Information furnished by O/o DGHS, Panchkula in February 2022.

Further, details related to distribution/installation of ventilators in the test-checked districts are given in ***Table 4.10.***

Table 4.10: Availability of Ventilators in test-checked districts

Make of ventilator	Hisar				Panipat				Nuh			
	No.	Date of Receipt	Date of Installation	Delay (in days)	No.	Date of Receipt	Date of Installation	Delay (in days)	No.	Date of Receipt	Date of Installation	Delay (in days)
BEL	11	10 February 2020	22 February 2020	12	2	05 August 2020	05 August 2021	365	-	--	--	--
AgvA Healthcare	5	10 November 2021	23 December 2021	43	10	26 May 2021	31 July 2021	66	-	--	--	--
yna Medtech Private Limited	8	15 December 2021		8	0	--	--	--	8	31 August 2021	11 October 2021 (5)	41
											14 October 2021 (3)	44
Total	**24**				**12**				**8**			

Source: Information furnished by DGHS, Haryana in February 2022

It is evident from the above table that:

i. In case of all the 44 ventilators received, there were delays in installation with an average delay of 49 days (ranging from 8 to 365 days). Further, it was noticed that in case of two ventilators, there was delay of upto one year in the installation.

ii. Moreover, during the field visit (June 2022) in CHC, Punhana (Nuh), it was found that four ventilators were not in use due to shortage of staff.

4.4.3 Availability of Oxygen Concentrators (OCs) under Covid 19 in Health Institutions

When any patient gets severely infected with COVID-19, the oxygen levels in the body can get low. To keep oxygen levels at the normal range, the patient needs to be given medical oxygen. Medical oxygen can be made available through various devices like oxygen concentrators, PSA[7] Oxygen Plants, Compressed Gas Cylinders, Liquid Medical Oxygen etc.

To fast-track the availability of Medical Oxygen in Health institutions, an IT-enabled Management Information System called OxyCare was developed by the Ministry of Health and Family Welfare, Government of India to track each oxygen device for providing better services to the patients. As of February 2022, Oxygen Concentrators (OCs) and PSA Plants are being monitored using this system. Secure QR Code has been placed on each Oxygen Device, which is read by mobile app to facilitate various tasks in a secure and fast manner. The OCs were allocated to the Health Institutions during the period 2021-22. Details of OCs received and distributed under COVID-19 are shown in ***Table 4.11***.

Table 4.11: Availability of OCs in the State of Haryana

No. of OCs allocated to health institutions	1,645
No. of OCs received in health institutions	1,632
No. of OCs not received in health institutions	13
No. of OCs installed	1,632
Functional OCs	1,526
Non-functional OCs	106
No. of OCs connected to Mobile App	730

Source: Information furnished by DGHS, Haryana in February 2022.

It is evident from the above table that:

i. Out of total 1,645 allocated OCs, 1,632 OCs were delivered to various Health Institutions in State of Haryana.

ii. Out of total 1,632 installed OCs, only 1,526 OCs were functional and out of these functional OCs, only 730 OCs were connected through mobile app.

iii. As per status report dated 22 February 2022, 13 OCs have still not been received in the concerned Health Institutions.

4.5 Procurement of drugs

Timely supply of drugs of good quality, which involves procurement as well as logistics management, is of critical importance in any health system. As mentioned earlier, the State Government established (January 2014) Haryana Medical Services Corporation Limited (HMSCL) for purchase of drugs,

[7] Pressure Swing Adsorption

consumables and equipment (including installation and maintenance) for various health institutions in the State. Data of "Online Drug Inventory & Supply Chain Management System (ODISCM)" was provided to Audit by HMSCL in November 2021 for the period 2016-2022 (upto November 2021) Scrutiny of the data revealed the following:

4.5.1 Drugs valuing ₹ 1.52 crore purchased from blacklisted firm

As per condition 1.5 of Durg purchase policy, 2018, bidders are not eligible to submit bids for the product/products for which the firm/company has been blacklisted/debarred due to quality failure of drugs/consumables by the Haryana Government/Corporation or by any other State/Central Government or Organisation during the period of blacklisting or debarring. Thus, medicines are not to be purchased from blacklisted firms. Paragraphs 10.3 and 10.4 of the Policy prescribes that furnishing of wrong information and false documents would make the firm ineligible and liable to be debarred/blacklisted from participation and in case of any document submitted by the bidder or his authorised representative was found to be forged, false or fabricated, the bid will be rejected and bid security deposit/performance security would be forfeited.

During audit, it was observed that a firm "Nestor Pharmaceuticals Limited" was blacklisted for supply of Folic Acid and Ferrous Sulphate tablet by Gujarat Medical Services Corporation Limited in February 2017 for three years. Scrutiny of records revealed that HMSCL had purchased Folic Acid and Ferrous Sulphate medicine worth ₹ 1.52 crore from the firm during the period May 2019 to December 2019. This firm was also blacklisted by HMSCL in September 2018 for three years for concealing information regarding its blacklisting by Gujarat Medical Services Corporation Limited.

On a similar issue which was pointed out in paragraph 3.6.2.5 of CAG's Audit Report No. 3 of 2019, the Public Accounts Committee (PAC) recommended (March 2021) that the matter be got inquired into thoroughly to fix responsibility on the erring persons and action taken report be submitted to the Committee within a period of one month.

Audit observed that despite the blacklisting of the firm by HMSCL as well as PAC's recommendation for inquiry and fixing responsibility in the similar matter, HMSCL purchased huge quantities of drugs from a blacklisted firm which was unjustified. Further, as per the Drug Purchase Policy, 2018, the bid was to be rejected and bid security deposit/performance security was to be forfeited in such cases. However, no such action was taken against the firm. This was not only a violation of the Drug Purchase Policy, 2018 but also tantamount to extension of undue benefit to the blacklisted firm.

4.5.2 Drug/medicines suppliers not blacklisted despite multiple quality failures

As per condition 8.2 of Durg purchase policy, 2018 (1) If any store/stores supplied against the Rate Contract (RC) were found to be Not of Standard Quality (NSQ) on the test analysis from Government or Government approved laboratory empaneled and / or inspection by competent authority, the firm would be liable to replace the entire quantity of failed batch irrespective of the fact that part or whole of the supplied stores may have been consumed. The Department/ HMSCL would have the right to deduct the amount from any of the past or present liability. (2) In case of more than two instances of quality failure the RC shall be cancelled, and the firm would be debarred for three years to participate in the tendering process.

During audit, it was noticed that during the period 2016-21, 15 suppliers[8] had supplied drugs/medicines which were tested as NSQ (Not of standard quality) on more than two instances and payment of ₹ 5.67 crore had also been made for these supplies during the period 2016-21. HMSCL had blacklisted four firms[9] but did not blacklist the other 11 firms which was in contravention to the drug purchase policy.

HMSCL replied (January 2023) that out of 15 firms, two firms were having Directorate of Supplies & Disposals (DS&D), Haryana rate contract and therefore, action would be taken by DS&D. One firm was having Cetral Public Sector Undertaking (CPSU) rate contract and therefore, status regarding NSQ of the drugs was communicated to the department concerned. Further, in respect of the remaining 12 firms, six firms were already blacklisted by HMSCL and the decision regarding blacklisting of another six firms would be taken only after closure report of Quality Control Division of HMSCL.

4.5.3 Non-charging/recovering of interest on advances given to HMSCL of ₹ 3.98 crore

As per U.O. No. 28/43/2010-1B&C of March 2011, Finance Department, Government of Haryana, all Boards/ Corporations/ Societies, to whom various departments provide funds for works/ purchases have to pay an interest @ six *per cent* per annum to such departments on half yearly basis, till the funds are actually utilised by them. A margin of two weeks between date of receipt of fund and date of utilisation can be allowed as interest free period. The

[8] (i) Bochem Healthcare Pvt. Ltd, (ii) Crystal Pharmaceuticals, (iii) Curetech Skincare, (iv) Delux Surgical, (v) Devparv Surgico, (vi) Healthium Medtech Private Limited, (vii) Hindustan Laboratories, (viii) Indian Drugs and Pharmaceuticals Limited, (ix) Kwality Pharmaceutical Pvt Ltd, (x) Medicamen Biotech Limited, (xi) Micron Pharmaceuticals, (xii) Nestor Pharmaceuticals Limited, (xiii) Reliable Pro detect Biomedical Pvt Ltd, (xiv) Synocm Healthcare Ltd., (xv) Zest Surgical Pvt. Limited.

[9] (i) Syncom Healthcare Ltd, (ii) Devparv Surgico, (iii) Hindustan Laboratories, (iv) Kwality Pharmaceutical Pvt Ltd.

Administrative Department is responsible for recovering the funds from such entities on half yearly basis and deposit the same in receipt head 0049- Interest Receipt.

Mission Director, National Health Mission, Panchkula had released an advance of ₹ 65.94 crore to HMSCL during 2016-17 to 2020-21 for procuring medicines/ medical equipment. However, HMSCL did not procure and supply these medicines and equipment within two weeks from the date of advance payment. Thus, as per the above guidelines, interest of ₹ 3.98 crore was to be charged from HMSCL for holding the funds for the period beyond two weeks of payment till the supply was made. However, NHM failed to recover the interest of ₹ 3.98 crore on the advances given to HMSCL.

4.5.4 Non-refund of late fee charges to indenting departments of ₹ 9.30 crore

Vide notification dated 31st October 2014 the Government of Haryana allowed HMSCL to charge 4 *per cent* processing fee from the indenting departments on all purchases/works/services made/executed on behalf of those departments.

As per the information supplied to audit, HMSCL has levied penalty worth ₹ 9.30 crore from the supplier firms for delayed supply of medicine/ equipment procured for indenting departments during the period 2016-21.

Thus, the amount received on account of penalty should be refunded to the indenting departments because the Corporation is only a mediator agency for procuring drugs/equipments for the indenting departments and is entitled to receive only 4 *per cent* processing charges.

HMSCL stated (January 2023) that the matter would be looked into and the amount would be deposited to the indenting department after calculating the amount due of the department concerned.

4.5.5 Non-supply, short and delayed supply of drugs to the warehouses and to the health institutions by HMSCL

As per conditions 3.1 and 3.2 of Durg purchase policy 2018, delivery must be completed at the destinations mentioned in the purchase order for the entire quantity before the end of 60 days from the date of issue of purchase order. This time limit is 75 days for the drug items that require sterility test.

(i) Delay in Supply of Drugs/Consumables to arehouses

During the period 2016-21 (upto November 2021), HMSCL had issued 6,343 Purchase Orders (POs) to the suppliers for supply of drugs/medicines/ consumables at warehouses and health institutions. Out of these 6,343 POs, no supply was made in 1,079 POs by the suppliers. The number of POs issued and supply not made by suppliers against POs are given in ***Table 4.12***.

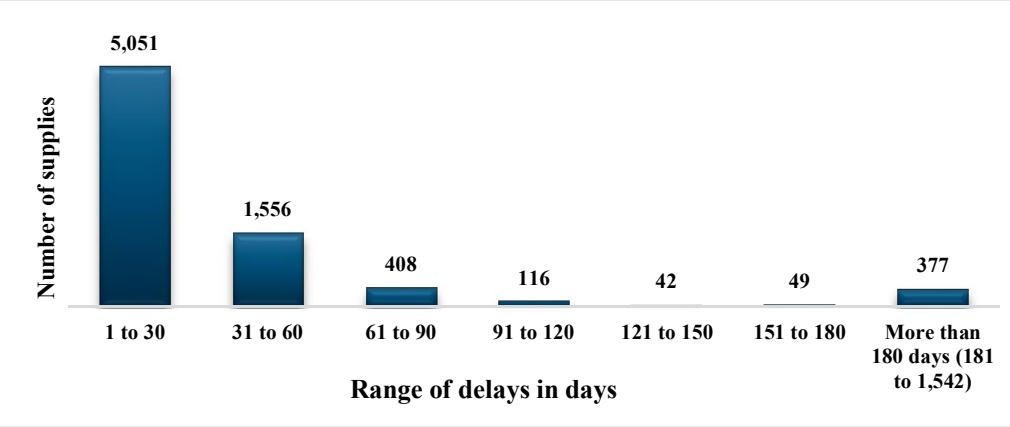
Table 4.12: Delay in Supply of Drugs/ Consumables by Firms to Warehouses

No. of POs issued by HMSCL	No. of POs against which supplies made by suppliers	No. of POs against which no supply received	Remarks
6,343	5,264	1,079	Out of these 1,079 POs, 130 POs have status cancelled whereas status of the remaining 949 POs have not been updated even after 170-1,957 days since their issuance.

Source: Analysis of data from Online Drug Inventory and Supply Chain Management System (as of November 2021).

Further, it was also observed that 22,659 supplies were made at different warehouses against 5,264 POs where drugs/consumables were supplied by suppliers. Out of these 22,659 cases of supplies, drugs/ consumables were supplied with delay in 7,599 supplies. The delays observed in 7,599 cases of supplies are shown in ***Chart 4.1***.

Chart 4.1: Range of Delay in supply of drugs to warehouse



Source: Analysis of data from Online Drug Inventory and Supply Chain Management System (as of November 2021).

This delay not only impacted user agencies of HMSCL but also caused undue hardship to the patients who are the ultimately beneficiaries. For instance, NHM Haryana had issued 88 indents to HMSCL for supply of drugs and equipment related to child health, referral transport, maternal health, Rashtriya Bal Swasthya Karyakram, etc. during 2016-21. In 43 out of 88 cases, the time taken from indent received to supply made was 6 months to more than 3 years. Further, in 21 cases[10], supplies have not been made by HMSCL to NHM till date (November 2021) even after lapse of a period of one to four years. In these 21 cases, HMSCL had received advance of ₹ 45.51 crore. The delay has not only affected the implementation of schemes but has also deprived the beneficiaries of the intended benefits.

HMSCL stated (January 2023) that procurement for the indented items is initiated (i) if approved sources are present on valid HMSCL Rate Contract for

[10] Indents for Mobile dental van, SNCU & NBSU equipment, neonatal care ambulance, IFA & calcium tablets, rapid HIV & dual testing kits for pregnant women etc.

the indented items as on date, then purchase orders are placed accordingly after taking necessary approval from competent authority and (ii) if approved sources are not available, HMSCL Rate Contract is arranged for which e-tenders are published. Purchase orders are issued after the funds against the indents are transferred to HMSCL by the indenting department. The reply of HMSCL is not tenable as NHM had already transferred the advance to HMSCL but supplies were made to NHM in 43 cases with delay of more than three years and in 21 cases, no supply had been made even after lapse of a period of one year to four years.

(ii) Non-levy of penalty worth ₹ 8.66 crore for non-supply of medicines to HMSCL

As per conditions 3.1 and 3.2 Durg purchase policy, 2018 delivery period would be 60 days from the date of Purchase Order and in case of drug items requiring sterility test, the delivery period would be 75 days. Further, condition 3.6 of Durg purchase policy 2018, stipulates that in case of supply of drugs of less than 60 *per cent* of ordered quantity within the delivery period, penalty of 20 *per cent* of unexecuted value would be levied along with risk purchase from approved source as per drugs purchase policy or local market at risk and cost of the firm. As per condition 8.1 drugs purchase policy 2018, such a penalty is recoverable from any amount payable to the supplier.

It was observed that as of October 2021, in 264 cases, the suppliers had not supplied the drugs within the stipulated time. The total value of supply in these 264 cases was ₹ 43.32 crore. The total penalty recoverable in these cases works out to be ₹ 8.66 crore (20 *per cent* of ₹ 43.32 crore) which was not recovered using Bank Guarantee or any other means till January 2022.

HMSCL stated (January 2023) that an amount of ₹ 94.25 lakh had been deducted from the vendors. In case of the remaining recovery, it would be made from the bill of the firms by the Accounts Wing and the details would be submitted to Audit when the recovery was made.

(iii) Delayed Supply/Non-Supply of Drugs/Consumables to health institutions by District warehouses

Health institutions in the State send the requisition for drugs to seven warehouses[11] which supply the drugs to health institutions against their requisitions. Data analysis of ODISCM portal revealed that health institutions in the State of Haryana raised 11,05,981 requisitions to the warehouses from 2016-17 to 2020-21 but received drugs (Full/Short supply) for 9,60,667 (87 *per cent*) requisitions.

[11] Warehouses: (i) Ambala, (ii) Bhiwani, (iii) Gurugram, (iv) Hisar, (v) Kaithal, (vi) Karnal, and (vii) Rohtak

Out of a total of 11,05,981 requisitions made by the health institutions, full supply was made in 7,89,124 (71.4 *per cent*) requisitions, short supply was made in 1,71,543 (15.5 *per cent*) requisitions and no supply was made in the remaining 1,45,314 (13.1 *per cent*) requisitions.

Quantity of drugs requisitioned by health institutions and supplies made by warehouses in the State during the period 2016-21 is shown in ***Table 4.13***.

Table 4.13: Delay in Supply of Drugs/ Consumables by Warehouses to Health Institutions

Quantity of drugs requisitions by Health Institutions (Number in crore)	Quantity of drugs supplied by Warehouses (Number in crore)	Supply (%)	Delay in Supplying Drugs	
			Range of time (In days)	Quantity Supplied (in crore)
415.47	288.93	69.54	upto 7	256.13
			8 – 15	26.06
			16-30	5.10
			31-180	1.56
			More than 180	0.08

Source: Analysis of data from ODISCM (as of November 2021)

The above table shows that warehouses provided only 69.54 *per cent* of the total drugs requisitioned by health institutions.

Further, drugs requisitioned by health institutions and supplied by warehouses in the three test-checked districts was given in ***Table 4.14***.

Table 4.14: Delay in Supply of Drugs/ Consumables by Warehouses to Health Institutions of test-checked Districts

Name of District	Quantity of drugs requisitioned (in lakh)	Quantity of drugs supplied (in lakh)	Supply (%)	Delay (in days)
Panipat	1,163	954	82.02	1 to 244
Hisar	2,998	1,957	65.27	1 to 139
Nuh	1,946	1,215	62.44	1 to 229

Source: Analysis of data from ODISCM (as of November 2021)

Thus, in the test-checked districts, the supply of drugs indented by health institutions to warehouses ranged between 62.44 *per cent* and 82.02 *per cent*. The warehouse had supplied drugs to health institutions with a delay up to 244 days.

This was one of the most important reasons for non-availability of essential drugs in the health institutions.

HMSCL replied (January 2023) that there were instances of delay in pick-up of supplies by the health institutions due to non-availability of vehicles or absence of pharmacist. In such cases, the indented quantities would be issued to other health facilities as the ODISCM portal is regulated by issuance and not by indented pattern. Sometimes, particular drugs/items were not available at the time of physical issuance, hence, these were shown pending in the portal. In case of short supply, issuance of the medicines from the respective warehouse was to be done to rationalise the issuance and ensure stock availability to all the other health institutions.

The reply was not maintainable as the main reason for delayed supply to health facilities was delay in receipt of drugs by HMSCL from suppliers (as discussed in sub-para *4.5.5(i)*). Further, approximately 30 *per cent* drugs had not been supplied to the health institutions due to inadequate availability at warehouses.

(iv) Non-availability of medicines/drugs for patients

Audit obtained prescription slips from 120 OPD patients of District Hospitals (DHs), Panipat, Hisar and Nuh. Scrutiny of these prescription slips revealed that all medicines/drugs were not being provided to the patients in DH, Panipat and Hisar. However, in the case of DH, Nuh, all medicines were being provided to the patients. The details of the medicines/ drugs prescribed, the number of medicines/drugs provided to the patients in DH Panipat and DH Hisar are given in ***Table 4.15***.

Table 4.15: Non-availability of medicines/drugs for the patients

Name of the Hospital	Number of medicines prescribed by doctors	Medicines/drugs provided by the hospital	Non/short supply of medicine drugs	Percentage of medicine/ drugs not supplied
Panipat	154	122	32	20.78
Hisar	176	121	55	31.25

Source: Prescription slips issued by doctors was collected in April 2022 (Panipat) and June 2022 (Hisar)

From the above table, it is evident that all the medicines prescribed were not being provided to the patients. There was shortage of medicines by 20.78 *per cent* and 31.25 *per cent* in DH, Panipat and Hisar respectively.

Thus, due to non-supply, short-supply or delay in supply of drugs to the warehouses by HMSCL and by warehouses to Health Institutions, District Hospitals could not provide all the prescribed medicines to the patients as discussed in earlier paragraphs. As a result, the patients of the District Hospitals had to bear the cost of medicines from their own pocket and the objective of providing free medicines to the patients was not fully achieved.

4.5.6 Input controls

In ODISCM data, when the supplier dispatches the drug to a warehouse, the dispatch date is captured in the field named “Start Date_of_Delivery”, which is entered by the supplier. The date when drugs reach the warehouse is captured in field named “Actual_Wh_Receipt Date”, which is entered by the concerned warehouse employee. There should not be any case where the date of dispatch is earlier than the date of delivery. These become crucial fields because penalty for delayed supply was calculated on the basis of these dates.

On analysis of data, it was found that there were 3,769 cases, where the entered receipt date was prior to the entered dispatch date. Audit observed that this became possible as no validation control was enforced for this field and user at warehouse could have entered any date as receipt date.

HMSCL, in its reply, admitted (January 2023) that "Physical receiving date" field was an open date field in software and that receiving date was entered by warehouse users only. It also stated that the NIC/NICSI Support team has been directed to implement the restriction of the receiving date in the online portal.

4.5.7 Accepting drugs having shelf life less than 60 or 75 *per cent*

As per condition 2 of Durg purchase policy, 2018 the drugs/ consumables which are supplied should not be older than 1/4th (25 *per cent*) of its shelf life from the date of manufacture and it should have 3/4th (75 *per cent*) of its shelf life remaining at the time of delivery and in case of vaccines and biologics and imported products the remaining shelf life of 3/5th (60 *per cent*) or more is accepted at the time of delivery.

During the period 2016-17 to 2020-21, HMSCL had placed purchase orders for supply of various drugs/vaccines and the supplier had supplied drugs/vaccines at warehouses. Out of the total supply orders placed during the above period, the supply in respect of supply order worth ₹ 19.11 crore were accepted having left over shelf-life ranging from 27.16 *per cent* to 74.98 *per cent*. Drugs/ consumables except vaccines, biologicals and imported products should not have been accepted for these supplies. Further, it was noticed that drugs/vaccines valuing ₹ 1.84 crore out of ₹ 19.11 crore, were accepted where the remaining shelf life was less than 60 *per cent* which was required not to be accepted by HMSCL as it was in contravention to the Drugs Purchase Policy.

HMSCL replied (January 2023) that in certain cases, on the request of the firm and keeping in view the urgency and criticality of the drug, the relaxation in shelf life was given to the firms after taking approval from the competent authorities in larger patients welfare. Thus, there is no loss to the Government and the goods were made available to the patients keeping in view the interests of patient care and welfare. The reply is not tenable as acceptance of such drugs/vaccines was in contravention of Drugs Purchase Policy and was an undue favour to the suppliers.

4.5.8 Loss due to non-replacement of expired medicines

As per condition 2.3 of Durg purchase policy 2018, HMSCL, the bidder should give an undertaking that the firm would replace the unused expired stores with fresh goods. Further, the firm would be informed by HMSCL about expiry of stock 180 days in advance.

Data analysis of ODISCM revealed that expired medicines worth ₹ 14.52 crore (₹ 6.19 crore at warehouses and ₹ 8.33 crore at other health institutes) were lying in the warehouses/health institutions. HMSCL did not take adequate steps to get medicines in the warehouses/health institutions replaced by the concerned firm before the expiry date by issuing advanced directions before 180 days of

expiry date as per the policy. This resulted in loss of drugs/medicines amounting ₹ 14.52 crore.

HMSCL stated (January 2023) that the amount of ₹ 6.90 crore could not be recovered under replacement conditions for expired drugs as drugs/goods had expired at health institutions. An amount of ₹ 3.71 crore was not recovered for replacement as the purchase orders were issued by Haryana Rate contract (HRC)/ESI/other sources in which clause of replacement of expired drugs did not exist. Out of the balance amount of ₹ 2.21 crore, ₹ 0.59 crore had been deducted from the bills of firms and the remaining recovery would be made from the firm's bills/performance security. The reply is not tenable as against the total recovery of ₹ 14.52 crore, recovery of ₹ 0.59 crore only has been affected. The Department should devise a mechanism for replacing the drugs expiring at health facilities. Moreover, the clause related to replacement of expired drugs should have been incorporated by the Department before purchasing drugs on other department's RCs.

4.5.9 Inordinate delay in procurement of sanitary napkin packets and blocking of funds of ₹ 6.86 crore

The Ministry of Health and Family Welfare launched (2011) the scheme for Promotion of Menstrual Hygiene among adolescent girls in the age group of 10-19 years in rural areas as part of the Adolescent Reproductive Sexual Health (ARSH) in Reproductive and Child Health (RCH II) scheme with specific reference to ensure coverage of 25 *per cent* rural adolescent girls. The objectives of the scheme were (a) to increase awareness among adolescent girls on menstrual hygiene; (b) to increase access to and use of high-quality sanitary napkins to adolescent girls in rural areas and (c) to ensure safe disposal of sanitary napkins in an environmentally friendly manner. Upper limit to support sanitary napkin procurement with NHM funds for the first time was ₹ 12 per pack of six napkins inclusive of all taxes which were to be sold to adolescents girls at the rate of ₹ six per pack by Accredited Social Health Activists (ASHAs) through door-to-door sale and also utilising the platforms of school and Anganwadi Centres.

The Mission Director, NHM Haryana transferred (December 2017) an amount of ₹ 4.89 crore to HMSCL for procurement of 49.21 lakh sanitary napkin packets. Again, an amount of ₹ 1.97 crore was transferred (August 2018) for procurement of an additional 24.61 lakh sanitary napkin packets.

However, NHM Haryana could not finalise the specification of sanitary napkins up to April 2020. Revised indent for 59.67 lakh packets (₹ 11.50 per packet) was issued in June 2020. In November 2020 (approximately after three years of payment of the first advance), 47.74 lakh sanitary napkin packets worth ₹ 5.49 crore were supplied. Balance supply order of 11.93 lakh (59.67 lakh - 47.74 lakh) sanitary napkins packets worth ₹ 1.37 crore was still (November 2021) pending.

The inordinate delay of three years (approximately) in supply of sanitary napkin packets not only blocked government money amounting to ₹ 6.86 crore (₹ 4.89 crore + ₹ 1.97 crore) but also defeated the social objectives of the scheme and deprived the beneficiaries of the intended benefits.

NHM replied (January 2023) that due to some administrative reasons the procurement of sanitary napkin was delayed and the matter was being regularly followed up with HMSCL. The reply is not tenable as specific reasons for delay were not provided and the balance supply of napkins of ₹ 1.37 crore was still pending.

Procurement of drugs by HMSCL had several shortcomings including non-supply, short-supply and delay in supply of drugs to the warehouses and health institutions, delay in processing of the indents, non-levy of penalty for non-supply of medicines, wrong entry of supply date resulting in undue benefit to the suppliers, procurement of medicines from blacklisted firms and not blacklisting firms repeatedly supplying sub-standard drugs. These shortcomings have adverse impact on availability of quality medicines at medical facilities, which was evident from availability of drugs at test-checked facilities. Some of these issues were already pointed out in in CAG's report no. 3 of 2019, Haryana and Public Accounts Committee had recommended investigation and corrective measures. Despite that, HMSCL has failed to improve its functioning.

4.6 Quality control mechanism in respect of drugs

As per condition 7 of Durg purchase policy 2018, all batches of drugs procured were to be subjected to quality tests through its empanelled laboratories. The Department has to draw a sample out of every batch and send it to one of the empanelled laboratories. If the sample is declared as not of standard quality (NSQ) then the consignment is to be rejected and drugs of the batch were not to be issued to health institutions.

4.6.1 Supply of NSQ (not of standard quality) to the health institutions issued to patients

Data analysis of ODISCM portal for the period 2016-21 revealed that seven warehouses supplied drugs/medicines in 9.61 lakh cases to the health institutions. Out of this, in 7,975 cases, a total of 376 lakh drugs/medicines supplied to health institutions were NSQ (Not of Standard Quality) and these drugs were further issued to the patients in these health institutions. Further, it was observed that out of these 7,975 cases of NSQ drugs/medicines, in 7,947 cases drugs/medicines were supplied to the health institutions from the warehouses before getting the test reports from the laboratories and in the remaining 28 cases, NSQ drugs were supplied to the health institutions even after receipt of the laboratories test report. The test reports of these drugs in 7,975 cases came 1 to 595 days after their dispatch to the health institutions from warehouses.

Further, in the test-checked districts, i.e., Panipat, Nuh and Hisar, drugs supplied to health institutions in 1,042 cases were not of standard quality thus posing a risk to the health of the patients. It was further observed that the test reports of these medicines were received in the warehouses with a delay of up to 547 days after their dispatch to health institutions.

HMSCL stated (January 2023) that drugs were distributed only if these were declared to be of Standard Quality. However, in some cases, random sampling was conducted by State Drug Controller Haryana (SDC) from warehouses/ health institutions after distribution and got tested and could be declared NSQ later on. In such cases, as soon as the letter or test report is received from the SDC Haryana, the item is blocked in the portal. The reply is not tenable as during physical inspection of the test-checked health facilities, it was found that most of these NSQ drugs were not only supplied to the health institutions, but also issued to the patients.

As discussed in Paragraph 4.5.2, 15 suppliers had supplied NSQ drugs/ medicines, on more than two occasions. Continued procurement of drugs from these suppliers despite their drugs being tested as NSQ displays callous attitude of HMSCL.

4.6.2 Drugs/Consumables not sent for testing and delay in testing in Laboratories

After receiving the samples from warehouses, the codification process of samples was done and thereafter they were sent to empanelled laboratories for testing. After receiving the result of the test, it was finally updated in the system. Analysis of the dump data of ODISCM portal since inception of the portal up to October 2021 revealed the following as given in ***Table 4.16***.

Table 4.16: Drugs/Consumables not sent for testing and delay in testing in laboratories

Stage	Process	Number
Warehouses (WHs) to HMSCL	No. of drug batches received at WHs	23,189
	No. of batches sent for testing (by WHs to HMSCL)	23,084
	No. of batches not sent for testing (by WHs to HMSCL)	105
HMSCL to testing laboratories	No. of samples for which codification done by HMSCL (for testing) out of the total 23,084 batches received	20,568
	Total no. of samples that reached the labs, out of the 20,568 codified batches	20,450
No. of samples received by HMSCL but not codified		2,516
No. of samples received and codified but not sent to the labs		118
No. of samples for testing sent with delay of more than 30 days		2,052

Source: Analysis of data from Online Drug Inventory and Supply Chain Management System.

As seen from the above table, out of 23,189 batches received at different warehouses excluding vaccines, covid drugs/consumables, 23,084 batches were sent to HMSCL office for testing. 105 batches were not sent from warehouses to HMSCL for testing. Out of these 105 batches, it was also observed that 28 batches were further distributed to health institutions without getting tested.

Codification of samples was done at HMSCL before sending them to labs for testing. As seen from the table above, out of the total 23,084 samples received at HMSCL, codification of 2,516 samples was not done and further not sent to labs for testing.

Further, out of the total 20,568 samples sent to labs for testing, the trail of 118 samples is not available on ODISCM portal. The outcome of test results of these 118 samples was not known. However, these drugs/consumables have been supplied to health institutions. HMSCL had also sent 2,052 samples out of 20,568 samples, with a delay of more than 30 days after receiving the sample from warehouses. Thus, the delay was at HMSCL's end and ranged between 31 and 431 days in these 2,052 cases.

It was also observed that among the cases that reached the laboratories for testing, the laboratories took more than 21 days in 2,578 cases for testing the samples against the time limit of seven days for un-sterile items and 21 days for sterile items. The range of delay in these cases is given in ***Table 4.17***.

Table 4.17: Range of Delay in Sample Testing

Days taken for testing	22-30 days	31-60 days	More than 60 days
Number of samples	1,301	859	418

Source: Analysis of data from Online Drug Inventory and Supply Chain Management System (as of October 2021).

These drugs/consumables were supplied to institutions before getting test results.

HMSCL replied (January 2023) that testing of drugs/medicines were conducted with offline codification for all the items. Further it was stated that many times due to non-availability of rate contract for testing with empanelled lab for certain items, the testing was delayed due to unavoidable circumstances. Moreover, in cases of delay in sample testing, penalty is being imposed on the empanelled labs as per policy. The fact remains that there was delay in testing the drugs/consumables.

4.6.3 Not conducting sample test and not obtaining test reports for locally purchased medicines/ drugs

As per purchase guidelines for districts issued by the State government in January 2017, District Hospitals were allowed to make local purchases of medicines/ consumables, which were not available with HMSCL warehouse. However, the guidelines did not prescribe any quality testing mechanism for local purchase. Further, as per conditions of Durg purchase policy, 2018, the supply should be accompanied with in-house report and random testing of drugs will be undertaken from Government approved laboratories.

The test-checked health institutions (MCHs and DHs) had procured medicines/ drugs from the local market and rates contract firms valuing ₹ 2,093 lakh during

the period 2016-21. These drugs were purchased locally and no quality testing was undertaken for the purchase. In the absence of quality testing of drugs, hospitals were unaware about the quality of drugs supplied to the patients. Thus, failure to ensure quality testing diluted the mechanism for supply of quality drugs to the patients.

The Principal Medical Officer, Panipat admitted (March 2022) that no quality check had been done.

During the exit conference, the ACS to Government of Haryana, Health and Family Welfare department, accepted (January 2023) the audit observations and agreed to put in place a system of sample testing in case of locally purchased medicines.

4.6.4 Manual/ SOP for storage of drugs in the pharmacy in test-checked health institutes

As per IPHS 2012 norms, the District Hospitals shall have standard operating procedure for stocking, preventing stock out of essential drugs, receiving, inspecting, handing over, storage and retrieval of drugs, checking quality of drugs, inventory management (ABC[12] & VED[13]), storage of narcotic drugs, checking pilferage, date of expiry, pest and rodent control, etc., in the pharmacy (dispensary).

District Hospitals, Hisar (May 2022) and Mandikhera (June 2022) had maintained manual/Standard Operating Procedure for storage of drugs in the pharmacies whereas DH Panipat (December 2021) had not maintained it.

4.7 Deficiency in inventory control of medicine and improper storage of medicine in test-checked MCHs and Family Welfare Department

Physical verification of pharmacy/drug store in MCH Nalhar in May 2022 revealed that the central drug store was located in the basement of the hospital which was not air conditioned and during the rainy season water seepage occurs in the central store. Shelves/racks were not labelled for medicine storage.

The Director, MCH Nalhar replied (June 2022) that only one storage hall in the basement was provided with air conditioning and that the seepage in the central drug store would be rectified during special repair work to be executed by Haryana Police Housing Corporation.

Further, the Director, Family Welfare Department, Haryana receives supplies from Government of India for onward supply to field offices. A joint inspection of the State Warehouse of Director, Family Welfare Department, Haryana

[12] 'A' in ABC analysis signifies the most important goods, 'B' indicates moderately necessary goods, and 'C' indicates the least essential inventory.

[13] VED stands for Vital, Essential, Desirable

carried out in February 2022 revealed that there was no specific place/room for storing contraceptives. Cartons of Tubal Rings were lying in the seating area of the office itself.

4.8 Irregular procurement of drugs at higher cost through local purchase by MCH Agroha

Rule 2.10 of the Punjab Financial Rules as applicable to Haryana says that every Government employee incurring or sanctioning expenditure from the revenues of the State should be guided by high standards of financial propriety. Each Head of Department is responsible for enforcing financial order of strict economy at every step.

Directorate of Medial Education & Research (DMER) had issued (May 2020) instructions to all Government medical colleges that prior consent of DMER office is necessary before placing any order of such items which are available on rate contract with HMSCL.

During the audit of MCH, Agroha in March 2022, it was observed that the institute is purchasing medicines from suppliers/distributors and not from the manufacturers directly. Unlike purchasing from the manufacturer directly, price paid to suppliers/distributors for purchase of medicine includes their profit margin also. During the period 2016-21, the practice of local purchase of medicines was widely prevalent in the institution. No benchmark price was decided by the committee of the institute while purchasing the medicine from the suppliers/distributors. It is also pertinent to mention that the institution did not place any demand with HMSCL since January 2020.

During the course of audit, test-check of prices of medicines purchased by the institute with the prices of rate contract made by HMSCL during the period August 2019 to March 2020 revealed that amount paid for various medicines through local purchase by the institute was higher by 7.34 to 177.08 *per cent* (except in one outlier case where procurement was made at 1,899 *per cent* higher rate) compared to the prices negotiated in rate contracts by HMSCL. This led to excess expenditure of ₹ 13.43 lakh (22.57 *per cent*) on purchase of medicine worth ₹ 59.49 lakh.

Further, it was also noticed that rate contract done for 29 types of medicine from the period 16 September 2019 to 10 April 2020 (around seven months) was based on single quotation received. Moreover, clause related to generic medicines was also not incorporated in the bidding documents by the institution while inviting tenders.

The Director, MCH Agroha replied (April 2022) that there was no bar on manufacturers participating in the tender and whenever any manufacturer submits the lowest (L1) price for any item it was selected. Further, the delayed supply from HMSCL was the reason for local purchases.

The reply was not tenable as MCH Agroha had purchased medicines at local level at higher cost than the rate contract negotiated by HMSCL.

4.9 Constitution of expert committee to ensure timely availability of drugs in the hospitals

As per conditions 4.2.3. and 4.2.3.1 of purchase guidelines for districts issued in January 2017 states that the district hospitals should prepare the plan for utilisation of forthcoming funds by February of each year. Further, each district should conduct two meetings under the chair of Civil Surgeon (CS) in the months of February and August.

DH Panipat and DH Mandikhera had not conducted meetings in the months of February and August during 2016-21 and had not prepared any plan for requirement/utilisation of drugs and funds for future requirements.

The PMO Panipat replied (April 2022) that guidelines by the Government are noted and would be taken care of in future.

4.10 Non-availability of adequate medicine counter in Outpatient department

According to IPHS 2012 norms, for every 200 OPD patients, there should be one counter for dispensing medicine at the pharmacy.

All test-checked health institutions had counters within the benchmark mentioned above except MCH Nalhar and DH Mandikhera. The average OPD load per day at MCH Nalhar (in May 2022) and DH Mandikhera (in June 2022) was around 1,000 to 1,200 patients. However, only two drugs dispensing counters were available in both the hospitals against the required six counters.

4.11 Procurement and Supply of medical equipment

HMSCL acts as the central procurement agency for procuring equipment for various healthcare institutions of the State. Audit observed the following while auditing purchase of equipment by HMSCL.

4.11.1 Non-monitoring of procurement of medical equipment

National Health Mission (NHM) transfers funds and issues indents to HMSCL for purchase of equipment, medicines etc. HMSCL completes the tendering process and procures the indented medical equipment, medicines etc. NHM must closely monitor the supply made, timely installation of medical equipment and availability of skilled manpower to operate these machines/equipment. If there was any delay in procurement, NHM must resolve the issues so that timely supply can be made.

NHM transferred ₹ 18.29 crore during the period September 2018 to March 2021 to HMSCL for procurement of medicines/ medical equipment for the Maternity Wing of NHM. However, NHM did not have the details of the scheduled date of delivery, quantity received, date of receipt, amount utilised, amount balance, etc. against the indent.

NHM stated (November 2021) that for better monitoring of medicine and medical equipment indents, coordination meeting was organised on the first and third Monday of each month in HMSCL. Moreover, User ID and passwords have also been generated for Online Drug Inventory and Supply Chain Management System (ODISCMS) of HMSCL to know the status of each drug indented by NHM. The fact remains that despite all facilities, Maternity Wing of NHM failed to provide information related to scheduled date of delivery, quantity received, date of receipt, amount utilised, balance amount, etc. for the aforesaid procurement which showed that the monitoring mechanism needed improvement.

4.11.2 Non-procurement of ambulances

Haryana Government had approved 'Atal Janani Vahini Sewa' scheme in 2018-19 for making operational the 24x7 free ambulance services under NHM Haryana. The ambulance service was dedicated to pregnant women for ante-natal checkup, delivery, drop back home and postnatal checkup. An amount of ₹ 28.50 crore was released to HMSCL in April 2019 and November 2020 for procurement of 188 ambulances. Against 188 ambulances, only 44 ambulances were provided by HMSCL in June 2021.

Further, ₹ 5.63 crore were transferred to HMSCL for purchasing 17 neonatal care ambulances in April 2019. No neonatal care ambulance has been delivered by HMSCL (January 2023). Funds transferred for procurement of ambulances and status of procurement is given in ***Table 4.18***.

Table 4.18: Funds transferred for procurement of ambulances and actual procurement made by HMSCL

(₹ in crore)

Ambulance type	Source of funds	Amount transferred	Date	Indent for number of ambulances	Ambulances provided	Expenditure
Neonatal care	IMR grant	5.63	April 2019	17	Nil	Nil
Patient Transport	Atal Janani Vahani Sewa	7.50	April 2019	68	44	4.85
Patient Transport		21.00	November 2020	120	Nil	Nil
		34.13		**205**	**44**	**4.85**

As evident from the above, against the indent of 205 ambulances only 44 ambulances were provided by HMSCL. Funds amounting to ₹ 29.28 crore remained blocked with HMSCL and the intended benefits could not be derived.

HSMCL stated (January 2023) that due to change in specifications by NHM, change in vehicle emission norms (BS IV to BS VI) and non-receipt of bids in tendering process, the ambulances could not be purchased. Even on GeM portal

tenders could not be finalised twice due to single bids. The reply was not maintainable as HMSCL failed to procure the ambulances despite availability of funds and deprived the beneficiaries from benefits.

4.12 Conclusion

Availability of all essential drugs was not maintained in the test-checked health institutions. Similar deficiency was noticed for AYUSH drugs as well. Absence of essential drugs forces beneficiaries to arrange for these medicines from outside. All prescribed essential equipment were also not available in the test-checked hospitals. Issues such as non-supply, delayed supply, purchase from blacklisted firm, invalid entry in the drug portal, local purchase at higher cost, accepting drug supply having less than prescribed shelf life, etc., were noticed in the procurement of drugs. In the quality assurance aspect, issues such as supply of substandard medicines and absence of sample testing for local purchase were noticed. Further, delays in supply and non-supply of ambulances and sanitary napkins were also seen.

4.13 Recommendations

1. **The Department should ensure timely procurement and testing of drugs/medicines/equipment for ensuring adequate availability of essential drugs and equipment at all health institutions.**
2. **Online Drug Inventory and Supply Chain Management System should be updated to capture deficiencies in availability of essential drugs at health institutions dynamically and consequently help better monitoring and planning of drug availability in health institutions.**
3. **Accountability should be fixed in cases of procurement of medicines from blacklisted firm and not blacklisting firms repeatedly supplying sub-standard drugs.**
4. **In case of locally purchased medicines by health institutions, a system of sample testing like the procedure adopted by HMSCL should be adopted.**
5. **SOP for proper storage of medicines should be adopted by all health institutions.**

Chapter-5
Healthcare Infrastructure

Chapter-5

Healthcare Infrastructure

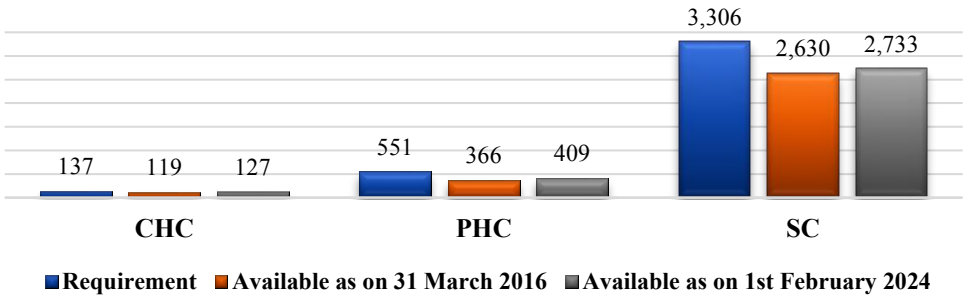
The overall objective of Indian Public Health Standards (IPHS) 2012, is to provide healthcare that is quality oriented and sensitive to the needs of the people. IPHS are the main driver for continuous improvements in quality. The performance of health institutions can be assessed against these set standards. The services that the health institutions are expected to provide have been grouped as Essential (minimum assured services) and Desirable (which we should aspire to achieve). The services include out-patient department (OPD), in-patient department (IPD) and Emergency services. Due importance is to be given to Newborn Care, Psychiatric services, Physical Medicine and Rehabilitation services, Accident and Trauma services, Dialysis services and Anti-retroviral therapy.

IPHS were first developed in 2007 and revised in 2012. These standards cover Sub Health Centres (SHCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub Divisional Civil Hospitals (SDCHs) and District Hospitals (DHs). They provide guidance on the infrastructure, human resources, drugs, diagnostics, equipment, quality, and governance requirements for delivering health services at these facilities.

5.1 Inadequate availability of CHCs, PHCs and SCs *vis- -vis* prescribed norms

According to Census 2011, the State of Haryana has a population of 2.53 crore (1.65 crore rural and 0.88 crore urban). As per IPHS 2012 norms, a PHC is a basic health unit to provide an integrated curative and preventive healthcare to the rural population with emphasis on preventive and promotive aspects of healthcare. The CHCs constitute the secondary level of healthcare, which are designed to provide referral healthcare for the cases from PHCs as well as specialist healthcare to the rural population approaching the centre directly. There should be a CHC for a population of 1,20,000, a PHC for a population of 30,000 and a Sub-Centre (SC) for a population of 5,000. There was a shortage of CHCs, PHCs and SCs against IPHS norms in the State. Availability of CHCs, PHCs and SCs as of March 2016 and as of February 2024 is shown in ***Chart 5.1***.

Chart 5.1: Requirement and availability of CHCs, PHCs and SCs



Source: Information furnished by DGHS, Haryana and NHM, Haryana.

From ***Chart 5.1***, it may be seen that as on 31 March 2016, there were 119 CHCs, 366 PHCs[1] and 2,630 SCs. Over a period of eight years, only eight CHCs, 43 PHCs and 103 SCs were added in the State. In comparison with the IPHS norms, shortage of CHCs, PHCs and SCs was 7 *per cent*, 26 *per cent* and 17 *per cent* respectively.

DGHS intimated (December 2022) that annual targets have not been fixed for upgradation/establishment of new CHCs/PHCs/SCs. However, overall targets have been fixed for opening of new health institutions keeping in view the population as per Census 2011. District-wise details of CHCs/PHCs/SCs against requirement is given in ***Table 5.1***.

Table 5.1: District-wise details of CHCs, PHCs and SCs against requirement

District Name	Rural Population as per 2011 census	CHCs			PHCs			SCs		
		Required	Actual	No of persons per CHC	Required	Actual	No of persons per PHC	Required	Actual	No of persons per SC
Ambala	6,27,576	5	5	1,25,515	21	17	36,916	126	107	5,865
Bhiwani & Charkhi Dadri	13,13,123	11	9	1,45,903	44	36	36,476	263	227	5,785
Faridabad	3,70,878	3	4	92,720	12	8	46,360	74	55	6,743
Fatehabad	7,62,423	6	5	1,52,485	25	20	38,121	153	135	5,648
Gurugram	4,72,179	4	3	1,57,393	16	12	39,348	95	86	5,490
Hisar	11,90,443	10	8	1,48,805	40	29	41,050	238	202	5,893
Jhajjar	7,15,066	6	6	1,19,178	24	20	35,753	143	133	5,376
Jind	10,28,569	9	8	1,28,571	34	25	41,143	206	187	5,500
Kaithal	8,38,293	7	4	2,09,573	28	22	38,104	168	147	5,703
Karnal	10,50,514	9	9	1,16,724	35	24	43,771	210	152	6,911
Kurukshetra	6,85,430	6	5	1,37,086	23	16	42,839	137	119	5,760
Mahendargarh	7,89,233	7	6	1,31,539	26	20	39,462	158	148	5,333
Nuh	9,65,157	8	6	1,60,860	32	17	56,774	193	110	8,774
Palwal	8,06,164	7	6	1,34,361	27	17	47,421	161	95	8,486
Panchkula	2,48,063	2	3	82,688	8	6	41,344	50	47	5,278
Panipat	6,50,352	5	7	92,907	22	14	46,454	130	91	7,147
Rewari	6,66,902	5	5	1,33,380	22	18	37,050	134	116	5,749
Rohtak	6,15,040	5	6	1,02,507	21	17	36,179	123	119	5,168
Sirsa	9,75,941	8	6	1,62,657	33	26	37,536	195	162	6,024
Sonipat	9,96,637	8	8	1,24,580	33	30	33,221	200	177	5,631
Yamuna Nagar	7,41,376	6	8	92,672	25	15	49,425	149	118	6,283
Total	**1,65,09,359**	**137**	**127**[2]	**1,29,995**	**551**	**409**	**40,365**	**3,306**	**2,733**	**6,041**

Source: Population data obtained from Statistical Handbook of Haryana 2021-22 issued by Department of Economic and Statistical Affairs, Haryana (Pg 9 to 13). Information regarding CHCs, PHCs and SCs furnished by the NHM Haryana as of February 2024.

In the three selected districts[3], there was a shortfall in availability of CHCs in district Nuh (25 *per cent*) and Hisar (20 *per cent*) while in district Panipat, seven CHCs were available against the required number of five CHCs. There was shortfall in availability of PHCs in district Nuh (47 *per cent*), Panipat (36 *per cent)* and Hisar (28 *per cent*). Further, there was a shortfall in availability of SCs in district Nuh (43 *per cent*), Panipat (30 *per cent)* and Hisar (15 *per cent*).

[1] The State has not established PHC in the village which is having a CHC. As per reply of the Department (February 2023), 119 PHCs were shown as co-located with the 119 CHCs and these are not counted separately to avoid staff duplication.

[2] Including four SDCHs (Loharu, Indri, Ganaur and Radaur) still working as CHCs.

[3] (i) Hisar, (ii) Nuh and (iii) Panipat

Due to low availability of CHCs/PHCs/SCs *vis- -vis* population as per the norms, patients would have to visit tertiary care/private health facilities even for minor ailments.

The Department replied (February 2023) that the Government is continuously working on opening of new Health Institutions in the State.

5.2 Infrastructure availability

The IPHS 2012 norms are the main driver for continuous improvement in quality and serve as the benchmark for assessing the functional status of health facilities. The IPHS 2012 norms have been used as the reference point for public healthcare infrastructure planning and up-gradation in the States and UTs. However, the State Government has not mapped availability of infrastructure, services and human resources against IPHS norms and there was no centralised database of services available across government health institutions. Audit found wide variations across similar type of health institutions across districts as detailed in subsequent paragraphs without specific reason or planning to upgrade them in a phased manner.

Audit assessed the availability in the test-checked health institutions of the three selected districts (Panipat, Nuh and Hisar) for field study. The following health institutions were test-checked:

i. All three District/General Hospitals of selected districts
ii. Three out of 6 Sub Divisional Civil Hospitals
iii. Ten out of 18 Community Health Centres (CHCs)
iv. Two out of 4 Urban Health Centres (UHCs)
v. 19 out of 52 Primary Health Centres (PHCs)
vi. 5 out of 10 Urban PHCs

The general up-keep, availability of beds and infrastructure are discussed in this chapter. Other services, availability of medicine, human resources and building infrastructure have been discussed in other chapters of the report.

5.3 Appearance and up-keep/planning and lay out of health institutions require upgrade

IPHS 2012 norms prescribe good appearance and up-keep of hospitals, environmental friendly features, circulation areas and other disaster prevention measures.

Table 5.2: Appearance and up-keep in test checked Health Institutions

Particulars	Required (IPHS norms)	DH, Panipat	SDCH, Samalkha	DH, Mandikhera (Nuh)	DH, Hisar	SDCH, Narnaund	SDCH, Adampur
Environmental friendly features	Rainwater harvesting, solar energy use and use of energy-efficient bulbs/ equipment. Provision should be made for horticulture services including herbal garden.	Yes	Yes	No	No	Yes	Yes
Circulation areas	Circulation areas comprise corridors, lifts, ramps, staircase and other common spaces etc. The flooring should be anti-skid and non-slippery.	Yes	Yes	Yes	Yes	Yes	Yes
Disaster prevention measures	Earthquake proof measures – structural and non- structural should be built in to withstand quake as per geographical/State Government guidelines. (for seismic zone V)	Yes	Yes	No	No	Yes	Yes
	Firefighting equipment	Yes	Yes (except fire hydrant and smoke detector was not functional)	Yes (No fire hydrant and smoke detector)	No	Yes (sand buckets not available)	Yes

Source: Information furnished (January 2022 to June 2022) by test-checked Health Institutions.

The general appearance and up-keep varied vastly across the test-checked health institutions. Some images of the facilities are shown below.

Spitting of gutkha/pan masala on the walls of DH Mandikhera (7 June 2022)

Seepage from roof at newly constructed SDCH Samalkha (6 March 2022)

Garbage heap around the premises of PHC Siwah (29 March 2022)

Unhygienic condition of toilet at PHC Jamalgarh (17 June 2022)

Unhygienic and broken toilet at SC Gokulpur (Nuh) (17 June 2022)

Untidy and unhygienic toilet at PHC Siwah (29 March 2022)

Rain water logging in DH Hisar (25 July 2022)

IPD ward was well maintained in DH Panipat (25 April 2022)

Clean and well kept linen at DH Panipat (25 April 2022)

The buildings in DH Mandikhera, DH Hisar, SDCH Samalkha, Government ANM School of Nursing, Mandikhera (Nuh) and most of the residential accommodation of the selected health institutions were not maintained and were in dilapidated condition. On the other hand, in DH Panipat, the IPD ward was well maintained and linen was clean and well arranged.

5.4 Availability of beds in the health institutions

As per IPHS 2012, India's Public Health System has been developed over the years as a 3-tier system, namely:

i. Tertiary care (Medical Colleges),

ii. Secondary care (DH, SDCH and selected CHCs); and

iii. Primary care (remaining CHCs and PHCs).

However, while calculating the patient-bed ratio in a district, it should primarily rely on the facilities from PHC to DH since tertiary care facilities (Medical Colleges) not only caters to the district where it is located, but also caters to other districts.

5.4.1 Availability of beds in Health Institutions not mapped across the State

The National Health Policy, 2017 recommends two beds per 1,000 population. As per IPHS 2012 norms, the bed strength of a district hospital varies from 75 to 500 beds depending on the size, terrain and population of the district. The size of a district hospital is a function of the hospital bed requirement, which in turn is a function of the size of the population it serves. In India the population size of a district varies from 35,000 to 30,00,000 (Census 2001).

To achieve the benchmarks set under National Health Policy and IPHS 2012 as above, Government should make plan for each of the districts based on its population, local epidemiology, burden of disease, community requirements, health-seeking behaviour of the population, and contribution of the private sector. However, Government of Haryana had not made district-wise plan detailing the status of bed availability in public and private sector health institutions.

The Department stated (February 2023) that tender for mapping of Health Institutions of Haryana has already been awarded and is likely to be completed in the next six months.

5.4.2 Availability of beds in SDCH and CHCs was not as per norms

IPHS 2012 provides that SDCH should have more than 30 beds in in-patient department. Further, the CHC should have 30 IPD beds with one operation theatre, labour room, X-ray, ECG and laboratory facility. A PHC covers a population of 30,000 with six IPD beds. The availability of IPD beds along with Maternal and

Child Care beds in DHs/SDCHs/CHCs/PHCs in the State of Haryana is given in ***Table 5.3***.

Table 5.3: Total number of IPD beds and allocated for Maternal and Child Care in various Health Institutions

Name of Health Institution	Total Number of Health Institutions	Total Number of IPD Beds	Number of Beds allocated for Maternal and Child Care
DHs	22	3,968	1,225
SDCHs	41	2,338	823
CHCs	126	2,708	1,005
PHCs	406	1,997	No specific allocation (allocation as per requirement)
Total		**11,011**	**3,053**

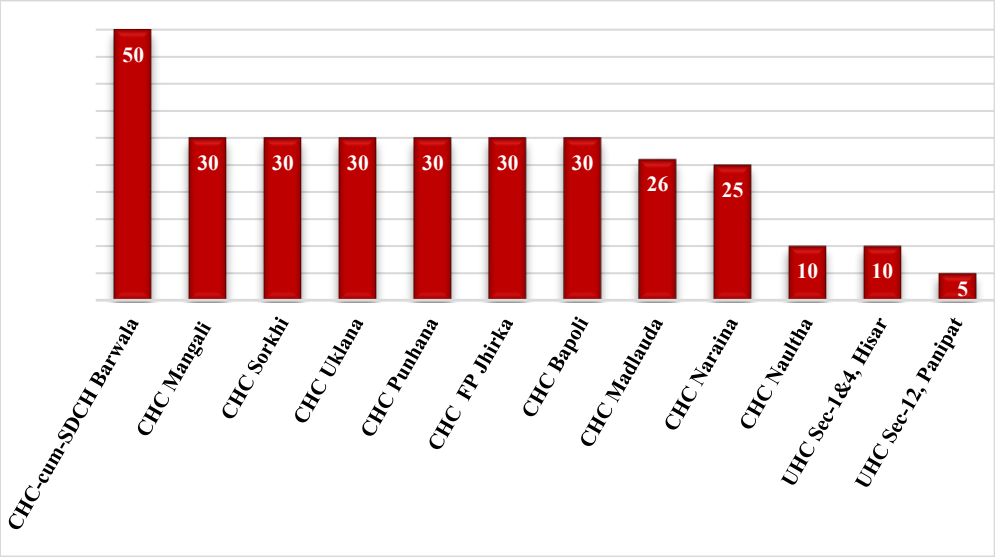
Source: Information furnished by health institutions (April/May 2023).

Seven[4] SDCHs had less than 31 IPD beds. Fifty-nine CHCs out of 126 CHCs had less than 30 IPD beds.

5.4.3 Availability of beds in CHCs/PHCs was not adequate

Audit collected information (April-May 2023) from the test checked 12 CHCs and found that only seven CHCs had beds as per norms as shown in ***Chart 5.2***.

Chart 5.2: Availability of beds in test-checked CHCs



Source: Information furnished by test-checked CHCs (April/May 2023).

Further, against the norm of six IPD beds, in nine out of 24 test checked PHCs/ UPHCs six or more IPD beds were available. Seven[5] PHCs/UPHCs had less than six beds and eight[6] PHCs/ UPHCs did not have any in-patient bed. Reasons for non-availability of adequate number of IPD beds in CHCs/PHCs were sought in the test-checked districts.

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4 SDCHs (i) Devrala, (ii) Hailey Mandi, (iii) Shahbad, (iv) Mohindergarh, (v) Kanina, (vi) Chautala and (vii) Kharkhoda.

5 PHCs (i) Hasangarh,(ii) Daultpur, (iii) Atta, (iv) Mandi, (v) Siwah, (vi) Pattikalyana and (vii) UPHC Raj Nagar, Panipat.

6 PHCs (i) Ladwa, (ii) Agroha, (iii) Israna, (iv) Rair Kalan, and UPHCs - (v) Char Qutab Gate Hansi, (vi) Patel Nagar Hisar, (vii) Rajeev Colony and (viii) Hari Singh Colony.

The Department clarified (January 2023) that PHC Naultha had 10 beds as it was upgraded to CHC in December 2016 in the old building. UHC Sector 1 and 4, Hisar was having 10 beds due to space constraints.

5.5 Achievement under National Quality Assurance Programme

National Quality Assurance Standards (NQAS) have been developed keeping in mind the specific requirements for public health institutions as well as global best practices. NQAS are currently available for DHs, CHCs, PHCs and UPHCs. Standards are meant for providers to assess their own quality for improvement as well as facilities for certification. Under National Quality Assurance Programme, certifications are envisaged at state and national level of certification. Financial incentives are also given as per level and scope of certification.

As of March 2022, against the total number of 717 public health institutions, only 108 (15 *per cent*) were NQAS certified. The category wise certification during the period 2016-22 in the State is shown in ***Table 5.4***.

Table 5.4: Number of health facilities (category wise) receiving NQAS certification

Type of facility	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Total
DH	3	1	1	2	1	0	8
SDCH	0	0	1	2	1	0	4
CHC/UCHC	0	1	0	2	1	0	4
PHC/UPHC	0	8	26	39	14	5	92
Total	**3**	**10**	**28**	**45**	**17**	**5**	**108**

Source: Information furnished by Haryana State Human Resource Centre, Panchkula.

Further, it was observed that only 12 health institutions out of 93 health institutions were NQAS certified in the selected districts with a shortfall of 86.05 *per cent*. Moreover, none of the CHCs in the selected districts has been certified under NQAS scheme. NQAS facilities-wise achievement in the selected three districts is given in ***Table 5.5***.

Table 5.5: Number of Health institutions (HIs) which achieved NQAS in test-checked districts

Type of Health Institutions	Panipat		Hisar		Nuh	
	Number of HIs	NQAS certified His	Number of His	NQAS certified HIs	Number of HIs	NQAS certified HIs
DH	1	0	1	1	1	0
SDH	1	0	5	1	0	0
CHC/UCHC	7	0	8	0	4	0
PHC/UPHC	12	3	27	4	19	3
Total	**21**	**3**	**41**	**6**	**24**	**3**

Source: Information supplied by District Quality Assurance Units in test-checked districts (Panipat: as on 31 December 2021, Hisar: as on 31 March 2022 and Nuh: as on 31 May 2022).

The office of State Health Systems Resource Centre, Haryana (HSHRC) replied (October 2022) that Haryana had made year-wise growth in NQAS certification. The fact, however, remains that only 14 *per cent* of health institutions were NQAS certified.

5.6 Health and Wellness Centres

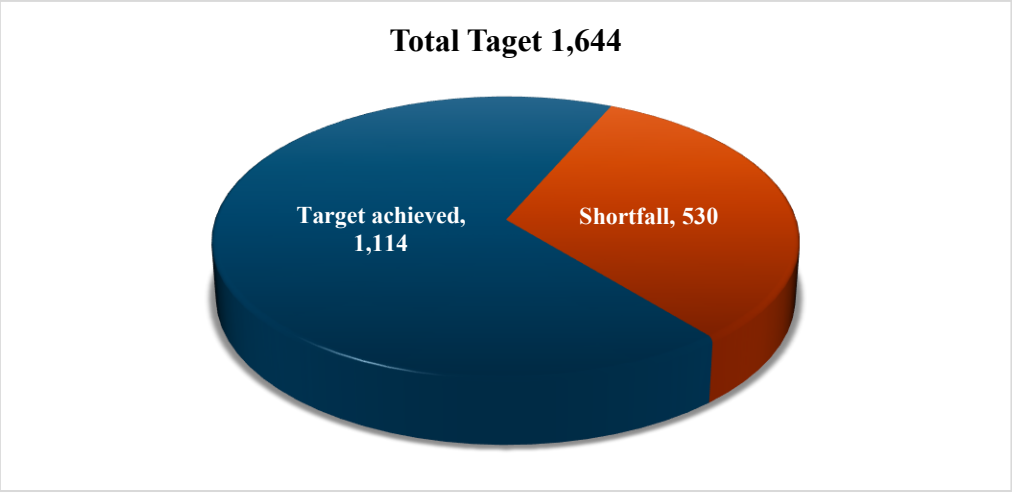
The National Health Policy, 2017 recommends strengthening the delivery of Primary Healthcare, through establishment of "Health and Wellness Centres (HWCs)" as the platform to deliver Comprehensive Primary Healthcare and calls for a commitment of two third of the health budget to primary healthcare.

As per Ayushman Bharat Comprehensive Primary Healthcare through Health and Wellness Centres operational guidelines, in February 2018, the Government of India (GoI) announced that 1,50,000 HWCs would be created by transforming existing SCs and PHCs to deliver comprehensive primary healthcare and declared this as one of the two components of Ayushman Bharat. The other component of Ayushman Bharat, namely the Pradhan Mantri Jan Arogya Yojana (PMJAY) aims to provide financial protection for secondary and tertiary healthcare. These HWCs were conceptualised to ensure the highest possible level of health and well-being at all ages, through a set of preventive, promotive, curative and rehabilitative services.

5.6.1 Non achievement of targets for infrastructure strengthening of HWCs

In accordance with GoI's decision in the year 2017-18, the National Health Mission, Haryana decided (September 2018) that all existing SCs, PHCs and some UPHCs would be upgraded into HWCs in a phased manner by 2024. As per information furnished by the Department, the targets fixed and achievements under upgradation of HWCs during 2016-21 are given below:

Chart 5.3: Target/achievement for upgradation of HWCs in Haryana

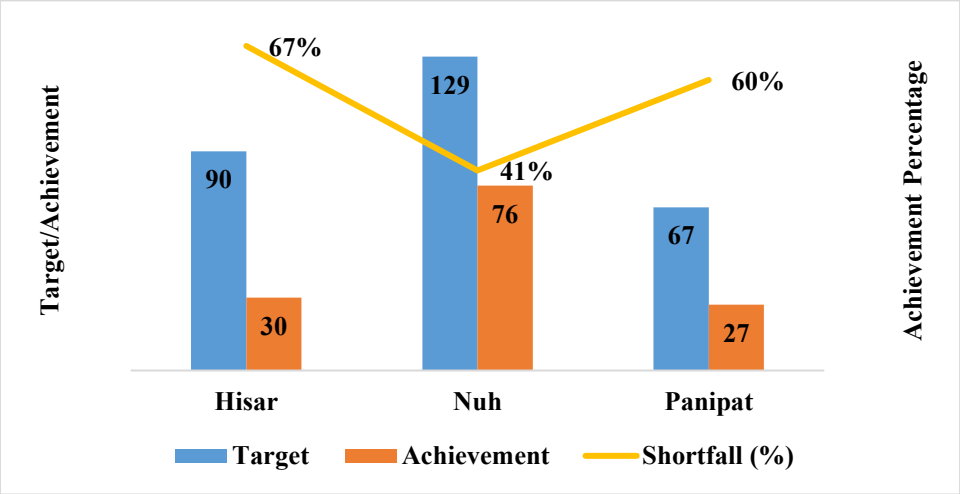


Source: Information supplied by National Health Mission, Haryana.

GoI had approved a budget of ₹ 291.27 crore for upgradation of 1,644 SCs into HWCs during the period 2016-21 in the State. However, NHM Haryana had utilised only ₹ 35.84 crore and could complete infrastructure strengthening of only 1,114 HWCs upto November 2021. Thus, the pace of utilisation of budget and upgradation of SCs and PHCs/UPHCs to HWCs was slow.

The status of upgradation of HWCs in the test-checked three districts is given in ***Chart 5.4***.

Chart 5.4: Status of upgradation of HWCs in test-checked districts



Source: Information supplied by selected District Health Societies.

It was observed that in the test-checked districts, out of 286 targeted HWCs, only 133 HWCs could be upgraded with a shortfall of 53 *per cent*. The minimum shortfall was seen in district Nuh, while maximum shortfall was seen in district Hisar. The lack of availability of services in the test-checked upgraded HWCs has been detailed in Chapter 3.

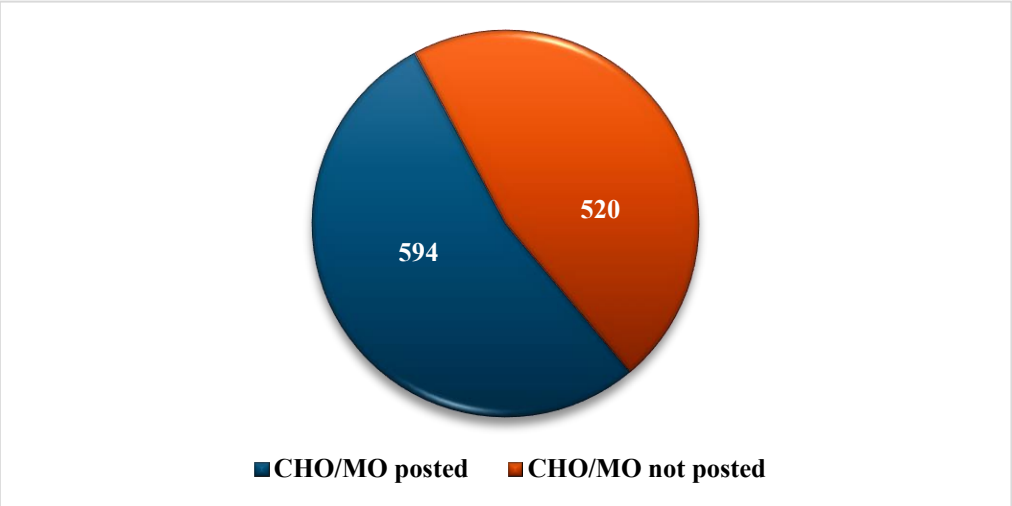
NHM replied (January 2023) that the budget for infrastructure strengthening of HWCs was advanced to PWD (B&R) during the period 2019-23. However, PWD (B&R) surrendered funds for 873 sites where no work was started, citing shortage of staff. They were presently in the process of hiring a new agency for the purpose.

5.6.2 Operationalisation of HWCs

As per Comprehensive Primary Healthcare guidelines for HWCs, a key addition to the primary health team at the SC-HWC, would be the Mid-level Health Provider (MLHP) who would be a Community Health Officer (CHO). The CHO would be either a BSc in Community Health or a Nurse (GNM or BSc) or an Ayurveda practitioner, trained and certified through IGNOU/other State Public Health/Medical Universities for a set of competencies in delivering public health and primary healthcare services.

The number of up-graded HWCs, which were not operationalised in the State of Haryana and the test-checked three districts is given in ***Chart 5.5*** and ***Chart 5.6*** respectively.

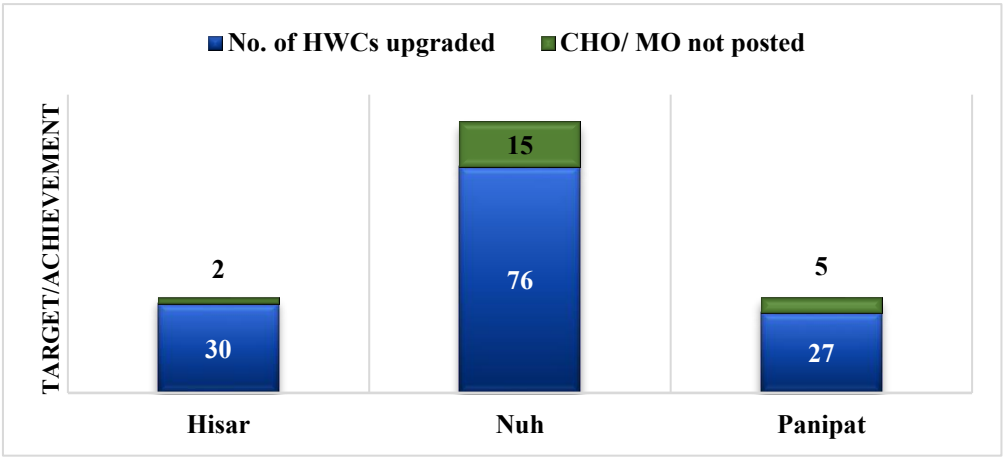
Chart 5.5: Number of HWCs upgraded and not fully operationalised in State of Haryana



Source: Information supplied by NHM, Haryana

As intimated by the Department, NHM Haryana had fixed target (up to March 2021) for upgradation and operationalisation of 1,644 SCs and PHCs to HWCs. Against the target, NHM could upgrade 1,114 (upto November 2021) and out of these 1,114 HWCs, only 594 HWCs could be operationalised by deploying Community Health Officers (CHO). In the remaining 520 HWCs, CHOs could not be deployed. These HWCs therefore could not be made fully operational to provide the full services as per HWC guideline. Non-achievement of targets had hampered delivery of health services in the State.

Chart 5.6: Upgraded HWCs and non-operational HWCs in test-checked Districts



Source: Information supplied by selected DHSs.

Out of a total 133 upgraded HWCs in the test-checked districts, no CHO/MO was posted in 22 HWCs. The maximum number of vacant posts of CHO/MO were seen in district Nuh.

As per the HWC guidelines, the rationale for introducing this new cadre of health provider is to augment the capacity of the HWC to offer expanded range of services closer to the community, thus improving access and coverage with a commensurate reduction in out-of-pocket expenditure. However, due to non-posting of CHOs in the upgraded HWCs, the above objective could not be fully achieved.

NHM replied (January 2023) that recruitment of 671 CHOs was advertised during the year 2020-21. But due to multiple litigation and as per directions issued by Hon'ble High Court, only 236 CHOs were engaged. Decision of the High Court for the remaining 435 posts was still awaited and action would be taken accordingly. Further, NHM had again advertised for recruitment of 1,314 CHOs and the recruitment process for 787 CHOs had been completed. NHM had assured that all upgraded HWCs would be operationalised by the end of the financial year 2022-23.

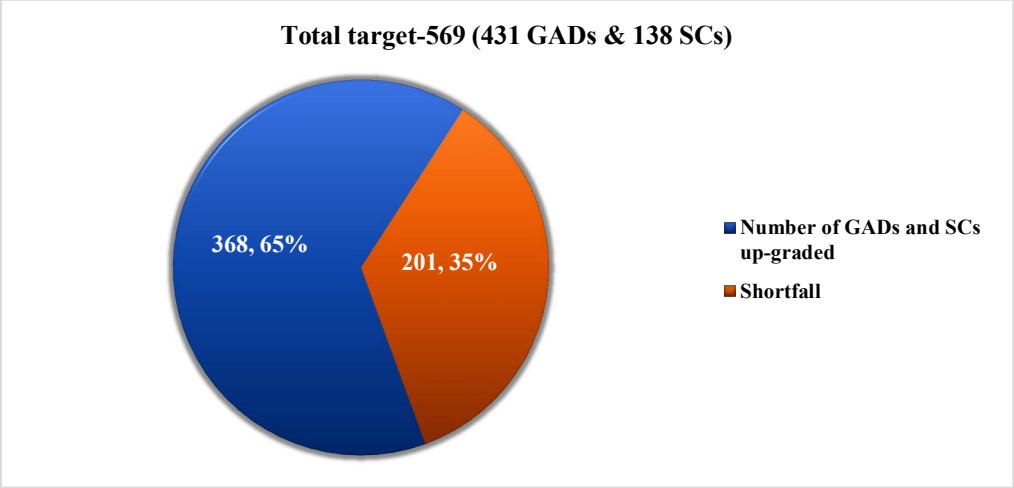
5.7 AYUSH Health & Wellness Centres

As per Ayushman Bharat AYUSH Health and Wellness Centres (AHWCs) operational guidelines (January 2019), 10 *per cent* of the existing Government AYUSH dispensaries (GADs) and SCs were to be upgraded to AHWCs under Ayushman Bharat. Further, the AHWC would be considered functional once the delivery of service is initiated. The service delivery includes preventive, promotive, curative and rehabilitative healthcare services.

Government of India approved a Centrally Sponsored Scheme on a 60:40 basis (Centre:State) for upgradation of 569 GADs/SCs to AHWCs at a cost of ₹ 57.06 crore[7] during the period 2019-22 in the State. GoI had allocated ₹ 34.24 crore[8] (60 *per cent* of ₹ 57.06 crore) for upgradation for the period 2019-22. As of February 2023, 368 out of 569 GADs/SCs had been upgraded by utilising an amount of ₹ 51.69 crore[9].

The number of GADs and SCs upgraded into AHWCs in the State of Haryana and the test-checked three districts is given in ***Chart 5.7*** and ***Chart 5.8*** respectively.

Chart 5.7: Number of GADs and SCs up-graded into AHWCs in State of Haryana



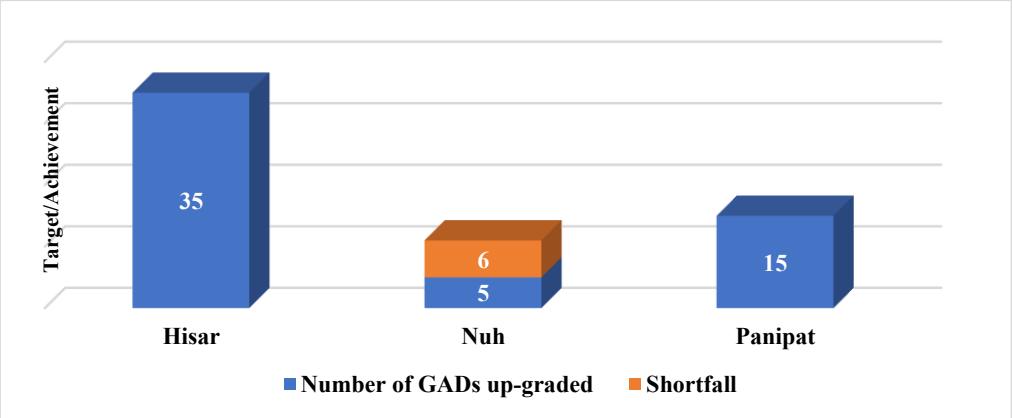
Source: Information furnished by Department of AYUSH, Haryana.

[7] ₹ 57.06 crore = 2019-20: ₹ 13.49 crore + 2020-21: ₹ 41.17 crore + 2021-22: ₹ 2.40 crore.
[8] ₹ 34.24 crore = 2019-20: ₹ 8.09 crore + 2020-21: ₹ 24.71 crore + 2021-22: ₹ 1.44 crore.
[9] ₹ 51.69 crore = 2019-20: ₹ 13.49 crore + 2020-21: ₹ 36.55 crore + 2021-22: ₹ 1.65 crore.

The remaining 201 GADs/SCs (63 GADs & 138 SCs) could not be upgraded due to bad condition of the buildings, which required major repairs. Further, work on any of the targeted 138 SCs was not even started for upgradation due to non-identification of SCs. The key principle to upgrade these GADs and SCs into AHWCs was to ensure universal access to an expanded range of care. Thus, due to non-upgradation of these targeted AHWCs, preventive, promotive, curative and rehabilitative healthcare could not be provided to the masses in the catchment areas of these AHWCs. The availability of services in the AHWCs in the test-checked districts has been discussed in Chapter 3.

The Department of AYUSH replied (January 2023) that the work on 138 SCs could not be started due to delay in finalisation of list of SCs by NHM. Further, work on 29 units (21 GADs + 8 SCs) was still under progress. The work order for establishment of 121 SCs and 10 GADs had now been placed on the executing agency.

Chart 5.8: GADs and SCs upgraded into AHWCs in test-checked districts



Source: Information furnished by O/o District Ayurvedic Officers (DAO) of test-checked districts.

In the test-checked districts, shortfall in upgradation of AHWCs was found only in district Nuh (55 *per cent*). Further, it was also observed that the office of the District Ayurvedic Officer, Hisar got six[10] AHWCs constructed through Executive Engineer Panchayati Raj, Hisar. The construction work of these AHWCs was completed between October 2020 and December 2020, but these AHWCs could not be made fully functional as of June 2022. This was due to various reasons such as non-appointment of staff, non-availability of furniture and non-availability of equipment.

The Department replied (January 2023) that these six dispensaries (Hisar) were constructed by Panchayati Raj and were not considered for upgradation as either construction work was near completion or these were not handed over to the Department. But now (March 2022) these dispensaries had been taken into consideration for upgradation and included in the work order already issued to

[10] AHWCs (i) Uglana, (ii) Madanheri, (iii) Khanpur, (iv) Mehjad, (v) Lohari Ragho and (vi) Badchapar

the executing agency. The District Ayurvedic Officer, Nuh replied (June 2022) that the AHWCs were announced in December 2019 and due to onset of COVID-19, the upgradation work of the AHWCs could not be completed on time. The reply is not tenable since there were no ban on construction works when the period of COVID-19 was over.

5.8 Status of new construction and upgradation works

As per the data furnished by office of DGHS, during April 2016 to November 2022, 291[11] Civil works with administrative approval of ₹ 1,908.88 crore were sanctioned. Of which two Civil works were already in progress on 1 April 2016. Out of these 291 civil works, 186 works were related to construction of new buildings, whereas the remaining 105 civil works were related to upgradation, renovation, extension etc. of the already existing infrastructure.

During the period from 2016-17 to 2022-23 (upto November 2022), 250 civil works were taken up, out of which only 173 works were completed with an expenditure of ₹ 590.77 crore. The balance 41 (291-250) civil works could not be taken up due to the following reasons:

i. Eleven civil works (2 works of 2017-18, 6 of 2019-20, 2 of 2020-21 and 1 of 2021-22) could not be taken up due to non-availability of encumbrance free site.

ii. 21 works (one work of 2019-20, two works of 2020-21, 12 works of 2021-22 and 6 works of 2022-23) could not be taken up due to delays in finalisation of administrative approval, detailed estimates, tendering process and/or start of work.

iii. Nine civil works were held up due to other reasons like non-transfer of requisite funds, rescinding of agreement and change in scope of work.

Further analysis of the data revealed that 173 works with an expenditure of ₹ 590.77 crore were completed during the above-mentioned period. Only 60 works were completed in time and in case of the remaining 113 works, there were delays in completion, as summarised in ***Table 5.6***.

Table 5.6: Summary of delays in completed works

Period of delay	No. of civil works	Expenditure incurred (₹ in crore)
No. of works completed in time	60	231.44
No. of works completed with a delay upto one year	78	237.49
No. of works completed with a delay beyond one year but upto 2 years	27	79.64
No. of works completed with a delay beyond 2 years	8	42.20
Total	**173**	**590.77**

Source: Data furnished by DGHS, Haryana

[11] Six Civil works A/A ₹ 147.81 crore were sanction between June 2014 to March 2016

In case of the three selected districts, out of the 32 works taken up for completion, only 25 works could be completed. Only 12 works were completed within the scheduled completion time, whereas in case of the remaining 13 works, there were delays ranging from 2 months to 38 months (delays of upto one year in nine cases, delays of one year in one case, and more than two years in 3 cases). Further in case of the remaining seven incomplete works, it was noted that delays were due to slow pace of work and delay in finalising estimates as summarised in ***Table 5.7***.

Table 5.7: Status of incomplete works in selected districts

Sr. No.	District	Name of work	Start Date	Cumulative expenditure as of October 2022 (₹ in lakh)	Work status
1	Hisar	Construction of 50 bedded to 100 bedded Hospital at Narnaund	16 March 2019	985.32	95 *per cent* work executed- In progress
2	Hisar	Construction of PHC Sindhar	21 February 2020	399.98	95 *per cent* work executed- In progress
3	Nuh	Special repair for various residences and road and parking in Civil Hospital at Mandikhera	16 January 2020	105.16	40 *per cent* work executed. Road & parking work completed and repairing work of the building is in progress.
4	Nuh	Construction of PHC with residential accommodation of Village Bisru	26 August 2021	264.46	65 *per cent* work executed.
5	Nuh	Construction of District TB Centre in General Hospital at Mandikhera	--	0.00	Detailed estimate & DNIT returned to SE Gurugram for compliance of the observations. Now rough cost estimate uploaded on Haryana Engineering Works (HEW) portal for tendering process.
6	Panipat	Construction of Mother and Child block at Civil Hospital Panipat	06 June 2021	240.53	28 *per cent* work executed.
7	Panipat	Construction of platform, shed for oxygen plant and a room for plant's operator in the campus of CHC, Bapoli	--	0.00	Detailed Estimate under preparation

Source: Data furnished by DGHS, Haryana

The delay in completion of the various construction and upgradation works has not only resulted in the blocking of funds in those works, but also has resulted in denial of the intended benefits to the general public.

5.9 Infrastructure not put to use appropriately in test-checked health institutions

Audit noticed several instances in the test-checked institutions where civil structures were not put to proper use as detailed below:

i. SDCH, Samalkha was shifted to a new building constructed in 2020. However, even after two years the building was not taken over (as on 6 March 2022) by the Department due to a number of deficiencies in the civil structure. Further, operation theatres constructed in SDCH, Samalkha had not been put to use since 2020. The deficiencies are given

in Para 3.5 of Chapter-3 in detail and complete detail of deficiencies is given as a case study below.

ii. Labour room available at PHC, Atta and UHC, Sector 12, Panipat was not put to use.

iii. Under jurisdiction of CHC Firozpur Jhirka, out of the selected four sub centres, three sub centres i.e Hirwari, Bukharka and Ganduri were established in 2015 but were not in use. The SMO, CHC Firozpur Jhirka stated (June 2022) that the sub centres remained non-functional due to non-posting of required staff.

Case Study: SDCH Samalkha

The SDCH, Samalkha was upgraded from CHC in the year 2014. It was shifted in November 2020 to a newly constructed building of SDCH despite having many structural deficiencies. The building had not been formally taken over by Health Department as on 6 March 2022.

During the joint inspection, many deficiencies as detailed below were noticed:

- There were leakages from roof of OPD building and Isolation ward.
- There were cracks in the walls of Dental OPD room and Emergency ward. Cracks were found on outer side of walls of OPD building.
- Plaster of walls was found peeled off at many places.
- Flush of male toilet was not working and there were no water taps installed in some of the female toilets. There were no incinerators installed in any of the female toilets.
- Fire hydrants were not working.
- High-Tension wires were passing over hospital premises.
- Oxygen plant installed in January 2022 was found non operative.
- There was water logging in the basement due to leakage from the side walls and roof.
- Separate laundry facilities were not available and it was carried out in one of the toilets.
- Outlet pipes of toilets and washbasins of General ward were broken.
- False ceiling of operation theatre was broken.
- Due to non-availability of surgeons, operation theatre and equipment were not utilised. Water filter was found covered and it was found installed in open area on a roof.
- There was no sewerage treatment facility and sewage was being dumped in open pit.
- X-ray machines were lying idle due to non-posting of radiographer.

Further, there were vacancies of 7 doctors against the sanctioned strength of 11 doctors, 5 staff nurse against sanctioned strength of 15 staff nurse and

3 vacancies of paramedical staff against the 7 sanctioned posts. The hospital was providing OPD services in only General Medicine and Dental.

The status of the building which is not even two years old is shown through the images given below:

<table>
<tr><td> </td><td> </td></tr>
<tr><td>Broken false ceiling of Operation Theatre</td><td>Cracks in the building facade</td></tr>
<tr><td> </td><td> </td></tr>
<tr><td>Water seepage through roof in the hospital building</td><td>Cracks in the building facade</td></tr>
<tr><td> </td><td> </td></tr>
<tr><td>Peeling off plaster/paint of roof dental room</td><td>Seepage in OPD patient waiting area</td></tr>
<tr><td> </td><td> </td></tr>
<tr><td>High-Tension wires were passing through hospital premises</td><td>Water filter installed in open area on the roof of the hospital</td></tr>
</table>

5.10 State Tuberculosis Hospital, Hisar

State Tuberculosis (TB) Hospital, Hisar was established during the year 1960. The hospital caters to the need of OPD/ IPD along with diagnostic services for TB patients. The TB Hospital was set up with 75 beds, which is now reduced to 25 beds due to dilapidated condition of the hospital building since 2015. Specific norms for services and resources such as OPD, IPD, diagnostic services, equipment, etc. in the TB hospital do not exist. During physical inspection (31 January 2023), it was found that building structure and the residential accommodation were in a dilapidated condition.

Residential quarters at TB Hospital, Hisar	**Toilet for IPD wards at TB Hospital, Hisar**

PWD Department had recommended to declare the building as condemned in the year 2015 and the State Government gave approval for dismantling the TB hospital in October 2016. Thereafter, TB hospital authorities requested (March 2016) PWD to provide estimates for dismantling. In June 2022, PWD supplied an estimate for dismantling one portion of the building. However, despite many requests (March 2016 to December 2022), PWD did not provide complete estimates for dismantling the hospital building.

5.10.1 Availability of essential medicines and manpower in TB Hospital

Central TB Division has prescribed 15 types[12] of essential drugs for treatment of TB. However, five medicines[13] were not available in the hospital. Further, important drugs like Rifampcin and Pyrazinamide were not available since June 2022 and October 2022 respectively.

All five sanctioned posts of Medical Officers including Medical Superintendent, two posts of Pharmacy Officers and 12 posts of Sr. Nursing Officer/Nursing Officer were filled-up.

[12] (i) Rifampcin, (ii) High dose H, (iii) Ethambutol, (iv) Pyrazinamide, (v) Levofloxacin, (vi) Moxifloxacin/High Dose Mfx, (vii) Ethionamide, (viii) Cycloserine, (ix) Na-PAS, (x) Pyridoxine, (xi) Clofazimine, (xii) Linezolid, (xiii) Amoxyclav, (xiv) Bedaquiline and (xv) Delamanid.

[13] (i) Rifampcin, (ii) Pyrazinamide, (iii) Na-PAS, (iv) Amoxyclav and (v) Delamanid

5.10.2 Non-availability of Separate IPD wards for Multi Drug Resistance (MDR) TB Patients

As per Revised National Tuberculosis Control Programme (RNTCP) guidelines, 2017, the MDR ward should be located away from the other wards with preferably a separate passage for the patients to access to the toilets.

However, the wards for drug sensitive TB patients and MDR Patients were adjacent to each other in TB Hospital, Hisar, which was in contravention of the RNTCP guidelines. Further, the IPD beds were not categorised separately for paediatrics, male and female patients. Moreover, functional toilets were also not available with the IPD wards.

5.10.3 Non-availability of critical diagnostic services

In TB Hospital, Hisar, diagnostic services relating to X-ray, Sputum Smear Microscopy and Cartridge Based Nucleic Acid Amplification Test (CBNAAT) were available. However, CBNAAT machine, being an important test for detecting MDR TB patients, was not functional during the month of March 2016 and April 2016 (due to non-availability of AC in the Lab) and during December 2020 and June 2021 to April 2022 (due to non-functioning of the machine and non-availability of cartridges). Further, during physical inspection (31 January 2023), it was also observed that a Complete Blood Count (CBC) machine was non-functional for more than three months. Thus, the objective of GoI to provide free drugs and diagnostic services to TB patients could not be achieved.

5.10.4 Availability of infrastructure in DMC lab

As per Guidance for accreditation of laboratories under RNTCP for Mycobacterial Culture & DST guidelines, minimum space for culture and DST laboratory includes:

i. Adequate space for washing and sterilisation

ii. Space for storing sterile items

iii. Media preparation and inspissation[14] room

iv. Walk-in cold room

v. Culture room and culture reading area

vi. Walk-in incubator room/space for keeping large-sized incubators to hold cultures

vii. Space for keeping the deep freezer, BOD Incubator, etc.

[14] Technique to solidify as well as disinfect serum containing media.

However, none of the infrastructure facilities were available in the DMC lab. Further, during physical inspection, it was also found that the two freezers for laboratory were installed in the hospital corridor due to shortage of space.

5.10.5 Availability of equipment in laboratory

As per servicing standard operating procedure of key lab equipment[15], a laboratory should have a biological safety cabinet (BSC), Air Handling Unit (AHU), Refrigerated Centrifuge (RC) and Autoclave.

It was found that none of the above equipment was available in the hospital. Thus, in the absence of these equipment, the proper protection and optimal functioning of lab could not be ensured.

5.10.6 Infection control management

As per Airborne Infection Control guidelines, a facility infection control / bio-medical waste management plan should be in place. There should be a facility infection control committee and bio-medical waste management committee.

Infection control plans serve to establish visible commitment of facility and facility administration to infection control, articulate clear policies and procedures to ensure proper implementation and make staff roles and responsibilities clear. The facility infection control plan should describe specific measures to be taken and staff roles and responsibilities on ensuring implementation. The plan should also identify the resources in terms of human, material and funding for executing the infection control plan.

It was observed that infection control committee and bio-medical waste management committee were not constituted in the hospital. Further, risk assessment of the health facilities was also not conducted for infection control plan. Checklist for hygiene and infection control was also not available. Further, the facility of autoclave was also not available for sterilisation of instruments, glass ware or media solution in the diagnostic TB laboratory and for decontamination of biological material consisting of infectious waste. Thus, in the absence of a proper plan, the safety of hospital staff and patients was at risk.

[15] **BSC**: Biological Safety Cabinets (Class II) provide protection for experiments (product), personnel and environment. **AHU**: Air handling system is part of TB containment facility and offers protection for personnel, experiments (product) and environment by ensuring directional air flow and maintaining the laboratory under constant negative pressure. **RC**: A refrigerated centrifuge is intended to separate particles in a liquid by sedimentation. In TB laboratory, refrigerated centrifuges are used for the sedimentation of tubercle bacilli and their concentration within liquefied sputa or body fluids. **Autoclave**: The autoclave by using saturated steam under pressure is the most effective means of sterilisation of instruments, glass ware or media solution in the general diagnostic TB laboratory and for decontamination of biological material consisting of infectious waste.

5.11 Delay in setting up of 50 bedded integrated AYUSH Hospital at Village Mayyer, Hisar

Operational Guidelines, 2014 for AYUSH services provide that the main objective of AYUSH services is to enhance coverage of healthcare system through cost effective AYUSH services by focusing on core competency areas of AYUSH through upgrading AYUSH hospitals and dispensaries, co-location of AYUSH facilities at PHCs, CHCs, DHs and setting up of upto 50 bedded integrated AYUSH hospitals. Further, financial assistance upto ₹ 900 lakh (for undertaking construction, with lump sum provision for staff quarters fixtures, equipment, etc.) will be provided by GoI to the States/ UT Governments for setting up of upto 50 bedded integrated AYUSH hospitals as a one-time grant.

Ministry of AYUSH, GoI, accorded approval (2015-16) for construction of 50 bedded integrated AYUSH hospital under National AYUSH Mission in Haryana. Land was identified in the premises of Directorate of AYUSH, Panchkula and an amount of ₹ 233.34 lakh (₹ 83.34 lakh, ₹ 100 lakh and ₹ 50 lakh during 2015-16, 2016-17 and 2017-18 respectively) was approved. Another project of National Institute of Ayurveda was approved for district Panchkula and a proposal was sent (April 2019) to Ministry of AYUSH, GoI by the Director General, AYUSH Department, Haryana to relocate the 50 bedded integrated AYUSH hospital from district Panchkula to village Mayyer. The proposal was approved by the Ministry in June 2019, an amount of ₹ 1,085.18 lakh (₹ 675 lakh from National Ayush Mission + ₹ 410.18 lakh from State budget) were earmarked (September 2019) for the construction of the above hospital. Accordingly, ₹ 675 lakh were released to Executive Engineer, Provincial Division No. III, PWD B&R, Hisar for construction of the above hospital (January 2020). The Department intimated that against the administrative approval of ₹ 1,085.18 lakh, an expenditure of ₹ 812.30 lakh had been incurred (January 2022). However, the hospital did not start functioning as the building was still under construction. Thus, even after a lapse of more than seven years, the main objective to enhance coverage of the healthcare system could not be achieved due to change in site.

The Department replied (January 2023) that 80 *per cent* work had been completed and sanctioned strength for the AYUSH hospital has also been approved. The fact remains that even after a lapse of more than seven years, the hospital could not be made functional.

5.12 Establishment of medical colleges

5.12.1 Medical Institutions in the State

As of January 2024, there were a total of nine medical colleges (including PGIMS, Rohtak) in the State, out of which six medical colleges were functional. Out of these nine colleges, four colleges were in existence before March 2016 and the remaining five colleges (including one acquired private medical college, Chhainsa district Faridabad) were sanctioned during the period 2016-23. The details of these colleges are given below:

(a) Colleges as of March 2016- The State had only one functional Post Graduate Institute and three functional medical colleges having 590 MBBS seats and 360 Post Graduate (PG) seats. The position of medical institute/colleges is given in ***Table 5.8***.

Table 5.8: Details of Medical Institute/colleges established in the State till March 2016

Name of Medical College	Year of establishment	Number of MBBS Seats	Number of PG Seats
PGIMS, Rohtak	1960	250	259
BPS Khanpur Kalan, Sonipat	2012	120	28
SHKM Nalhar, Nuh	2013	120	21
MAMC Agroha, Hisar (Aided)	2002	100	52
Total		**590**	**360**

Source: Website of National Medical Commission

(b) New colleges during 2016-23-During 2016-23, three medical colleges at Jind, Narnaul and Karnal with 420 MBBS seats (along with 19 PG seats for medical college, Karnal) were sanctioned under State Plan. One medical college at Bhiwani with 150 MBBS seats was sanctioned under Centrally Sponsored Scheme. Out of these four sanctioned medical colleges, only one (at Karnal) is functional as of February 2023 as detailed in ***Table 5.9***.

Table 5.9: Details of medical colleges sanctioned after March 2014

Name of Medical College	Number of MBBS Seats	Year of sanction	Status
Jind	150	2020	Under construction (67 *per cent* completed)
Narnaul	150	2019	Under construction (90 *per cent* completed)
Karnal	120	2017	Functional
Bhiwani (Centrally Sponsored Scheme)	150	2014	Under construction (90 *per cent* completed)

Source: Information supplied by DMER and website of National Medical Commission

Apart from these, one private medical college at Chhainsa (Faridabad) was acquired by the State Government from a failed private management in 2020. This medical college was functional with intake of 100 MBBS students from academic year 2022-23 onwards.

Further, one All India Institute of Medical Sciences (AIIMS) in Haryana was sanctioned by GoI in February 2019 for which all expenditure (except land) is

to be incurred by GoI. For this purpose, the State Government identified approximately 210 acre land in Rewari, for which lease deed for approximately 149 acre land had been executed till January 2023.

5.12.2 Delay in submission of proposals/DPRs leading to non-establishment of colleges

Ministry of Health & Family Welfare, GoI, apprised (30 August 2019) the State Governments that it had launched Phase III of Centrally Sponsored Scheme for establishment of new medical colleges or institutes with facilities for post graduate medical education in districts where there were no medical colleges. The scheme envisaged project cost of ₹ 325 crore per college, sharable between the GoI and State Governments in the ratio of 60:40. It was also requested to identify the district/referral hospital fulfilling the prescribed criteria as per guidelines of the scheme and send the proposals along with detailed project report (DPR) for consideration. The same was again requested by GoI in December 2019. Further, GoI also informed that these colleges would become functional by the year 2022-23 and instructed the State Government to expedite submission of proposals along with DPRs to avail benefit of this scheme.

In phase I of the above scheme, the State Government selected one Government Medical College, Bhiwani and in phase II, no government college was selected. The State Government decided (February 2020) to establish three new medical colleges attached with the existing district/referral hospital in Haryana at Yamuna Nagar, Kaithal and Sirsa. But neither the proposal for opening of new medical colleges nor the DPRs were sent to the GoI within the prescribed time. Further, during a review meeting (August 2020) held with Ministry of Health and Family Welfare it was intimated that due to non-submission of DPRs, the proposal/DPRs could not be approved by the GoI.

Thus, the possibility of getting three new MCs under the scheme could not be materialised and State Government was deprived of central assistance valuing ₹ 585 crore[16] due to non-submission of proposals/DPRs by the Department.

The Department stated (January 2023) that the executive agencies were to submit the Master Plan and layout by January 2022, however, these were submitted in February and March 2022. Thus, delay in preparation of DPR and consequent failure to comply with the timelines had resulted in the three medical colleges not being included under the GoI scheme.

5.12.3 Unfruitful expenditure on construction of boundary wall

With a view to improve the shortage of doctors and to correct their skewed distribution, a Centrally Sponsored Scheme (75:25, later changed to 60:40 as per 14th Finance Commission recommendation) of "Establishment of new

[16] ₹ 385 crore per college x 3 colleges x 60 *per cent* = ₹ 585 crore

Medical Colleges attached with existing district/ referral hospitals" having more than 200 bed strength in identified districts across the country had been devised during XII Plan period by Ministry of Health & Family Welfare, GoI. Further, as per guidelines in consultation with the State Government on the basis of the following criteria:

i. Districts where there is no medical college, either Government or Private.

ii. District/referral hospital having bed strength of 200 or more. Where there are two different hospitals for male and female patients at a District Headquarters, the combined bed strength of both would be considered for this purpose.

iii. District/referral hospitals which are located on a unitary piece of land of 20 acres or in such manner that another piece of land is available within 10 km radius, with total area of not less than 20 acre and the smaller piece of land not less than five acre in size.

Accordingly, the State Government decided (April 2014) to open a Government Medical College at Bhiwani. A committee chaired by Director General Medical Education and Research , Haryana had identified (July 2014) 179 *Bigha*, 12 *Biswa* (37 acre, 3 *anal*, 6 *Marla*) of Panchayat land at Prem Nagar which is 7-8 Kms from Bhiwani on Bhiwani-Hansi Road. The Gram Panchayat passed a resolution (No. 5 dated 15 May 2015 and No. 2 dated 4 October 2016) for lease of this land to Medical Education and Research Department, Haryana for a period of 33 years at the rate of ₹ 1/- per acre per year for establishment of a Medical College at village Prem Nagar. The Governor of Haryana accorded approval (November 2016) for lease of this land.

The work for construction of a boundary wall around the selected site was allotted (June 2018) to a contractor for an amount of ₹ 97.64 lakh and was to be completed in 12 months. The work was completed (13 July 2019) after incurring an expenditure of ₹ 94.01 lakh.

The ACS, MER observed (July 2019) that the site proposed for medical college at Prem Nagar was unsuitable due to distant location from District Hospital. The matter remained undecided and finally the site adjacent to District Hospital, Bhiwani was selected at which the construction work was under progress and 90 *per cent* work executed upto February 2023. Thus, due to change of site at Prem Nagar, Bhiwani to another site, the expenditure incurred on construction of the boundary wall was unfruitful.

The Department replied (January 2023) that due to technical reasons pointed out by the executive agency, the Government approved a new site for the establishment of Government Medical college. The boundary wall constructed at the site would be used for some other scheme of the Government. The reply

is not tenable as the feasibility of the proposal for construction of medical college at Prem Nagar site should have been checked by the Department before construction of the boundary wall.

5.12.4 Establishment and infrastructure of Nursing Institutes in test-checked districts

(i) eneral Nursing and Midwifery School, Hisar

In GNM School, Hisar, the infrastructure was not found to be as per norms described in Indian Nursing Council (INC) Act, 1947. As per norms, there should have been six laboratories in a nursing training school. It was observed that all labs were available, but none of them was of the prescribed area. One lab was established in a store which was very small to accommodate 20 students. Further, Multipurpose hall, Common room, Staff room, Vice Principal room, proper library, Audio visual aids room and proper faculty room were not available in the school. Transport facility was also not found available. Availability/non-availability of facilities in the hostel is given in ***Table 5.10***.

Table 5.10: Availability of facilities in GNM School, Hisar (status as of April 2022)

Name of facilities	Availability
Hostel room	10 hostel rooms were available with size of 180 sq. feet per room. As per guidelines issued by INC, in a room 50 sq. feet space is required for each student. So, these rooms are suitable for three students, whereas five to six students were presently staying in one room. Thus, size and accommodation for students was not as per INC norms.
Toilet and bathroom	Available but requires renovation.
Recreation	Not Available
Visitor's room	Available but not having attached toilet facility.
Kitchen and dining hall	Available but not having adequate seating capacity as per the students' strength.
Pantry	Not Available
Washing and ironing room	Not Available
Canteen	Not Available

Source: Information furnished by GNM college, Hisar
Facilities which are not available are shaded in red colour and facilities which are available but not as per norms are shaded in pink colour.

DMER replied (January 2023) that the inspection of GNM School, Hisar was conducted and funds for carrying out certain special repair works were allotted (April 2022) to PWD, B&R Department. However, the reply did not clarify whether the scope of work would address all the deficiencies pointed out in audit.

(ii) Auxiliary Nursing and Midwifery School, Mandikhera

ANM School Mandikhera (Nuh) was being run (as on June 2022) in the hostel building of GNM School of Nursing. There were no proper rooms for Principal, teachers & clerical staff. There was no playground for students and no separate teaching block was available. No audio-visual aids were available in the school. The hostel building provided for the GNM School of Nursing was being used

as hostel campus for ANM students also. Though there was a room for recreation but TV was not available. No staff personnel were deployed to the hostel as per the requirement of INC norms. Principal, warden, kitchen helper, security guard were not deployed. One cook and sweeper were taken from district hospital on temporary basis.

(iii) Non-utilisation of newly constructed NM School of Nursing building in district Nuh

A new building for GNM School which includes teaching block and hostel was constructed at Mandikhera with an expenditure of ₹ 9 crore. The same was inaugurated by the Chief Minister, Haryana on 17 November 2017 and was taken over by the CMO, Mandikhera on 10 December 2018. During joint inspection by audit (23 June 2022), it was noticed that after taking over, the hostel of the building was being utilised by the ANM School of Nursing for teaching facility and hostel facility, whereas the teaching block was partially utilised by the CMO, Mandikhera. The second and third floors were locked and found unutilised. Due to non-maintenance of the building, it was found to be in a very bad condition as many doors and other accessories were infested by termite. No initiative had been taken by the authority to start GNM School of Nursing in this building. Thus, the constructed building was not being fully utilised.

Top floor of Government ANM school of Nursing, Mandikhera, Nuh

5.13 Non-availability and non-maintenance of residential accommodation

As per IPHS 2012 norms, all medical and para-medical staff are to be provided with residential accommodation. If accommodation cannot be provided due to any reason, then the staff may be paid house rent allowance and, in that case, they should stay in the vicinity of the health institutions, so that they are available 24 x 7. Availability of residential accommodation in the test-checked (between January 2022 and July 2022) health institutions is given in ***Table 5.11***.

Table 5.11: Availability of Residential Accommodation in test-checked Health Institutions

Name of district	Name of Health Facility	No. of quarters available	No. of quarters occupied	Status
Hisar	**DH, Hisar**	49	17	Out of 49 government quarters, only 17 quarters have been allotted for which HRA recovered.
	SDCH, Adampur	18	11	Out of 17 residential accommodations, six were not occupied. SMO residence was also not occupied.
	SDCH, Narnaund	19	3	Three quarters occupied by medical officers and 16 quarters of staff nurses and other Staff have been declared condemned by PWD (B&R) Department.
	CHC, Mangali	11	0	Not worth living in due to dilapidated condition.
	CHC, Sorkhi	3	0	Not worth living in due to dilapidated condition. The matter has been taken up with the PWD (B&R) Department for condemnation of these quarters.
	CHC, Uklana	17	2	Four quarters for medical officers are not worth living in and the matter has been taken up with PWD (B&R) Department for repair. Out of six quarters for staff nurse, only one is occupied and rest are vacant. Similarly, out of seven quarters for other staff, only one is occupied and rest are vacant.
	CHC, Barwala	22	10	Only 10 quarters allotted to staff, rest of the quarters are vacant.
	UCHC, Hisar (Sec 1&4)	NIL		Not available
	PHC, Kaimri	3	1	One occupied and rest not worth living in due to bad condition.
	PHC, Talwandi Rukka	4	0	Not worth living in due to dilapidated condition.
	PHC, Puthi Mangal Khan	4	0	Not worth living in due to bad condition.
	PHC, Puthi Samain	3	0	Not worth living in due to bad condition.
	PHC, Hasangarh	3	0	Vacant
	PHC, Daultpur	1	0	Not worth living in due to dilapidated condition.
	PHC, Ladwa	0	0	Not available
	PHC, Agroha	Nil		Not available
	PHC, Dhansu	NIL		Not available
	UPHC, Char Qutub Gate Hansi	NIL		Not available
	UPHC, Patel Nagar	NIL		Not available
Panipat	**DH, Panipat**	8	1	Only one quarter was occupied. Rest of the quarters were neither got repaired nor got condemned during 2016-21.
	SDCH, Samalkha	Nil		Not available
	CHC, Bapoli	11	0	Not in use, were used as store only.
	CHC, Madlauda	7	7	Occupied by the officers/officials.
	CHC, Naraina	11	0	Not occupied by the officers/officials. The residential quarters were in dilapidated condition.
	CHC, Naultha	9	0	Not in use/abandoned since 2005.
	UCHC, Sector-12 Panipat	Nil		Not available
	All the selected PHCs (HWCs)	Nil		Not available
Nuh	**DH, Mandikhera**	80	80	All the quarters were occupied but not maintained properly.
	CHC, Firojpur Jhirkha	Nil		Under construction.
	CHC, Punhana	8	8	Occupied
	PHCs (HWCs), Jamalgarh	6	0	The civil works of residential accommodation was not completed and they were found vacant.
	PHC, Biwan	Nil		Not available
	PHC, Nagina	3	3	Occupied
	PHC, Singar	Nil		Not available

Source: Information furnished by test-checked health institutions

It was observed that:

i. In the test-checked hospitals there were 174 residential quarters. Out of these, only 112 quarters were allotted/ occupied, 39 quarters (32+07) were vacant at DH Hisar and SDCH Adampur and 16 quarters were condemned at SDCH Narnaund. Seven quarters at DH Panipat were not in good condition but had not got repaired/ condemned. Residential accommodation at DH Mandikhera had cracks in the wall, windows

were without window panes and electric wires were hanging outside. No residential accommodation was available at SDCH Samalkha.

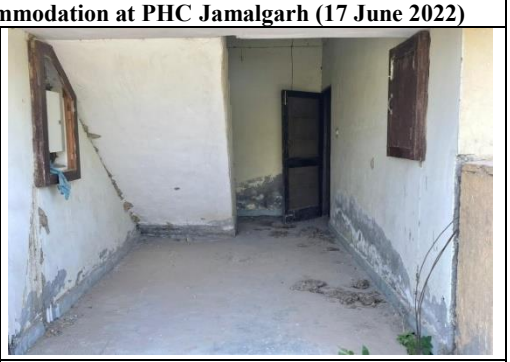
ii. In the test-checked CHCs/ UHCs there were 99 residential quarters, out of which only 27 quarters were allotted/ occupied, nine quarters at CHC Naultha were condemned. Quarters at CHC Maglani and Naraina were in dilapidated condition. Quarters at CHC Bapoli were being used as store. No residential accommodation was available at CHC Firozpur Jhirka (under construction), UHC (Sec 1&4) Hisar and UHC (Sec 12) Panipat.

iii. In the test-checked PHCs/ UPHCs (24), residential accommodation was available in eight[17] PHCs/ UHCs and in 16 PHCs/UPHCs no residential accommodation was available. Out of these eight PHCs, residential accommodation available in six PHCs of Hisar district were in dilapidated condition and were not worth living in and the residential accommodation at PHC Nagina was occupied.

iv. At PHC Jamalgarh, two residential quarters for medical officers and four residential quarters for staff nurses were in dilapidated condition. Doors, windows glass, side railing and wire in electricity fittings were not available.

Incomplete civil structure of residential accommodation at PHC Jamalgarh (17 June 2022)

SMO's residence at CHC Bapoli was being used as store (24 March 2022)



Dilapidated residential accommodation at CHC Naraina (29 March 2022)

[17] PHCs (i) Kaimri, (ii) Talwandi Rukka, (iii) Puthi Mangal Khan, (iv) Puthi Samain, (v) Hasangarh, (vi) Laultpur, (vii) Jamalgarh and (viii) Nagina

5.14 Conclusion

Estimation, planning and creation of requisite infrastructure facilities are essential for ensuring the provision of optimum level of healthcare facilities. As highlighted in this chapter, there was inadequate availability of health institutions as compared to the prescribed norms. There were planning deficiencies and avoidable delays in various construction works like ensuring encumbrance-free site, obtaining requisite administrative approvals and delays in the tendering process. There were shortfalls in achievement of the targets of upgradation of HWCs and AHWCs. Instances of lack of proper up-keep and maintenance of the already constructed/available infrastructure were also noticed, which resulted in these being not fully utilised for the intended purposes.

5.15 Recommendations

1. **The Government should make a plan for determining the requirements and providing the requisite infrastructural facilities in each district, on the basis of its population, local epidemiology, health-seeking behaviour of the population, contribution of the private sector and the benchmarks set under National Health Policy and IPHS norms.**

2. **The Government may look into the issues of delays in start and/or completion of planned infrastructural works, with a view to remove the bottlenecks and ensure speedy completion.**

3. **The Government may put in place necessary procedures and provisions for effective utilisation of the already available infrastructure, so that the intended benefits can be fully achieved, and cases of idle infrastructure are avoided.**

4. **The Department should maintain statistical data of availability of beds in CHCs, PHCs and HWCs for future planning.**

Chapter-6
Financial Management

Chapter-6

Financial Management

6.1 Budget allocation and expenditure on Health Sector (Central and State Government)

Finances for health infrastructure and management of health services in the State are sourced through the State budget. Details of allocation of budget and expenditure incurred from Government of India (GoI) and Government of Haryana (GoH) and savings in Department of Health and Family Welfare during 2016-17 to 2022-23 is given in ***Table 6.1***.

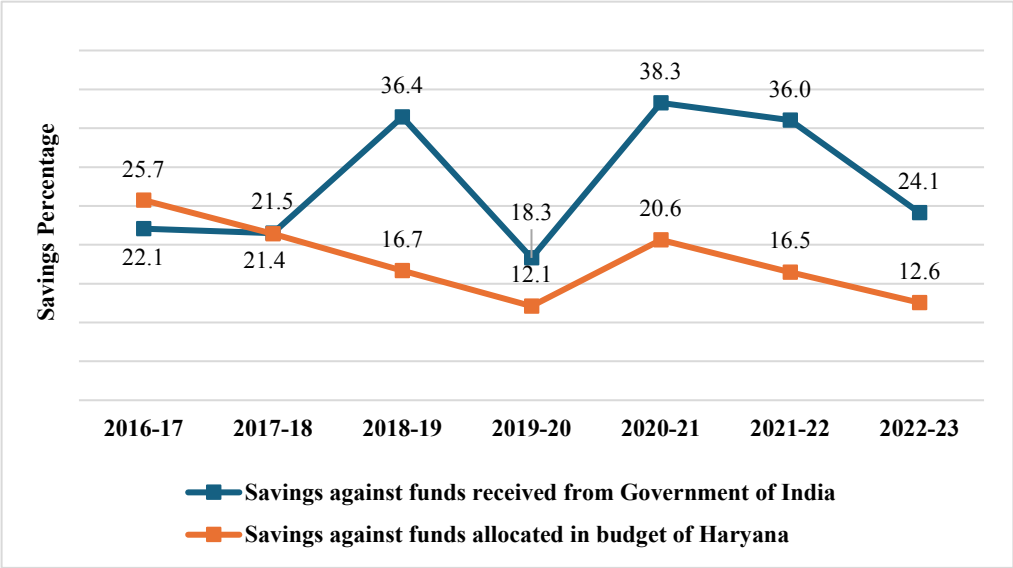
Table 6.1: Budget provision and expenditure on Health Sector (GoI and GoH)

(₹ in crore)

Year	Government of India			Government of Haryana		
	Budget Provision	Expenditure	Savings	Budget Provision	Expenditure	Savings
2016-17	532.36	414.77	117.59	3,541.36	2,629.66	911.70
2017-18	563.82	442.56	121.26	3,733.87	2,933.91	799.96
2018-19	734.54	466.81	267.73	4,260.23	3,550.36	709.87
2019-20	720.84	588.83	132.01	5,007.62	4,401.29	606.33
2020-21	1,013.77	625.94	387.83	6,581.32	5,223.39	1,357.93
2021-22	1,225.19	783.90	441.29	7,320.13	6,113.63	1,206.50
2022-23	1,457.05	1,105.43	351.62	7,541.93	6,594.70	947.23
Total	**6,247.57**	**4,428.24**	**1,819.33**	**37,986.46**	**31,446.94**	**6,539.52**

Source: Appropriation Accounts

Chart 6.1: Savings against Total Budget Provision (*per cent*)



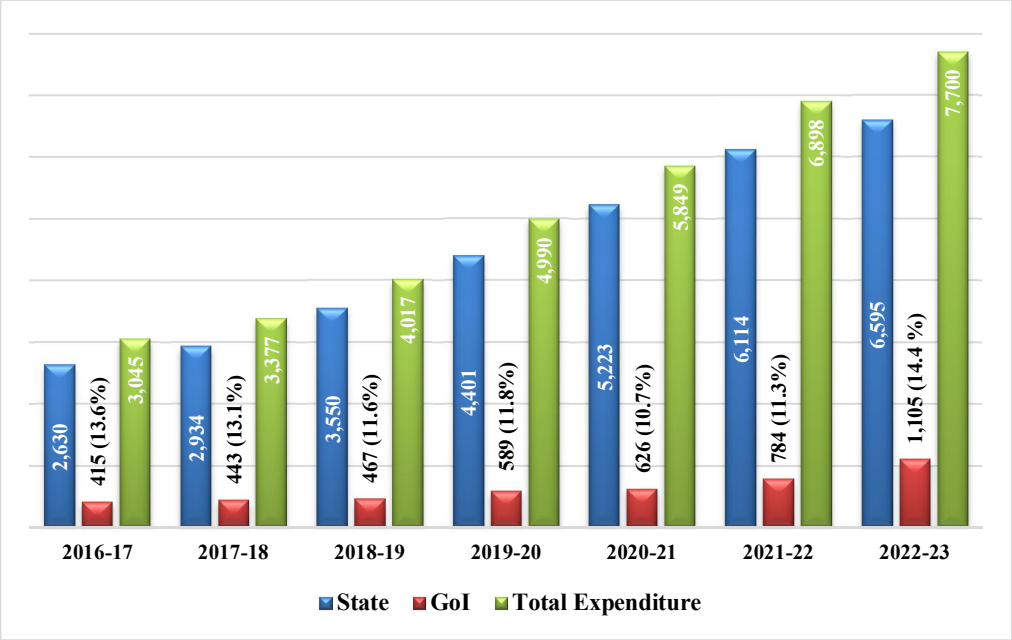
Source: Appropriation Accounts

It is evident from the above that funds ranging from 18.3 *per cent* to 38.3 *per cent* against the total budget allocated by GoI and from 12.1 *per cent* to 25.7 *per cent* against the budget allocated by the State Government on the health sector could not be utilised during 2016-17 to 2022-23.

6.2 Share of expenditure on Health Sector by GoI and State Government

The State Government implements Central Sharing Schemes, in which funds received/ expenditure incurred are in the ratio of 60:40 (Centre:State). Besides, various State Plan schemes and Central Sector schemes are also implemented by the Health and Family Welfare Department. Expenditure incurred under all schemes under GoI and State as well as total expenditure during 2016-17 to 2022-23 is given in ***Chart 6.2***.

Chart 6.2: Expenditure incurred under all schemes under GoI and State as well as total expenditure during 2016-17 to 2022-23



Source: Appropriation Accounts

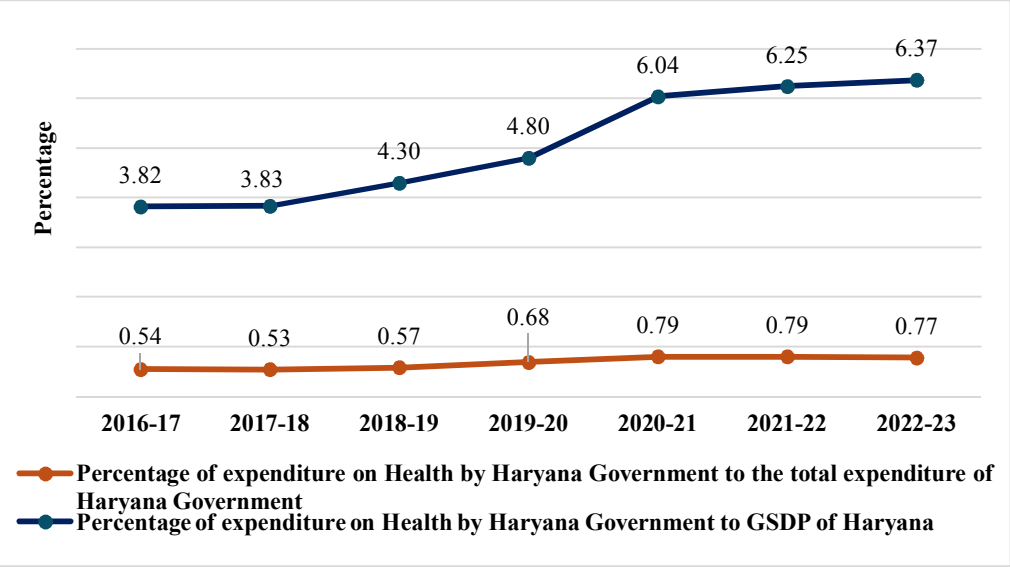
From the above, it can be seen that out of the total expenditure incurred by the State Government on Health Sector, contribution of GoI ranged between 10.7 *per cent* and 14.4 *per cent.*

6.3 Expenditure on Health Sector by the State *vis-a-vis* National Health Policy norms

Paragraph 2.4.3.1 of National Health Policy, 2017, envisages increase on health expenditure by Government as a percentage of GDP from the existing 1.15 *per cent* to 2.5 *per cent* by 2025 and increase State sector health spending to more than 8 *per cent* of their budget by 2020.

Chart 6.3 indicates the percentage of the State expenditure on Health sector to GSDP of Haryana and its total expenditure.

Chart 6.3: Percentage of State expenditure on health *vis-a-vis* GSDP of Haryana and *vis-a-vis* total expenditure



Source: Finance and Appropriation Accounts of respective years and information of GSDP on current prices obtained from Department of Economic and Statistical Affairs, Haryana

From the above, it may be seen that against the target of 8 *per cent*, government spending on the health sector remained between 3.82 *per cent* and 6.37 *per cent* of the total expenditure during 2016-17 to 2022-23. The expenditure has increased from ₹ 3,044.43 crore during 2016-17 to ₹ 7,700.13 crore during 2022-23. Similarly, as against the target of 2.5 *per cent* of GSDP (to be achieved by 2025), the expenditure on health increased from 0.54 *per cent* to 0.77 *per cent* of GSDP during 2016-17 to 2022-23. As such, there is still scope for the Government to increase expenditure on the health sector.

6.4 Revenue and Capital Expenditure

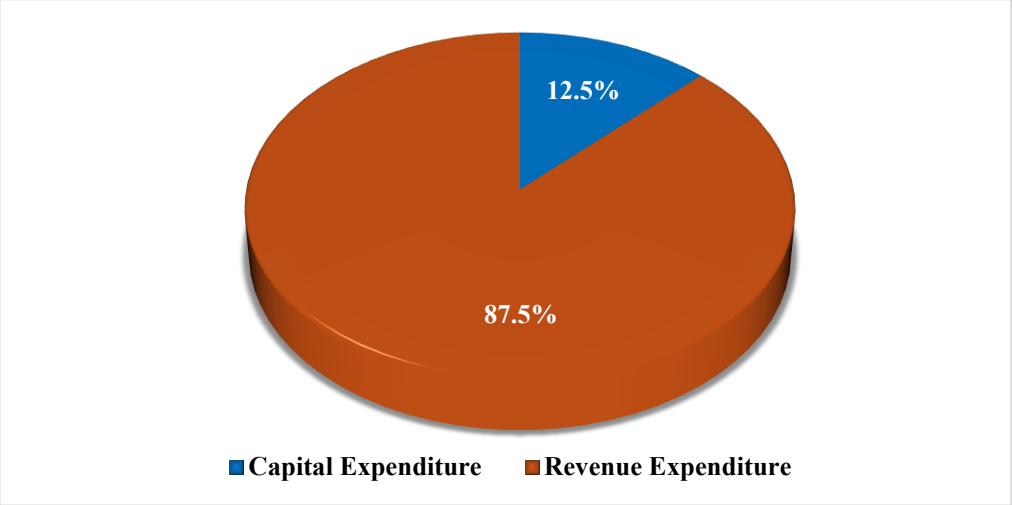
6.4.1 Revenue and Capital Expenditure

Revenue expenditure includes establishment expenses, Grants-in-Aid to various health institutions, expenditure on training programmes, immunisation programme, family planning programmes, Employees State Insurance Scheme, various schemes/programmes of State/ Central Government, assistance to other Non-Government Institutions and purchase of medicines.

Capital expenditure includes construction/major repairs to buildings of health institutions, acquisition of land and strengthening of State Drug Regulatory System.

Out of the total expenditure of ₹ 35,875.18 crore incurred on health during 2016-23, revenue expenditure was ₹ 31,406.35 crore (87.5 *per cent*) while capital expenditure was ₹ 4,468.83 crore (12.5 *per cent*) as indicated in the following ***Chart 6.4***.

Chart 6.4: Percentage of Capital Expenditure vis-a-vis Revenue Expenditure for the years 2016-17 to 2022-23



Source: Appropriation Accounts

6.4.2 Preparation of unrealistic budget

As per the instructions issued (October 2019) by the Finance Department, Government of Haryana, the budget estimates should be submitted online by the Departments after consolidation of the entire budget proposals by the Drawing and Disbursing Officers/Budget Controlling Officers (BCOs). Further, information regarding physical achievements for the previous year (2019-20) and physical targets for the next financial year (2020-21) was also to be submitted while preparing budget estimates for the financial year 2020-21.

However, physical achievements of the previous year (2019-20) were not submitted by the BCOs while submitting the budget estimates for the period 2020-21 in respect of various schemes implemented by the Director General, Health Services (DGHS) in violation of the instructions of the Finance Department. There was no demand assessment for funds from the district offices/implementing agencies. Rather the fund requirements were centrally decided by the programme officers concerned in DGHS office who prepared the Explanatory Memorandum of the Schemes based on the approximate previous years' expenditure. The same process was followed in the subsequent years also.

In case of preparation of budget estimates for the purchase of medicines and equipment from Haryana Medical Services Corporation Limited (HMSCL), it was noticed that there was annual demand assessment which is uploaded on the Online Drug Inventory and Supply Chain management System by the District offices. However, the same was not considered and the budget estimates were based on the previous year's expenditure plus the normal escalation of 10 *per cent*. Thus, no bottom up/systematic approach was being followed in preparing the budget estimates.

The Director General, Health Services in their reply stated (June 2022) that the budget is prepared in respect of recurring and non-recurring development schemes. The demand in respect of the recurring development schemes is not received from the districts. Thus, the budget in respect of these schemes is proposed based on the increase in the previous year's budget and is uploaded online on the Finance Department portal.

In respect of non-recurring schemes, the respective programme officers submit the memorandum of scheme and seek the budget through the online portal of the Finance Department. Only after uploading the information about the physical targets/achievements, the budget estimates are put into process.

However, the Department could not produce any document/evidence of submission of physical targets/achievements by the programme officers.

6.5 Budget allocation and expenditure on important components under National Health Mission

National Health Mission (NHM), Haryana received funds in 60:40 ratio from GoI and Government of Haryana. There was wide variation in the budget provision and actual expenditure during the period from 2016-17 to 2022-23. Important components under NHM with very high variations are shown in ***Table 6.2***. The year-wise details of budget allocated, expenditure incurred and funds remaining unutilised is given in ***Appendix 6.1.***

Table 6.2: Budget allocation and Expenditure on important components under NHM

Name of Scheme	Total budget for 2016-17 to 2022-23 (₹ in lakh)	Total expenditure for 2016-17 to 2022-23 (₹ in lakh)	Percentage of total expenditure to budget	*Per cent* utilisation							Sparkline for seven years from 2016-17 to 2022-23
				2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	
National Vector Borne Disease Control Programme (NVBCP)	2,466	1,482	60	60	59	68	37	57	61	78	
Information, Education & Communication (IEC)/ Behavior Change Communication (BCC)	9,478	5,127	54	47	50	48	44	39	59	71	
Iodine Deficiency Disorder (IDD)	287	43	15	33	0	0	0	0	20	50	
Procurement of equipment/drugs funds	28,862	11,139	39	12	29	33	67	24	48	41	
New Constructions/ Renovation and Setting up funds	30,084	1,738	6	24	10	85	47	2	1	10	
Hospitals Strengthening funds	30,371	6,075	20	1,156	118	36	2	8	25	33	
Innovation activity	5,278	1,099	21	134	4	8	25	73	13	35	

Source: Information furnished by NHM, Haryana

As can be seen from the above table, the utilisation percentage varied across the years. There were persistent savings or excess or both in these schemes. For instance,

i. In case of National Vector Borne Disease Control Programme, out of the budget provision of ₹ 2,466 lakh, only ₹ 1,482 lakh (60 *per cent*) was utilised. The Management in its reply (January 2024) stated that the reasons

for under-utilisation of funds were the declining trend of incidence of malaria and non-purchase of equipment/microscope and Bi-valent rapid diagnostic test kits for malaria from Haryana Medical Services Corporation Limited. Further, some activities such as training and procurement of logistics etc. were also hampered due to COVID-19 pandemic.

ii. Budget provision under Information Education & Communication (IEC)/Behaviour Change Communication (BCC) was enhanced every year (except 2020-21) but NHM incurred expenditure ranging between 39 and 71 *per cent* during 2016-17 to 2022-23.

The MD, NHM Haryana replied (January 2023/February 2024) that less expenditure for the years 2016-17 to 2022-23 was due to non-finalisation of pending payments of printing firms and that efforts were being made for maximum utilisation of budget by the concerned wings/divisions.

iii. In Iodine Deficiency Disorder (IDD) component, NHM had utilised 33 *per cent* funds in the year 2016-17 and did not incur any expenditure during the period 2017-18 to 2020-21. However, it expended 20 and 50 *per cent* of the funds in the years 2021-22 and 2022-23 respectively.

The MD, NHM Haryana replied (January 2023/February 2024) that the National Iodine Deficiency Disorders Control Programme (NIDDCP) was initially monitored by DGHS Haryana from 2016-17 to 2020-21 and due to delay in procurement procedure, the expenditure could not be booked. The programme was shifted to NHM in November 2020. In 2021-22, the indent for the procurement of salt testing kits was raised to HMSCL but due to single bid participation by the vendor, the same could not be procured timely.

iv. For procurement of equipment/drugs, funds were utilised ranging from 12 to 67 *per cent*. The MD, NHM intimated (February 2024) that the delay was on the part of HMSCL. Out of funds of ₹ 157.95 crore transferred to HMSCL by NHM, only ₹ 39.89 crore have been utilised so far.

v. Budget provisions for new construction/renovation and setting up of CHCs, PHCs and Sub Centre was increased from ₹ 1.91 crore in the year 2016-17 to ₹ 122.75 crore in the year 2022-23 but percentage of utilisation ranged between 1 to 47 *per cent* during the period from 2016-17 to 2022-23 except 85 *per cent* during the year 2018-19.

The MD, NHM Haryana replied (January 2023) that various communications have been made to PWD (B&R) to expedite the work.

vi. Budget provision for hospital strengthening was increased from ₹ 0.47 crore to ₹ 78.30 crore during 2016-17 to 2022-23. The percentage

of expenditure incurred during the years 2016-17 and 2017-18 was 1,156 and 118 *per cent* respectively. Further, for the years 2018-19 to 2022-23, it ranged between 2 to 36 *per cent*.

The MD, NHM Haryana replied (January 2023) that the budget has been approved for hospital strengthening activities i.e construction of additional building, major upgradation of CHCs, PHCs, HWCs. The funds were released to PWD (B&R) for the above purposes and the works are in progress. The balance amounts will be booked on receipt of utilisation certificates in respect of the advances given to PWD (B&R).

vii. There was wide variation in utilisation of funds of innovation activities during 2016-17 to 2022-23. The utilisation of funds ranged between 4 to 134 *per cent* during the same period.

The MD, NHM Haryana replied (November 2022) that this being a new activity, it takes time for approval from higher authorities before its launch. Further, the activity has to be carried out involving NGO partners and Ministry of Health & Family Welfare, GoI.

As evident from the above, expenditure on important activities of NHM was very less despite availability of budget.

6.5.1 Inadequacy of funds

Mukhya Mantri Muft Ilaaj Yojana (MMIY) was launched in January 2014, which seeks to provide free treatment in all Government Health Institutions. Following are the major components under MMIY

i. Surgeries under Surgery package programme (for Haryana residents only)

ii. Free basic laboratories investigations, along with free X-Ray, ECG and USG (wherever available in the Government Health Institutions)

iii. Free indoor services

iv. Free OPD services

v. Free drug supply

vi. Free referral transport/ambulance services

vii. Free dental treatment

Audit observed that bills in respect of Computed Tomography (CT) scan, dialysis center payments, medicines, lab charges, etc. amounting to ₹ 39.39 crore[1] were pending due to non-release of funds by the Department inspite of overall savings ranging from ₹ 606.33 crore to ₹ 1,357.93 crore during 2016-17 to 2022-23.

[1] ₹ 18.06 crore (2018-19); ₹ 18.25 crore (2019-20) and ₹ 3.08 crore (2020-21)

Due to huge pendency of bills, the vendors curtailed/intimated that they would curtail their supplies/services which created inconvenience in running the health services smoothly.

Thus, inadequate funds were released to the Health Institutions to meet their requirements which impacted the delivery of health services in the State.

6.6 Delay in release of funds to implementing agencies

In respect of various Centrally Sponsored Schemes, the funds are transferred to the NHM Society through the State Treasury. The Ministry of Finance, Department of Economic Affairs, Government of India fixed (October 2017) the rate of interest that should be claimed by State Health Societies where the delay in transfer of funds from State Treasury to State Health Societies is more than 15 days. So, the funds are ideally expected to be transferred to the State Health Society/NHM or to any other Department within 15 days of credit in the State treasury.

However, the State Government released the funds with delays (in case of two Directorates) ranging between 1 and 262 days beyond the prescribed period during the years 2016-17 to 2020-21. This resulted in interest of ₹ 18.79 crore becoming due to the State Health Societies from the State Government as shown in ***Table 6.3***.

Table 6.3: Delay in release of funds to implementing agencies during the years 2016-17 to 2020-21

(₹ in crore)

Name of the Directorate	Amount sanctioned	No delay	Amount released with delay between 1 and 15 days from the prescribed period	Amount released with delay between 16 days and six months from the prescribed period	Amount released with delay more than 6 months from the prescribed period	Interest Amount
State Health Society/ National Health Mission	1,391.46	0	81.84	1,305.59	4.03	16.13
Director General, AYUSH	140.10	0	0	132.56	7.54	2.66
Total	**1,531.56**	**0**	**81.84**	**1,438.15**	**11.57**	**18.79**

Source: Information furnished by NHM/AYUSH

The Mission Director (MD), NHM Haryana stated (January 2023) that NHM Haryana is making earnest efforts to receive the funds from the State Treasury.

The Director General, AYUSH Department stated (January 2023) that Grants-in-Aid (GIA) could not be withdrawn from the State treasury unless sanction of State Share is received from the Finance Department. This led to delay in release of GIA.

6.7 Non-submission of Utilisation Certificates

DGHS releases quarterly advances to HMSCL for the purchase of medicines and equipment. After receipt of funds, Purchase Orders (POs) are placed online through the online portal of HMSCL. Against these advances, HMSCL furnishes the Utilisation Certificates (UCs) to DGHS.

On scrutiny of UCs of advances in respect of two schemes[2], it was observed that the UCs were furnished by HMSCL on the basis of POs raised irrespective of whether the commitment was fulfilled by the supplier or whether the amount had actually been utilised.

During the years 2020-23, HMSCL furnished UCs for ₹ 17.56 crore to DGHS against 199 POs where supplies were incomplete or no payment was made to the suppliers.

The Managing Director, HMSCL accepted (January 2023) that previously Utilisation Certificates were being issued on the basis of supply order issued. In future, Utilisation Certificates would be issued after the funds are utilised.

6.8 Monitoring of funds across entities related to health

State Health Society/National Health Mission gives advances to various corporations, departments and companies for various purposes. Audit observed that adjustment of advances of ₹ 42.90 crore was pending since 2018-19 till date (June 2022) as detailed in ***Table 6.4***.

Table 6.4: Outstanding Advances as on June 2022

Sl. No.	Name of Company/Corporation/ Department etc.	Pending since	Outstanding advances (₹ in crore)
1	PWD (B&R) Executive Engineer, Nuh	2019-20	13.00
2	PWD (B&R) Executive Engineer, Panipat	2019-20	13.00
3	PWD (B&R) Executive Engineer, Panchkula	2019-20	8.40
4	PWD (B&R) Executive Engineer, Faridabad	2020-21	5.00
5	HLL Life Care Ltd.	2018-19	2.32
6	Social Justice and Empowerment Department	---	1.18
	Total		**42.90**

Source: Information furnished by NHM, Haryana.

The Mission Director, NHM replied (January 2023) that utilisation certificates of ₹ 1.18 crore had been adjusted and ₹ 41.72 crore remained unadjusted. In rest of the cases either the works were in progress or payments were held up due to some or the other reason.

Moreover, it was also observed that during the years 2020-21 and 2021-22, HMSCL received advances amounting to ₹ 614.75 crore for COVID-19. Against these funds, Emergency POs (COVID-19 POs) for the purchase of drugs and equipment amounting to ₹ 590.39 crore were raised during 2020-21

[2] Purchase of medicines for the hospitals and Schedule Caste patients

and 2021-22. However, the details of utilisation of funds against each advanced amount was not available with HMSCL as the manual system was followed in respect of purchases during COVID-19. Audit also noticed that the details regarding the status of the supply orders - whether completed/pending for execution - was also not available with HMSCL. The above instances indicate poor monitoring and internal control regarding advances received from various Departments. Thus, the Department should make efforts to obtain the details of the outstanding advances made to various departments and also authenticate the outstanding advances lying with HMSCL.

6.9 Non-adoption/delay in adoption of financial statements

Rule 24 (1) of Haryana Registration and Regulation of Societies Rules, 2012 states that every Society shall hold its Annual General Meeting (AGM) within a period of six months of the close of the financial year for approval and adoption of its duly audited annual accounts. Audit observed huge delays in finalisation of accounts of societies governed by the Health Department as detailed below:

i. Project Director, AIDS Control Society: Annual accounts for the financial years 2017-18 to 2020-21 were approved with delay beyond six months of the respective financial years. No Annual General Meeting was convened during the years in which these annual accounts were adopted.

ii. State AYUSH Society, Haryana: Records in respect of approval and adoption of financial statements were not furnished since its inception in 2014.

The Director General, AYUSH Department stated (January 2023) that the State AYUSH Society is preparing financial statements from the inception of National Ayush Mission (NAM) and also getting approval of the Audited Financial Statements. The fact remains that though the financial statements were being prepared, the same were not being approved and adopted in the AGM as required under Rule 24(1) of the Haryana Registration and Regulation of Societies Rules, 2012.

6.10 Budget and Expenditure for selected districts (GoI and State)

In test checked districts, year-wise revenue budget and revenue expenditure during 2016-22 pertaining to the Department of Medical Health and Family Welfare was as shown in ***Table 6.5***.

Table 6.5: Revenue Budget and Revenue Expenditure in test-checked Districts

(₹ in crore)

Year	Hisar		Panipat		Nuh		Total		
	B	E (in *per cent*)	B	E (in *per cent*)	B	E (in *per cent*)	B	E	Savings (*per cent*)
2016-17	68.00	67.21 (98.84)	39.91	40.40 (101.23)	22.43	18.09 (80.65)	130.38	125.69	3.60
2017-18	80.72	74.72 (92.57)	48.67	47.07 (96.71)	29.57	25.05 (84.71)	158.96	146.84	7.63
2018-19	81.87	81.43 (99.46)	51.28	50.49 (98.46)	38.17	35.27 (92.40)	171.32	167.19	2.41
2019-20	104.99	104.36 (99.40)	61.40	61.25 (99.76)	54.15	51.06 (94.29)	220.54	216.66	1.76
2020-21	122.43	122.92 (100.40)	69.98	69.11 (98.76)	49.58	47.77 (96.35)	241.99	239.79	0.91
2021-22	124.58	124.44 (99.89)	82.58	81.03 (98.12)	57.62	57.48 (99.76)	264.78	262.95	0.69
Total	**582.59**	**575.08 (98.70)**	**353.82**	**349.35 (98.74)**	**251.52**	**234.72 (93.32)**	**1,187.97**	**1,159.12**	**2.42**

Source: CMO Hisar, CMO Panipat and CMO Nuh (Health and Family Welfare)
Note: B: Budget and E: Expenditure

6.11 Other issues

6.11.1 Non-obtaining/renewal of the bank guarantee/FDR

As per the notification (7 December 2021) of the Medical Education and Research Department, Government of Haryana for establishment of a new self-financing/Private Nursing Institute, the Applicant Society/Trust/Company to whom a Letter of Intent has been issued shall be required to submit the Bank Guarantee/FDR of ₹ 15 lakh for each ANM/GNM[3] course and ₹ 20 lakh for each B.Sc Nursing, Post Basic B.Sc Nursing and M.Sc Nursing course valid for five years. No Objection Certificate shall be issued to an applicant only after deposit of said bank guarantee of the requisite amount by the applicant. The applicant shall furnish a renewed bank guarantee for another term of five years, at least six months in advance before the date of expiry of the original one.

Audit observed that 65 nursing institutes did not submit/renew the Bank Guarantees/FDRs amounting to ₹ 26.65 crore for 158 courses to Director, Medical Education and Research up to December 2023, although NOCs had been issued in all cases. These institutes were running the courses without submission/renewal of Bank guarantees/FDRs. Non-obtaining the bank guarantee/FDR entails a risk that in case the institution is not found to run/sustain itself, it would be difficult to ensure the continuation of the studies of the enrolled students, payment of the salary of the staff and other costs of running the institute.

[3] Auxiliary Nursing and Midwifery/General Nursing and Midwifery

6.12 Conclusion

There were savings ranging from 18.3 *per cent* to 38.3 *per cent* against the total budget allocated by GoI and from 12.1 *per cent* to 25.7 *per cent* against the budget allocated by State Government on Health Sector during 2016-17 to 2022-23. During the same period, GoI contributed between 10.7 *per cent* and 14.4 *per cent* of the total expenditure on health services in the State. Though the government spending on health sector increased from 3.82 *per cent* of total expenditure to 6.37 *per cent* during 2016-23, there was still scope to increase the spending on health services. No demand for assessment of funds were obtained from the district offices/implementing agencies. Instead, the fund requirements were centrally decided by the programme officers concerned in DGHS office on the basis of approximation of previous year's expenditure. In HMSCL, the budget estimates were based on the previous year's expenditure plus the usual escalation of 10 *per cent*. Thus, no bottom up/systematic approach was being followed in preparing the budget estimates. Further, there was wide variation in the budget provision and actual expenditure in various components under NHM. Under MMIY scheme, funds were not released by the Department as per demand despite overall savings.

6.13 Recommendations

1. **Government may increase budget allocation on health services in line with the guidelines of National Health Policy.**
2. **Budget allocation and allocative efficiency across sectors/ schemes impacting performance of the health sector need to be addressed by the Government.**
3. **Government may review the healthcare ecosystem in the State to identify the constraints/factors adversely impacting the absorptive capacity of funds and make concerted efforts for their resolution.**
4. **The budget estimates should be prepared keeping in view a bottom up/systematic approach by obtaining demand assessment from the field offices.**

Chapter-7
Implementation of Centrally Sponsored Schemes

Chapter 7

Implementation of Centrally Sponsored Schemes

Health being a State subject, the Central Government supplements the efforts of the State Governments in delivery of health services through various schemes of primary, secondary and tertiary care. The findings with respect to audit of implementation of centrally sponsored schemes in the State are discussed in the succeeding paragraphs:

7.1 National Urban Health Mission (NUHM)

The National Health Mission (NHM) is the flagship health sector scheme of GoI which encompasses two Sub-Missions - National Rural Health Mission (NRHM), 2005 and National Urban Health Mission (NUHM), 2013. The main programmatic components include Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. NHM envisages achievement of universal access to equitable, affordable and quality healthcare services that are accountable and responsive to people's needs.

To address the healthcare needs of the urban population, particularly urban poor, the Ministry of Health and Family Welfare has formulated NUHM as a Sub-Mission under an over-arching NHM to provide equitable and quality primary healthcare services to the urban population with special focus on slum and vulnerable sections of the society. Out of the three selected districts, NUHM was implemented in only Panipat and Hisar districts.

7.1.1 Mapping and Vulnerability Assessment

NUHM guidelines, 2017 required conduct of "Mapping and Vulnerability Assessment" to understand the available resources, service gaps and health needs of the urban residents, with a deliberate focus on the special needs of the vulnerable groups. It was recommended to conduct city mapping either through GIS (Geographical Information System) or through a manual consultative process. Vulnerability assessment was to assess vulnerability status of wards, slums and slum households in the city, to understand the vulnerability status of a particular slum and each household in the slum. 'Vulnerability Mapping and Assessment' was required to be done on a periodic basis. This may not be an extensive exercise and can be conducted in a sampled way as an annual exercise which can be linked to the annual planning and budgeting process.

Urban Community Health Centres (UCHCs) were to be made operational for every 2.5 lakh population, UPHCs were to be made operational with population of approximately 50,000-60,000 and were to be located preferably within a slum or near a slum area within half a kilometer radius, catering to a slum population of approximately 25,000-30,000.

Out of the three test-checked districts, NUHM was not implemented in district Nuh due to predominantly rural population and non-existence of large city. City Mapping was conducted in district Panipat and Hisar.

In Panipat city, six UPHCs were established after considering distance from slum areas. However, in Hisar city, four UPHCs were established within a limit of one to six kilometers radius distance from the identified slum areas, against the NUHM guidelines of setting up UPHCs within a half kilometer radius of the slum areas. Thus, it defeated the NUHM's objective of equitable and quality primary healthcare services to the urban population with special focus on slum and vulnerable sections of the society in district Hisar. Further, city mapping in both the districts was done in 2016-17 and thereafter, assessment for requirement of further UHCs/ UPHCs was not done in any of the test checked districts.

In its reply the Department stated (January 2023) that every year more number of UPHCs are approved by the GoI and are made operational. The reply is not tenable as the Department failed to establish the UPHCs within the distance limit prescribed as per NUHM guidelines.

7.1.2 Outreach services and Orientation Workshop of NUHM

As per operational guidelines for conducting Outreach Sessions in Urban Areas, outreach services can be categorised into two types - Monthly outreach sessions/Urban Health and Nutrition Days (UHNDs) and Special Outreach Sessions to be held periodically as per the local requirements of the specific population subgroups. Further, as per Record of Proceedings (ROP), one meeting per month (Orientation workshop) was to be organised in all the districts (except Nuh and Mahendragarh), in all the Urban PHCs. Details of Outreach Sessions held in the test-checked districts during the period 2016-21 are given in ***Table 7.1***.

Table 7.1: Status of Outreach Sessions and Orientation Workshops during 2016-21

Name of District	Target	Achievement	Shortfall	Shortfall (*per cent*)
Outreach session				
Hisar	480	232	248	51.67
Panipat	720	35	685	95.14
Orientation workshop				
Hisar	40	32	8	20.00
Panipat	60	32	28	46.67

Source: Information furnished by DHS in test-checked districts.

It is evident from the above table that Outreach camps were organised with a shortfall of 51.67 *per cent* in Hisar and 95.14 *per cent* in Panipat. The main reason for not achieving the target in Panipat was due to non-availability of specialist doctors. Further, there was shortfall of 20 *per cent* to 47 *per cent* in the selected districts in organising workshop during the period 2016-21. No

reasons were offered for the shortfall in achievement of targets under outreach sessions and orientation workshops.

The Department stated (January 2023) that in district Panipat, the target was not achieved due to non-availability of specialist doctors. Further, during the years 2019-20 and 2020-21, outreach activities were highly affected because of lockdown and COVID pandemic restrictions. The fact remains that the shortfall in organising outreach sessions and orientation workshops in district Panipat was 95.48[1] and 47.92[2] *per cent* respectively during the period 2016-20 i.e., before COVID. Further, the outreach camps could have been organised by the Department by involving the doctors available with the Department to reduce the shortfall to the extent feasible.

7.2 Family Welfare Scheme

India was the first country in the world to launch a National Programme for Family Planning in 1952[3]. Following its historic initiation, the Family Planning programme has undergone many transformations in terms of policy and actual programme implementation. Post the International Conference on Population and Development (ICPD) 1994 held in Cairo, there was a de-emphasis on Family Planning globally with the donors substantially reducing the funding for Family Planning (FP) programmes. However, subsequently it was realised that without increasing use and access to contraceptives, it would be difficult to impact the high maternal, infant and child mortality. Thereafter a gradual shift occurred from clinical approach to the reproductive child health approach. The National Population Policy (NPP) in 2000 brought about a holistic and a target free approach which accelerated the reduction of fertility. Current family planning efforts includes contraceptive services, spacing methods, permanent methods, emergency contraceptive pills and pregnancy testing kits. Out of the above-mentioned family planning methods, spacing methods and emergency contraceptive pills are discussed in the succeeding paragraphs:

7.2.1 Non-disbursement of compensation to sterilisation acceptors (Male/Female)

As per guidelines (September 2007) issued by MoH&FW, GoI, for compensation package to acceptors of sterilisation, the mission steering group of National Rural Health Mission has considered and approved further revision in the compensation package to acceptors of sterilisation (with particular boost to male participation in family planning) i.e. Vasectomy and Tubectomy in public health facilities and accredited private health facilities to all categories in High Focus states and BPL/SC/ST in Non High Focus states. Further, as per

[1] Outreach Session during the period 2016-20: Target- 576, Achievement-26

[2] Orientation workshop during the period 2016-20: Target- 48, Achievement-25

[3] Source: Annual Report 2015-16 of the Ministry of Health and Family Welfare

Enhanced Compensation Scheme 2014 for sterilisation service, Haryana State was included in High Focus States.

Compensation scheme for sterilisation acceptors provides compensation for loss of wages to the beneficiary and also to the service provider team for conducting sterilisation. Under this scheme, the Government of India releases compensation for sterilisation acceptors to both female and male. A woman who undergoes sterilisation operation (Tubectomy) in the Government Hospital gets ₹ 1,400 and a man who undergoes sterilisation operation (Vasectomy) gets ₹ 2,000. Further, men and women who undergo sterilisation operation in Accredited Private/NGO facilities get ₹ 1,000.

Out of 15,376 total cases of sterilisation acceptors, compensation in 1,961 cases[4] was not paid in the selected districts during the audit period. Further, scrutiny of the report generated from the PFMS portal in district Panipat showed that as of January 2022, 445 cases are pending for approval. Out of these 445 cases, in 115 cases Aadhar seeding was also done but they were still pending for approval. Further, the details of sterilisation acceptors during the period 2016-21 in the three test-checked districts are given in ***Table 7.2***.

Table 7.2: Number of Sterilisation acceptors (Tubectomy/Vasectomy)

Year	Tubectomy			Vasectomy		
	Nuh	Hisar	Panipat	Nuh	Hisar	Panipat
2016-17	400	450	1,861	2	16	89
2017-18	488	840	1,821	3	26	62
2018-19	629	958	1,818	2	35	63
2019-20	570	840	1,878	1	28	73
2020-21	474	594	1,307	14	16	18

Source: Information submitted by District Family Welfare Officers in test-checked districts.

The main objective of the compensation scheme is to boost the participation of men and women in family planning. Thus, non-payment to these 1,961 cases of sterilisation acceptors in test-checked districts would have dis-incentivised further takers. This could also be corroborated by the data submitted by district Hisar and Nuh as the number of tubectomy acceptors increased during the period 2016-19; while it decreased during the period 2019-20. Further, there was decrease in all the three districts during 2020-21.

The Department stated (January 2023) that non-payment of compensation to sterilisation acceptors was due to non-availability of Aadhar based DBT bank accounts and related documents of the beneficiaries. The reply is not acceptable as the payment to the sterilisation acceptors was not disbursed even after linking their bank accounts to the Aadhar card in district Panipat.

[4] Nuh: 1,117 cases, Hisar: 399 cases and Panipat: 445 cases.

7.2.2 Delay in settlement of claims under Family Planning Indemnity Scheme

There has been growing concern about the quality of sterilisation services being offered, particularly at the camp facilities. The continuing high number of complications, failures and deaths following sterilisations also results in increased litigation being faced by the providers, which is another barrier in scaling up the sterilisation services. To address this issue, Government of India had introduced the "Family Planning Indemnity Scheme, 2013". The available financial benefits under the Family Planning Indemnity Scheme are upto maximum ₹ two lakh in case of death, failure and complication following sterilisation. The stipulated time limit for settlement of claims under Section-I of the scheme is 21 days in cases of failure, after submission of all required documents. Claim limit is ₹ 30,000 in case of failure of sterilisation.

Number of failure cases[5] settled within limit and with delay under Family Planning Indemnity Scheme in the test-checked districts is as given in ***Table 7.3***.

Table 7.3: Number of sterilisation failure cases during 2016-21 settled with delay

Range of delay (in days)	Panipat	Nuh	Hisar
	Total cases: 17	Total cases: 06	Total cases: 40
1 -120 days	7	0	20
121-240 days	4	3	4
241-360 days	2	1	5
361-480 days	1	0	4
481-600 days	0	0	3
601-617 days	1	0	2

Source: Information supplied by Dy. CS (FW) in test-checked districts.

Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicting moderate performance and red colour depicting poor performance.

It is evident from the above table that a total of 63 cases relating to failure of sterilisation were received in the test-checked districts during the period 2016-21. Out of these 63 cases, only six cases were settled within the time limit of 21 days. In the remaining 57 cases, the actual time taken in settlement of claims ranged from 1 day to 617 days[6]. It cannot be denied that delay in settlement of cases may lead to further disenchantment of the public towards these family planning measures.

Further, as per the guidelines, claim limit is ₹ 30,000 per case in case of failure. But, in district Nuh, payment in four cases under Family Planning Indemnity scheme was made of ₹ 2.4 lakh (₹ 0.60 lakh x 4 cases) against due amount of ₹ 1.2 lakh (₹ 30,000 per case). Thus, an excess payment of ₹ 1.2 lakh was made. The excess payment was made based on the direction issued (January 2020) by Deputy Civil Surgeon (FW), Nuh. Moreover, these four claimants submitted their

[5] It was stated by the Department that there was no case of complication and death except failure following sterilisation in any of the test-checked districts.

[6] The claim was submitted on 16 May 2016 but actual payment was made on 13 February 2018 (delay of 617 days) in Panipat.

claims before January 2020. No such cases of excess payments were found in the other two test-checked districts of Hisar and Panipat.

The Department stated (January 2023) that as per the Family Planning Indemnity Scheme, there was no stipulated time limit of 21 days. All claims under Family Planning Indemnity Scheme were settled at the earliest after submission of the required documents including sterilisation certificate by the beneficiaries. The reply is not tenable as Paragraph 8.1.8 under Section I of the Family Planning Indemnity Scheme clearly mentions that the stipulated time limit for settlement of claims would be 21 days after submission of all the required documents.

7.2.3 Achievement of targets for Sterilisation and spacing methods

Family planning has undergone a paradigm shift and emerged as a key intervention to reduce maternal and infant mortalities and morbidities. It is well-established that the States with high contraceptive prevalence rate have lower maternal and infant mortalities. Greater investments in family planning can thus help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induced abortion and eliminate most of these deaths. The target and achievement of various components of family planning services in the State of Haryana is given below:

Table 7.4: Targets and achievements of Sterilisation and Spacing methods in Haryana during the period 2016-21

(Figures in thousands)

Family Planning services	Target	Achievement	Achievement (*per cent*)
Vasectomy	25	9	36
Tubectomy	360	272	76
IUCD insertion	1,044	1,036	99
Condom users	1,00,000	89,101	89
Oral pills users	3,750	4,575	122

Source: Information supplied by NHM, Haryana.

Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicting moderate performance and red colour depicting poor performance.

Thus, there was maximum achievement in oral pills usage; while the minimum achievement was in vasectomy services. The Mission did well in improving the usage of oral pills and intrauterine contraceptive device (IUCD) insertion as the actual users were 22 *per cent* more and just less that one *per cent* short respectively than the targets/ achievements.

The target and achievement of various components of family planning services in the test-checked districts is given below:

Table 7.5: Targets and achievements of Sterilisation and Spacing methods in test-checked districts during 2016-21

Family Planning services	Target	Achievement	Achievement (*per cent*)
Vasectomy	3,040	522	17
Tubectomy	64,690	50,916	79
IUCD insertion	1,86,650	1,46,586	79
Condom users	1,45,80,000	1,07,24,598	74
Oral pills users	5,00,500	5,57,083	111

Source: Information supplied by DFWO in test-checked districts.

Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicting moderate performance and red colour depicting poor performance.

In the test-checked districts, it was observed that achievement in sterilisation cases was ranging between 17 and 111 *per cent* during 2016-21; which shows that targets were not achieved except in case of oral pills usage.

The Department replied (January 2023) that the total fertility rate of Haryana has decreased from 2.1 to 1.9. It was also mentioned that family welfare programme is a voluntary programme and eligible couples cannot be forced to use any particular contraceptive method so as to achieve the targets in Family Welfare Programme in the State.

While it is true that the programme is to be voluntarily adopted, given the positive impact it has on child and mother's health, it needs to be duly encouraged by spreading awareness and ensuring timely payments, which was not done as discussed in paragraphs **7.2.1** and **7.2.2**.

7.3 Revised National TB Control Programme (RNTCP)

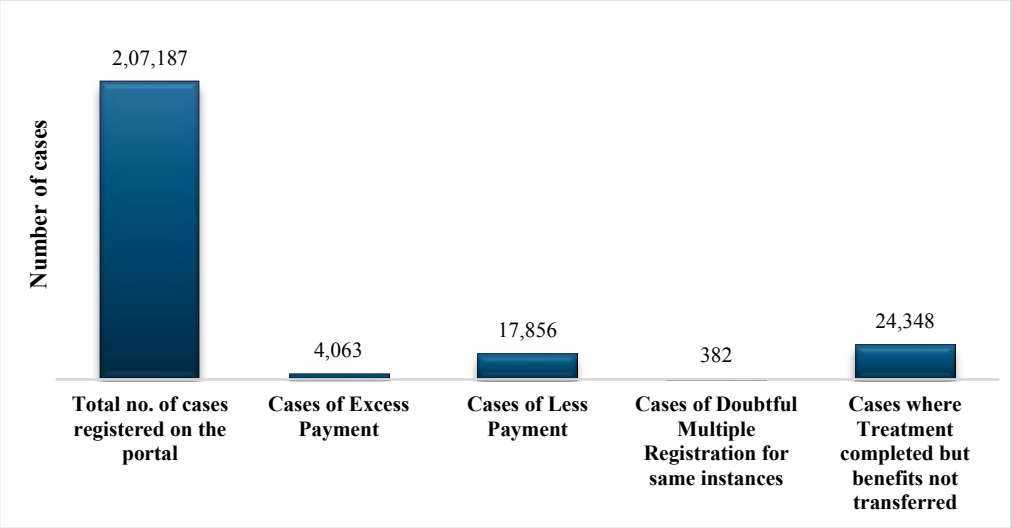
Nikshay Poshan Yojana (NPY), 2018 is an incentive scheme of National Tuberculosis Elimination Programme (NTEP) aimed at providing financial support to Tuberculosis (TB) patients for their nutrition. When a patient is diagnosed with TB, he is enrolled on NIKSHAY portal and payments are made to him under Nikshay Poshan Yojana (NPY) and subsequently during the course of their treatment. At the time of notification of TB patient on the portal, a benefit of ₹ 1,000 is created as an advance. The second benefit gets generated on completion of 56 days from the date of TB treatment initiation, then the subsequent benefit is created @₹ 500 for every month of treatment at the end of every 28 days from the date of benefit generation for the previous incentive. Disbursement of payment to TB patients was started online through Direct Benefit Transfer (DBT) from April 2018.

The data of patient registered from April 2018 to March 2021 on the Nikshay Poshan Yojana (NPY) was obtained from the office of State TB Project Officer, Panchkula and after analysing the data, the following irregularities were noticed:

7.3.1 Irregularities in implementation of NIKSHAY Poshan Yojana

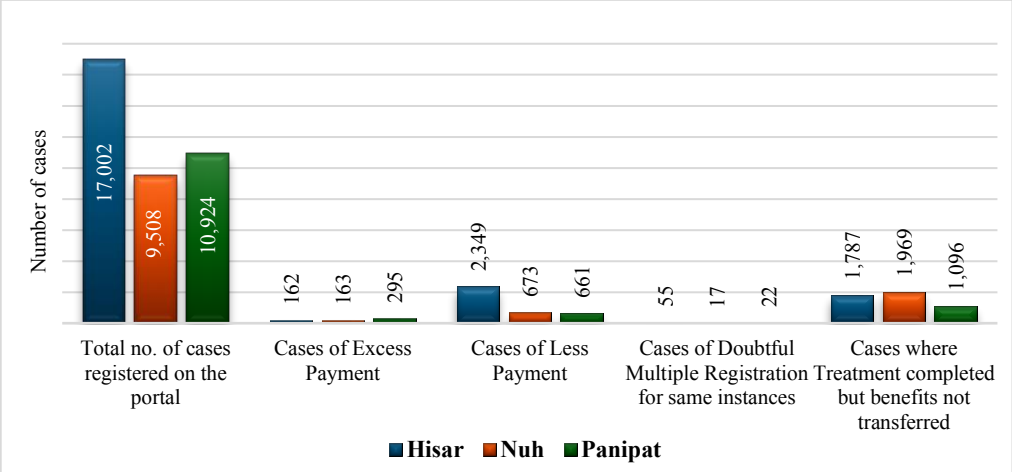
Details of patients registered on NPY portal in the State of Haryana and in the test-checked three districts is as follows:

Chart 7.1: Implementation of NPY in Haryana State



Source: Data furnished by State TB Project Office

Chart 7.2: Implementation of NPY in test-checked districts



Source: Data furnished by State TB Project Office

It was observed that:

i. Total 2,07,187 patients were registered in Haryana State and out of these, 24,348 patients were not provided any benefits of NPY despite the fact that bank account numbers of 8,054 cases out of 24,348 cases had already been uploaded on the portal. Further, in the selected districts, out of total 37,434 registered patients of TB, benefits to 4,852 patients were not provided while the bank accounts of 1,573 TB patients (out of 4,852 patients) in these districts were already uploaded on Nikshay portal. These patients have undergone full treatment of TB and their status on the portal was shown as 'Cured'. These patients have not opted to forgo the benefits of NPY.

ii. Further, during analysis of data, it was also observed that treatment in some instances continued beyond six months, or one year or two years or more. However, the payment in these cases were not made as per their length of treatment. In some cases, there was no chronology in the dates of diagnosis, enrolment and treatment initiation date i.e. there were instances where enrolment date and/or treatment initiation date was before diagnosis date.

iii. On the basis of entries of commencement and completion dates of the treatment of patients, Audit calculated the treatment length and the amounts payable to them under NPY. The calculation of amount payable was done on the assumption that the ₹ 1,000 advance payment for the initial period of 56 days was made on the day of commencement of treatment, and the subsequent payments of ₹ 500 were made at the end of every 28 days. It was noted that out of the total registered patients in the database, in case of 4,063 patients, the amount paid as shown in the database was more than the amount arrived by way of the above calculation. In case of these 4,063 patients, the treatment length ranged upto 691 days, and hence the amount payable by the Department was ₹ 103.69 lakh in these cases. However, as per the database an amount of ₹ 143.53 lakh was paid in these cases. Thus, it is not ascertainable whether these are a result of data entry errors or there has been an actual excess payment of ₹ 39.83 lakh in contravention to the prescribed limit fixed by Government in NPY. Similarly, in case of 17,856 patients whose treatment period was shown ranging between 56 and 1,075 days, the amount payable by the Department was arrived to be ₹ 656.88 lakh. However, the amount paid as shown in the database was ₹ 396.33 lakh, indicating less payment by an amount of ₹ 260.54 lakh. Out of the above cases, the number of instances in the three selected districts were 620 cases[7] with probable excess payment of ₹ 6.39 lakh, and 3,683 cases[8] with probable short payment of ₹ 64.21 lakh.

iv. Further, doubtful cases of registration were also noticed where registration was done twice for the same instance of TB, in case of 382 patients in the database with 94 cases pertaining to the three selected districts. In these instances, of doubtful registrations, there were duplicates having the same bank account number, year and month of diagnosis, and first four character of case name.

All these instances show that the veracity of this data could not be vouched for. Moreover, the excess payment instances and doubtful multiple registration,

[7] Payment was to be made ₹ 13.42 lakh to 620 beneficiaries. Actual payment made was ₹ 19.81 lakh.

[8] Payment was to be made ₹ 132.84 lakh to 3,683 beneficiaries. Actual payment made was ₹ 68.63 lakh.

mentioned above could not be ascertained on the basis of this data. Thus, Department needs to review the registration procedure and examine the portal to weed out any such instances.

The Department, while accepting the observation, clarified (January 2023) that discrepancies have occurred due to errors in the NIKSHAY portal leading to the rejection of batches; external payment done through PFMS not captured by NIKSHAY portal; death of some patients during initial months of treatment; some cases of multiple registrations. For short payments, it was stated that the errors were due to delayed acceptance of patients transferred to other districts and incorrect account information provided. No reply was furnished with regard to probable excess payment.

7.3.2 Delay in payment of NPY to TB Patients

Analysis of the data of Nikshay portal of Haryana for the period April 2018 to March 2021 revealed that in the selected districts, out of the total 2,07,187 patients registered on the portal, 1,33,094 patients who had undergone full treatment and whose treatment outcome was "Cured", were provided first payment with an average delay of 36 days (ranging from 1-1248 days) under Nikshay Poshan Yojana. The delay in making the first payment to these TB cases in Haryana State and in the test-checked districts is as per details given in ***Table 7.6***.

Table 7.6: Number of patients receiving benefits with delay in Haryana State and three test-checked districts

Delay (days between treatment initiation Date & first payment created)	No. of Patients			
	Haryana	Hisar	Nuh	Panipat
01-15 days	76,544	6,230	3,144	4,701
16-30 days	12,770	1,107	619	865
31-60 days	15,110	1,199	715	902
61-90 days	8,205	765	383	361
91-120 days	5,629	539	167	299
121-150 days	4,231	402	104	176
151-180 days	3,568	320	67	164
More than 180 days (181-1248 days)	7,037	763	274	195
Total	**1,33,094**	**11,325**	**5,473**	**7,663**

Source: Data furnished by State TB Project Office.
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicting moderate performance and red colour depicting poor performance.

Further, in the test-checked districts in 1,232 TB cases the first payment was made after completion of treatment with delay of more than 180 days. The delay in payment has resulted in forfeiting the objective of the scheme and depriving the beneficiaries from its intended benefits.

The Department while accepting the observations replied (January 2023) that the delays in payment were mainly due to frequent errors in DBT portal; rejection and reprocessing of bank account details; non availability of bank

details to the staff timely; frequent updations in Nikshay portal which caused delayed payment processing.

7.3.3 Not providing of complete treatment to TB patients

When a patient is diagnosed with TB, he is enrolled on NIKSHAY portal and payments are made to him under Nikshay Poshan Yojana (NPY) DBT scheme to provide nutritional support at the time of notification and subsequently during the course of their treatment. As per DBT manual for NTEP, as a patient is initiated on treatment, Nikshay (tentatively) calculates the Treatment End Date as Treatment Initiation date + 167 days. Benefits generation stops when the Treatment End date of a patient has crossed. For patients where treatment must be extended beyond 167 days, the user needs to update and extend the "Treatment End date".

Analysis of the data of Nikshay portal of Haryana for the period April 2018 to March 2021 revealed that out of the total 2,07,187 patients registered on Nikshay portal during the period, 6,602 patients were provided treatment for less than 167 days as shown in the table below. Details of duration of treatment provided to the patients (Outcome is cured or treatment complete) in Haryana and in the test-checked districts is given in ***Table 7.7***.

Table 7.7: Number of patients receiving treatment for less than 167 days

Treatment Duration (in days)	Number of Patients			
	Haryana	Hisar	Nuh	Panipat
1-30 days	283	16	4	10
31-60 days	173	14	1	10
61-90 days	169	18	2	5
91-120 days	338	33	9	24
121-150 days	961	62	25	66
151-166 days	4,678	249	198	362
Total	**6,602**	**392**	**239**	**477**

Source: Data furnished by State TB Project Office.

Note: Colour grading has been done on colour scale with green colour depicting satisfactory coverage of treatment period; yellow colour depicting moderate coverage and red colour depicting poor coverage

Further, in all three test-checked districts, out of total registered patients on the portal, 1,108 patients were not provided treatment for the entire 167 days. In all these cases treatment outcome is "Cured" or "Treatment Complete". It indicates that complete treatment was not provided to these patients but their treatment outcome was updated to "Cured" or "Treatment Complete" on portal. This brings into question the reliability of the data.

The Department replied (January 2023) the treatment was shown less than the stipulated 167 days due to patients shifting health institutions during treatment period without updating relevant details in NIKSHAY and some patients had not continued the follow up and the outcome was wrongly entered as treatment complete. The reply corroborates the audit contention regarding veracity of the data available in the portal.

7.3.4 Updating TB diagnostic test reports on MIS

As per RNTCP guidelines, 2017, all the TB patients are to be registered on e-NIKSHAY portal by their certified providers as beneficiaries and their details such as mobile number and bank account number entered. An alpha-numeric Beneficiary ID is generated for patients which is used by him/her to avail the services at every point. TB diagnostic test reports (Digital X-ray and GeneXpert test) and monthly prescriptions will be updated in this MIS, which will assist TB case management system in maintaining an end-to-end diagnostic and treatment trail of the patient. However, it was found that diagnostic reports were not updated on MIS by TB Hospital, Hisar.

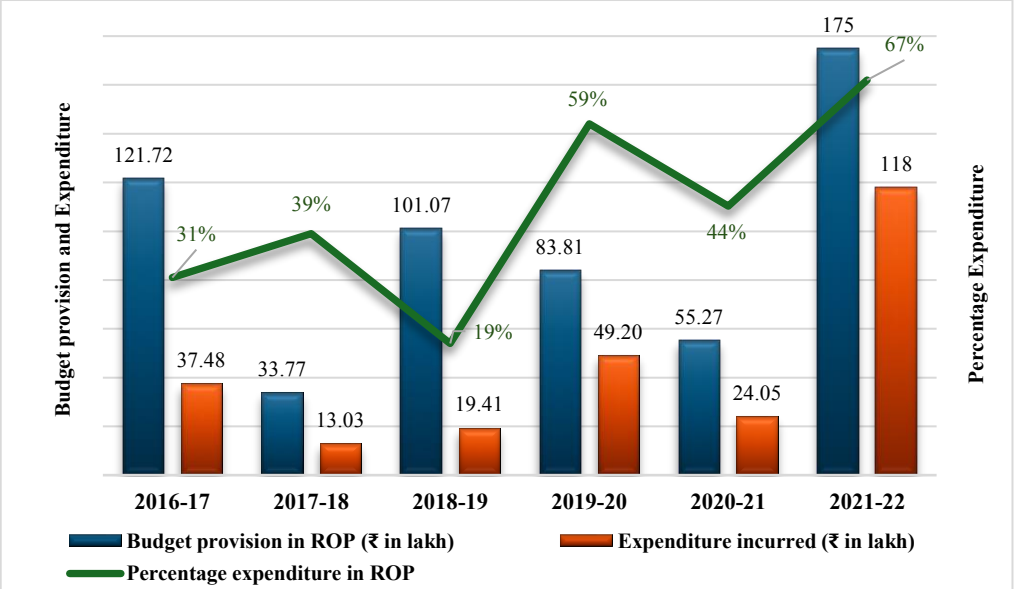
7.4 National Mental Health Programme

The objective of the National Mental Health Programme (NMHP) is to provide mental health services including prevention, promotion and long term continuing care at different levels of district level health care system. The audit findings observed in the implementation of the NMHP are discussed in the succeeding paragraphs:

7.4.1 Non-utilisation of funds under National Mental Health Programme

As per Financial Management Report (FMR), maintained by NHM the budget provision and expenditure incurred on NMHP by NHM, Haryana during the period 2016-22 is shown in ***Chart 7.3***.

Chart 7.3: Budget provision and expenditure under NMHP in State of Haryana



Source: Information supplied by NHM, Haryana.

From the above data, it is evident that while the Government of India had been regularly making budget provision for NMHP but NHM had utilised only 19 *per cent* to 67 *per cent* of the budget.

The State Programme Officer (Mental Health and De-Addiction), DGHS Haryana stated (November 2021) that District Mental Health Programme (DMHP) was new at district level, the recruitment for which could not be done leading to unspent balances. Moreover, training could not be conducted due to the non-relieving of doctors for training and procurement of equipment also could not be finalised. The fact remains that funds were available during the year 2016-22 but not utilised properly which led to shortage of manpower, trained man-power and equipment etc. in districts. The non-availability of services due to non-utilisation of budget properly under Mental Health Programme are discussed in the succeeding paragraphs.

7.4.2 Implementation of Mental Health Programme in selected districts

As per NMHP, 2015 (part 2 (E)), the services at DHs include outpatient services, counselling services and in-patient services. Further, in out-patient services, given the scarcity of the skilled manpower in mental health specialities in the country, the OPD services in mental health/ psychiatry services shall be provided by doctors who may be trained General Duty Medical Officers (GDMOs). However, in districts where trained MO is not available, the services of a private psychiatrist may be utilised. In counselling services, all patients (and their attendants, if available and only if the patients agree to involve them) assessed by the trained doctor, should receive counselling/psycho-social interventions/ psycho-education, as per the clinical needs. In-patient services include patient of mental disorders, who require in-patient management and should be admitted in a dedicated ward which is exclusively meant for this purpose.

Further, as per NMHP, 2015, (part 2 (F)) services at CHCs will include: (i) out-patient services for walk-in patients and patients referred by the PHC which will be provided by the trained medical officer. In addition to this, in-patient services will also be provided for emergency psychiatry illnesses. (ii) Counselling services shall be provided by the Clinical Psychologist/trained Psychologist. (iii) Continuing care and support to persons with severe mental disorders (SMD).

Availability of services under NMHP in 16 test-checked health institutions (DHs/SDCHs/CHCs) is given in ***Table 7.8***.

Table 7.8: Availability of mental health services in test-checked health institutions

Sr. No.	Particulars	DHs (03)	SDCHs (03)	CHCs (10)
1	Provisions of out-patient services for walk-in-patient and patients referred by the PHC	3	3	6
2	Early identification, diagnosis and treatment of common mental disorders (anxiety, depression, psychosis, schizophrenia, Manic Depressive Psychosis) .	3	NA	NA
3	In-patient services for emergency psychiatry illnesses.	3	0	1
4	Counselling services by Clinical Psychologist/ Trained Psychologist.	3	0	1
5	Continuous care and support to persons with Severe Mental Disorders (SMD). (This includes referral to district hospital for SMD patients and follow up based on treatment plan drawn up by the Psychiatrist at the DH)	3	0	2

Source: Information supplied by test-checked health institutions (Panipat: April 2022, Nuh: June 2022 and Hisar: June-July 2022).
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicting moderate performance and red colour depicting poor performance

It was observed that:

i. Provisions of out-patient services for walk-in-patient and patients referred by the PHCs were not available in four CHCs (Sorkhi, Naraina, Naultha and Madlauda).

ii. In-patient services for emergency psychiatry illnesses were not available in three SDCHs (Adampur, Narnaund and Samalkha) and nine CHCs (Firojpur Jhirkha, Punhana, Sorkhi, Mangali, Uklana, Bapoli, Naraina, Madlauda and Naultha).

iii. Counselling services were not available in three SDCHs (Adampur, Narnaund and Samalkha) and nine CHCs (Firojpur Jhirkha, Punhana, Sorkhi, Mangali, Uklana, Bapoli, Naraina, Madlauda and Naultha).

iv. Continuing care and support to persons with Severe Mental Disorder (SMD) was not provided to the patients in three SDCHs (Adampur, Narnaund and Samalkha) and eight CHCs (Punhana, Uklana, Sorkhi, Mangali, Bapoli, Naraina, Madlauda and Naultha).

The Department replied (January 2023) that there was a shortage of psychiatrists in the Health Department. Further, MoHFW, GoI launched the National Tele-Mental Health Programme in the Union Budget 2022-23 to develop digital mental health network throughout India. It would provide counselling and treatment services for mental health problems.

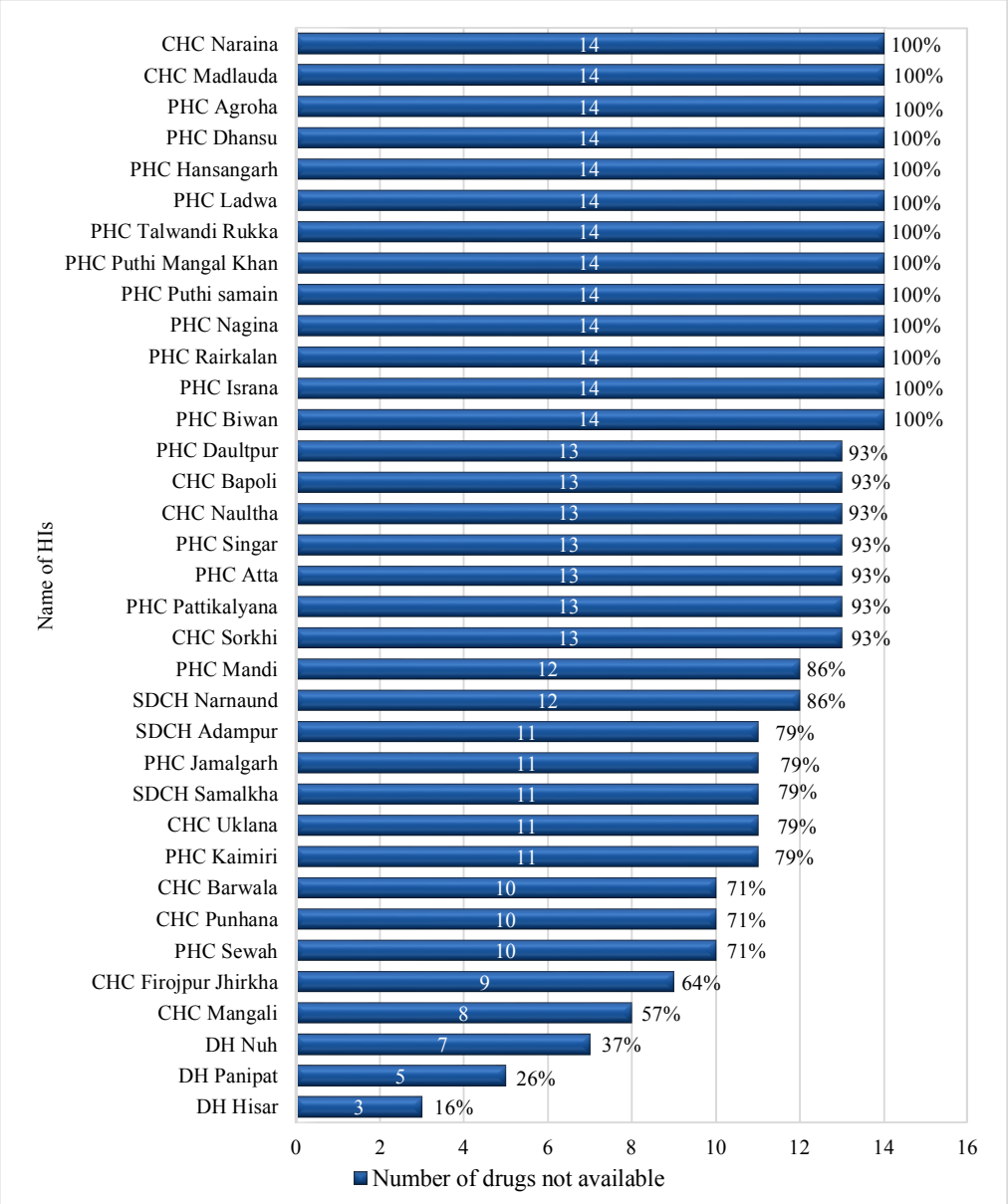
The fact remains that despite the availability of budget under NMHP, the envisaged services were not available at all test-checked health facilities.

7.4.3 Availability of Mental Health Programme drugs in selected health institutions

As per instruction dated 08 May 2018 issued by Ministry of Health and Family Welfare, Government of India, 19 types of psychotherapeutic drugs/ medicines for

seven types of mental health conditions should be available at DHs and 14 types of drugs should be available at SDCHs/CHCs/PHCs. As per data supplied by test-checked health institutions (DHs: 3, SDCHs: 3, CHCs: 10 and PHCs: 19), the shortfall (percentage) in availability of mental health drugs is as follows:

Chart 7.4: Shortfall (percentage) of mental health drugs in test-checked health institutions



Source: Information furnished by test checked HIs. (Panipat: April 2022, Nuh: June 2022 and Hisar: June-July 2022)

It was observed that:

i. Shortfall in DH, Hisar was 16 *per cent*; in DH, Panipat it was 26 *per cent*; and in DH, Nuh it was 37 *per cent*.

ii. Shortage of drugs was 100 *per cent* in 14 health institutions.

iii. Shortfall of 75 to 99 *per cent* was seen in 13 health institutions.

iv. Shortfall upto 75 *per cent* was seen in five health institutions.

7.5 National Programme for Health Care of the Elderly (NPHCE)

The National Programme for Health Care for the Elderly (NPHCE) is an articulation of the international and national commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and National Policy on Older Persons (NPOP) adopted by the Government of India in 1999 and Section 20 of "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" dealing with provisions for medical care of Senior Citizens.

As per FMR, the budget provision and expenditure incurred on National Programme for Health Care of the Elderly (NPHCE) by NHM, Haryana during the period 2016-17 to 2021-22 is as under:

Table 7.9: Budget provision and expenditure under NPHCE in the State of Haryana

(₹ in lakh)

Year	Budget	Expenditure	Expenditure (In *per cent*)
2016-17	175.38	102.18	58
2017-18	14.91	9.48	64
2018-19	48.08	3.81	8
2019-20	61.82	34.84	56
2020-21	70.29	33.40	48
2021-22	91.00	59.00	65
Total	**461.48**	**242.71**	**53**

Source: Information supplied by NHM, Haryana.

Note: Colour grading has been done on colour scale with yellow colour depicting moderate *per cent* and red colour depicting very less *per cent* of expenditure.

From the above table, it is evident that the Government of India had been regularly making budget provision for National Programme for Health Care of the Elderly (NPHCE). However, NHM, Haryana could utilise only 8 *per cent* in the year 2018-19 and a maximum of 65 *per cent* in the year 2021-22.

Deputy Director (SS) NCD, Office of DGHS Haryana, Panchkula stated (November 2021) that the major unspent amount was on human resource, training, machinery and equipment. Recruitment as per district Record of Proceeding (ROP) was not allowed by NHM, so the post could not be filled and the budget remained unspent. Moreover, non-recurring funds could not be utilised as the post of Rehabilitation Workers was not approved in ROP by GOI. The fact remains that the budget utilisation was only 53 *per cent* during the period 2016-22.

7.6 National Tobacco Control Programme

Government of India launched (2007-08) the National Tobacco Control Programme (NTCP) , with aim to (i) create awareness about harmful effects of tobacco consumption, (ii) reduce production and supply of tobacco products, (iii) ensure effective implementation of provisions under "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" (COTPA) (iv) help people quit tobacco use, and (v) facilitate implementation of strategies for

prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control .

As per FMR, the budget provision and expenditure incurred on NTCP by the NHM, Haryana is as under:

Table 7.10: Budget provision and expenditure under NTCP in the State of Haryana

(₹ in lakh)

Year	Budget	Expenditure	Expenditure (in *per cent*)
2016-17	73.28	0	0
2017-18	41.71	5.78	14
2018-19	232.30	0	0
2019-20	70.86	0	0
2020-21	171.50	42.12	25
2021-22	215.00	107.00	50
Total	**804.65**	**154.90**	**19**

Source: Information supplied by NHM, Haryana.

Note: Colour grading has been done on colour scale with yellow colour depicting moderate performance; while red colour depicting poor performance.

From the above table, it is evident that the Government of India had been regularly making budget provision for NTCP but NHM had incurred nil expenditure during the years 2016-17, 2018-19 and 2019-20 and utilised 14 *per cent* and 50 *per cent* in 2017-18 and 2021-22 respectively.

Audit observed that NTCP programme was not having manpower to manage it as two districts i.e., Ambala and Kurukshetra had hired consultants and all the other 20 districts did not have any staff. The Department had not deputed any staff for the implementation of the NTCP Programme, due to which the programme was not implemented effectively which shows poor planning on the part of the Department. NTCP programme is mainly Information, Education and Communication (IEC) programme. State Government should have enhanced its capacity to absorb funds for successful implementation of NTCP because success of NTCP programme depends on success of IEC related activities.

The Department stated (January 2023) that NTCP is a new programme, and specialised manpower is not available. However, the fact remains that even after a period of more than six years, the required manpower could not be deployed to implement the programme in the State.

7.6.1 School Awareness Programmes under NTCP

As per point 2 of operational guidelines (2015) of NTCP, School awareness programmes should be conducted to help the youth and the adolescents to acquire knowledge, attitude and skills that are required to make informed decisions and to understand the consequences of tobacco use. Selection of schools should be done carefully with a combination of government and private schools. 70 schools in one district per year should be adopted and included in the school awareness programme. The target and achievement under school awareness programme in the test-checked districts is as shown in ***Table 7.11***.

Table 7.11: Target/Achievement in School Awareness Programme under NTCP

Year	Target			Achievement			Achievement (%)		
	Public School	Private School	Coaching Institutes	Public School	Private School	Coaching Institutes	Public School	Private School	Coaching Institute
2016-17	881	NA	NA	784	NA	NA	89	NA	NA
2017-18	882	NA	NA	655	NA	NA	74	NA	NA
2018-19	1,290	353	18	1,075	304	8	83	86	44
2019-20	1,281	353	18	1,098	292	6	86	83	33
2020-21	586	378	22	365	229	13	62	61	59

Source: Information supplied by NTCP unit of test-checked districts.
NA: Targets were not set by any of the test-checked districts.
Note: Colour grading has been done on colour scale with green colour depicting most achievement; yellow colour depicting moderate achievement and red colour depicting least achievement.

It was observed that achievement in school awareness programmes ranged between 62 *per cent* and 89 *per cent* for public schools during the year 2016-21, while 61 *per cent* to 86 *per cent* for private schools and 33 *per cent* to 59 *per cent* for coaching institutes during the years 2018-21. Further, it was also observed that school awareness programme was not conducted in district Nuh during the years 2016-20 and in district Panipat during the years 2016-18. During the year 2020-21, a target of 54 educational institutes (Public and Private) was set in district Nuh under School Awareness Programme which was not adequate because as per guidelines, at least 70 schools in one district per year should be selected. Moreover, no private schools/ institutes were selected in district Hisar for school awareness programme during the period 2016-21.

7.7 National Programme for Control of Blindness

The National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100 *per cent* centrally sponsored programme with the goal of achieving a prevalence rate of 0.3 *per cent* of the population by 2020. The programme involved a four-pronged strategy comprising strengthening service delivery, developing human resources for eye care, promoting outreach activities and public awareness and developing institutional capacity.

As per FMR, budget provision and expenditure incurred on NPCB by NHM, Haryana during the period 2016-17 to 2021-22 was as per details given in ***Table 7.12.***

Table 7.12: Budget provision and expenditure under NPCB in State of Haryana

(₹ in lakh)

Year	Budget Provision in ROP	Expenditure incurred	Expenditure (In *per cent*)
2016-17	365.00	220.05	60
2017-18	209.00	88.73	42
2018-19	496.75	105.03	21
2019-20	458.13	183.41	40
2020-21	728.45	312.52	43
2021-22	871.00	333.00	38
Total	**3,128.33**	**1,242.74**	**40**

Source: Information supplied by NHM, Haryana.
Note: Colour grading has been done on colour scale with yellow colour depicting moderate *per cent* and red colour depicting very less *per cent* of expenditure.

From the above table, it is evident that the Government of India had been regularly making budget provision for NPCB during the years 2016-17 to 2021-22, but NHM had utilised minimum 21 *per cent* in the year 2018-19 and maximum 60 *per cent* in the year 2016-17.

The Department stated (January 2023) that expenditure was expected to increase in the upcoming financial year, but the number of cataract surgeries had not increased in the said financial year, which led to incurring of less expenditure. The reply is not tenable as during the last four years the maximum expenditure was 43 *per cent* of the budget provision, which indicates poor planning of the Mission.

7.8 Janani Suraksha Yojana

Janani Suraksha Yojana (JSY), 2005 is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional deliveries among the poor pregnant women. For pregnant women of Below Poverty Line (BPL) and of Scheduled Castes (SC)/ Schedule Tribes (ST) going to a public health institution for delivery, an amount of ₹ 700 and ₹ 600 for rural and urban areas respectively was to be disbursed to beneficiary in one go, at the health institution. Moreover, ₹ 500 was to be given for delivery at home to BPL women. The mother and the ASHA (wherever applicable) should get their entitled money within five working days of delivery. Further, from the State budget, an additional amount of ₹ 1,500 was to be given on delivery by pregnant women belonging to SC/ST category.

The number of deliveries under BPL and SC categories and incentive paid during 2016-17 to 2020-21 in the test-checked sub centres is given in ***Table 7.13***.

Table 7.13: Incentive paid under JSY in test-checked Sub-centres (2016-21)

Name of District	BPL Category		SC Category		
	No. of deliveries	No. of deliveries in which incentive amount was paid	No. of deliveries	No. of deliveries in which incentive amount was paid	
		NHM		State Budget	NHM
Panipat	687	12	1,642	117	54
Hisar	41	38	204	61	125
Nuh	2,864	93	443	111	81
TOTAL	**3,592**	**143**	**2,289**	**289**	**260**

Source: Information supplied by test-checked sub-centres

Thus, a total of 3,592 (BPL) and 2,289 (SC) deliveries took place in the selected sub-centres. Out of 3,592 beneficiaries of BPL category, payment to only 143 beneficiaries was made. Out of total 2,289 deliveries of SC category, payment to only 289 (State budget) and 260 (NHM) beneficiaries was made.

Further, it was also found that out of the total 31 test checked sub-centres[9], cash assistance either from National Health Mission or the State budget was not delivered in nine sub-centres[10] under JSY scheme. Moreover, cash assistance provided in sub-centres Biwan and Hathangaon (years 2016-18, district Nuh), sub-centres Bithmara, Budha Khera, Litani, Sandlana, Talwandi Rukka, Juglan, Bhaklana, Sulkhani, Dhansu and Daya (years 2016-21, district Hisar) could not be ascertained due to non-availability of records.

The Department stated (January 2023) that JSY payment was not being paid in Nuh district during 2016-18 due to non-availability of bank account of beneficiaries and now financial assistance under JSY is being paid. The Department's claim could not be verified due to non-availability of records as indicated above.

7.9 Immunisation of children

According to the World Health Organisation (WHO) guidelines, a child should be fully immunised with all basic vaccinations. These basic vaccines are Bacille Calmette-Guerin (BCG), Hepatitis B, Oral Polio Vaccine (OPV), Diphtheria Pertussis Tetanus (DPT), Measles, Tetanus Toxoid (TT) etc.

7.9.1 Implementation of immunisation programme in State of Haryana

As per information supplied by the Department, it was observed that the achievement of full immunisation of infants (0-1 year) in Haryana ranged between 79 and 90 *per cent* during the period 2016-21 and the coverage percentage was also increasing every year. Further, the achievement for immunisation of children (1-2 years) ranged between 74 and 90 *per cent* for DPT, OPV and Measles in the State. The target/achievement in immunisation of DPT, TT10 and TT16 of five to 16 years age of children is given below:

Table 7.14: Target/achievement in immunisation of 5 to 16 years age of children

Year	DPT		TT10		TT16		Achievement (*per cent*)		
	Target	Achievement	Target	Achievement	Target	Achievement	DPT	TT10	TT16
2016-17	5,11,000	3,50,410	5,23,000	2,61,963	5,59,000	2,21,708	69	50	40
2017-18	5,18,000	3,05,441	5,30,000	2,36,943	5,67,000	2,08,658	59	45	37
2018-19	5,32,500	2,97,159	5,25,000	2,24,052	6,19,900	2,07,446	56	43	33
2019-20	5,39,500	3,98,955	5,31,900	2,52,561	6,28,100	2,07,043	74	47	33
2020-21	5,49,950	4,18,585	5,42,190	2,88,892	6,40,280	1,98,098	76	53	31

Source: Information supplied by NHM, Haryana.

Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicting moderate and red colour depicting poor performance.

[9] Hisar: 13 SCs, Panipat: 10 SCs and Nuh: 08 SCs.

[10] SC, Nohra, Baljattan, Balana, Gawalra, Bandh, Sehar Malpur (district Panipat) SC Gokalpur (except one case in 2020-21), Khankar Kheri, Bhadas (except year 2016-17) (district Nuh)

From the above table, it is evident that achievements against the targets of Diphtheria Pertussis Tetanus (DPT) Booster II up-to 5-year children ranged from 56 to 76 *per cent*, Tetanus Toxoid 10 (TT10) for 10 years children ranged from 43 to 53 *per cent* and TT 16 for 16 years children ranged from 31 to 40 *per cent* during the period 2016-17 to 2020-21. This indicates the dismal performance of TT10 and TT16 immunisation in the State, as compared to the DPT immunisations.

The Department replied (January 2023) that it had started an initiative of Special Immunisation week (SIW) from March 2022 in every quarter to increase the coverage of 5-16 years age group. Further, government (Rashtriya Bal Swasthya Karyakram) teams had also started covering private schools for vaccination in a phased manner, and gradually children who dropped out from schools would also be covered under this initiative for DPT booster II, TT10 and TT 16.

7.9.2 Implementation of immunisation programme at selected SCs of selected districts

As per IPHS 2012 norms, Maternal and Child Health Care essential services require full immunisation of all infants and children against vaccine preventable diseases as per guidelines of GoI. The vaccination schedule of various vaccines administered to the infants is given below:

i. **BCG:** At birth (for institutional deliveries) or along with DPT-1 (upto one year if not given earlier),
ii. **Hepatitis B – 0:** At birth for institutional delivery, preferably within 24 hrs of delivery,
iii. **OPV-0:** At birth for institutional deliveries within 15 days,
iv. **OPV 1, 2 and 3:** At 6 weeks, 10 weeks & 14 weeks,
v. **DPT 1, 2 and 3:** At 6 weeks, 10 weeks & 14 weeks,
vi. **Hepatitis B-1, B-2 and B-3:** At 6 weeks, 10 weeks & 14 weeks,
vii. **Measles 1 & 2:** At 9-12 months and 16-24 months,
viii. **Vitamin-A (Ist dose):** At 9 months with measles.

As per immunisation programme of IPHS norms, a fully immunised infant is one who has received BCG, three doses of DPT, three doses of OPV, three doses of Hepatitis B and Measles before one year of age. During the period 2016-21, achievement in vaccination administered to infants (live birth) in the test checked SCs is given below:

Table 7.15: Achievement of immunisation programme in test-checked SCs (Total 31 SCs[11]) during 2016-21

			(in percentage)
Name of Vaccine	**Nuh**	**Panipat**	**Hisar**
BCG	63	68	96
Hepatitis B - 0	14	24	66
OPV - 0	29	56	95
OPV 1	78	99	94
OPV 2	64	95	92
OPV 3	52	92	91
DPT 1, penta 1	34	49	80
DPT 2, penta 2	24	47	78
DPT 3, penta 3	19	46	77
Hepatitis B - 1	33	19	14
Hepatitis B - 2	31	19	14
Hepatitis B - 3	25	28	13
Measles 1	85	87	91
Measles 2	58	83	89
Vitamin-A (1st dose)	84	79	89

Source: Information supplied by test-checked SCs.
Note: Colour grading has been done on colour scale with green colour depicting satisfactory performance; yellow colour depicting moderate and red colour depicting poor performance.

It is evident from the above table that:

- The performance in vaccinating infants/children under immunisation programme in district Nuh is poor as compared to district Hisar and Panipat.
- Further, it was seen that the achievement in vaccination of Hepatitis B-1, B-2, and B-3 was poor in all test-checked SCs of the selected districts.
- BCG, Hepatitis B-0 and OPV-0 vaccines are to be administered to infants at birth. It was however observed that the full immunisation of infants could not be achieved during the period 2016-21.

7.10 Conclusion

The implementation of test checked centrally sponsored schemes like NUHM, Family Welfare, Nikshay Poshan Yojana etc. in the State of Haryana was not commensurate with the targets set for the respective schemes. There were shortfalls in utilisation of the allotted funds. There were delays in payment of financial assistance/incentive under Family Welfare Scheme, Janani Suraksha Yojana and Nikshay Poshan Yojana. Further, efforts to increase the awareness amongst the various stakeholders which could result in greater participation and enthusiasm towards the various programmes was also found inadequate.

[11] Record was not maintained in SC, Bhaklana and Kheri Gagan (Hisar) for the period 2016-21 and in SC, Gokalpur and Khankar Kheri (Nuh) for the period 2016-18.

7.11 Recommendations

1. **Monitoring and implementation mechanisms of various programmes need to be reviewed to ensure that distribution of resources (both human and financial) are made as per actual requirements, to avoid instances of shortages or excesses.**

2. **Government may review the data collection mechanisms to ensure availability of a reliable monitoring mechanism.**

3. **Government may attempt to increase awareness and outreach through various activities, for making the target population aware of the benefits along with removal of fears and/or misconceptions and increase participation.**

Chapter-8

Adequacy and effectiveness of the regulatory mechanisms

Chapter-8

Adequacy and effectiveness of the regulatory mechanisms

National Health Accounts[1] (NHA) is a tool to describe health expenditures and flow of funds in both Government and private sector in the country. Focus of NHA is on describing (1) entities[2] that provide resources to spend for health goods and services in the health system (2) entities[3] receiving and managing funds from financing sources to pay for or to purchase health goods and services; (3) entities[4] receiving finances to produce/provide health goods and services and (4) use of funds across various health care services[5].

The data shows that expenditure was incurred through Government sector as well as private sector to provide health care. Thus, the role of Government is not limited to only Government hospitals but also to regulate the private sector hospitals, clinics, pharmacies, etc. in the healthcare sector. Therefore, the existence of a regulatory mechanism is important to protect healthcare consumers from health risks, provide a safe working environment for healthcare professionals and to ensure public health and welfare provided through health programmes.

Regulatory agencies thus monitor individual and corporate healthcare practitioners and facilities, inform the Government about changes in the way the healthcare industry operates, ensure higher safety standards and attempt to improve healthcare quality and follow local, state and federal guidelines.

Implementation of the following Acts have been covered in this audit:

- Clinical Establishment Act, 2010
- Haryana Private Health Sciences Educational Institutes Act, 2012
- Standards prescribed under National Medical Commission Act, 2019

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1 National Health Accounts (NHA) estimates for India for Financial Year 2018-19 released in year 2022.

2 (a) Union Government: 11.71 *per cent,* (b) Enterprises: 5.51 *per cent,* (c) Others: 2.03 *per cent,* (d) State Government: 19.63 *per cent*, (e) Local Bodies: 1.01 *per cent* and (f) Household Revenues: 60.11 *per cent*.

3 (a) Other Schemes: 5.07 *per cent*, (b) Private Health Insurance: 7.25 *per cent,* (c) Union Government: 11.30 *per cent,* (d) Government Health Insurance (GHI): 6.04 *per cent,* (e) State Government: 14.27 *per cent,* (f) Local Bodies: 2.84 *per cent* and (f) Out of Pocket Expenditure: 53.23 *per cent*.

4 (a) Providers of Preventive Care: 5.34 *per cent,* (b) Government Hospitals: 17.34 *per cent,* (c) Others: 2.49 *per cent,* (d) Private Hospitals: 8.69 *per cent,* (e) Patient Transport: 3.40 *per cent,* (f) Government Clinics: 7.75 *per cent,* (g) Private Clinics: 4.37 *per cent*, (h) Diagnostic Labs: 3.92 *per cent,* (i) Pharmacies: 22.60 *per cent* and (j) Admin Agencies: 4 *per cent*.

5 (a) Governance and Administration: 3.96 *per cent,* (b) Preventive Care: 9.44 *per cent,* (c) Other functions: 3.03 *per cent,* (d) Pharmaceutical and other medical goods: 22.49 *per cent,* (e) Patient transport: 3.50 *per cent,* (f) Inpatient Curative Care: 34.55 *per cent,* (g) Outpatient Curative Care: 18.86 *per cent* and (h) Lab and Imaging: 4.17 *per cent*.

- Policy for Establishment by self-financing (Private) Nursing Institutes/ Medical Colleges
- Haryana Nurse and Nurse Midwives Act, 2017
- Haryana State Council for Physiotherapy Act, 2020
- Drugs and Cosmetics Act, 1940 and Rules, 1945
- Bio-Medical Waste Management Rules, 2016
- Atomic Energy (Radiation Protection) Rules, 2004

8.1 Implementation of the Clinical Establishments Act and Rules in the State

The Central Government passed the Clinical Establishment (Registration and Regulation) Act, 2010 (Act No. 23 of 2010) (CEA, 2010) dated 18 August 2010. The aim of this Act was to provide registration and regulation of clinical establishment with a view to prescribe minimum standards of facilities and services which may be provided by them so that the mandate of Article 47 of the Constitution for improvement in public health may be achieved. GoI further framed the Clinical Establishment (Central Government) Rules, 2012 in May 2012. The Haryana Government, Health Department vide Haryana Clinical Establishments (Registration and Regulation) Adoption Act, 2018 (HCEAA, 2018) notified through a gazette notification dated 9 April 2018 adopted the CEA, 2010. Subsequently, vide notification dated 13 July 2018 the Haryana Government notified the Haryana Clinical Establishments (Registration and Regulation) Rules, 2018 (HCE Rules, 2018).

As per provision of Section 2(C) of the CEA, 2010, clinical establishment means a hospital, maternity home, nursing home, dispensary, clinic, sanatorium or an institution by whatever name called that offers services, facilities requiring diagnosis, treatment or care for illness, injury, deformity, abnormality or pregnancy in any recognised system of medicine established and administered or maintained by any person or body of persons, whether incorporated or not, and shall include a clinical establishment owned, controlled or managed by (a) a Government or a department of the Government, (b) a trust, whether public or private; (c) a corporation registered under a central, provincial or state act, whether owned by the Government; (d) a local authority; and (e) a single doctor.

The deficiencies observed in implementation of CEA, 2010 and HCE Rules, 2018 are discussed in the succeeding paragraphs:

8.1.1 Registration of Private Clinics/Hospitals in the State under Clinical Establishment Act 2010 was restricted to Clinics/Hospitals with more than 50 beds

As per provisions of CEA, 2010, no person shall run a clinical establishment unless it has been duly registered in accordance with the provisions of this Act. CEA, 2010 provides for both provisional registration (without inspection) and permanent registrations (only after inspections). In case of provisional registration, the Act stipulates that the provisional registration certificate shall be valid only upto a period of twelve months from the date of issue of the registration certificate. Application of renewal of registration is to be made at least one month before the expiry of the existing registration certificate. Permanent registration shall be granted only when a clinical establishment fulfils the prescribed standards for registration as prescribed by the Central Government as per CEA, 2010. In cases of clinical establishments in respect of which standards have been notified by the Central Government, provisional registration shall not be granted or renewed beyond a maximum period of two years from the date of notification of standards, and they will have to apply for permanent registration thereafter.

It was observed that 268 private hospitals (more than 50 beds) and 330 diagnostic laboratories were provisionally registered in the State of Haryana as of December 2023. While adopting the CEA, 2010, the State of Haryana restricted the provision of registration to clinical establishments having more than 50 beds, thereby restricting its applicability. Accordingly, private clinical establishments which have bed capacity less than 50 beds are not being registered under the CEA, 2010, and are thereby out of its regulatory ambit. As such, the prescribed minimum standards of facilities and services cannot be ensured in unregistered clinical establishments having less than 50 bed capacity.

Further, it was noted that although the provisional registration certificates were being issued for a period of twelve months and the proforma of provisional registration certificate specified in the HCE Rules, 2018 mentioned that the registration was subject to the provisions of CEA, 2010 and the rules made thereunder, however no specific mention in respect of validity period of provisional certificate was made in the text of HCE Rules, 2018. Further, the condition that in cases of clinical establishments in respect of which standards have been notified by the Central Government provisional registration shall not be granted or renewed beyond a maximum period of two years from the date of notification of standards, was also not included in the HCE Rules, 2018. Further in these cases, they will have to apply for permanent registration thereafter which was only to be given after inspection and compliance with minimum standards.

Thus, the aim of the Act to provide registration and regulation of clinical establishment with a view to prescribe minimum standards of facilities and services was not fully achieved.

During the exit conference, Additional Chief Secretary (ACS), Health and Family Welfare Department stated (January 2023) that the recommendation of audit to extend it to cover all establishments in a phased manner would be considered.

8.1.2 Registration of Medical Diagnostic Laboratories (or Pathological Laboratories)

The Central Government had notified the minimum standards in respect of Medical Diagnostic Laboratories (or Pathological Laboratories) in May 2018. The main amendment in the said notification was the definition of minimum standards of facilities and services for diagnostic labs and a schedule detailing the basic requirements for various types of laboratories along with requirement of infrastructure, human resource etc. Section 23 of the Clinical Establishments (Registration and Regulation) Act, 2010 states that in case of Clinical Establishments in respect of which standards have been notified by the Central Government, provisional registration shall not be granted or renewed beyond:

i) A period of two years from the date of notification of the standards in case of clinical establishments which came into existence before the commencement of this Act.

ii) A period of two years from the date of notification of the standards for clinical establishments which came into existence after the commencement of this Act but before the notification of the standards; and

iii) A period of 6 months from the date of notification of standards for clinical establishments which came into existence after the standards have been notified.

It was noted that in continuation of the earlier legislations, the Government of Haryana issued a notification on 14 March 2019, vide which it was notified that the HCEAA, 2018 would also apply to all clinical establishments relating to diagnosis or treatment of diseases where any investigative or diagnostic services are carried out with the aid of laboratory or medical equipments. However, no minimum standards were prescribed for human resources or equipments required for the diagnostic laboratories.

The Health Department is continuing the provisional registration of the 330 laboratories in the State and has not registered them permanently even after the passage of more than four years from the date of notification of prescribed minimum standard for labs by the Central Government. It is pertinent to note

that where the clinical establishments in respect of which standards have been notified by the Central Government, provisional registration shall not be granted or renewed beyond the time limit prescribed as per Section 23 of the said Act. However, the condition of permanent registration and accompanying inspections were not made mandatory in the Acts and Rules framed by the Haryana Government.

During the exit conference (January 2023) the ACS stated that about registration of pathological labs continuing provisionally beyond two years, the matter would be taken up with Government of India to allow permanent registration on their portal.

It was further stated that the State Council had noted the issue of non-acceptance of online payments in the Central portal and had directed to State Nodal Officer, State Clinical Establishment Act Cell to pursue the issue with GoI. However, no records were available with regard to communication by the Health Department and Central Clinical Establishment Authority to resolve the issue for initiating the permanent registration of laboratories.

Thus, quality assurance of the diagnostic labs cannot be ascertained in absence of minimum standards. The prescribed minimum standards of facilities and services cannot be ensured in unregistered clinical establishments. As permanent registration was only to be given after inspection and compliance with minimum standards, failure to make permanent registration mandatory resulted in all the labs being run with provisional registration. As such, it cannot be ensured whether or not the labs are following the prescribed minimum standards and the quality assurance of the test conducted by the labs cannot be obtained.

8.1.3 Functioning of State Clinical Establishments Council

According to the HCE Rules, 2018, the Government was required to constitute a State Council headed by a Chairman. The State Council is responsible for implementation of the CEA, 2010 and Rules in the State. It was also stipulated in the Rules that the State Council shall meet at least once in six months. The main function of the Authority (i.e State Council) under the HCE Rules, 2018 is to grant, renew, suspend or cancel registration of any clinical establishment, to enforce the provisions of the Act and Rules made thereunder etc.

Haryana State Clinical Establishments Council was constituted in September 2018 under the chairmanship of Administrative Secretary, Health Department. As already highlighted above, only provisional registrations were being done in the State and no minimum standards had been prescribed as of yet. Further, as against the minimum requirements of seven half-yearly meetings till March 2022, only one meeting of the Council could be held (February 2022).

The Department in its reply stated (October 2021) that the meetings could not be held due to the prevailing COVID pandemic. The contention of the Department does not hold good as no meeting was held even before onset of the COVID pandemic. The Health Department should take necessary action to conduct the meetings of the Council regularly.

8.2 Directorate of Medical Education and Research

The Directorate of Medical Education and Research (DMER) had been carved out of the Health Department as a separate Directorate in January 2009 for the upgradation and expansion of Medical, Dental, Ayurveda, Homeopathy and Para-medical education. Subsequently, a separate department of Medical Education and Research was established in September 2014.

The shortcomings observed in the regulatory role of DMER are discussed in the succeeding paragraphs:

8.2.1 Deficiencies in implementation of Haryana Private Health Sciences Educational Institutes Act, 2012

With a view to provide for the regulation of admission, fixation of fee and maintenance of educational standards in private health sciences educational institutes in the State of Haryana and for the matters connected therewith or incidental thereto, Haryana Private Health Science Educational Institutions (Regulation of Admission, Fixation of Fee and Maintenance of Educational Standards) Act, 2012 (HPHSEI Act) was notified on 11 April 2012. DMER discharges its duties and function regarding regulation of admissions, fee matters and examination in all medical institutions along with formulation of policies for ensuring quality medical education in the light of this act. Under the provisions of the Act, DMER has to ensure fairness and quality of education and safeguard the interest of students through periodical inspections and obtaining periodical returns from all institutions including Govt/private/ autonomous bodies and universities.

Audit observed that DMER had notified policies regarding medical colleges as per National Medical Commission (NMC) norms, prepared a draft medical education policy which is under approval, and carried out assessment works as per NMC norms, along with registration of medical practitioners. However, certain shortcomings were observed as given below:

i. As per Section 9 (3) of HPHSEI Act, 2012 the State Government may require a private institution to file such return, as may be prescribed or provide such information, as it deems appropriate in the interest of quality of education.

   It was intimated (May 2022) by DMER that no such timely returns have been submitted/filed by the private institutes and were obtained as and

when required. However, copies of the same were not provided to audit in support of the claim.

ii. As per provision of Section 16 of HPHSEI Act, 2012 inspection committee may be constituted for inspection of the affairs of private institutes to ensure the quality of education imparted and compliance with the extant provisions.

It was stated that an inspection committee was constituted in August 2018 for inspection of all medical educational institutions under the purview of DMER. It was further stated that although only one inspection was carried out by the Government during the period 2016-17 to 2021-22, annual inspections are being carried out by the respective universities.

iii. Section 10 of the Act provides for the facility to receive complaints and initiate enquiries into the allegations and impose fines or take appropriate action.

It was noticed that during the year 2021, 118 complaints were received and 66 were settled and 52 are still under process. In 2022, (till June 2022), 87 complaints were received and 38 had been settled, while 49 were still pending to be processed. However, for the period 2016 to 2020, no such information with respect to complaints and disposal thereof was available with the office.

8.2.2 Establishment and infrastructure of Medical Education Institutes

The National Medical Commission Act (NMC), 2019 provides for a medical education system that improves access to quality and affordable medical education, ensures availability of adequate and high-quality medical professionals and enforces high quality and ethical standards in all aspects of medical services. In exercise of the power conferred by Section 57 of NMC Act, 2019 (30 of 2019), the "Minimum requirements for annual M.B.B.S Admissions Regulations, 2020" were notified on 28 October 2020. The main objective was to prescribe the minimum requirements of accommodation in the medical colleges and institutions and their associated teaching hospitals, staff (teaching and technical) and equipment in the college department and hospitals.

As per norms every medical college/ institute approved for MBBS admissions shall have 24 departments. Every approved medical college shall have the required area, accommodation for staff and equipment for each department as given in Schedule I, II and III prescribed with regulations. The medical college should be established with an annual intake capacity of 100/150 students and can be increased to 150/200/250 MBBS admissions annually, as per the prescribed phase-wise requirements. As per the above minimum requirement regulations prescribed by the NMC, the institutes complying with terms and

conditions and qualifying the minimum standards can only be designated/graded as recognised. A checklist was prepared by Audit on infrastructure and other basic amenities in the educational institutes (Medical Colleges) required as per norms of Schedule I, II and III of NMC Act, 2019 and information in this checklist was collected from the medical colleges of the State.

It was noted during audit that in pursuance of these regulations, only six out of the 12 medical colleges were recognised in the State. DMER intimated (January 2023) that the number of recognised institutes has increased to eight.

However, non-availability of infrastructure and other basic amenities were observed in four educational institutes (Medical colleges) which were required as per norms of NMC Act, 2019. The position is shown in ***Table 8.1***.

Table 8.1: Status of facility not available in four colleges as on May 2022

Name of college	Particular as per schedule 1,2,3 of NMC ACT, 2019	Requirement as per provision	Actual position in Institute
MCH Nalhar, Nuh	Department	24 Department	21 Department
	Skill lab	600 sq. meter	Under process
GMCW Khanpur Kalan, Sonipat	Department	24	22
	Pharmacology practical lab	8	3
	Skill lab	600 sq. meter	Under construction
	Gymnasium and synthetic Track	Must be available	Under construction
	BMW management	Must be available	Being done but Bar coding is under process
	Child Care Centre	Must be available	Under process
KCGMC, Karnal	Department	24	21
	Cafeteria and gymnasium	Must be available	Not available
	BMWM	Must be available	Certificate only available till 31 March 2022 and renewal awaited
	Child Care Centre	Must be available	Not available
Sh. A.B. Vajpayee Govt. Medical College, Faridabad	College Council Skill lab of 600 sqm	Must be formed	Not formed
	Medical education unit	Must be formed	Not available
	Child Care Unit	Must be formed	Not formed
	OPD FOR 8 Patients	Must be formed	Under process
	Gymnasium/sports complex	Must be formed	Not available
	Close circuit television	Must be formed	Under process

Source: Information supplied by DMER

8.3 Functioning of State Nursing Council

Haryana Nurses Registration Council was constituted as an autonomous body by Government of Haryana in the year 1973. Thereafter, Haryana Government constituted 'Haryana Nurses and Nurse-Midwives Council' in March 2017 with its headquarters at Panchkula, under a new Act viz. "Haryana Nurses and Nurse-Midwives Act, 2017". This Act provided for the constitution of the Haryana Nurses and Nurse-Midwives Council for registration of Nurses, Nurse-Midwives and for the registration of institutions imparting training and prescribing qualifications to such institutions and for matters connected therewith or incidental thereto.

It was noted that the Council was carrying out the functions of registration of courses, institutes and nurses along with conduct of exams. However, the

Council was found wanting in case of carrying out the inspections of the respective institutes.

As per section 26 of the Act, the Council may conduct periodical inspections and appropriate enquiry to ensure the maintenance of required standards. Further as per section 27, in case of failure to comply with terms and conditions of the recognition, the Council may withdraw such recognition. As per the decision in the 44th General Body Meeting held in January 2020, the Council decided to inspect the nursing institutes every three years instead of every year. However, it was noticed that after enforcement of Haryana Nurse and Nurse Midwives Act, 2017, only one inspection was conducted in May 2018. The next inspection which was due to be conducted in 2021, was not conducted. Thus, in the five-year period (2017-2022), only one inspection could be conducted.

In its reply (May 2022), the Department informed that though the inspection was due to be conducted in 2021 but since the Nursing policy of 2019 has been amended by the State Government in 2021 and the amended policy is under litigation, the Department could not decide whether the Nursing policy 2019 or the Nursing policy 2021 is to be followed for taking any action.

8.4 Functioning of State Council for Physiotherapy

The State Government notified the "Haryana State Council for Physiotherapy Act, 2020" in March 2020. This Act provided for the constitution of 'Haryana State Council for Physiotherapy' for the purpose of registration of physiotherapists, recognition of training institutions and for coordination and determination of standards of education in the field of physiotherapy.

The main function of the Council is to regulate the practice of profession by persons with recognised physiotherapy qualification and to maintain the register of physiotherapists for Haryana. As per provision 21(2) of the Act, any recognised university or institution in India other than the State of Haryana which grants qualifications in Physiotherapy may apply to the Council seeking recognition of the physiotherapy qualification being imparted by them. The Council shall further submit the proposal to the Government along with its recommendation to grant recognition to the physiotherapy qualification provided by such recognised university or institution, by notification in the official gazette.

During audit, it was observed that proposal for constitution of members as per provisions contained in Sections 3 and 4 of Haryana State Council for Physiotherapy Act, 2020 had been sent to Government (September 2022). Since the constitution of the Council was under process and was pending at the level of the State Government, no meeting was conducted till the date of audit although the function of registration of practitioners was being carried out. In the absence of records, it could not be ensured in audit as to whether or not the functions related to recognition of physiotherapy institutions were being carried out.

During the exit conference, Registrar, Director, Haryana State Council for Physiotherapy stated that now the Council has been constituted and one meeting has been conducted **(**December 2022**)**.

8.5 Director General of Ayush

In Haryana, the registration of Ayurveda and Unani practitioners is regulated by the Council of Indian Medicine, Haryana under the Punjab Ayurvedic and Unani Practitioners Act, 1963[6], which was notified on 13 December 1963. It was framed to consolidate and amend the law relating to registration of Practitioners of Ayurvedic and Unani System of Medicine and to regulate the practice in such systems.

Similarly, Punjab Homoeopathic Practitioners Act, 1965[7] regulates the registration of Homeopathy Practitioners in the State, and was notified on 18 June 1965. This Act was framed to regulate the qualifications and to provide for the registration of Practitioners of Homeopathic System of Medicine in the State of Haryana.

(A) GoI notified the National Commission of Indian System of Medicine Act, 2020 (NCISM) on 21 September 2020, to provide for a medical education system that improves access to quality and affordable medical education and ensures availability of adequate and high-quality medical professionals. It was noted that although this Act extended to the whole of India, the notification regarding implementation of the Act in the State of Haryana was still under consideration of the State Government (July 2022). Thus, the Ayurveda and Unani practitioners still continue to be regulated by the Punjab Ayurvedic and Unani Practitioners Act, 1963 in the State of Haryana.

As per provision of the Punjab Ayurvedic and Unani Practitioners Act, 1963, there should be a Council consisting of a Chairman and 11 other members, for carrying out the provisions of the Act. Out of 11 members, four members would be appointed by the State Government and the remaining seven members would be elected by the registered practitioners amongst themselves. The tenure of the Council would be five years from the date of its first meeting.

The first meeting of the current Council was held on 28 May 2014 and hence its tenure ended on 27 May 2019. However, the election of members of the Council could not be held up to July 2022, and the incumbent Council members were carrying out the various official functions.

As per provisions of the Act the Council would appoint a Registrar, whose main function was to maintain a register of practitioners in the prescribed form containing the name, address and qualifications of every registered practitioner

[6] Punjab Ayurvedic and Unani Practitioners Act 1963 is also applicable in Haryana.

[7] Punjab Homoeopathic Practitioners Act 1965 is also applicable in Haryana.

together with the dates on which qualifications were acquired. Further, every registered medical practitioner should get his registration renewed within one month of expiry of the period of 5 years of registration. If the registration is not renewed as per the prescribed provision, the name shall thereafter stand removed from the register. It was observed that although registrations were being carried out, there were deficiencies in the renewal process. It was intimated (July 2022) by the Registrar that 276 practitioners who had been registered during the year 2016-17, were required to get their registrations renewed in the year 2021-22. However, till January 2023, only 155 registrations had been renewed and the remaining 120 practitioners did not apply for renewal. As no follow-up by way of inspections etc. was carried out with regard to these 120 pending renewals, it could not be ascertained in audit as to whether these practitioners had continued to operate without compliance of the requisite registrations and associated regulations.

In relation to the notification regarding full implementation of NCISM Act, 2020 in the State, the Council replied (July 2022) that there already exists a Council, however, the notification regarding implementation of NCISM Act, 2020 is yet to be issued by the State Government. It was further stated that the matter of election of members was under active consideration by the Government. With regard to the pending renewal of 120 practitioners, Department accepted that these practitioners are required to be renewed.

(B) GoI notified the National Commission for Homeopathy Act, 2020 (NCH) on 21 September 2020, with the purpose to provide for a medical education system that improves access to quality and affordable medical education and ensures availability of adequate and high-quality medical professionals in the field of homeopathic medicine. It was noted that although this Act extended to the whole of India, the notification regarding implementation of the Act in the State of Haryana was still under consideration of the State Government (July 2022). Thus, the Homeopathic Practitioners continue to be regulated by the Punjab Homoeopathic Practitioners Act, 1965 in the State of Haryana.

As per provision of the Punjab Homeopathic Practitioners Act, 1965 there should be a Council consisting of a Chairman and 11 other members, for carrying out the provisions of the Act. Out of 11 members, three members would be appointed by the State Government and the remaining eight members would be elected by the registered practitioners from amongst themselves. The tenure of the Council would be five years from the date of its first meeting.

The first meeting of the current Council was held on 18 July 2016 and hence its tenure ended on 17 July 2021. However, the election of new Council members was not initiated yet, and the incumbent council was carrying out the various official functions of registration and regulation of the practitioners.

During the exit conference, the Department stated (January 2023) that the appointment of Chairman and other members was in process.

8.6 Drug Controller of the State- Non-achievement of targets fixed for inspection

Department of Food and Drug Administration was carved out as an independent department from the Health Department in Haryana in January 2011 for more effective administration of Food Standard and Safety Act 2006 and Drugs & Cosmetics Act, 1940 and Rules, 1945. These statutes are aimed at ensuring supply of quality medicines, cosmetics and foodstuff to the public at large at affordable prices and also safeguarding the unwary public from misleading advertisement of drug/food articles and drugs abuse. Prior to this, food and drugs control programme in the State was functioning under the Director General Health Services.

As per provisions contained in Drugs and Cosmetics Act, 1940, District Drug Control Officer (DCO) has to conduct inspection of retail and wholesale firms for further quality analysis. Information supplied by the Department revealed that there had been shortfall in the achievement of targets fixed for inspections to be conducted by the DCOs.

The percentage of shortfall in achievement of targets fixed for inspection is shown in ***Table 8.2***.

Table 8.2: Shortfall in achievement of targets fixed for inspection

Year	Sanctioned Strength of DCOs	DCOs in position	Annual target for inspection	Achievement	Shortfall	Shortfall (In *per cent*)
2016-17	46	18	20,040	9,406	10,634	53%
2017-18	46	16	20,040	11,772	8,268	41%
2018-19	46	15	20,040	13,273	6,767	34%
2019-20	46	15	22,524	20,290	2,234	10%
2020-21	46	14	22,524	18,058	4,466	20%
2021-22	46	12	22,524	16,611	5,913	26%

Source: Departmental information

It is evident from the table that there has been shortfall in achievement of targets fixed for inspection to be conducted by DCOs which ranged between 10 *per cent* and 53 *per cent* mainly due to shortage of DCOs.

The Commissioner, Food and Drugs Administration Haryana, Panchkula while accepting the audit observation stated (January 2023) that the main reason for shortfall in achievement of targets in the years 2016-17 and 2017-18 was shortage of Drugs Control Officers in the Department. However, the reply was silent about the remaining period.

8.7 State Pharmacy Council

State Pharmacy Council is a statutory body constituted under the Pharmacy Act, 1948 (Central Act) which extends to the whole of India. As per the Act, the State Council should be constituted which will consist of a total of 15 members (seven elected members[8]; five members nominated by State Government and three ex-officio members[9]).

As per information supplied by the State Pharmacy Council in exercise of the powers conferred under Section 19 of the Pharmacy Act, 1948 the State Government constituted the State Council (March 2014) with six elected members, five nominated members and three ex-officio members. Thus, the Council consisted of (as of July 2022) 14 members only, instead of the stipulated 15 members.

Further, as per provision of Section 26A of the Act, the Council with the prior approval of the State Government should appoint Inspector for inspection, to enquire, and investigate the complaints made in writing in respect of any contravention of the Act. It was observed that the Council had made no such appointments till June 2022. The Council in its reply informed that the proposal for appointment of pharmacy inspectors is under process (since January 2016) at the State Government level.

8.8 Bio Medical Waste Management

GoI in exercise of the powers conferred by the Environment (Protection) Act, 1986 and in supersession of Bio-Medical Waste (Management & Handling) Rules, 1998, published the Bio-Medical Waste Management Rules, 2016 (BMWM Rules, 2016) on 28 March 2016. These rules stipulate duties of the occupier or operator of a common Bio-Medical Waste Treatment Facility as well as the identified authorities. These rules apply to all persons who generate, collect, receive, store, transport, treat, dispose or handle bio-medical waste in any form including a healthcare facility. The prescribed authority for enforcement of the provisions of these rules in respect of all the health care facilities in any State/Union Territory is the respective State Pollution Control Board (SPCB)/Pollution Control Committee.

As per BMW Rules, 2016 "Bio-medical waste" means any waste, which is generated during the diagnosis, treatment or immunisation of human beings or animals or research activities. "Bio-medical waste treatment and disposal

[8] Six from amongst themselves by registered pharmacists of the State and one from amongst themselves by the members of each medical council or the Council of medical registration of the State.

[9] Chief Administrative Medical Officer of the State; officer-in-charge of Drugs Control Organisation of the State & The Government Analyst defined under the Drug and Cosmetics Act, 1940, ex-officio, or such one as the State Government may appoint.

facility" means any facility wherein treatment, disposal of bio-medical waste or processes incidental to such treatment and disposal are carried out and includes common bio-medical waste treatment facilities. “Health Care Facility” (HCF) means a place where diagnosis, treatment or immunisation of human beings or animals is provided irrespective of type and size of health treatment system and related research activity. "Occupier" means a person having administrative control over the institution and the premises generating bio-medical waste. "Operator of a common bio-medical waste treatment facility" means a person who owns or controls a Common Bio-medical Waste Treatment Facility (CBMWTF) for the collection, reception, storage, transport, treatment, disposal or any other form of handling of bio-medical waste.

During scrutiny of records of Haryana State Pollution Control Board (HSPCB), it was noted that the Department was publishing on its website the list of authorised HCFs with regard to BMW generation, treatment and disposal. Further, inspections of HCFs were being conducted regularly, along with conduct of co-ordination meetings with the Health Department and conducting awareness/ training programmes, to increase the awareness, adoption and compliance with the BMW rules. Further, while no specific grievance redressal mechanism with regard to bio-medical waste management was in operation, however, all types of complaints related to various types of pollution received through online portals such as CM Window, Public Grievance (PG) portal and Social Media Grievances Tracker (SMGT) portal were being disposed of after taking required action.

However, some shortcomings with regard to the authorisation and operation of HCFs were noticed and are discussed in the succeeding paragraphs:

8.8.1 Healthcare Facilities generating Bio Medical Wastes without obtaining authorisation from HSPCB

Bio-Medical Waste Management Rules, 2016 provides that every occupier or operator handling bio-medical waste, irrespective of the quantity shall apply to HSPCB, for grant of authorisation, who shall grant the provisional authorisation. Further, these rules provide that every occupier or operator of common bio-medical waste treatment facility shall submit an annual report to the prescribed authority on or before the 30th of June of every year, giving the details of the respective treatment facility including location, waste quantities generated etc. This information is to be compiled, reviewed and analysed for the whole State and sent to the Central Pollution Control Board (CPCB).

During scrutiny of records, it was noted that there were many HCFs which were in operation without applying for the authorisation from HSPCB. It was further noted that all the authorised HCFs were not submitting the annual reports. As per annual reports available on the website of HSPCB, year-wise details of such HCFs are shown in ***Table 8.3***.

Table 8.3: Operation of unauthorised HCFs during the years 2016 to 2022

Year	Total Number of HCFs in operation	Number of HCFs operating without authorisation	Percentage of HCFs operating without authorisation	Number of Occupiers who did not submit annual report	Percentage of cases of non-submission of annual report
2016	3,167	24	1%	294	9%
2017	3,412	352	10%	215	6%
2018	4,079	133	3%	157	4%
2019	5,526	193	3%	1,217	22%
2020	6,320	157	2%	2,332	37%
2021	6,898	179	3%	1,988	29%
2022	7,107	169	2%	2,281	32%

Source: Information taken from Annual Reports uploaded on the portal of HSPCB
Colour code: Color coding done on graded colour scale with red colour depicting most non-compliance; yellow colour depicting moderate non-compliance and green colour depicting least non-compliance.

From the above table, it is evident that during the years 2016 to 2022, except for the year 2017, one to three *per cent* of the HCFs had been in operation without authorisation. There has been an average number of 166 HCFs operating without authorisation during the years 2018-2022. Further, it is also evident that compliance to the provision for submission of annual reports has deteriorated during the years 2019-2022. Range of non-submissions of annual reports varied from 22 *per cent* to 37 *per cent*, during the years 2019-2022 with an average of 1,955 units. This indicates an inadequate regulatory mechanism on Bio Medical Waste Management in the State.

In its reply, the Board informed (January 2024) that the number of non-applicant HCFs has reduced to 150. Show cause notices have been issued to the remaining violating HCFs. The next course of action will be initiated against the violators for which necessary directions are being issued to the respective regional offices of the Board. The fact remains that stringent action has not been taken by the Board for non-compliane of BMW Rules, 2016.

(i) Non-adoption of Bar code system

As per Rule 8 of the BMWM Rule, 2016, bio-medical waste shall be segregated into containers or bags. Further, bar code and global positioning system shall be added within one year from the date of notification of these rules (i.e. from 28 March 2016).

The Board stated (June 2022) that 4,021 HCFs (out of 6,815 HCFs) adopted bar coding system till the month of June 2022 which was 59 *per cent* only, whereas it was required to be completed within one year after the date of notification (i.e. 28 March 2016).

In 2022, Board has started the process of implementation of the barcode system. However, the system is yet to be made fully operational.

(ii) Non-conduct of third-party inspection of the existing Common Bio Medical aste Treatment acilities

Schedule-III of BMWM Rules, 2016 specifies that it is the duty of the SPCB to undertake and support third party audits of the common bio-medical waste treatment facilities (CBWTF) in the State.

During scrutiny of records of HSPCB, as per annual report submitted to the CPCB for the year 2021, it was noted that there were 11 CBWTFs in operation in the State but no third-party audit had been conducted so far. In this regard, it was stated (June 2022), that the Board was in the process of assigning third party audit to some reputed institutes. The fact remains that no third-party audit had been conducted for six years from the date of notification of the above rules.

8.9 License for imaging equipment and their operation

As per Rule 3 of Atomic Energy (Radiation Protection) Rules, 2004 (AERP Rules, 2004) issued by Department of Atomic Energy, Government of India, no person shall, without a licence (a) establish a radiation installation for siting, design, construction, commissioning and operation; and (b) decommission a radiation installation. Further, no person shall handle any radioactive material or operate any radiation generating equipment except in accordance with the terms and conditions of a licence. A license shall be issued for sources and practices associated with the operation of computed tomography (CT) and interventional radiology x-ray unit.

Government of Haryana (GoH) vide its notification Number 30/7/2002-6HBII dated 23 February 2005 and 49/40/2014-6BHII dated 10 July 2015 established the Office of Directorate of Radiation Safety (DRS) as an independent agency under the Health Department of Govt. of Haryana for implementing the Atomic Energy Act, 1962 and Atomic Energy (Radiation Protection) Rules, 2004. As per the notification, DRS will perform the following functions to implement the Act and Rules effectively:

i. To review the inspection report of each and every X-ray unit in the State submitted by authorised radiation safety inspector and after being satisfied with the safety status of the unit shall recommend to the Atomic Energy Regulatory Board (AERB) that it can be issued a registration number.

ii. Send a progressive report of activities of the DRS associated with the rules to AERB once in a six month period.

No records relating to inspections conducted at district level or progress reports being sent to AERB were found available with the Department, which reflects non-performance of duties and functions by DRS. The Department in its reply (June 2022) stated that necessary directions in this regard had been issued to all

the civil surgeons from time to time to ensure the compliance of AERP Rules, 2004. The reply is not tenable as there was no record available with the DRS regarding instruction issued to the Rediological Safety Officers (RSOs) at field level (Civil Surgeons) and also DRS did not conduct any inspection and never sent any scheduled compliance report/progress report to the AERB, which were required to be sent every six months.

8.10 Conclusion

While the Legislature has developed a statutory framework for regulation of the medical sector, implementation of the Rules by the Government was not effective. While adopting the CEA Act, 2010, the State Act was made applicable only to clinical establishments having more than fifty beds, and thus, private clinical establishments having less than 50 beds were kept out of the regulatory mechanism. Resultantly, the prescribed minimum standards of facilities and services cannot be ensured in these unregistered clinical establishments. Further, even after four years from the date of notification of minimum standards in respect of Medical Diagnostic Laboratories, the Health Department is continuing provisional registration instead of permanent registration. The functioning of other regulatory bodies was also not in full compliance of the respective acts, with issues of non-constitution of requisite councils, lack of regular meetings, irregular inspections, lack of monitoring etc. being noticed. Thus, the mechanism developed by the legislature to regulate the various constituents of medical sector remained ineffective as the Government did not implement the provisions in true spirit and the enforcement remained ad-hoc and perfunctory.

8.11 Recommendations

1. **Government should extend provisions of CEA, 2010 to all clinical establishments including both private hospitals and diagnostic laboratories in a phased manner.**
2. **Government may adopt the GoI standards notified for diagnostic labs and make permanent registration mandatory to ensure compliance with minimum standards as per CEA, 2010.**
3. **Government may take up the matter with GoI for resolving issues related to the online portal for permanent registration of Medical Diagnostic Laboratories.**
4. **Government may ensure that the targeted number of inspections of firms engaged in retail and wholesale selling/supply of drugs are carried out to ensure quality of the drugs sold.**

5. **Government may ensure that all utilities generating bio-medical waste comply with the provisions with regard to authorisation, bar coding, annual returns along with third party inspection to regulate the generation and disposal of bio-medical waste.**

6. **Government may ensure that the regulatory body of State Council for Physiotherapy is constituted as per the respective statutory norms.**

7. **Government may ensure that the various regulatory bodies may adopt an adequate and effective monitoring mechanism to guarantee conformity with the necessary minimum standards.**

Chapter-9
Sustainable Development Goal-3

Chapter 9

Sustainable Development Goal (SDG) - 3

The Sustainable Development Goals - 2030 Agenda was adopted by United Nations General Assembly in September 2015 to set out a vision of a world free of poverty, hunger, disease and want to be achieved by 2030. There are 17 SDGs (SDG - 1 to SDG -17) and 169 targets under these 17 SDGs. India is committed to the 2030 Agenda and SDGs have been taken as the key contours of envisioning development up to the local level.

In India, National Institution for Transforming India (NITI) *Aayog* is responsible for overall coordination of the SDGs and the Ministry of Statistics and Programme Implementation (MoSPI) is responsible for the formulation of the National Indicator Framework (NIF) to monitor the SDGs.

The State Government had launched Haryana Vision 2030[1] in June 2017 and had established (August 2018) the Sustainable Development Goals Coordination Centre (SDGCC) under Swarna Jayanti Haryana Institute for Fiscal Management (SJHIFM) as a part of the Finance & Planning Department in collaboration with the United Nations Development Programme (UNDP). SDGCC is meant to work as a resource and knowledge hub, a think tank and a monitoring post for the Government of Haryana. It was aimed to facilitate the planning and implementation process of the Haryana Vision 2030 in the State.

The health and well-being of all, at every stage of life, has been taken in Sustainable Development Goal -3 (SDG-3). The Goal addresses all major health priorities, including reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage; and access to safe, effective, quality and affordable medicines and vaccines. Under SDG-3, a total of 13 targets have been fixed to be accomplished by 2030 as given in ***Table 9.1***.

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[1] Vision 2030 for Haryana envisage Haryana as a vibrant, dynamic and resurgent unit of federal India. A State where farms overflow with produce; the wheels of industry grind uninterrupted; none feels deprived; people have a sense of fulfilment, the youth sense of pride, and women enjoy not only safety, security and equal opportunities but also feel empowered. '*Antyodaya'*, minimum government and maximum governance, and making the State a better place to live in.

Table 9.1: Brief description of targets fixed under SDG-3

Sl. No.	Target no.	Brief description of targets to be achieved by 2030
1	3.1	To reduce the global maternal mortality ratio to less than 70 per 1,00,000 live births.
2	3.2	To end preventable deaths of new borns and children under 5 years of age, aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
3	3.3	To end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
4	3.4	To reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
5	3.5	To strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
6	3.6	By 2020, to halve the number of global deaths and injuries from road traffic accidents.
7	3.7	To ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
8	3.8	To achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
9	3.9	To substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
10	3.a	To strengthen the implementation of the World Health Organisation Framework Convention on Tobacco Control in all countries.
11	3.b	To support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines.
12	3.c	To substantially increase health financing and the recruitment, development, training and retention of the health workforce.
13	3.d	To strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

9.1 Planning and mapping of budget for SDG-3

9.1.1 Non-preparation of Strategic plan and Action plan for SDGs

The State Government and UNDP entered into a Memorandum of Agreement (MoA) in August 2018 for ensuring achievement of targets set in Haryana SDG Vision 2030 with an estimated cost of ₹ 25.61 crore for a period of three years, against which an amount of ₹ 5 crore had been released to UNDP during November 2018 to July 2021. It was agreed to deliver 7 years' Strategic Plan and 3 years' Action Plan along with generating SDG awareness among all stakeholders, SDG localisation at district and gram panchayat level, developing sophisticated technology based tools to monitor SDGs and collecting data.

During 2018-21, SDGCC with the help of UNDP had formulated SDG Budget Allocation Reports, Output-Outcome Framework Reports, Best Case Practice Booklets, SDG-Non-Governmental Organisation Alignment Report, SDG-Corporate Social Responsibility Alignment Report, SDG-University Alignment Report, District SDG Profile booklets, consultation meetings and workshops for generation of awareness. However, no action had been taken for formulation of strategic plan and action plans.

SDGCC replied (June 2023) that they are remained committed to ensure that each Government Department can articulate their strategic plans. The reply is not tenable as it was responsibility of SDGCC to formulate seven years' strategic plan and three years' action plan with the help of UNDP.

9.1.2 Budgeting for Sustainable Development Goals focusing SDG-3

Budgets provide a concrete measure of real commitment to the goals, while expenditure against the budget shows whether Government had followed the plan or not. There are several ways in which SDGs are being integrated in budgeting i.e. (i) mapping of budget allocations against SDGs; (ii) including a narrative in the budget document to broadly explain how the budget corresponds to SDGs; (iii) using SDG achievements to evaluate budget outcomes; and (iv) resorting to SDGs as a tool to rationalise resource allocation and decide financing priorities.

The State Government had adopted 'mapping of budget allocations against SDGs' and mapped the existing programmes/schemes with relevant SDGs in the State Budgets for the financial years 2018-19 to 2022-23. Further, Outcome-Output Framework Reports from 2019-20 onwards were formulated, which serve as a guide for each department to achieve the desired goals by using the SDG framework and enabling informed decisions about resource allocations.

Scrutiny of records focusing on SDG-3 revealed the following shortcomings:

(i) In the State budget documents and budget allocation reports of SDGCC for the years 2018-19 and 2019-20, the existing schemes were linked with 15 Goals (except SDG-14 and 17) and allocations were indicated Goal-wise. The allocation was not given target-wise i.e. the whole amount allocated under SDG-3 was meant for all the 13 targets collectively. In absence of target-wise allocation, it was not possible to assess impact of allocation i.e. which targets were given more attention.

SDGCC replied (June 2023) that the impact is measured at the 'SDG' level because many targets are contributing towards a particular SDG. The reply is not tenable as the targets are the sub-set of an SDG and in absence of target-wise planning and allocation, the impact of allocation for a particular target cannot be assessed.

The details of allocations, departments and programmes/schemes mapped under SDG-3 for the period 2018-21 are mentioned in ***Table 9.2***.

Table 9.2: Budget, Expenditure and programmes/schemes mapped for SDG-3

Particulars	2018-19	2019-20	2020-21	2021-22	2022-23
No. of Departments mapped	12	16	12	12	10
No. of Programmes/Schemes mapped	88	88	90	86	137
Budget Estimate (₹ in crore)	2,894.65	3,150.67	3,337.37	3,494.18	8,047.54
Actual Expenditure (₹ in crore)	2,326.08	2,633.73	5,468.38	4,814.23	Not available

Source: SDG Budget Allocation Reports

(ii) Scrutiny of the SDG Budget Allocation Reports and the Budget documents revealed that the Government had mapped the programmes/ schemes to more than one SDG, according to the nature and alignment of the programme/scheme objectives with the different SDGs. Further, the budget allocations under these programmes/schemes were made equally for various mapped SDGs. For example, as per Budget Document 2019-20, an amount of ₹ 8 crore was allocated for a programme under Ayush Department, which was aligned against three SDGs (3, 5 and 10) equally i.e. ₹ 2.67 crore for each SDG.

(iii) The actual expenditure incurred under the various aligned SDGs cannot be assessed in a particular programme/scheme. For instance, the amount actually incurred for the individual SDG-3, SDG-5 and SDG-10 out of the total expenditure of ₹ 8 crore under the programme/scheme under Ayush Department cannot be assessed.

SDGCC replied (June 2023) that due to non-establishment of any mechanism, 'equal weightage approach' was followed. The appropriate mechanism was yet to be established (June 2023). The reply is reflective of the failure on the part of SDGCC as the responsibility of mapping the budget allocation was with SDGCC.

(iv) Budget Allocation Reports of SDGCC do not reveal quantum-wise expenditure on individual programme/schemes of a department for the correspondingly mapped SDG. Instead, it gives the consolidated expenditure of a department under the mapped SDG. For example, against the budget estimate of ₹ 49.85 crore for eight programmes/ schemes of AYUSH Department in SDG Budget Allocation Report 2019-20, actual expenditure was ₹ 67.16 crore.

Thus, documents formulated by SDGCC did not provide information about the target-wise expenditure incurred, to enable the Government to measure the progress under a particular target under SDG-3.

9.2 Formulation of State Indicator Framework and District Indicator Framework

To monitor and measure the progress of SDGs, State Government had to formulate State Indicator Framework (SIF) and District Indicator Framework (DIF) in consultation with the National Institution for Transforming India (NITI) Aayog. The State Governments have been given flexibility to develop their own indicators taking into consideration local priorities to monitor SDGs and NIF will serve as a basis.

There are 28 Global Indicators and 41 National Indicators for measuring progress in all the 13 targets under SDG-3. In Haryana, State Indicator Framework (SIF 1.0) was formulated in August 2021 wherein the State had adopted 39 national indicators for 12 targets[2].

In addition, 21 Haryana Specific Indicators were formulated for six targets (3.1, 3.2, 3.3, 3.4, 3.7 and 3.c). 18 district indicators for 5 targets (3.1, 3.2, 3.3, 3.7 and 3.8) were also formulated which was published[3] in 2020-21.

9.3 Performance of Indicators for SDG-3

The State Government had published the first Haryana Sustainable Development Goals Index Report for the year 2020-21 capturing achievements against 10 NIF indicators as given in ***Table 9.3*** covering 8 targets (out of 13) of SDG-3.

Table 9.3: Description of indicators under SDG-3

Sl. No.	Indicator	Name of Indicators	Brief description of indicators
1	3.1.1	Maternal mortality rate	The proportion of maternal deaths per 1,00,000 live births per annum.
2	3.2.1	Under 5 mortality rate	The proportion of deaths of children before reaching the age of five years per 1,000 live births.
3	3.2.3	Percentage of fully immunised children	The percentage of children aged 12-23 months who had received all the basic vaccinations for BCG, Measles and three doses of Pentavalent vaccine.
4	3.3.1	HIV incidence per 1,000 uninfected population	The number of people newly infected with HIV in the reporting period per 1,000 uninfected population.
5	3.3.2	Notification of cases of Tuberculosis per one lakh population	The estimated number of new and relapse TB cases (all forms of TB, including cases in people living with HIV) arising in a given year, expressed as a rate per 1,00,000 population.
6	3.4.2	Suicide rate	The number of suicides reported per 1,00,000 population during reference year.
7	3.6.1	Death rate due to road traffic accidents	The number of persons died due to road accidents calculated as rate per 1,00,000 population during reference year.
8	3.7.3	Percentage of institutional deliveries	The percentage of deliveries conducted in a health facility during the period of one year or five years.
9	3.8.2[4]	Monthly per capita out of pocket expenditure on health	Monthly per capita out of pocket expenditure on health as a share of monthly per capita consumption expenditure.
10	3.c.1	Availability of physicians, nurses and midwives	The number of physicians, nurses and midwives per 10,000 population.

Source: SDG National Indicator Framework Baseline Report 2015-16

A comparative analysis of 10 indicators (***Appendix 9.1***) was done by Audit based on SDG India Index for 2018-21, SDG National Indicators Framework Baseline Report 2015-16 issued by Ministry of Statistics and Programme Implementation and National Family Health Survey-5, 2019-21. The comparative improvement/decline of performance of indicators are presented in the following graphs.

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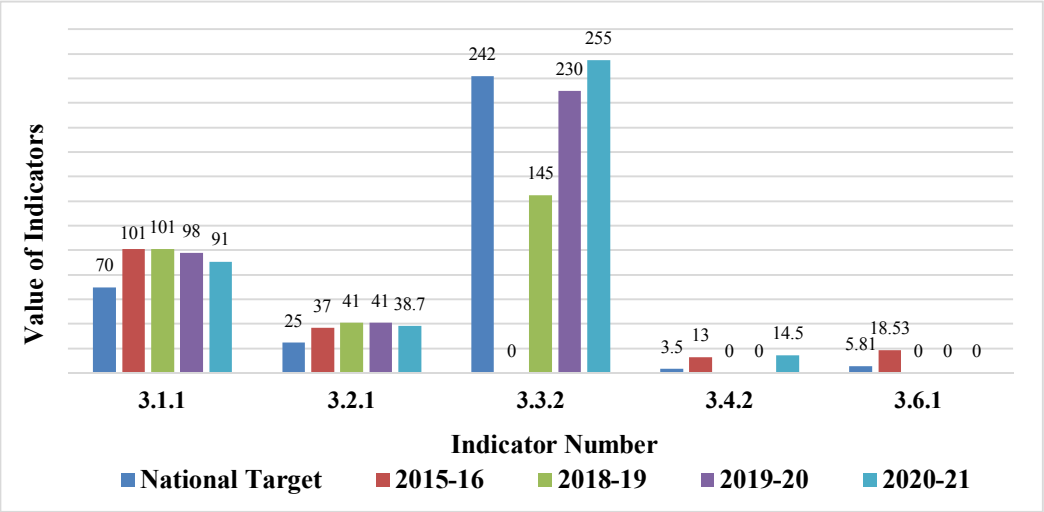
2 No indicator fixed for the 13th target being national level indicator i.e. 3.d. - Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

3 Haryana Provisional District Sustainable Development Goals Index 2020-21.

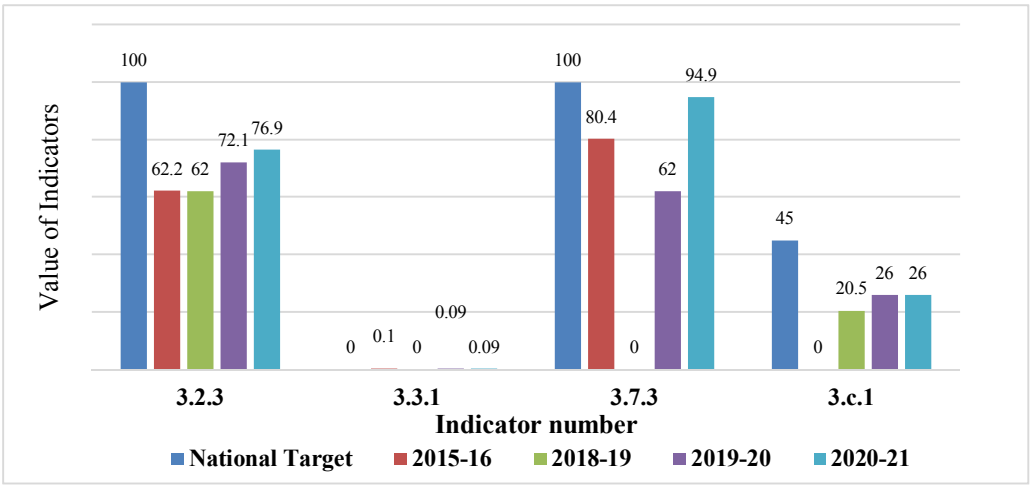
4 Analysis of this indicator has not been done here due to data available only for one-year (2020-21) i.e.no year-wise progressive data is available.

Chart 9.1: Maternal Mortality Rate (3.1.1), Under 5 mortality rate (3.2.1), TB cases per lakh (3.3.2), Suicide Rate (3.4.2) and Death Rate due to Accidents (3.6.1) during 2015-21



Source: SDG India Index for 2018-21, SDG National Indicators Framework Baseline Report 2015-16 issued by Ministry of Statistics and Programme Implementation and National Family Health Survey-5, 2019-21

Chart 9.2: Percentage of immunised children (3.2.3), HIV incidence per 1,000 uninfected population (3.3.1), Percentage of institutional deliveries (3.7.3), Availability of physicians, nurses and midwives (3.c.1) during 2015-21 under SDG-3



Source: SDG India Index for 2018-21, SDG National Indicators Framework Baseline Report 2015-16 issued by Ministry of Statistics and Programme Implementation and National Family Health Survey-5, 2019-21

Four indicators showing unsatisfactory performance are discussed below:

i. Indicator 3.2.1 'Under 5 mortality rate per 1,000 live births' showed upward movement from 37 in 2015-16 to 41 in 2018-20 and ultimately 38.7 in 2021 whereas the national target for this indicator is fixed at 25.

ii. Indicator 3.4.2 'Suicide Rate per 1,00,000 population' showed upward movement from 13 in 2015-16 to 14.5 in 2020-21 i.e., it was more than four times than the national target of 3.5.

iii. Indicator 3.c.1 'Total physicians, nurses and midwives per 10,000 population' showed upward movement from 20.5 in 2018-19 to 26 in

2019-20 and continued to be 26 in 2020-21 whereas the national target is fixed at 45.

iv. Indicator 3.6.1 'Death Rate Due to Road Traffic Accidents (per 1,00,000 population)' is 18.53 for 2015-16 whereas the national target for the same is 5.81.

Thus, it is evident that performance on these four indicators meant for evaluating progress of SDG-3 was not satisfactory with reference to national targets.

SDGCC replied (June 2023) that to address the negative trend of indicators, various concerned departments such as the Department of Health and Family Welfare, Road and Traffic Department, Public Works Department are working.

9.3.1 Analysis of expenditure made for SDG-3 during 2018-21

Analysis of budget allocations and expenditure for SDG-3 ***(Appendix 9.2 and 9.3)*** during 2018-21 revealed that there was increase in expenditure on health services whereas the indicators for SDG-3 do not present a satisfactory picture as discussed above.

SDGCC replied (August 2023) that they are only aligning the budget of departments and departmental activities are performed by the Health and Family Welfare Department itself. The reply affirms the audit comment that activities which were required to be undertaken by SDGCC for suggesting corrective measures were not undertaken by them.

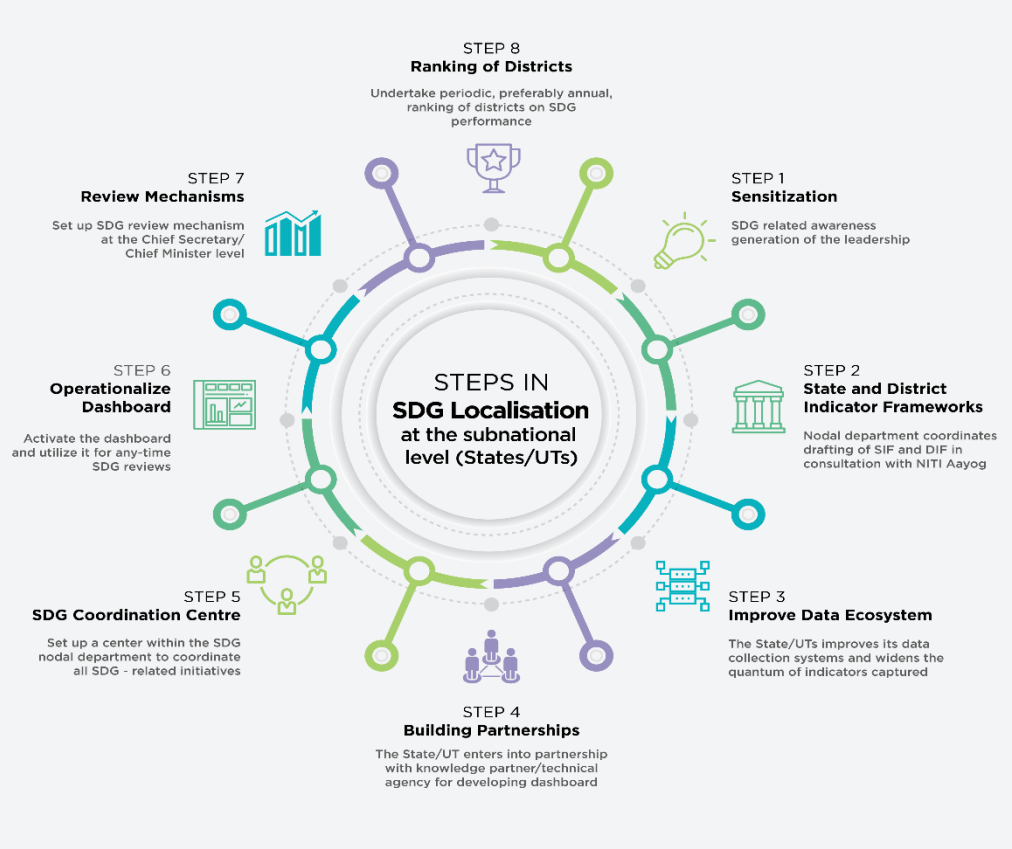
Thus, there is a requirement for identifying reasons behind and exploring remedies for suggesting corrective measures to the departments concerned by SDGCC.

9.4 Intervention and coordination

India presented its second Voluntary National Review (VNR) in July 2020 to United Nations' High-Level Political Forum (HLPF)[5]. The title of the presentation, 'Decade of Action: Taking SDGs from Global to Local' was meant to make compliance of the commitments towards involvement of multi-stakeholders and localising the SDGs. The second VNR provides for 8 steps (mentioned below) towards SDGs localisation at sub-national level i.e. at State/UT level in India.

[5] As a signatory to the 2030 Agenda for Sustainable Development, India is committed to participating in the international review of the progress of SDGs on a regular basis. The foremost platform for international follow-up and review of the 2030 Agenda is the United Nations' HLPF, which has been meeting annually since 2016 under the auspices of the UN Economic and Social Council (ECOSOC).

In the HLPF, UN member countries present their Voluntary National Review (VNR) on the implementation of SDGs. The VNRs serve as a basis for the international review of the progress on the SDGs.



Scrutiny of records (2018-21) of SDGCC/SJHIFM about efforts made for localisation of SDGs and achievement thereof and shortcomings noticed by Audit are mentioned below:

Step 1-Sensitisation i.e. SDGs related awareness generation of leadership:

- SDGCC did not reach out to Local Government constituted under 73rd and 74th Constitutional amendment Acts. Records of the SDGCC also did not reveal that sensitisation efforts were made for the benefit of functionaries at district, block and village levels of the State Government.
- Activities were not organised for encouraging participation of stakeholders like NGOs, Educational institutions, Business organisations etc. in the SDGs mission of Haryana.
- SDG First networking platform was launched (November 2019) by the SDGCC for online consultation with Industry Associations/NGOs in Haryana to deliberate on development issues. However, only two events (Universal Healthcare in November 2019 and December 2019) were organised on this platform during 2018-21.

Step 2-State and District Indicator Frameworks (SIF and DIF): SIF and DIF have been framed as discussed in **Paragaraph 9.2.**

Step 3-Improve data ecosystem: In the State, 21 Haryana Specific Indicators were developed, but these were not published in Haryana SDG Index Report 2020-21. Instead only 10 NIF indicators had been published, which had the

same data sources[6] as of India SDG Index Report 2020-21. Thus, the Haryana SDG Index Report is a replication of India SDG Index Report 2020-21.

Step 4-Building partnerships: The State had entered into partnership with UNDP for developing dashboard and technical support.

Step 5-SDG Coordination Centre: SDG Coordination Centre was established in August 2018. However, the SDGCC is not functioning at its full strength, as proposed at the time of establishment of the centre. It was proposed that the SDGCC will have Project Management Unit having 7 personnel on UNDP roll, recruited and guided by UNDP, while funded by SJHIFM and Project Implementing Unit (PIU) having 27 personnel on SJHIFM roll. There was provision of 6 Divisional Coordinators and 6 Divisional Data Operators under PIU for monitoring and evaluation purpose. In reality, the SDGCC worked with 5 personnel (on average) under PMU during 2018-22. PIU did not become functional as of April 2022. Reasons for not functioning at its full strength and non-functioning of PIU were not recorded in the files of the SDGCC.

Moreover, Divisional Level SDG Coordination Committee headed by Commissioner and District Level SDG Coordination Committee headed by District Magistrate were proposed to be constituted during establishment of the SDGCC. No such committee was constituted till completion of audit.

The SDGCC while accepting the facts, intimated (June 2023) that due to unforeseen circumstances and logistical constraints, the recruitment process could not be completed. Further, it was also intimated that the draft guidelines regarding establishment of 'District SDG Cell' is under consideration.

Step 6- Operationalise Dashboard: Development of SDG Dashboard is still under process (June 2023).

Step 7-Review mechanisms: It was proposed during the establishment of SDGCC that SDG Mission Committee (SDGMC) headed by Chief Minister and State Level Coordination Committee (SLCC) headed by Chief Secretary were to be constituted. SDGMC was to meet every six months while SLCC was to meet every three months to review the progress made for SDGs.

However, no such review committee was constituted except for constitution of a Project Steering Committee (PSC) jointly co-chaired by Finance and Planning Secretary, Government of Haryana and UNDP for periodic review of project activities (the project of establishment of SDGCC).

As per records of the SDGCC, the PSC met only four times (two times in 2019 and two times in 2020) during the period August 2018 to April 2022.

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[6] Health Management Information System and National Family Health Survey of Ministry of Health and Family Welfare, Civil Registration System & Sample Registration System of Ministry of Home Affairs, GoI, etc.

Step 8-Ranking of districts: The SDGCC formulated Haryana Provisional SDG District Index 2021 for achieving the SDGs. The first edition of this Index was based on 15 SDGs (out of 17), 49 targets (out of 169) and 95 indicators with ranking of the districts based on their performance across 15 SDGs.

SDGCC replied (June 2023) that they are working on activities such as sensitisation of departmental officials, building of mechanism for institutionalising the output-outcome framework report, SDG budget allocation reports, documentation of best practices, SDG district profiles, etc.

Thus, it is evident from the above that the eight steps process to be adopted for localisation of the SDGs in the states, was not effectively executed in the State of Haryana. Further, the SDGs could not reach effectively to the lower strata of the State Government as well as local Government even after a lapse of more than six years out of the total 15 years period for the implementation of the SDGs.

9.5 Conclusion

The State adopted 39 NIF indicators which covered 12 targets in its State Indicator Framework (SIF). The State was able to publish only 10 Indicators covering 8 targets (out of 13) even after lapse of six years out of 15 years' timeframe for achievement of SDG. SDGCC had not formulated 7 years' strategic plan and 3 years' action plan for implementation of SDGs. Budget was not allocated target-wise, in absence of which, it is not possible to assess impact of allocation on a particular target. Performance in four indicators of SDG-3 was not satisfactory with reference to national targets. Eight steps process to be adopted for localisation of the SDGs in the State was not executed effectively.

9.6 Recommendations

1. **The State Government may take steps to adopt more indicators in Haryana SDG Index Report to present a comprehensive picture for measuring and monitoring the performance of the State in achievement of SDG.**
2. **Comprehensive strategic plan and action plan with well-defined milestones for measuring and monitoring implementation, should be formulated after due consultations.**
3. **Reports prepared by the SDGCC should have information on target-wise actual spending showing performance against the planned budget expenditure thereby assisting in judicious and adequate resource allocations.**

4. **SDGs Dashboard should be operational and SDG Mission Committee (SDGMC) as well as State Level Coordination Committee (SLCC) should be constituted for ensuring availability of data and creation of a continuous monitoring and reporting framework.**

5. **Achievement in respect of SDG-3 is not satisfactory despite increase in expenditure for SDG-3. The SDGCC should analyse the reasons and suggest corrective measures.**

6. **Initiatives for enhancing public awareness and sensitisation about SDGs must be stepped up so that the process of implementation becomes participatory and inclusive.**

Chandigarh **(SHAILENDRA VIKRAM SINGH)**
Dated: 29 August 2024 **Principal Accountant General (Audit), Haryana**

Countersigned

New Delhi **(GIRISH CHANDRA MURMU)**
Dated: 9 September 2024 **Comptroller and Auditor General of India**

Appendices

Appendix 1.1

(Reference: Paragraph Introduction; Page 1)

Responsibilities of Health Department as per Business of the Haryana Government (Allocation) Rules, 1974

Responsibilities of Health Department as per Business of the Haryana Government (Allocation) Rules are:

i. Adulteration of foodstuffs and other goods.
ii. Blood Transfusion Service and Blood Transfusion Centres in the State.
iii. Chemical Laboratory, Karnal.
iv. Drugs and poisons and objectionable advertisements relating to drugs and medicines.
v. Establishment matters relating to officers and staff under the administrative control of the Department except matters allotted to the General Administration Department.
vi. Family Planning.
vii. Grant-in-aid to local bodies (or hospitals and dispensaries, Ayurvedic *Aushadhalayas* and other institutions.
viii. Hospitals, Dispensaries, Primary and Rural Health Centres.
ix. Infectious diseases, hospitals for their treatment and other measures for their suppression.
x. Lunacy and mental deficiency including places for the reception or treatment of lunatics and mental deficient.
xi. Medical attendance on Government servants and their families.
xii. Maternity and child welfare.
xiii. Medical inspection of school children.
xiv. Prohibition of inoculation and making the Primary vaccination and revaccination of children compulsory.
xv. Prohibition of smoking in Cinema Halls.
xvi. Public Health, Epidemic Diseases and Sanitation.
xvii. Registration of births and deaths.
xviii. St. John Ambulance Association and Red Cross Society.
xix. Supply of unclaimed bodies of deceased persons to hospitals and medical and teaching institutions for therapeutic purposes or for the purpose of anatomical operation and research work.
xx. The Homoeopathic system of medicine.
xxi. The Indigenous systems of medicine.
xxii. The Pharmaceutical profession.
xxiii. Use of eyes of deceased persons for therapeutic purposes.
xxiv. Venereal diseases.

Appendix 1.2
(Reference: Paragraph 1.6; Page 9)
List of selected Hospitals, CHCs, PHCs, Sub Centres and Ayurvedic Dispensaries

District	Hospitals	CHCs	PHCs	Sub Centres	Ayurvedic Dispensaries
Hisar	1. DH, Hisar 2.SDCH, Adampur 3.SDCH, Narnaund (3 out of total six Hospitals in the district)	Barwala	Agroha	Siwani Bolan	Bado Rangdan
			Dhansu	Dhansu	Balak
				Sulkhani	Bangla
		Uklana	Hasangarh	Litani	Bhagana
				Sandlana	Chaudhriwali
			Daulatpur	Bithmara	Chirod
				Budakhera	Kalirawan
		Mangali	Kaimiri	Juglan	Kalwas
			Ladwa	Daya	Khark Punia
				Bado Brahmnan	Madan Hedi
			Talwandi Rukka	Talwandi Rukka	Nangthla
		Sorkhi	Puthi Mangal Khan	Kheri Gagan	Nara
			Puthi Saimain	Bhaklana	Tokaspatten
		Hisar (Sec 1&4 UHC)	UPHC, Char Qutub Gate Hansi		
			UPHC, Patel Nagar		
Nuh (Mewat)	DH, Nuh (Total one Civil Hospitals in the district)	Firozpur Jhirka	Biwan	Biwan	Lahawas (Pinagwa)
				Hirwari	Pinangwa
			Nagina	Ganduri	Hassanpur Tauru
				Bhukaraka	Manota
		Punhana	Jamalgarh	Gokulpur	Silkho (29 May 2019)
				Dudoli	Agon
				Hathan Gaon	Reghar
			Singar	Pema Khera	
Panipat	1.DH, Panipat 2.SDCH, Samalkha (Total two Civil Hospitals in the district)	BAPOLI	Sewah	Goela Khera	Bapoli
				Khalila (Prahladpur)	Dehra
		Matlauda	Rair Kalan	Nohra	Dhramgarh
				Bal Jattan	Pathri
		NARAINA	Atta	S.Malpur	
				Machhroli	
			Pattikalyana	Dehra	
		Naultha	Israna	Bandh	
			Mandi	Balana	
				Gawalra	
		Panipat (Sec-12, UHC)	UPHC Raj Nagar		
			UPHC Hari Singh Colony		
			UPHC Rajeev Colony		
Total	**06**	**10+2**	**24**	**31**	**24**

In addition to the above selection, one TB Hospital (Hisar); two medical colleges (MC Agroha and MC Nalhar); one GNM School of Nursing (Hisar) and one ANM Training School (Mandikhera, Nuh) were selected for field study.

Appendix 1.3
(Reference: Paragraphs 1.7; Page 10 and Paragraph 3.1.8; Page 56)
Feedback report on survey of doctors and patients

A survey of doctors and patients selected on random basis was conducted (April-June 2022) during performance audit to get feedback from doctors and patients' satisfaction.

Citi en Charter

During survey of test checked hospitals, it was noticed that all the selected hospitals displayed Citizen Charter except DH Mandikhera (Nuh). User charges were not displayed in SDCH Narnaund. Further, it was noticed that the Charter of all the hospitals depicted all information about services not available and about equipment not in order except DH Mandikhera, SDCH Samalkha, SDCH Adampur and SDCH Narnaund.

Dietary Services

During joint physical verification of dietary services in test checked hospitals, it was observed that dietary services were available in all hospitals. No dedicated kitchen and Menu Chart for dietary services was available except in DH Hisar. Dietician and facility of serving trolly was available only in DH Panipat and DH Hisar. The food supplied to the patients was not patients specific such as diabetic, semi-solid and liquid; system of diet counselling to the patients, formulation of caloric requirement and accordingly setting diet for the patients was not adopted; types of the diets were not prescribed by the Department; protective gears (apron, head gear, clear plastic gloves) were not used by the cooks in the kitchen those serving food and quality of diet was checked by a competent person on regular basis as prescribed in IPHS Guidelines except DH Mandikhera and DH Hisar. No staff deployed for cooking and distribution of foods to IPD patients and no FSSAI registration certificate were issued under food safety and standard Act 2006 in any of the test checked hospitals.

Hospital acilities

Timings/working hours of OPD and other services were displayed; complaint register was maintained, kept available to beneficiaries and potable water facility was available in all the test checked hospitals except DH Mandikhera. Patients and visitors were sensitised and educated through appropriate IEC/BCC approaches; procedures for taking informed consent before treatment and procedures were established; patients were informed about his/her rights and responsibilities and adequate visual privacy was provided at every point of care in all tests checked hospitals except in DH Panipat.

Doctors' Survey

33 doctors from the test checked hospitals were surveyed. It was observed that out of these doctors 13 doctors had MBBS or equivalent degrees and 20 doctors had higher degrees. 23 doctors had been posted in the respective hospitals upto 5 years, 7 doctors had been posted for more than 5 years but upto 10 years and 3 doctors had posting tenure more than 10 years. 12 *per cent* of doctors stated that they were not provided with all the required infrastructure in the hospital to see the patients. 52 *per cent* of the doctors surveyed stated that they had to attend to more than 70 patients per day and 48 *per cent* of doctors stated that they had to work more than 6 hours per day. 30 *per cent* of doctors stated that the generic medicines/ medicines as prescribed were not available in the hospital pharmacy. 42 *per cent* of doctors stated that they had heavy patient load, 55 *per cent* stated that they had normal patient load and only three *per cent* stated they had less patient load. 32 doctors were satisfied with the process of the registration of the medical practitioner in the hospital, whereas one doctor stated that there should be roster of doctors at registration counter. 67 *per cent* of doctors stated that the registration number (doctor) was not displayed in the clinic, prescription, and receipts. 12 *per cent* of doctors stated that they had no trained medical staff. 88 *per cent* of doctors feel that improvement to be made in the health care infrastructure in the Government hospitals as per the requirement of the patients. 21 *per cent* of doctors stated that monthly meetings were not held among the doctors to discuss or address the issues faced by the hospital. 91 *per cent* of doctors stated that there was a monitoring system in place for patients requiring long term/continuous treatment (with ailments like TB/HIV etc.).

In-patient survey

In the test checked hospitals, 39 in-patients were surveyed. It was found that 54 *per cent* of in-patients were admitted for 3 days or less, 13 *per cent* were admitted for more than 3 but upto 5 days, whereas 33 *per cent* in-patients were admitted for more than five days. 67 *per cent* patients stated that it took less than or equal to 30 minutes to get admitted whereas 33 *per cent* patients did not specify the time but stated that they got admitted the same day. All the patients stated that admission/information about the ongoing treatment was shared with patients or attendants regularly. 54 *per cent* of patients stated that the doctors visit upto 4 times a day, 15 *per cent* stated that the doctors visited more than 4 times a day and 31 *per cent* did not state any specific number of visits. 18 *per cent* stated that they had to pay out of pocket for the medicines/diagnostic tests/lab services etc. All the surveyed in-patients stated that the responses of the Nurses in the ward were prompt; the behavour of the staff was dignified and respectful; the complaints were attended promptly and action taken on them; clean and adequate toilet facilities were available for male and female patients and garbage was removed from the patient care area regularly. Only 3 *per cent* patient told that facilities for differently abled persons were not available;

intravenous/insertions like Saline drips and catheters etc. were monitored and changed, whenever needed and other prescribed medications given periodically by the nursing staff; the facilities for the prescribed investigations (lab/radiology) were made available by the Hospital and effective security system was in place at patient care areas. Only two patients stated that consent was not taken from family member/attendant before treatment. Out of these in-patients, two patients at SDCH Adampur stated that only 80 *per cent* of prescribed drugs were made available at Pharmacy and wards. Three patients at SDCH stated that doctors were not available during the night. 18 *per cent* patients stated that the services of attendant were not provided for patients requiring trolley/wheelchair. 10 *per cent* of patients stated that the food provided was not sufficient and 33 *per cent* stated that the food provided was not as per the diet prescribed by the Doctor.

ut-patient survey

Total number of patients: 120 (10 patients per DH and SDHC; while five patients per CHC).

During field study of selected health institutions (DHs/SDCHs/CHCs), total 120 number of patients were involved for conducting OPD patients survey. During analysis of the patient survey proformas, it was noticed that 29 *per cent* patients said that Enquiry/May I Help desk was not available with the competent staff. According to 14 *per cent* patients, seating arrangements was not adequate at registration/OPD counter. OPD hours for doctors and rate list were not displayed according to 29 *per cent* and 51 patients respectively. Further, the 26 *per cent* patient said that number of registration counters were not adequate in health institutions. 48 *per cent* patient informed that patient calling system was not satisfactory.

From further analysis it was found that all prescribed medicines were not made available to 31 *per cent* by hospital pharmacy. 27 *per cent* (pathological tests) and 54 *per cent* (radiology tests) patients said that all test recommended by the doctors were not done by the hospital. 13 *per cent* patient objected that complaint box was not available in test checked health institutions.

Time Survey

Further, time taken for the following services in test-checked health institutions i.e. 30 patients from DHs, 30 patients from SDCHs and 60 patients from CHCs was also analysed based on OPD survey:

(i). Time (in minutes) taken for registration

Time (in minutes)	DHs				SDCHs				CHCs			
	upto10	10-20	20-30	30-40	upto10	10-20	20-30	30-40	upto10	10-20	20-30	30-40
No. of Patients	5	7	15	3	26	04	0	0	56	04	0	0

It was observed that 50 *per cent* of the patients (15) in DHs took 20-30 minutes, in SDCHs 87 *per cent* (26) took upto 10 minutes, in CHCs 93 *per cent* patients took upto 10 minutes to get themselves registered.

(ii) Waiting time (in minutes) before a patient could consult the Doctor

Time (in minutes)	DHs				SDCHs				CHCs			
	upto10	10-20	20-30	Above 30	upto10	10-20	20-30	Above 30	upto10	10-20	20-30	Above 30
No. of Patients	0	01	25	04	21	09	0	0	53	07	0	0

It was observed that 83 *per cent* (25) of the patients in DHs had to wait for 20-30 minutes, in SDCHs 70 *per cent* (21) and in CHCs 88 *per cent* (53) of the surveyed patients had to wait for upto 10 minutes before they could consult the doctors.

(iii) Consultation time (in minutes)

Time (in minutes)	DHs				SDCHs				CHCs			
	Upto 3	3-5	5-10	Above 10	Upto 3	3-5	5-10	Above 10	Upto 3	3-5	5-10	Above 10
No. of Patients	0	29	01	0	0	25	5	0	23	25	7	1 (4 patients did not mention any time.)

It was observed that in test-checked DHs, doctors consulted 97 *per cent* of the patients (29), in SDHCs 83 *per cent* (25) and in CHCs 42 *per cent*s of the surveyed patients were consulted for 3-5 minutes. Four patients in CHCs did not mention any time for consultation.

(iv) Time (in minutes) taken by patients for receiving medicines from Pharmacy

Time (in minutes)	DHs				SDCHs				CHCs			
	Upto 3	3-5	5-10	Above 10	Upto 3	3-5	5-10	Above 10	Upto 3	3-5	5-10	Above 10
No. of Patients	02	18	02	08	0	14	11	05	22	12	19	7

It was observed that for getting medicines from drug pharmacy in test-checked DHs, 60 *per cent* and in SDCHs 47 *per cent* of the surveyed patients had to wait for 3-5 minutes; while in CHCs 37 *per cent* patients had to wait upto 3 minutes.

Drugs Management acilities

All test checked hospitals have air-conditioned pharmacy except SDCH Samalkha and SDCH Adampur. Rest, all the prescribed norms such as Labeled shelves/racks, Drugs stored above the floor, 24-hour temperature recording of cold storage area, Poisons kept in a locked cupboard etc. were followed/ available in the test checked hospitals.

ire-fighting Services

No objection certificate (NOC) was not obtained from Fire Department and no smoke detector was in place/ functional in any of the test checked hospitals except DH Panipat. The provision of alarm in case of fire was in place only in DH Panipat and SDCH Samalkha. Neither underground backup water for fire was available nor was underground static water tank constructed for meeting the fire contingency in any of the test checked hospitals except DH Panipat, DH Hisar and SDCH Samalkha. Evacuation plan routes for fire exit were not displayed in SDCH Samalkha and SDCH Narnaund.

Appendix 1.4
(Reference: Paragraph 1.8; Page 10)
Audit Criteria

i. Atomic Energy (Radiation Protection) Rules, 2004.

ii. Bio Medical Waste Management Rules, 2016.

iii. Business of the Haryana Government (Allocation) Rules, 1974

iv. Sample Registration System bulletin issued office of the Registrar General & Census Commissioner, India

v. State Drug Purchase Policy 2015 and 2018

vi. Guidelines for local purchase by District, District hospitals 2017

vii. Operational Guidelines for Comprehensive Primary Health Care through Health and Wellness Centres, 2018

viii. Ayushman Bharat AYUSH Health and Wellness Centres operational guidelines (January 2019)

ix. Operational Guidelines for AYUSH Services 2014

x. Operational Guidelines for Quality Assurance in Public Health Facilities, 2013

xi. Guidelines on Airborne Infection Control in Healthcare and Other Settings

xii. Revised National TB Control Programme Guidelines, 2017

xiii. Guidance for accreditation of laboratories under Revised National TB Control Programme for Mycobacterial Culture and DST (Drug Sensitive TB)

xiv. Budget instructions of the Finance Department, Government of Haryana.

xv. Haryana Registration and Regulation of Societies Rules, 2012

xvi. Mukhymantri Muft Ilaaj Yojana (MMIY) Guidelines

xvii. National Urban Health Mission Guidelines, 2013

xviii. Enhanced Compensation Scheme 2014 for sterilization services

xix. Manual for Family Planning Indemnity Scheme 2013

xx. NIKSHAY 2018: Direct Benefit Transfer Manual for National Tuberculosis Elimination Programme

xxi. Guidelines for implementing of District Level Activities under National Mental Health Programme, 2015

xxii. National Programme for Health Care for the Elderly (NPHCE)

xxiii. National Tobacco Control Programme (NTCP)

xxiv. National Programme for Control of Blindness (NPCB)

xxv. Janani Suraksha Yojana (JSY)

xxvi. Maternal and Neonatal Health Toolkit 2013.

xxvii. Guidelines for Antenatal Care and Skilled Attendance at Birth, 2010.

xxviii. Child Death Review Operational Guidelines, 2014 issued by Ministry of Health and Family Welfare, Government of India.

xxix. Comprehensive Abortion Care Training and Service Delivery Guidelines, 2018

xxx. National Disaster Management (NDM) Guidelines (Hospital Safety), 2016.

xxxi. Haryana Private Health Sciences Educational Institutes Act, 2012

xxxii. Standards prescribed under National Medical Commission Act, 2019

xxxiii. Policies for Establishment by Self-financing (Private) Nursing Institutes/ Medical Colleges

xxxiv. Drugs and Cosmetics Act, 1940 and Rules 1945.

xxxv. National Quality Assurance Standards

xxxvi. Haryana Nurse and Nurse Midwives Act, 2017

xxxvii. Haryana State Council for Physiotherapy Act, 2020

xxxviii. Annual reports and Minutes of meetings of Haryana State Pollution Control Board (HSPCB) and Director General Health Services.

xxxix. Commitments of Government of India for implementation of SDGs presented before the United Nations' High-Level Political Forum (HLPF) (under the auspices of the UN Economic and Social Council (ECOSOC)) through Voluntary National Review (VNR) 2020: The VNR provides for eight steps towards SDGs localisation at sub-national level i.e. at State/UT level in India.

xl. Haryana Vision 2030 for implementation of SDGs

xli. Memorandum of Agreement executed between Government of Haryana and the United Nation Development Programme (UNDP)

xlii. Framework/Reports issued by National Institution for Transforming India (NITI) Aayog and Ministry of Statistics and Programme Implementation (MoSPI), Government of India /

xliii. Global Indicator Framework

xliv. Annual Administrative Reports and other related Acts, Manuals, guidelines/ instructions issued by the State Government in relation to the PA.

Appendix 2.1

(Reference: Paragraph 2.2.4; Page 25 and Paragraph 3.3.3; Page 68)

(i) Details of availability Human Resources in SDCHs

Name of SDCH	Specialists/Doctors			Nurses			Paramedics			Other staff		
	S	P	V/ E(+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)
Ambala Cantt.	68	56	18	102	53	48	58	33	43	25	19	24
Naraingarh	51	37	27	44	23	48	45	19	58	26	6	77
Bawanikhera	14	9	36	20	13	35	17	4	76	13	7	46
Siwani	14	11	21	20	8	60	17	5	71	9	4	56
Tosham	14	11	21	20	12	40	17	9	47	12	9	25
Ballabhgarh	14	11	21	20	14	30	17	5	71	22	12	45
Ratia	14	4	71	20	14	30	18	10	44	15	5	67
Tohana	49	27	45	44	28	36	46	22	52	30	9	70
Hailymandi	9	7	22	10	4	60	10	0	100	7	1	86
Pataudi	14	15	(+)7	20	11	45	17	5	71	12	8	33
Sohana	14	12	14	20	14	30	18	5	72	13	4	69
Adampur	14	12	14	20	14	30	18	8	56	12	5	58
Barwala	14	8	43	20	20	0	19	9	53	17	10	41
Hansi	14	12	14	20	20	0	18	14	22	19	10	47
Narnaund	51	18	65	44	18	59	48	13	73	15	10	33
Bahadurgarh	68	64	6	102	89	13	68	32	53	25	13	48
Matanhail	14	14	0	20	12	40	17	5	71	7	4	43
Beri	14	14	0	20	8	60	17	9	47	7	4	43
Uchana	14	4	71	20	14	30	18	11	39	22	12	45
Narwana	14	12	14	20	29	(+)45	18	24	(+)33	29	12	59
Safidon	14	7	50	20	15	25	17	13	24	15	8	47
Gulha	14	8	43	20	9	55	18	13	28	11	2	82
Kalayat	14	9	36	20	16	20	18	18	0	12	10	17
Assandh	51	24	53	45	18	60	48	15	69	18	4	78
Nilokheri	14	26	(+)86	20	30	(+)50	18	9	50	17	6	65
Shahabad	51	26	49	44	28	36	45	8	82	14	4	71
Kanina	14	12	14	20	17	15	18	7	61	11	9	18
Mahendragarh	51	21	59	44	36	18	45	13	71	17	10	41
Hodal	14	10	29	20	10	50	18	11	39	22	6	73
Kalka	14	17	(+)21	20	6	70	17	12	29	16	7	56
Samalkha	14	11	21	20	16	20	18	18	0	13	11	15
Kosli	14	12	14	20	14	30	15	9	40	11	6	45
Kalanaur	14	11	21	20	18	10	18	11	39	14	12	14
Meham	14	8	43	20	18	10	18	14	22	17	9	47
Chautala	14	8	43	20	13	35	18	1	94	13	2	85
Dabwali	51	35	31	45	21	53	50	11	78	18	11	39
Ellanabad	14	9	36	20	6	70	17	5	71	8	1	88
Kharkhoda	14	12	14	20	17	15	18	14	22	10	7	30
Gohana	14	13	7	20	18	10	17	20	(+)18	17	14	18
Jagadhri	51	27	47	44	26	41	46	8	83	23	8	65
Devrala	3	0	100	2	1	50	4	1	75	2	1	50
Total	**960**	**664**	**31**	**1,150**	**771**	**33**	**1,022**	**473**	**54**	**636**	**312**	**51**

S=Sanctioned post, P=In position, V=Vacant Posts, E = Excess (+)
Source: HRMS Data (October 2022).
Colour code: Red colour depicts most shortage, pink colour depicts moderate shortage, light pink colour/white colour depicts no shortage/excess.

(ii) Details of Human Resources availability in CHCs

Name of District	Name of CHCs	Specialists/Doctors			Nurses			Paramedics			Other staff		
		S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)
Ambala	Ambli	9	7	22	10	1	90	10	3	70	8	0	100
	Barara	9	8	11	10	6	40	10	5	50	8	2	75
	Charmastpur	9	7	22	10	4	60	11	5	55	9	4	56
	Mullana	9	10	(+)11	10	4	60	11	6	45	14	9	36
	Shahzadpur	9	9	0	10	2	80	10	5	50	9	3	67
Bhiwani	Loharu	14	10	29	20	11	45	19	32	(+)68	13	15	(+)15
	Dhanana	9	7	22	10	6	40	10	22	(+)120	10	6	40
	Jamalpur (Bhiwani)	9	2	78	10	6	40	10	6	40	6	3	50
	Kairu	9	6	33	10	11	(+)10	11	25	(+)127	10	12	(+)20
	Manheru	9	6	33	10	6	40	11	6	45	7	5	29
	Miran	9	3	67	10	7	30	11	7	36	10	9	10
Charkhi Dadri	Bond Kalan	9	8	11	10	6	40	11	8	27	7	7	0
	Gopi	9	6	33	10	8	20	11	7	36	24	4	83
	Jhojhu Kalan	9	8	11	10	9	10	11	30	(+)173	11	8	27
Faridabad	Kheri Kalan	9	10	(+)11	10	3	70	11	22	(+)100	27	2	93
	Kurali	9	9	0	10	5	50	10	4	60	12	6	50
	Pali	9	7	22	10	5	50	10	0	100	6	0	100
	Tigaon	9	8	11	10	5	50	10	0	100	8	0	100
Fatehabad	Badopal	9	7	22	10	4	60	10	4	60	7	6	14
	Bhattu Kalan	9	6	33	10	9	10	11	6	45	11	4	64
	Bhuna	9	3	67	10	8	20	10	6	40	13	9	31
	Bhuthan Kalan	9	4	56	10	6	40	10	2	80	8	1	88
	Jakhal	9	7	22	10	7	30	11	5	55	9	5	44
Gurugram	Bhora Kalan	9	12	(+)33	10	6	40	10	3	70	6	5	17
	Farrukh Nagar	9	5	44	10	6	40	10	18	(+)80	17	6	65
	Ghangola	9	10	(+)11	4	3	25	11	5	55	9	2	78
Hisar	Aryanagar	9	12	(+)33	10	12	(+)20	11	9	18	15	20	(+)33
	Khanda Kheri	9	4	56	10	6	40	10	4	60	6	4	33
	Mangali	9	7	22	10	9	10	12	13	(+)8	9	15	(+)67
	Mirchpur	9	5	44	10	7	30	11	4	64	8	5	38
	Sisai Bola	9	3	67	10	7	30	10	4	60	14	6	57
	Siswal	9	9	0	10	6	40	11	6	45	15	11	27
	Sorkhi	9	2	78	10	5	50	11	9	18	9	10	(+)11
	Uklana	9	5	44	10	7	30	10	15	(+)50	10	8	20

Name of District	Name of CHCs	Specialists/Doctors			Nurses			Paramedics			Other staff		
		S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)
Jhajjar	Badli	9	7	22	10	7	30	11	27	(+)145	9	3	67
	Chhara	9	10	(+)11	10	9	10	11	10	9	6	2	67
	Dhakla	9	8	11	10	6	40	11	6	45	7	5	29
	Dhigal	9	8	11	10	8	20	10	6	40	6	4	33
	Dubaldhan	9	9	0	10	5	50	11	6	45	11	4	64
	Jamalpur (Jhajjar)	9	9	0	10	7	30	10	24	(+)140	7	4	43
Jind	Alewa	9	7	22	10	5	50	10	3	70	6	4	33
	Julana	9	8	11	10	7	30	12	32	(+)167	23	13	43
	Kalwa	9	6	33	10	8	20	11	9	18	11	7	36
	Kandela	9	9	0	10	7	30	10	10	0	10	5	50
	Kharak Ramji	9	5	44	10	4	60	11	10	9	7	5	29
	Muana	9	4	56	10	5	50	10	15	(+)50	7	2	71
	Ujhana	9	5	44	10	4	60	11	5	55	7	4	43
Kaithal	Kaul	9	3	67	10	3	70	11	9	18	13	3	77
	Pundri	9	4	56	10	8	20	10	4	60	6	5	17
	Rajound	9	4	56	10	4	60	11	11	0	11	6	45
	Siwan	9	5	44	10	6	40	11	8	27	7	4	43
Karnal	Indri	14	11	21	20	14	30	18	9	50	16	8	50
	Ballah	9	3	67	10	2	80	11	8	27	9	2	78
	Gharaunda	9	7	22	10	6	40	11	8	27	10	5	50
	Kunjpura	9	8	11	10	0	100	10	4	60	8	3	63
	Nighdu	9	5	44	10	2	80	10	2	80	6	0	100
	Nissing	9	3	67	10	4	60	12	9	25	10	6	40
	Padha	9	1	89	10	0	100	10	2	80	6	0	100
	Sambhali	9	4	56	10	0	100	10	2	80	6	0	100
	Taraori	9	7	22	10	8	20	11	15	(+)36	7	1	86
Kurukshetra	Pehowa	14	15	(+)7	20	15	25	18	13	28	11	7	36
	Barna	9	15	(+)67	10	5	50	10	12	(+)20	8	4	50
	Babain	9	7	22	10	3	70	10	5	50	7	1	86
	Jhansa	9	9	0	10	6	40	11	10	9	8	2	75
	Ladwa	9	7	22	10	7	30	10	6	40	14	4	71
	Mathana	9	7	22	10	9	10	10	3	70	10	4	60
Nuh	Firozpur Jhirka	9	8	11	10	7	30	11	5	55	8	5	38
	Nuh	9	7	22	10	6	40	11	10	9	13	9	31
	Pinagwan	9	2	78	10	2	80	10	1	90	6	0	100
	Punhana	9	11	(+)22	10	8	20	11	10	9	32	3	91
	Tauru	9	13	(+)44	10	11	(+)10	10	10	0	8	8	0

Name of District	Name of CHCs	Specialists/Doctors			Nurses			Paramedics			Other staff		
		S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)
Mahendragarh	Ateli	9	8	11	10	6	40	11	10	9	13	11	15
	Dochana	9	10	(+)11	10	5	50	10	10	0	8	5	38
	Nangal Choudhary	9	9	0	10	2	80	11	3	73	8	5	38
	Nangal Sirohi	9	8	11	10	7	30	11	6	45	9	4	56
	Satnali	9	6	33	10	7	30	11	8	27	11	6	45
	Sehlang	9	9	0	10	6	40	11	4	64	7	3	57
Palwal	Alawalpur	9	9	0	10	2	80	11	13	(+)18	16	3	81
	Aurangabad	9	8	11	10	7	30	11	10	9	9	2	78
	Badoli	9	0	100	10	0	100	10	0	100	6	0	100
	Dudhola	9	9	0	10	6	40	11	7	36	8	1	88
	Hathin	9	7	22	10	6	40	11	2	82	23	2	91
	Soundh	9	7	22	10	3	70	8	2	75	5	1	80
	Hassanpur	3	4	(+)33	2	2	0	4	0	100	0	2	(+)200
	Mandkola	3	2	33	2	1	50	4	1	75	0	2	(+)200
Panchkula	Nanakpur	9	7	22	10	3	70	9	4	56	6	0	100
	Raipur Rani	9	10	(+)11	10	5	50	10	24	(+)140	13	12	8
Panipat	Ahar	9	5	44	10	5	50	11	13	(+)18	20	4	80
	Bapoli	9	4	56	10	4	60	11	11	0	6	3	50
	Dadlana	9	6	33	10	3	70	10	1	90	6	2	67
	Khotpura	9	7	22	10	5	50	10	3	70	6	2	67
	Madlauda	9	7	22	10	4	60	10	4	60	7	2	71
	Naraina	9	6	33	10	4	60	10	21	(+)110	6	1	83
	Naultha	9	8	11	10	6	40	10	15	(+)50	11	6	45
Rewari	Bawal	9	11	(+)22	10	6	40	11	9	18	14	9	36
	Gurawara	9	8	11	10	3	70	11	20	(+)82	8	7	13
	Khol	9	7	22	10	4	60	10	12	(+)20	7	3	57
	Meerpur	9	9	0	10	4	60	11	8	27	16	6	63
	Nahar	9	9	0	10	6	40	11	27	(+)145	15	7	53
Rohtak	Chiri	9	8	11	10	8	20	10	6	40	8	5	38
	Kahnaur	9	6	33	10	8	20	10	7	30	10	7	30
	Kiloi	9	11	(+)22	10	13	(+)30	11	28	(+)155	12	6	50
	Lakhanmajra	9	9	0	10	8	20	10	6	40	8	4	50
	Madina	9	10	(+)11	10	8	20	10	21	(+)110	10	5	50
	Sampla	9	8	11	10	8	20	11	11	0	12	8	33

Name of District	Name of CHCs	Specialists/Doctors			Nurses			Paramedics			Other staff		
		S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)	S	P	V/ E (+) (In *per cent*)
Sirsa	Baragudha	9	6	33	9	4	56	11	3	73	8	4	50
	Kalanwali	9	4	56	10	7	30	10	2	80	7	4	43
	Madhosinghana	9	7	22	9	7	22	11	8	27	14	7	50
	Nathusari Chopta	9	7	22	10	3	70	10	1	90	6	1	83
	Odhan	9	9	0	10	6	40	10	4	60	29	7	76
	Rania	9	5	44	10	9	10	11	4	64	13	6	54
Sonipat	Badkhalsa	9	8	11	10	7	30	11	29	(+)164	9	4	56
	Bhainswal Kalan	9	7	22	10	11	(+)10	10	7	30	7	4	43
	Firozpur Bangar	9	10	(+)11	10	9	10	10	7	30	7	5	29
	Ganaur	9	8	11	10	8	20	11	19	(+)73	7	8	(+)14
	Juan	9	4	56	10	12	(+)20	11	32	(+)191	7	5	29
	Mundlana	9	6	33	10	12	(+)20	11	20	(+)82	8	6	25
	Purkhas	9	6	33	10	9	10	10	6	40	10	5	50
Yamuna Nagar	Akbarpur	9	3	67	10	2	80	10	0	100	6	1	83
	Bilaspur	9	5	44	10	7	30	11	7	36	10	5	50
	Chhachhauli	9	4	56	10	5	50	10	2	80	6	3	50
	Khizrabad	9	5	44	10	3	70	11	2	82	8	0	100
	Mustafabad (Sarswati Nagar)	9	6	33	10	5	50	12	5	58	10	4	60
	Naharpur	9	3	67	10	3	70	11	3	73	10	3	70
	Sadhaura	9	6	33	10	2	80	11	3	73	12	4	67
	Radaur	14	7	50	20	5	75	19	8	58	12	10	17
	Total	**1,142**	**871**	**24**	**1,276**	**742**	**42**	**1,348**	**1,144**	**15**	**1,252**	**606**	**52**

S=Sanctioned post, P=In position, V=Vacant Posts, E = Excess (+)

Source: HRMS Data (October 2022).

Colour code: Red colour depicts most shortage, pink colour depicts moderate/least shortage, light pink colour/white colour depicts no shortage/excess.

(iii) Details of availability of Human Resources in PHCs

Sr. No.	Name of District	Name Of PHCs	Specialists/Doctors			Nurses			Paramedics			Other staff		
			S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)
1.	Ambala	Bhurewala	3	3	0	2	0	100	4	2	50	0	0	0
2.		Bihta	3	2	33	2	0	100	4	4	0	0	0	0
3.		Boh	3	4	(+)33	2	1	50	4	1	75	0	0	0
4.		Chandsauli	3	2	33	2	0	100	4	0	100	0	0	0
5.		Dhanana	3	3	0	2	0	100	4	1	75	0	0	0
6.		Kesri	3	4	(+)33	2	0	100	4	0	100	0	0	0
7.		Kurali	3	4	(+)33	2	1	50	4	3	25	1	0	100
8.		Majari	3	3	0	2	0	100	4	4	0	1	1	0
9.		Naggal	3	2	33	2	0	100	4	3	25	1	1	0
10.		Nahoni	3	3	0	2	1	50	4	1	75	1	0	100
11.		Naneola	3	2	33	2	0	100	4	0	100	0	0	0
12.		Nurpur	3	3	0	2	0	100	4	5	(+)25	0	0	0
13.		Panjokhra	3	3	0	2	0	100	4	3	25	1	1	0
14.		Pathrehri	3	2	33	2	1	50	4	2	50	1	0	100
15.		Saha	3	3	0	2	0	100	4	2	50	0	0	0
16.		Samlehri	3	2	33	2	0	100	4	3	25	2	1	50
17.		Ugala	3	2	33	2	1	50	4	1	75	1	0	100
18.	Bhiwani	Alakhpura	3	2	33	2	0	100	4	2	50	2	2	0
19.		Bamla	3	3	0	2	2	0	4	5	(+)25	0	0	0
20.		Barwa	3	3	0	2	2	0	4	4	0	1	0	100
21.		Behal	3	1	67	2	2	0	4	0	100	1	0	100
22.		Biran	3	2	33	2	2	0	4	1	75	1	0	100
23.		Busan	3	1	67	2	2	0	4	4	0	1	0	100
24.		Chang	3	1	67	2	2	0	4	3	25	0	0	0
25.		Dhanimahu	3	2	33	2	0	100	4	0	100	1	0	100
26.		Dhigawa Jatan	3	1	67	2	2	0	4	2	50	0	0	0
27.		Dinod	3	2	33	2	0	100	4	1	75	3	0	100
28.		Gurera	3	0	100	2	2	0	4	3	25	2	2	0
29.		Jhumpa Kalan	3	3	0	2	0	100	4	2	50	1	1	0
30.		Jui Kalan	3	2	33	2	0	100	4	0	100	0	0	0
31.		Kharak Kalan	3	1	67	2	2	0	4	5	(+)25	0	0	0
32.		Lilas	3	2	33	2	1	50	4	1	75	1	1	0
33.		Nakipur	3	1	67	2	2	0	4	1	75	0	0	0
34.		Nandgaon	3	2	33	2	2	0	4	4	0	0	0	0
35.		Pur	3	2	33	2	1	50	4	2	50	0	0	0
36.		Sandwa	3	0	100	2	2	0	4	1	75	0	0	0
37.		Sohansara	3	3	0	2	2	0	4	0	100	1	0	100
38.		Sui	3	0	100	2	1	50	4	3	25	2	0	100
39.		Talu	3	1	67	2	1	50	4	1	75	0	0	0
40.	Charkhi Dadri	Achina	3	2	33	2	0	100	4	3	25	0	0	0
41.		Badhra	3	2	33	2	1	50	4	2	50	1	1	0
42.		Balkara	3	2	33	2	1	50	4	3	25	0	0	0
43.		Chhapar	3	2	33	2	2	0	4	3	25	1	1	0
44.		Harodi	3	1	67	2	2	0	4	3	25	0	0	0
45.		Imlota	3	0	100	2	1	50	4	2	50	0	0	0
46.		Kadma	3	2	33	2	2	0	4	3	25	0	0	0
47.		Mai Kalan	3	1	67	2	2	0	4	1	75	1	0	100
48.		Mankawas	3	1	67	2	1	50	4	2	50	2	0	100
49.		Ranila	3	3	0	2	2	0	4	2	50	1	0	100
50.		Santokhpura	3	1	67	2	2	0	4	3	25	0	0	0
51.		Sanwar	3	3	0	2	1	50	4	3	25	0	0	0

Sr. No.	Name of District	Name Of PHCs	Specialists/Doctors			Nurses			Paramedics			Other staff		
			S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)
52.	Faridabad	Anandpur	3	3	0	2	0	100	4	1	75	1	0	100
53.		Dhoj	3	3	0	2	0	100	4	0	100	1	0	100
54.		Fatehpur Billoch	3	2	33	2	0	100	4	0	100	0	0	0
55.		Fatehpur Tegga	3	2	33	2	0	100	4	1	75	0	0	0
56.		Mohna	3	3	0	2	0	100	4	1	75	1	1	0
57.		Palla	3	2	33	2	1	50	4	1	75	2	0	100
58.		Panhera Khurd	3	2	33	2	0	100	4	1	75	0	0	0
59.		Sikri	3	3	0	2	0	100	4	0	100	0	0	0
60.		Pali Mohabatabad	2	1	50	0	0	0	0	0	0	2	0	100
61.	Fatehabad	Aherwan	3	2	33	2	2	0	4	3	25	0	0	0
62.		Bangaon	3	1	67	2	2	0	4	3	25	1	1	0
63.		Bhirdana	3	3	0	2	1	50	4	2	50	2	0	100
64.		Bighar	3	1	67	2	2	0	4	2	50	0	0	0
65.		Hassinga	3	2	33	2	2	0	4	1	75	0	0	0
66.		Hijrawankalan	3	0	100	2	2	0	4	1	75	0	0	0
67.		Indachhoi	3	0	100	2	1	50	4	1	75	0	0	0
68.		Jhalania	3	2	33	2	1	50	4	2	50	0	1	0
69.		Khabrakalan	3	1	67	2	1	50	4	1	75	0	0	0
70.		Khairati Khera	3	2	33	2	1	50	4	0	100	0	0	0
71.		Kullan	3	2	33	2	2	0	4	1	75	1	0	100
72.		Mamupur	3	1	67	2	1	50	4	1	75	0	0	0
73.		Mehmara	3	2	33	2	2	0	4	1	75	0	0	0
74.		Meyond Kalan	3	2	33	2	1	50	4	0	100	0	0	0
75.		Mp Rohi	3	1	67	2	2	0	4	0	100	0	0	0
76.		Nagpur	3	2	33	2	0	100	4	3	25	0	0	0
77.		Nehla	3	0	100	2	2	0	4	1	75	0	0	0
78.		Pilimandori	3	1	67	2	0	100	4	1	75	0	0	0
79.		Pirthla	3	2	33	2	2	0	4	3	25	2	0	100
80.		Samian	3	0	100	2	2	0	4	3	25	1	1	0
81.	Gurugram	Badshapur	3	4	(+)33	2	1	50	4	1	75	1	0	100
82.		Bhangrola	3	3	0	2	1	50	4	3	25	0	0	0
83.		Bhondsi	3	2	33	2	1	50	4	2	50	1	0	100
84.		Daulatabad	3	3	0	2	2	0	4	1	75	1	0	100
85.		Garhi Harsaru	3	3	0	2	2	0	4	1	75	0	0	0
86.		Gurgaon Village	3	3	0	2	2	0	4	4	0	1	0	100
87.		Hazipur	3	3	0	2	1	50	4	0	100	0	0	0
88.		Kasan	3	3	0	2	1	50	4	3	25	1	1	0
89.		Mandpura	3	3	0	2	1	50	4	1	75	0	0	0
90.		Nakhrola	3	3	0	2	1	50	4	1	75	1	0	100
91.		Palra	3	3	0	2	1	50	4	1	75	0	0	0
92.		Wazirabad	3	3	0	2	2	0	4	3	25	1	0	100
93.	Hisar	Agroha	3	2	33	2	2	0	4	3	25	3	2	33
94.		Balsamand	3	2	33	2	1	50	4	4	0	2	0	100
95.		Bass	3	1	67	2	1	50	4	2	50	3	2	33
96.		Bhanbhori	3	2	33	2	0	100	4	1	75	0	0	0
97.		Bichpari	3	2	33	2	1	50	4	1	75	0	0	0
98.		Choudharywas	3	2	33	2	2	0	4	3	25	2	0	100
99.		Chuli Bagrian	3	1	67	2	2	0	4	0	100	1	0	100
100.		Datta	3	2	33	2	2	0	4	2	50	0	0	0
101.		Daulatpur	3	1	67	2	1	50	4	2	50	1	0	100
102.		Dhansu	3	3	0	2	2	0	4	4	0	2	1	50
103.		Dobhi	3	2	33	2	0	100	4	3	25	2	1	50
104.		Gawar	3	3	0	2	1	50	4	3	25	1	0	100
105.		Gurana	3	2	33	2	1	50	4	4	0	0	0	0

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			S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)
106.		Hasangarh (Hisar)	3	3	0	2	1	50	4	2	50	1	0	100
107.		Kaimari	3	3	0	2	2	0	4	5	(+)25	3	0	100
108.		Kajlan	3	2	33	2	1	50	4	7	(+)75	0	0	0
109.		Kheri Lachab	3	1	67	2	0	100	4	1	75	0	0	0
110.		Ladwa	3	3	0	2	2	0	4	1	75	3	2	33
111.		Landhri	3	2	33	2	2	0	4	3	25	0	0	0
112.		Nalwa	3	3	0	2	0	100	4	2	50	0	0	0
113.		Neoli Kalan	3	3	0	2	2	0	4	2	50	1	0	100
114.		Pabra	3	2	33	2	2	0	4	2	50	2	0	100
115.		Puthi Mangal Kahan	3	0	100	2	1	50	4	1	75	3	0	100
116.		Puthi Samin	3	0	100	2	1	50	4	3	25	3	0	100
117.		Satroad Kalan	3	2	33	2	1	50	4	3	25	3	0	100
118.		Sindhar	3	0	100	2	1	50	4	0	100	0	0	0
119.		Talwandi Rukka	3	3	0	2	1	50	4	5	(+)25	1	0	100
120.		Thurana	3	1	67	2	0	100	4	1	75	0	0	0
121.		Umra	3	2	33	2	1	50	4	2	50	2	1	50
122.	Jhajjar	Badsa	3	3	0	2	1	50	4	1	75	0	0	0
123.		Bahu Jholari	3	3	0	2	0	100	4	0	100	0	0	0
124.		Barhana	3	3	0	2	2	0	4	3	25	0	0	0
125.		Bhambeva	3	3	0	2	2	0	4	2	50	2	0	100
126.		Birohar	3	0	100	2	0	100	2	0	100	2	2	0
127.		Chhudani	3	3	0	2	0	100	4	1	75	0	0	0
128.		Chhuhhakwas	3	3	0	2	2	0	4	2	50	0	0	0
129.		Dujana	3	3	0	2	2	0	5	5	0	1	0	100
130.		Jahangirpur	3	3	0	2	0	100	4	1	75	0	0	0
131.		Jahazgarh	3	3	0	2	2	0	4	3	25	0	0	0
132.		Jassourkheri	3	3	0	2	1	50	4	3	25	0	0	0
133.		Kannoda	3	2	33	2	2	0	4	3	25	0	0	0
134.		Kharhar	3	7	(+)133	2	2	0	4	3	25	2	0	100
135.		Machroli	3	3	0	2	2	0	4	1	75	0	0	0
136.		Majra	3	2	33	2	2	0	4	3	25	0	0	0
137.		Mandothi	3	3	0	2	0	100	4	2	50	1	1	0
138.		Nuna Majra	3	3	0	2	2	0	4	3	25	0	0	0
139.		Patoda	3	3	0	2	1	50	4	2	50	0	0	0
140.		Salhawas	3	3	0	2	0	100	4	0	100	0	0	0
141.		Silani	3	3	0	2	2	0	4	2	50	1	0	100
142.		Tumbaheri	3	3	0	2	2	0	4	1	75	1	0	100
143.	Jind	Amargarh	3	3	0	2	1	50	4	2	50	1	1	0
144.		Chattar	3	1	67	2	2	0	4	2	50	0	0	0
145.		Danoda Kalan	3	2	33	2	2	0	4	3	25	0	0	0
146.		Dariyawala	3	1	67	2	2	0	4	2	50	0	0	0
147.		Daulha	3	0	100	2	1	50	4	1	75	0	0	0
148.		Dhamtan Sahib	3	3	0	2	1	50	4	4	0	0	0	0
149.		Dhanouri	3	0	100	2	1	50	4	4	0	0	0	0
150.		Dharthrat	3	2	33	2	1	50	4	4	0	1	1	0
151.		Dhmerkha Kalan	3	3	0	2	1	50	4	1	75	0	0	0
152.		Durjanpur	3	1	67	2	1	50	4	2	50	0	0	0
153.		Ghogrian	3	2	33	2	0	100	4	1	75	0	0	0
154.		Hatt	3	0	100	2	1	50	4	1	75	0	0	0
155.		Jai Jaiwanti	3	3	0	2	1	50	4	3	25	0	0	0
156.		Karamgarh	3	2	33	2	0	100	4	2	50	0	0	0
157.		Karsindhu	3	1	67	2	1	50	4	2	50	0	0	0
158.		Kinana	3	2	33	2	1	50	4	3	25	0	0	0
159.		Lajwana Kalan	3	1	67	2	1	50	4	2	50	0	0	0

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160.		Nagura	3	1	67	2	1	50	4	3	25	0	0	0
161.		Nindana	3	1	67	2	1	50	4	4	0	0	0	0
162.		Rajana Kalan	3	2	33	2	0	100	4	2	50	2	0	100
163.		Ramrai	3	2	33	2	1	50	4	2	50	0	0	0
164.		Shamlo Kalan	3	1	67	2	1	50	4	3	25	0	0	0
165.		Sinsar	3	1	67	2	0	100	4	2	50	0	0	0
166.		Siwanamal	3	1	67	2	0	100	4	3	25	1	1	0
167.		Uchana Khurd	3	0	100	2	1	50	4	0	100	0	0	0
168.	Kaithal	Agondh	3	0	100	2	0	100	4	1	75	0	0	0
169.		Arnoli	3	2	33	2	0	100	4	2	50	0	0	0
170.		Badsikri	2	0	100	2	0	100	2	0	100	2	1	50
171.		Balu	3	1	67	2	0	100	4	2	50	0	0	0
172.		Batta	3	0	100	2	0	100	4	3	25	0	0	0
173.		Bhagal	3	3	0	2	1	50	4	0	100	0	0	0
174.		Deoban	3	1	67	2	1	50	4	3	25	0	0	0
175.		Dhand	3	0	100	2	0	100	4	2	50	1	0	100
176.		Habri	3	2	33	2	1	50	4	2	50	0	0	0
177.		Jakholi	3	1	67	2	1	50	4	4	0	1	1	0
178.		Kangthali	3	0	100	2	0	100	4	2	50	1	0	100
179.		Karora	3	0	100	2	1	50	4	2	50	0	0	0
180.		Keorak	3	2	33	2	0	100	4	3	25	1	0	100
181.		Kharakan	3	1	67	2	0	100	4	2	50	1	0	100
182.		Kithana	3	1	67	2	0	100	4	3	25	0	0	0
183.		Mundri	3	2	33	2	1	50	4	2	50	1	1	0
184.		Padla	3	2	33	2	0	100	4	2	50	0	0	0
185.		Pai	3	1	67	2	0	100	4	3	25	1	0	100
186.		Pharal	3	3	0	2	4	(+)100	4	10	(+)150	2	3	(+)50
187.		Rasina	3	1	67	2	0	100	4	1	75	0	0	0
188.		Sajuma	3	0	100	2	0	100	4	3	25	0	0	0
189.		Teek	2	1	50	2	0	100	3	1	67	3	0	100
190.	Karnal	Barota	3	2	33	2	2	0	4	3	25	0	0	0
191.		Barsat	3	1	67	2	2	0	4	3	25	1	1	0
192.		Bhadson	3	3	0	2	1	50	4	2	50	0	0	0
193.		Biana	3	1	67	2	0	100	4	2	50	0	0	0
194.		Choura	3	1	67	2	2	0	4	4	0	0	0	0
195.		Gagsina	3	1	67	2	0	100	4	2	50	1	1	0
196.		Gheer	3	3	0	2	0	100	4	4	0	1	1	0
197.		Gudha	3	1	67	2	0	100	4	1	75	0	0	0
198.		Gullahpur Sirohi	3	0	100	2	0	100	2	0	100	2	0	100
199.		Jalmana	3	1	67	2	2	0	4	2	50	1	0	100
200.		Jundla	3	2	33	2	0	100	5	2	60	0	1	0
201.		Kachhwa	3	2	33	2	1	50	4	1	75	0	0	0
202.		Khukhni	3	1	67	2	1	50	4	1	75	1	0	100
203.		Kutail	3	3	0	2	1	50	4	3	25	1	0	100
204.		Madhuban	3	2	33	2	2	0	4	3	25	0	0	0
205.		Mirghan	3	1	67	2	0	100	4	2	50	0	0	0
206.		Munak	3	0	100	2	0	100	4	2	50	0	0	0
207.		Padhana	3	1	67	2	0	100	4	1	75	0	0	0
208.		Popra	3	2	33	2	0	100	4	2	50	1	0	100
209.		Ramba	3	3	0	2	0	100	4	2	50	0	0	0
210.		Sagga	3	3	0	2	0	100	4	2	50	0	0	0
211.		Salwan	3	1	67	2	1	50	4	2	50	1	0	100
212.		Samana Bhau	3	1	67	2	0	100	4	0	100	0	0	0
213.		Uplana	3	2	33	2	1	50	4	1	75	0	0	0

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214.	Kurukshetra	Dhurala	3	1	67	2	0	100	4	1	75	0	0	0
215.		Kirmach	3	0	100	2	0	100	4	2	50	0	0	0
216.		Amin	3	0	100	2	0	100	4	1	75	0	0	0
217.		Barot	3	2	33	2	0	100	2	0	100	2	0	100
218.		Deeg	3	3	0	2	1	50	4	3	25	0	0	0
219.		Gudha	3	3	0	2	1	50	4	2	50	0	0	0
220.		Ismailabad	3	1	67	2	1	50	4	1	75	2	0	100
221.		Kalsana	3	2	33	2	0	100	4	1	75	0	1	0
222.		Khanpur Kolian	3	3	0	2	1	50	4	3	25	1	0	100
223.		Pipli	3	3	0	2	2	0	4	4	0	1	1	0
224.		Ramgarh Ror	3	1	67	2	0	100	4	2	50	0	0	0
225.		Saina Saida	3	0	100	2	1	50	4	1	75	0	0	0
226.		Sarsa	3	1	67	2	0	100	4	1	75	0	0	0
227.		Tatka	3	1	67	2	1	50	4	0	100	0	0	0
228.		Thaska Mira Ji	3	1	67	2	1	50	4	2	50	0	0	0
229.		Thol	3	3	0	2	1	50	4	1	75	0	0	0
230.	Mahendragarh	Antri	3	3	0	2	2	0	4	0	100	2	0	100
231.		Bachhod	3	1	67	2	1	50	4	2	50	1	0	100
232.		Balaha Kalan	3	3	0	2	1	50	4	3	25	0	0	0
233.		Bamanwas	3	1	67	2	2	0	4	0	100	0	0	0
234.		Bayal	3	2	33	2	2	0	4	1	75	1	0	100
235.		Bhojawas	3	3	0	2	1	50	4	1	75	1	0	100
236.		Bigopur	3	1	67	2	2	0	4	1	75	0	0	0
237.		Budhwal	3	3	0	2	2	0	4	0	100	1	0	100
238.		Chhilro	3	1	67	2	2	0	4	1	75	0	0	0
239.		Dhanunda	3	3	0	2	2	0	4	5	(+)25	0	0	0
240.		Dongra Ahir	3	3	0	2	2	0	4	2	50	0	0	0
241.		Kanti	3	2	33	2	1	50	4	2	50	0	0	0
242.		Madhogarh	3	3	0	2	1	50	4	3	25	0	0	0
243.		Malra Bass	3	2	33	2	2	0	4	1	75	0	0	0
244.		Mandhana	3	2	33	2	2	0	4	0	100	0	0	0
245.		Mundia Khera	3	3	0	2	1	50	4	0	100	1	1	0
246.		Pali	3	3	0	2	1	50	4	3	25	0	0	0
247.		Rampura	3	1	67	2	2	0	4	1	75	1	0	100
248.		Sihma	3	4	(+)33	2	1	50	4	3	25	1	1	0
249.		Sirohi Bahali	3	2	33	2	1	50	4	1	75	2	0	100
250.	Nuh	Agon	3	1	67	2	0	100	2	0	100	2	0	100
251.		Bai	3	3	0	2	1	50	4	3	25	0	0	0
252.		Bichhor	3	1	67	2	2	0	4	2	50	0	0	0
253.		Bisru	3	2	33	2	0	100	4	0	100	0	0	0
254.		Biwan	3	1	67	2	1	50	4	3	25	0	0	0
255.		Ghasera	3	3	0	2	2	0	4	0	100	0	0	0
256.		Jamal Garh	3	3	0	2	1	50	4	1	75	0	0	0
257.		Jaurasi	3	2	33	2	2	0	4	0	100	0	0	0
258.		Kaliyaki	3	3	0	2	2	0	4	1	75	0	0	0
259.		Marora	3	2	33	2	2	0	4	0	100	0	0	0
260.		Mp Ahir	3	3	0	2	2	0	4	1	75	0	0	0
261.		Nagina	3	2	33	2	1	50	4	2	50	0	0	0
262.		Padheni	3	2	33	2	0	100	4	1	75	0	0	0
263.		Sikrawa	3	2	33	2	0	100	4	2	50	0	0	0
264.		Singar	3	2	33	2	2	0	4	0	100	0	0	0
265.		Sudaka	3	2	33	2	2	0	4	1	75	0	0	0
266.		Tigaon	3	3	0	2	1	50	4	2	50	0	0	0
267.		Ujina	3	1	67	2	2	0	4	1	75	0	0	0

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268.	Palwal	Allika	3	3	0	2	1	50	4	1	75	0	0	0
269.		Amerpur	3	3	0	2	1	50	4	2	50	1	0	100
270.		Bhiduki	3	1	67	2	0	100	4	0	100	0	0	0
271.		Bhulwana	3	3	0	2	1	50	4	0	100	0	0	0
272.		Chhainsa	3	2	33	2	1	50	4	1	75	0	0	0
273.		Deeghot	3	2	33	2	1	50	4	2	50	0	0	0
274.		Kalsada	3	2	33	2	0	100	4	0	100	0	0	0
275.		Khambi	3	1	67	2	0	100	2	0	100	2	0	100
276.		Kot	3	2	33	2	0	100	4	0	100	0	0	0
277.		Nangal Jat	3	3	0	2	2	0	4	0	100	1	1	0
278.		Rasulpur	3	3	0	2	2	0	4	3	25	1	0	100
279.		Sihol	3	2	33	2	1	50	4	0	100	0	0	0
280.		Solra	3	2	33	2	2	0	4	0	100	1	0	100
281.		Tappa Biloch Pur	3	2	33	2	2	0	4	2	50	0	0	0
282.		Uttawar	3	3	0	2	1	50	4	0	100	1	0	100
283.	Panchkula	Barwala	3	3	0	2	2	0	4	1	75	1	0	100
284.		Hangola	3	3	0	2	0	100	4	2	50	2	0	100
285.		Kot	3	3	0	2	1	50	4	0	100	1	0	100
286.		Morni	3	4	(+)33	2	1	50	5	5	0	0	0	0
287.		Old Panchkula	3	3	0	2	2	0	4	5	(+)25	0	0	0
288.		Surajpur	4	3	25	2	2	0	4	1	75	0	0	0
289.	Panipat	Atta	3	1	67	2	0	100	4	0	100	0	0	0
290.		Barana	3	0	100	2	1	50	2	1	50	2	0	100
291.		Chulkana	3	1	67	2	0	100	2	1	50	2	1	50
292.		Israna	3	1	67	2	0	100	4	3	25	0	0	0
293.		Kabri	3	0	100	2	0	100	2	0	100	2	1	50
294.		Kawi	3	2	33	2	0	100	4	1	75	0	0	0
295.		Mandi	3	1	67	2	0	100	4	2	50	0	0	0
296.		Patti Kalyana	3	1	67	2	0	100	4	0	100	1	0	100
297.		Rair Kalan	3	2	33	2	1	50	4	1	75	0	0	0
298.		Seenk	3	0	100	2	0	100	4	1	75	0	0	0
299.		Sewah	3	2	33	2	1	50	4	3	25	2	1	50
300.		Ugrakheri	3	1	67	2	1	50	4	4	0	0	0	0
301.		Ujha	3	0	100	2	0	100	4	2	50	0	0	0
302.		Urlana Kalan	3	0	100	2	0	100	4	2	50	0	0	0
303.	Rewari	Akera	3	3	0	2	1	50	4	1	75	0	0	0
304.		Bass Dudha	3	3	0	2	1	50	4	2	50	0	0	0
305.		Bawwa	3	2	33	2	0	100	4	2	50	0	0	0
306.		Bharawas	3	3	0	2	2	0	4	4	0	0	0	0
307.		Bohatwas Ahir	3	3	0	2	2	0	5	3	40	0	0	0
308.		Dahina	3	3	0	2	2	0	4	1	75	1	0	100
309.		Dharuhera	3	2	33	2	1	50	4	3	25	0	0	0
310.		Fatehpuri	3	3	0	2	2	0	4	2	50	1	0	100
311.		Gangicha Ahir	3	3	0	2	1	50	4	2	50	0	0	0
312.		Gudiyani	3	2	33	2	1	50	4	1	75	0	0	0
313.		Jatusana	3	3	0	2	2	0	4	3	25	1	0	100
314.		Kasola	3	2	33	2	2	0	4	2	50	1	0	100
315.		Lilodh	3	2	33	2	0	100	4	0	100	0	0	0
316.		Masani	3	3	0	2	2	0	4	2	50	0	0	0
317.		Rathanthal	3	2	33	2	0	100	4	1	75	0	0	0
318.		Sangwari	3	2	33	2	1	50	4	2	50	0	0	0
319.		Siha	3	4	(+)33	2	1	50	4	2	50	0	0	0
320.		Tankri	3	2	33	2	0	100	4	1	75	0	0	0
321.	Rohtak	Bahlba	3	0	100	2	2	0	4	3	25	0	0	0

Sr. No.	Name of District	Name Of PHCs	Specialists/Doctors			Nurses			Paramedics			Other staff		
			S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)
322.		Baland	3	3	0	2	2	0	4	3	25	1	0	100
323.		Baniyani	3	3	0	2	2	0	4	4	0	1	1	0
324.		Bhalout	3	2	33	2	1	50	4	4	0	0	0	0
325.		Farmana	3	1	67	2	2	0	4	0	100	0	0	0
326.		Ghillour Kalan	3	3	0	2	2	0	4	3	25	0	0	0
327.		Girawar	3	3	0	2	2	0	4	2	50	0	2	0
328.		Hassangarh	3	3	0	2	2	0	4	2	50	1	0	100
329.		Ismaila	3	3	0	2	2	0	4	3	25	0	0	0
330.		Karontha	3	3	0	2	2	0	4	4	0	0	0	0
331.		Kharawar	3	3	0	2	2	0	4	3	25	0	0	0
332.		Mokhra	3	1	67	2	1	50	5	3	40	0	0	0
333.		Nindana	3	1	67	2	2	0	4	1	75	0	0	0
334.		Pakasma	3	2	33	2	0	100	4	3	25	0	0	0
335.		Pilana	3	3	0	2	3	(+)50	4	2	50	1	0	100
336.		Samar Gopal Pur	3	2	33	2	2	0	5	4	20	2	0	100
337.		Sanghi	3	2	33	2	0	100	4	4	0	0	0	0
338.	Sirsa	Bani	3	2	33	2	2	0	4	0	100	0	0	0
339.		Bansudhar	3	2	33	2	2	0	4	1	75	0	0	0
340.		Bhavdeen	3	4	(+)33	2	2	0	4	0	100	0	0	0
341.		Dadu	3	2	33	2	1	50	4	0	100	1	0	100
342.		Darba Kalan	3	1	67	2	2	0	4	0	100	3	1	67
343.		Darbi	3	3	0	2	2	0	4	7	(+)75	3	1	67
344.		Desujodha	3	3	0	2	1	50	4	0	100	1	1	0
345.		Dhottar	3	2	33	2	1	50	4	1	75	0	0	0
346.		Ding	3	2	33	2	2	0	4	4	0	2	1	50
347.		Ganga	3	2	33	2	1	50	4	0	100	0	0	0
348.		Goriwala	3	2	33	2	2	0	4	2	50	0	1	0
349.		Jalmalera	3	2	33	2	1	50	4	0	100	0	0	0
350.		Jamal	3	2	33	2	1	50	4	0	100	0	0	0
351.		Jottanwali	3	3	0	2	0	100	4	2	50	0	0	0
352.		Kagdana	3	2	33	2	0	100	4	0	100	0	0	0
353.		Kaluana	3	2	33	2	2	0	4	1	75	0	0	0
354.		Keharwala	3	2	33	2	2	0	4	1	75	0	0	0
355.		Kharian	3	2	33	2	2	0	4	4	0	1	1	0
356.		Mallekan	3	1	67	2	1	50	4	1	75	0	0	0
357.		Panihari	3	3	0	2	2	0	4	3	25	1	0	100
358.		Panniwala Motta	3	2	33	2	2	0	4	1	75	0	0	0
359.		Randhawa	3	1	67	2	1	50	4	2	50	0	0	0
360.		Rori	3	0	100	2	0	100	2	0	100	3	0	100
361.	Sonipat	Ahulana	3	2	33	2	2	0	4	3	25	0	0	0
362.		Banwasa	3	2	33	2	1	50	5	6	(+)20	1	0	100
363.		Baroda	3	2	33	2	2	0	4	3	25	0	0	0
364.		Bega	3	3	0	2	2	0	4	3	25	0	0	0
365.		Bhatana Zafrabad	3	3	0	2	1	50	4	1	75	2	0	100
366.		Bhatgoan Maliyan	3	3	0	2	2	0	4	1	75	1	1	0
367.		Bhidhlan	3	3	0	2	2	0	4	3	25	0	0	0
368.		Butana	3	3	0	2	1	50	4	3	25	0	0	0
369.		Datauli	3	1	67	2	2	0	4	2	50	0	0	0
370.		Dubheta	3	2	33	2	2	0	4	3	25	1	0	100
371.		Farmana	3	3	0	2	2	0	4	3	25	1	0	100
372.		Halalpur	3	3	0	2	1	50	4	1	75	1	0	100
373.		Jagsi	3	3	0	2	1	50	4	2	50	0	0	0
374.		Jakhauli	3	3	0	2	3	(+)50	4	1	75	0	0	0
375.		Khanda	3	3	0	2	2	0	4	2	50	0	0	0

Sr. No.	Name of District	Name Of PHCs	Specialists/Doctors			Nurses			Paramedics			Other staff		
			S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)	S	P	V/E (+) (In *per cent*)
376.		Khanpur	3	3	0	2	2	0	4	3	25	0	0	0
377.		Khewra	3	1	67	2	1	50	4	2	50	0	0	0
378.		Kundli	3	3	0	2	2	0	4	2	50	0	0	0
379.		Lath	3	2	33	2	0	100	5	4	20	0	0	0
380.		Madina	3	3	0	2	2	0	4	3	25	2	0	100
381.		Mahra	3	4	(+)33	2	1	50	4	1	75	0	0	0
382.		Mohana	3	4	(+)33	2	1	50	4	1	75	0	0	0
383.		Moi Majri	3	3	0	2	2	0	4	3	25	1	0	100
384.		Murthal	3	3	0	2	1	50	4	2	50	2	0	100
385.		Nahari	3	2	33	2	2	0	4	3	25	0	0	0
386.		Rajlu Garhi	3	3	0	2	2	0	4	5	(+)25	0	0	0
387.		Rohat	3	2	33	2	1	50	4	2	50	1	0	100
388.		Rukhi	3	3	0	2	1	50	4	3	25	0	0	0
389.		Saragthal	3	2	33	2	2	0	4	1	75	0	0	0
390.		Shamri	3	2	33	2	1	50	4	2	50	0	0	0
391.		Sisana	3	3	0	2	2	0	4	1	75	0	0	0
392.	Yamuna Nagar	Alahar	3	3	0	2	0	100	4	0	100	1	0	100
393.		Antawa	3	2	33	2	0	100	4	0	100	0	0	0
394.		Arnauli	3	1	67	2	0	100	4	3	25	0	0	0
395.		Bhambhol	3	2	33	2	0	100	4	0	100	0	0	0
396.		Buria	3	2	33	2	1	50	4	4	0	0	0	0
397.		Haibatpur	3	2	33	2	1	50	4	1	75	0	0	0
398.		Kalanaur	3	1	67	2	1	50	4	0	100	1	0	100
399.		Khadri	3	1	67	2	0	100	4	0	100	0	0	0
400.		Kharwan	3	3	0	2	0	100	4	3	25	0	0	0
401.		Kot	3	1	67	2	1	50	4	1	75	0	0	0
402.		Mohri	3	1	67	2	0	100	4	0	100	0	0	0
403.		Mugalwali	3	1	67	2	2	0	4	0	100	0	0	0
404.		Ranjitpur	3	1	67	2	0	100	4	0	100	0	0	0
405.		Rasulpur	3	2	33	2	1	50	4	1	75	0	0	0
406.		Sabapur	3	2	33	2	1	50	4	1	75	0	0	0
		Total	**1,216**	**814**	**33**	**810**	**438**	**46**	**1,607**	**759**	**53**	**210**	**60**	**71**

S=Sanctioned post, P=In position, V=Vacant Posts, E = Excess (+)
Source: HRMS Data (October 2022).
Colour code: Red colour depicts most shortage, pink colour depicts moderate shortage, light pink/white colour depicts least shortage/excess.

Note: - *Men in position in respect of PHCs at serial no. 126, 170, 189, 198, 217, 250, 275, 290, 291, 293 and 360 was not linked in HRMS portal in October 2022 when the data was obtained by audit. Therefore, the information has been collected from the department in July 2023.*

Appendix 3.1
(Reference: Paragraph 3.1.1 and 3.1.2; Page 51-52)
(i) Availability of OPD (Specialists) Services in District Hospitals (Yes/No) (as on May 2023)

Sr. No.	Name of District Hospital	ENT	General Medicine	Pediatrics	General Surgery	Ophthalmology	Dental	Obstetric & Gynaecology	Psychiatry	Orthopedics
1	Ambala	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Bhiwani	N	Y	Y	Y	Y	Y	Y	Y	Y
3	Charkhi Dadri	Y	Y	N	N	N	Y	Y	N	Y
4	Faridabad	Y	Y	Y	Y	Y	Y	Y	Y	Y
5	Fatehabad	Y	N	Y	N	Y	Y	Y	Y	Y
6	Gurugram	Y	Y	Y	Y	Y	Y	Y	Y	Y
7	Hisar	Y	Y	Y	Y	Y	Y	Y	Y	Y
8	Jhajjar	N	Y	Y	Y	Y	Y	Y	N	Y
9	Jind	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Kaithal	Y	Y	Y	Y	Y	Y	N	Y	Y
11	Karnal	Y	Y	Y	Y	Y	Y	Y	Y	Y
12	Kurukshetra	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Mahendragarh at Narnaul	Y	N	N	Y	Y	Y	N	Y	Y
14	Mandikhera (Nuh)	Y	Y	Y	Y	Y	Y	Y	Y	Y
15	Palwal	Y	N	Y	Y	Y	Y	Y	N	Y
16	Panchkula	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Panipat	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Rewari	Y	Y	Y	Y	Y	Y	Y	Y	Y
19	Rohtak	Y	Y	Y	Y	Y	Y	Y	Y	Y
20	Sirsa	Y	Y	Y	N	Y	Y	Y	Y	Y
21	Sonipat	Y	Y	Y	N	Y	Y	Y	N	Y
22	Yamuna Nagar	Y	N	Y	Y	Y	Y	Y	N	Y

Source: Information furnished by District Hospitals
Colour code: Green colour/Y= Available; Red colour/N=Not available

(ii) Availability of OPD (Specialist) Services in Sub Divisional Civil Hospitals (Yes/No) (as on May 2023)

Name of SDCH	ENT	General Medicine	Pediatrics	General Surgery	Ophthalmology	Dental	Obstetric & Gynaecology	Orthopedics
Ambala Cantt	Y	Y	Y	Y	Y	Y	Y	Y
Naraingarh	Y	N	N	N	N	N	Y	N
Bawani Khera	N	N	N	N	N	Y	N	N
Tosham	N	N	N	N	N	Y	N	N
Siwani	N	N	N	N	N	Y	N	N
Devrala	N	N	N	N	N	N	N	N
Ballabhgarh	Y	Y	Y	Y	Y	Y	Y	Y
Tohana	Y	N	N	N	N	Y	Y	N
Ratia	N	N	N	N	N	N	N	N
Pataudi	N	N	N	N	Y	Y	Y	Y
Sohna	N	N	N	Y	N	N	Y	N
Haily Mandi	N	N	N	N	N	Y	N	N
Hansi	N	N	N	Y	Y	Y	Y	N
Barwala	N	N	N	N	N	Y	Y	N
Adampur	N	N	Y	N	N	N	N	N
Narnaund	N	N	N	N	N	Y	N	N
Bahadurgarh	Y	N	Y	Y	Y	Y	Y	Y
Beri	N	N	Y	N	N	Y	Y	Y
Mathanhail	N	N	N	N	N	Y	N	N
Safidon	N	N	Y	N	N	Y	N	N
Narwana	N	N	N	N	Y	Y	Y	N
Uchana	N	N	N	N	N	Y	N	N
Guhla	N	N	N	N	N	Y	N	N
Kalayat	N	N	N	N	N	N	N	N
Assandh	N	N	N	N	N	Y	N	N
Nilokheri	N	N	Y	N	N	Y	Y	N
Sahabad	N	N	Y	N	N	Y	N	N
Mahendragarh	N	N	Y	Y	N	Y	Y	Y
Kanina	N	N	N	N	N	Y	N	N
Hodal	N	N	Y	N	N	Y	Y	N
Kalka	N	N	Y	N	N	Y	Y	Y
Samalkha	N	N	N	N	N	Y	Y	N
Kosli	N	N	Y	N	Y	Y	Y	N
Kalanaur	N	N	Y	N	N	Y	N	N
Meham	N	N	N	N	N	Y	N	N
Dabwali	N	N	Y	N	N	N	Y	Y
Ellenabad	N	N	N	Y	N	Y	N	N
Chautala	N	N	N	N	N	Y	N	N
Gohana	N	N	N	N	N	Y	Y	N
Kharkhoda	N	N	N	N	N	Y	N	N
Jagadhari	N	N	Y	N	N	Y	Y	N

Source: Information furnished by Sub Divisional Civil Hospitals
Colour code: Green colour/Y= Available; pink colour/N=Not available

(iii) Availability of OPD services (General) in CHCs

Sr. No.	Name of CHC	General Medicine	Pediatrics	General Surgery	Dental	Obstetrics & Gynaecology	AYUSH	Emergency	Laboratory Services
1	Ambli	Y	N	N	Y	Y	N	N	Y
2	Barara	Y	Y	Y	Y	Y	Y	Y	Y
3	Mullana	N	N	N	Y	N	Y	Y	Y
4	Shahzadpur	Y	N	N	Y	N	Y	Y	Y
5	Chaurmastpur	Y	Y	Y	Y	Y	Y	Y	Y
6	Dhanana	Y	N	N	Y	N	N	Y	Y
7	Jamalpur	Y	N	N	Y	N	Y	Y	Y
8	Kairu	Y	N	N	N	N	Y	Y	Y
9	Loharu	N	N	N	Y	Y	Y	Y	Y
10	Manehru	Y	N	N	Y	N	N	Y	Y
11	Miran	Y	N	N	Y	N	N	Y	Y
12	Baund Kalan	Y	N	N	Y	N	N	Y	Y
13	Gopi	Y	Y	N	Y	Y	N	N	Y
14	Jhounju Kalan	N	N	Y	Y	Y	N	Y	Y
15	Kheri Kalan	Y	N	N	Y	N	Y	Y	Y
16	Kurali	N	N	N	Y	N	Y	N	Y
17	Tigaon	Y	N	N	Y	N	Y	N	N
18	Pali	Y	N	N	Y	N	N	N	Y
19	Bhattu Kalan	Y	Y	Y	Y	Y	N	N	Y
20	Badopal	N	N	N	Y	N	Y	Y	Y
21	Bhuna	Y	N	N	N	N	Y	Y	Y
22	Jakhal	Y	N	Y	Y	Y	N	N	Y
23	Bhuttan Kalan	N	N	N	Y	N	N	Y	Y
24	Bhora Kalan	N	N	N	Y	N	Y	Y	Y
25	Ghangola	N	N	N	Y	N	N	N	N
26	Farrukh Nagar	Y	N	N	Y	N	N	Y	Y
27	Uklana	Y	N	N	Y	Y	Y	N	N
28	Sisai	Y	Y	N	Y	Y	Y	N	Y
29	Arya Nagar	Y	Y	N	Y	Y	N	N	N
30	Mangali	Y	N	N	Y	Y	Y	Y	Y
31	Siswal	N	N	N	N	N	Y	Y	Y
32	Mirchpur	Y	N	N	N	Y	Y	Y	Y
33	Khanda Kheri	Y	N	N	Y	N	N	Y	Y
34	Sorkhi	Y	N	N	Y	N	N	Y	Y
35	Badli	Y	Y	Y	Y	Y	N	Y	Y
36	Chhara	Y	N	N	Y	N	Y	Y	Y
37	Dhakla	N	N	N	Y	Y	Y	Y	Y
38	Dubaldhan	Y	N	Y	Y	N	Y	Y	Y
39	Jamalpur	Y	Y	Y	Y	Y	Y	Y	Y
40	Dighal	Y	N	N	Y	N	Y	Y	Y
41	Kalwa	Y	N	N	Y	Y	N	Y	Y
42	Julana	Y	N	N	Y	Y	Y	Y	Y
43	Alewa	N	N	N	Y	Y	Y	N	Y
44	Muana	Y	N	N	Y	Y	N	N	Y
45	Kandela	N	N	N	Y	Y	Y	Y	Y
46	Ujhana	N	N	N	N	Y	N	N	Y

Sr. No.	Name of CHC	General Medicine	Pediatrics	General Surgery	Dental	Obstetrics & Gynaecology	AYUSH	Emergency	Laboratory Services
47	Kharak Ramji	Y	N	N	Y	Y	N	Y	Y
48	Kaul	Y	Y	N	N	Y	Y	Y	Y
49	Pundri	Y	Y	N	N	Y	N	Y	Y
50	Rajound	Y	Y	Y	Y	Y	Y	Y	Y
51	Siwan	Y	Y	Y	Y	Y	Y	Y	Y
52	Nigdu	Y	Y	N	Y	Y	N	Y	Y
53	Taraori	Y	N	N	Y	Y	Y	Y	Y
54	Padha	Y	N	N	Y	Y	N	Y	Y
55	Nissing	Y	N	N	Y	Y	Y	Y	Y
56	Sambhli	Y	Y	Y	Y	Y	Y	Y	Y
57	Kunjpura	Y	N	N	Y	N	Y	Y	Y
58	Ballah	Y	N	N	Y	Y	N	Y	Y
59	Gharaunda	Y	N	N	Y	N	Y	Y	N
60	Indri	Y	Y	N	Y	N	N	Y	Y
61	Babain	Y	Y	N	Y	Y	Y	Y	Y
62	Barna	Y	Y	N	Y	Y	N	Y	Y
63	Jhansa	Y	N	N	Y	Y	Y	Y	Y
64	Ladwa	Y	Y	N	Y	N	Y	Y	Y
65	Mathana	Y	Y	Y	Y	Y	Y	Y	Y
66	Pehowa	Y	N	N	Y	N	Y	Y	Y
67	Ateli	Y	N	N	Y	Y	Y	Y	Y
68	Dhochna	Y	N	N	Y	N	N	N	Y
69	Nagal Chaudhary	Y	Y	Y	Y	Y	Y	Y	Y
70	Nagal Sirohi	Y	N	N	Y	Y	Y	Y	Y
71	Selang	Y	N	N	Y	N	N	Y	Y
72	Satnali	Y	N	Y	N	N	N	Y	Y
73	Tauru	N	N	N	Y	Y	Y	Y	Y
74	Punhana	N	N	N	Y	Y	Y	Y	Y
75	Nuh	N	N	N	Y	N	Y	Y	Y
76	Pinangwan	N	N	N	Y	N	Y	Y	Y
77	FP Jhirka	Y	Y	N	Y	Y	Y	Y	Y
78	Hathin	N	N	N	Y	N	Y	Y	Y
79	Alawalpur	Y	N	N	Y	N	Y	N	Y
80	Dudhola	N	N	N	Y	N	N	N	Y
81	Sondhad	Y	N	N	Y	N	N	Y	Y
82	Badoli	N	N	N	Y	N	N	N	N
83	Mandkola	Y	N	N	Y	Y	Y	N	Y
84	Hassanpur	Y	N	N	Y	Y	N	N	Y
85	Aurangabad	N	N	N	Y	N	Y	N	Y
86	Nanakpur	Y	Y	Y	Y	Y	Y	N	Y
87	Raipur Rani	Y	Y	Y	Y	Y	Y	Y	Y
88	Khotpura	Y	N	N	Y	Y	N	Y	Y
89	Naraina	Y	N	N	Y	Y	N	Y	Y
90	Ahar	Y	N	N	Y	Y	Y	N	Y
91	Madlauda	Y	N	N	Y	Y	N	N	Y
92	Naultha	Y	N	N	Y	Y	Y	N	Y
93	Dadlana	Y	N	N	Y	Y	Y	Y	N

Sr. No.	Name of CHC	General Medicine	Pediatrics	General Surgery	Dental	Obstetrics & Gynaecology	AYUSH	Emergency	Laboratory Services
94	Bapoli	N	N	N	Y	Y	Y	Y	Y
95	Bawal	N	N	N	Y	N	Y	N	N
96	GurAwara	N	N	N	Y	N	Y	Y	Y
97	Khol	Y	N	N	Y	Y	Y	Y	Y
98	Meerpur	Y	Y	N	Y	N	Y	N	Y
99	Nahar	Y	N	N	Y	N	Y	Y	Y
100	Kahanaur	N	N	N	Y	N	N	Y	Y
101	Sampla	N	N	N	Y	N	Y	Y	Y
102	Kiloi	N	N	N	Y	N	Y	Y	Y
103	Chiri	Y	N	N	Y	Y	Y	Y	Y
104	Madina	N	N	N	Y	N	N	Y	Y
105	Lakhan Majra	N	N	N	Y	N	Y	Y	Y
106	Kalanwali	N	N	N	Y	N	Y	Y	Y
107	Odhan	Y	N	Y	Y	N	Y	Y	Y
108	Baragudha	N	N	N	Y	N	Y	N	Y
109	Rania	Y	Y	Y	Y	Y	Y	Y	Y
110	Madhosinghana	N	N	N	N	N	N	N	Y
111	Nathusari Chopta	Y	N	N	N	Y	N	N	Y
112	Badkhalsa	Y	N	N	Y	Y	Y	Y	N
113	Ferozpur Banger	N	N	N	Y	Y	N	N	Y
114	Juan	Y	N	N	Y	Y	Y	N	Y
115	Ganaur	Y	Y	N	Y	Y	Y	Y	Y
116	Mundlana	Y	Y	N	Y	Y	Y	Y	Y
117	Bainswal Kalan	Y	N	N	Y	N	N	N	Y
118	Purkhas	Y	N	N	Y	Y	N	N	Y
119	Bilaspur	N	N	N	Y	N	Y	Y	Y
120	Chhachhrauli	Y	N	N	Y	N	Y	Y	Y
121	Naharpur	N	N	N	Y	Y	Y	Y	Y
122	Radaur	N	N	N	Y	Y	Y	Y	Y
123	Partap Nagar/ Khizrabad	Y	N	N	Y	Y	Y	Y	Y
124	Sadhaura	N	N	N	Y	N	Y	Y	Y
125	Saraswati Nagar/ Mustafabad	Y	N	N	Y	N	Y	Y	Y
126	Akbarpur	Y	N	N	N	N	Y	Y	N

Source: Information furnished by CHCs
Colour code: Green colour/Y= Available; Red colour/N=Not available

Appendix 3.2
(Reference: Paragraph 3.1.5, Page 53)
(i) Details of OPD cases in DHs

Year	Panipat	Hisar	Mandikhera (Nuh)
2016-17	Data not available.	1,49,801	58,149
2017-18		2,30,848	92,411
2018-19		3,17,063	1,20,668
2019-20	3,39,186	3,51,772	1,72,901
2020-21	2,39,863	1,98,528	71,758
2021-22	2,70,529	1,32,169	91,087
2022-23	3,28,466	2,76,342	1,63,684
Total	**11,78,044**	**16,56,523**	**7,70,658**

(ii) Details of OPD cases in SDCHs in test checked districts

Year	Samalkha	Hansi	Barwala	Adampur	Narnaund
2016-17	76,787	95,292	85,200	18,090	62,973
2017-18	74,194	98,394	87,955	25,690	79,370
2018-19	81,785	1,03,523	82,190	18,077	72,057
2019-20	59,260	1,15,395	90,966	24,930	79,188
2020-21	46,006	39,622	51,046	17,975	40,046
2021-22	48,307	44,033	45,885	18,375	35,631
2022-23	58,570	91,478	65,577	20,036	46,789
Total	**4,44,909**	**5,87,737**	**5,08,819**	**1,43,173**	**4,16,054**

(iii) Details of OPD cases in CHCs in test checked districts

Year	Panipat	Hisar	Nuh
2016-17	1,38,747	2,21,493	2,40,255
2017-18	1,54,679	2,18,378	2,47,402
2018-19	1,55,934	2,19,017	2,30,629
2019-20	1,68,927	2,24,655	2,19,051
2020-21	1,55,858	1,70,586	1,56,285
2021-22	1,57,858	1,64,940	1,71,682
2022-23	1,76,873	1,95,202	1,84,282
Total	**11,08,876**	**14,14,271**	**14,49,586**

Appendix 3.3
(Reference: Paragraph 3.2.7; Page 63)
(i) Details of IPD cases in DHs

Name of DHs	Name of IPD	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	Total
Panipat	General Medicine	Data not available with the District Hospital			636	249	436	560	1,881
	General Surgery				337	198	119	323	977
	Opthalmology				207	175	217	296	895
	Accident & Trauma				1,350	1,416	1,611	2,300	6,677
	Paediatrics				1,639	893	1,187	1,396	5,115
	Others				17,189	21,878	22,404	24,598	86,069
	Total	**0**	**0**	**0**	**21,358**	**24,809**	**25,974**	**29,473**	**1,01,614**
Hisar	General Medicine	1,385	1,567	1,675	909	2,694	5,987	8,709	22,926
	General Surgery	2,066	3,049	3,794	4,303	4,632	4,240	4,936	27,020
	Opthalmology	Separate data not available with the District Hospital							
	Accident & Trauma	5,093	6,970	8,436	6,529	9,461	11,008	2,546	50,043
	Paediatrics	1,272	1,159	1,054	1,342	1,241	1,267	1,263	8,598
	Others (Eye, ENT & Others)	4,360	4,189	3,982	4,763	1,556	1,799	5,875	26,524
	Total	**14,176**	**16,934**	**18,941**	**17,846**	**19,584**	**24,301**	**23,329**	**1,35,111**
Nuh (Mandikhera)	General Medicine	281	674	1,531	1,028	730	733	1,649	6,626
	General Surgery	0	0	161	210	260	878	1,180	2,689
	Opthalmology	656	948	1,167	1,032	1,160	3,105	4,730	12,798
	Accident & Trauma	65	170	256	280	282	300	250	1,603
	Paediatrics	278	970	1,045	1,173	1,399	2,520	4,800	12,185
	Others	435	417	797	1,232	1,348	2,300	3,700	10,229
	Total	**1,715**	**3,179**	**4,957**	**4,955**	**5,179**	**9,836**	**16,309**	**46,130**

Note: Information related to IPD cases of DH Panipat for the year 2016-17 to 2018-19 was not available.

(ii) Details of IPD cases in SDCHs

Name of District	Name of SDCH	Name of IPD	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	Total
Panipat	Samalkha	General Medicine	490	620	524	465	453	1,240	1,642	5,434
		General Surgery	0	0	0	0	0	0	0	0
		Opthalmology	0	0	0	0	0	0	0	0
		Accident & Trauma	24	9	12	4	83	152	156	440
		Paediatrics	0	0	0	0	0	0	0	0
		Others	0	0	0	0	0	0	0	0
		Total	**514**	**629**	**536**	**469**	**536**	**1,392**	**1,798**	**5,874**
Hisar	Hansi	General Medicine	2,486	3,542	4,623	5,871	4,791	2,409	2,417	26,139
		General Surgery	0	0	8	27	15	4	56	110
		Opthalmology	0	0	0	3	1	0	30	34
		Accident & Trauma	1,098	1,298	1,689	2,238	893	1,185	945	9,346
		Paediatrics	1,237	1,141	1,367	1,098	18	1	3	4,865
		Others	1,626	1,848	1,056	968	787	438	1,932	8,655
		Total	**6,447**	**7,829**	**8,743**	**10,205**	**6,505**	**4,037**	**5,383**	**49,149**
	Barwala	General Medicine	Data not maintained separately.							
		General Surgery								
		Opthalmology								
		Accident & Trauma								
		Paediatrics								
		Overall IPD	8,865	8,875	7,906	8,157	3,715	4,152	6,352	48,022
		Total	**8,865**	**8,875**	**7,906**	**8,157**	**3,715**	**4,152**	**6,352**	**48,022**
	Adampur	General Medicine	5,058	8,027	9,028	8,003	4,016	3,079	5,054	42,265
		General Surgery	0	0	0	0	0	0	0	0
		Opthalmology	0	0	0	0	0	0	0	0
		Accident & Trauma	1,692	2,049	3,076	2,440	3,758	3,723	4,464	21,202
		Paediatrics	5,121	4,190	3,302	3,019	2,402	4,010	3,200	25,244
		Others	0	0	0	0	0	0	0	0
		Total	**11,871**	**14,266**	**15,406**	**13,462**	**10,176**	**10,812**	**12,718**	**88,711**
	Narnaund	General Medicine	1,412	1,514	1,725	1,954	1,242	1,317	1,745	10,909
		General Surgery	0	0	0	0	0	0	0	0
		Opthalmology	0	0	0	0	0	0	0	0
		Accident & Trauma	63	75	82	161	185	124	187	877
		Paediatrics	0	0	0	0	0	0	0	0
		Others	715	537	554	618	501	402	470	3,797
		Total	**2,190**	**2,126**	**2,361**	**2,733**	**1,928**	**1,843**	**2,402**	**15,583**

(iii) Details of IPD cases in CHCs in test checked districts

Name of District	Name of CHC	IPD	General Medicine	Surgery	Obstetrics & Gynaecology	Paediatrics	Others
Panipat	**Khotpura**	2016-17	CHC operationalised since 2019-20.				
		2017-18					
		2018-19					
		2019-20	10	0	10	0	0
		2020-21	9	0	15	0	0
		2021-22	111	0	8	0	0
		2022-23	66	0	86	0	0
		Total	**196**	**0**	**119**	**0**	**0**
	Naraina	2016-17	0	0	164	0	0
		2017-18	0	0	116	0	0
		2018-19	0	0	160	0	0
		2019-20	0	0	156	0	0
		2020-21	0	0	167	0	0
		2021-22	0	0	108	0	0
		2022-23	0	0	348	0	0
		Total	**0**	**0**	**1,219**	**0**	**0**
	Ahar	2016-17	99	0	466	464	0
		2017-18	67	0	580	578	0
		2018-19	208	0	353	352	0
		2019-20	129	0	326	325	0
		2020-21	5	0	496	492	0
		2021-22	8	0	557	455	0
		2022-23	5	0	109	108	0
		Total	**521**	**0**	**2,887**	**2,774**	**0**
	Madlauda	2016-17	4	0	300	0	10
		2017-18	4	0	0	0	7
		2018-19	4	0	0	0	8
		2019-20	42	0	45	0	19
		2020-21	756	0	293	0	92
		2021-22	872	0	400	0	89
		2022-23	1,102	0	454	0	119
		Total	**2,784**	**0**	**1,492**	**0**	**344**
	Naultha	2016-17	0	0	243	0	0
		2017-18	0	0	223	0	0
		2018-19	0	0	113	0	0
		2019-20	0	0	84	0	0
		2020-21	0	0	126	0	0
		2021-22	35	0	326	0	0
		2022-23	26	0	323	0	0
		Total	**61**	**0**	**1,438**	**0**	**0**
	Dadlana	2016-17	15	0	16	2	0
		2017-18	23	0	29	5	0
		2018-19	28	0	13	4	0
		2019-20	29	0	29	6	0
		2020-21	54	0	32	10	0
		2021-22	25	0	18	4	0
		2022-23	16	0	8	3	0
		Total	**190**	**0**	**145**	**34**	**0**
	Bapoli	2016-17	1,792	0	875	0	0
		2017-18	1,872	0	917	0	0
		2018-19	1,503	0	767	0	0
		2019-20	1,307	0	611	0	0
		2020-21	1,290	0	620	0	0
		2021-22	1,114	0	506	0	0
		2022-23	1,064	0	482	0	0
		Total	**9,942**	**0**	**4,778**	**0**	**0**

Name of District	Name of CHC	IPD	General Medicine	Surgery	Obstetrics & Gynaecology	Paediatrics	Others
Nuh	**Tauru**	2016-17	0	0	2,440	0	231
		2017-18	0	0	2,600	0	429
		2018-19	0	0	2,300	0	227
		2019-20 /	0	0	2,610	0	234
		2020-21	0	0	1,790	0	242
		2021-22	0	0	2,194	0	243
		2022-23	0	0	2,990	0	366
		Total	**0**	**0**	**16,924**	**0**	**1,972**
	Punhana	2016-17	0	0	1,289	0	3,167
		2017-18	0	0	991	0	4,127
		2018-19	0	0	1,129	0	2,899
		2019-20	0	0	1,246	0	4,647
		2020-21	0	0	694	0	2,424
		2021-22	0	0	912	0	3,764
		2022-23	0	0	1,137	0	370
		Total	**0**	**0**	**7,398**	**0**	**21,398**
	Nuh	2016-17	Data not maintained separately.				231
		2017-18					429
		2018-19					227
		2019-20					234
		2020-21					242
		2021-22					243
		2022-23					366
		Total	**0**	**0**	**0**	**0**	**1,972**
	Pinangwan	2016-17	Operational since 2022-23.				
		2017-18					
		2018-19					
		2019-20					
		2020-21					
		2021-22					
		2022-23	Data not maintained separately.				3,424
		Total	**0**	**0**	**0**	**0**	**3,424**
	Firojpur Jhirkha	2016-17	0	0	4,392	0	0
		2017-18	0	0	3,907	0	0
		2018-19	0	0	5,193	0	0
		2019-20	0	0	4,834	0	0
		2020-21	0	0	3,142	0	0
		2021-22	0	0	2,873	0	0
		2022-23	0	0	3,833	0	0
		Total	**0**	**0**	**28,174**	**0**	**0**
Hisar	**Uklana**	2016-17	Data not maintained separately.				639
		2017-18					562
		2018-19					501
		2019-20					429
		2020-21					461
		2021-22					363
		2022-23					391
		Total					**3,346**
	Sisai	2016-17	293	0	269	0	0
		2017-18	177	0	203	0	0
		2018-19	172	0	165	0	0
		2019-20	171	0	165	0	0
		2020-21	140	0	180	0	0
		2021-22	83	0	144	0	0
		2022-23	118	0	172	0	0
		Total	**1,154**	**0**	**1,298**	**0**	**0**

Name of District	Name of CHC	IPD	General Medicine	Surgery	Obstetrics & Gynaecology	Paediatrics	Others
	Arya Nagar	2016-17	0	0	533	71	590
		2017-18	0	0	475	87	483
		2018-19	0	0	422	95	435
		2019-20	0	0	505	91	504
		2020-21	0	0	337	62	291
		2021-22	0	0	289	56	294
		2022-23	0	0	347	64	483
		Total	**0**	**0**	**2,908**	**526**	**3,080**
	Mangali	2016-17	Data not maintained separately.				1,463
		2017-18					1,441
		2018-19					1,235
		2019-20					1,314
		2020-21					911
		2021-22					1,062
		2022-23					1,216
		Total					**8,642**
	Siswal	2016-17	Data not maintained separately.				116
		2017-18					109
		2018-19					112
		2019-20					119
		2020-21					128
		2021-22					165
		2022-23					190
		Total					**939**
	Mirchpur	2016-17	The CHC become operational from 2020-21.				
		2017-18					
		2018-19					
		2019-20					
		2020-21	Data not maintained separately.		106	Data not maintained separately.	
		2021-22			332		
		2022-23			516		
		Total			**954**		
	Khanda Kheri	2016-17	This CHC has been upgraded from PHC to CHC from June 2022.				
		2017-18					
		2018-19					
		2019-20					
		2020-21					
		2021-22					
		2022-23	Data is not maintained separately.				750
		Total					**750**
	Sorkhi	2016-17	668	0	248	0	
		2017-18	968	0	308	0	
		2018-19	1,626	0	320	0	
		2019-20	806	0	429	0	
		2020-21	696	0	350	0	
		2021-22	307	0	392	0	
		2022-23	30	0	226	0	
		Total	**5,101**	**0**	**2,273**	**0**	

Appendix 3.4

(Reference: Paragraph 3.3.1: Page 65; 3.3.4: Page 68; 3.6.1: Page 82; 3.6.6: Page 86; 3.8.1: Page 93; 3.8.3: Page 97; 3.8.4: Page 99; 3.8.5: Page 100; 3.8.6: Page 101; 3.8.7: Page 103; 3.8.9: Page 105)

(i) Availability of line and support Services in District Hospitals (Yes/No)

Sr. No.	Name of District Hospital	Emergency Services	Imaging Services	Pathology Services	Ambulance	Blood Bank	Bio-Medical Waste management	ICU	Oxygen	Mortuary	Dietary	Laundry services
1	Ambala	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	Bhiwani	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3	Charkhi Dadri	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	Faridabad	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	Fatehabad	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6	Gurugram	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
7	Hisar	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
8	Jhajjar	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
9	Jind	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
10	Kaithal	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
11	Karnal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12	Kurukshetra	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
13	Mahendragarh at Narnaul	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
14	Mandikhera (Nuh)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
15	Palwal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16	Panchkula	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17	Panipat	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
18	Rewari	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
19	Rohtak	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
20	Sirsa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
21	Sonipat	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
22	Yamuna Nagar	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes

Source: Information furnished by District Hospitals
Colour code: Green colour/Yes= Available; Red colour/No=Not available

(ii) Details of availability of Line and Support Services in SDCHs

Sr. No.	Name of SDCH	Emergency Services	Imaging Services	Pathology Services	Ambulance	Blood Bank	Bio(+)Medical Waste	ICU	Oxygen	Mortuary	Dietary	Laundry services
1	Ambala cantt	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	Naraingarh	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
3	Siwani	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	No	Yes
4	Tosham	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	No	Yes
5	Devrala	Yes	No	No	No	No	Yes	No	Yes	No	Yes	No
6	Bawani khera	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	No	Yes
7	Ballabgarh	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes
8	Tohana	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
9	Ratia	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
10	Pataudi	Yes	No	Yes	Yes	No	Yes	No	Yes	No	No	Yes
11	Sohna	Yes	No	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes
12	Haily Mandi	No	No	No	No	No	Yes	No	Yes	No	No	Yes
13	Hansi	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
14	Barwala	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes
15	Adampur	Yes	No	No	Yes	No	Yes	No	Yes	No	Yes	Yes
16	Narnound	Yes	No	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes
17	Bahadurgarh	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
18	Beri	Yes	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
19	Matanhill	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes
20	Safidon	Yes	No	No	Yes	No	Yes	No	Yes	Yes	No	Yes
21	Narwana	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
22	Uchana	Yes	No	No	Yes	No	Yes	Yes	No	No	No	Yes
23	Guhla	YES	No	No	Yes	No	Yes	No	Yes	No	Yes	Yes
24	Kalayat	No	No	No	Yes	No	Yes	No	No	No	Yes	Yes
25	Assandh	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes
26	Nilokheri	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No	No
27	Sahabad	Yes	No	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes
28	Kanina	Yes	No	Yes	Yes	No	Yes	No	Yes	No	No	No
29	Mahindergarh	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
30	Hodal	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes
31	Kalka	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
32	Samalkha	Yes	No	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes
33	Kosli	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
34	Kalanaur	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes
35	Meham	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	No	Yes
36	Dabwali	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
37	Ellenabad	Yes	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
38	Chautala	Yes	No	No	Yes	No	Yes	No	Yes	No	No	Yes
39	Gohana	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
40	Kahrkhoda	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes
41	Jagadhari	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes

Source: Information furnished by Sub Divisional Civil Hospitals
Colour code: Green colour/Yes= Available; pink colour/No=Not available

Appendix 6.1

(Reference: Paragraph 6.5; Page 175)

Year-wise details of budget allocated, expenditure incurred and funds unutilized in respect of various schemes under National Health Mission (NHM)

Sl No.	Particulars	2016-17				2017-18				2018-19				2019-20			
		Budget (₹ in lakh)	Expenditure (₹ in lakh)	Funds Unutilized (₹ in lakh)	*Per cent* Utilisation	Budget (₹ in lakh)	Expenditure (₹ in lakh)	Funds Unutilized (₹ in lakh)	*Per cent* Utilisation	Budget (₹ in lakh)	Expenditure (₹ in lakh)	Funds Unutilized (₹ in lakh)	*Per cent* Utilisation	Budget (₹ in lakh)	Expenditure (₹ in lakh)	Funds Unutilized (₹ in lakh)	*Per cent* Utilisation
1.	National Vector Borne Disease Control Programme (NVBCP)	184	111	73	60	182	108	74	59	158	107	51	68	497	183	314	37
2.	Information, Education & Communication (IEC)/ Behavior Change Communication (BCC)	518	244	274	47	752	372	379	50	936	451	485	48	1,576	697	879	44
3.	Iodine Deficiency Disorder (IDD)	71	23	48	33	63	0	63	0	33	0	33	0	30	0	30	0
4.	Procurement of equipment/ drugs funds	1,656	204	1,452	12	2,410	704	1,707	29	4,773	1,585	3,188	33	2,901	1,933	968	67
5.	New Constructions/ Renovation and Setting up funds	191	46	145	24	291	29	262	10	25	21	4	85	327	154	173	47
6.	Hospital Strengthening funds	47	540	-493	1,156	55	65	-10	118	6,098	2,167	3,931	36	7,506	131	7,375	2
7.	Innovation activity	211	283	-72	134	794	35	759	4	1,197	99	1,098	8	754	186	568	25
	Total	**2,878**	**1,451**	**1,427**	**50**	**4,547**	**1,313**	**3,234**	**29**	**13,220**	**4,430**	**8,790**	**34**	**13,591**	**3,284**	**10,307**	**24**

Sl No.	Particulars	2020-21				2021-22				2022-23			
		Budget (₹ in lakh)	Expenditure (₹ in lakh)	Funds Unutilized (₹ in lakh)	*Per cent* Utilisation	Budget (₹ in lakh)	Expenditure (₹ in lakh)	Funds Unutilized (₹ in lakh)	*Per cent* Utilisation	Budget (₹ in lakh)	Expenditure (₹ in lakh)	Funds Unutilized (₹ in lakh)	*Per cent* Utilisation
1.	National Vector Borne Disease Control Programme (NVBCP)	345	197	148	57	471	285	186	61	629	491	138	78
2.	Information, Education & Communication (IEC)/Behavior Change Communication (BCC)	1,422	556	866	39	1,919	1,137	782	59	2,355	1,670	685	71
3.	Iodine Deficiency Disorder (IDD)	31	0	31	0	33	7	26	20	26	13	13	50
4.	Procurement of equipment/drugs funds	4,722	1,129	3,593	24	6,539	3,153	3,386	48	5,861	2,431	3,430	41
5.	New Constructions/ Renovation and Setting up funds	8,932	215	8,717	2	8,043	63	7,980	1	12,275	1,210	11,065	10
6.	Hospital Strengthening funds	7,830	650	7,180	8	4,571	1,133	3,438	25	4,264	1,389	2,875	33
7.	Innovation activity	89	65	24	73	1,618	218	1,400	13	615	213	402	35
	Total	**23,371**	**2,812**	**20,559**	**12**	**23,194**	**5,996**	**17,198**	**26**	**26,025**	**7,417**	**18,608**	**29**

Appendix 9.1

(Reference: Paragraph 9.3; Page 229)

Comparative statement of Indicators (SDG-3) achievement as per India SDG Index Report, SDG NIF Baseline Report and National Family Health Survey-5 in respect of Haryana

Target No.	Indicator No. (As per GIF & NIF) & Indicators	State Target for 2022 as per Haryana Vision 2030	MoSPI's	NITI Aayog's			MoHFW's	Remarks (Achieved/Not Achieved by April 2022)	Target for 2030
			SDG NIF Baseline Report 2015-16	India SDG Index Baseline Report 2018-19, V 1.0	India SDG Index Report 2019-20, V 2.0	India SDG Index Report 2020-21, V 3.0	NFHS-5 Report 2019-21		
3.1	3.1.1 Maternal Mortality Rate	97	101	101	98	91	--	Achieved	70
3.2	**3.2.1 Under 5 mortality rate per 1000 live births**	**33**	**37**	**41**	**41**	**36**	**38.7**	Not achieved	**25**
3.2	3.2.3 (NIF_V-2.0) Percentage of fully immunised children in the age group 9-11 months	--	62.20	62	72.1	87	76.9	--	100
3.3	3.3.1 HIV Incidence per 1000 uninfected population	0.07	0.1	--	0.09	0.09	--	Not achieved	0
3.3	3.3.2 Total case notification of Tuberculosis per 1 lakh population	35% reduction in prevalence of TB	--	145	230	255	--	Not achieved	242
3.4	**3.4.2 Suicide Rate (per 100,000 population)**	--	**13**	**--**	**--**	**14.5**	**--**	**--**	**3.5**
3.6	**3.6.1 Death Rate Due to Road Traffic Accidents (per 1,00,000 population)**	**--**	**18.53**	**--**	**--**	**--**	**--**	**--**	**5.81**
3.7	3.7.3 (NIF) Percentage of institutional deliveries out of total deliveries reported	--	80.40	--	62	95.7	94.9	--	100
3.8	3.8.2 Monthly Per capita Out of Pocket Expenditure on Health as a share of monthly per capita consumption expenditure	--	-	-	-	10.40	-	--	7.83
3.c	**3.c.1 Total physicians, nurses and midwives per 10,000 population**	**--**	**--**	**20.5**	**26**	**26**	**--**	**--**	**45**

Note:- 1. As per Haryana Vision 2030, mid-term targets value for only four indicators were defined by Haryana Government.
2. The four indicators highlighted in bold shows negative trend.

Appendix 9.2

(Reference: Paragraph 9.3.1; Page 231)

Statement of SDG-3 Department & Programmes/schemes mapped, Budget and Expenditure during 2018-19 to 2020-21

Sustainable Development Goal-3			
Particulars	**2018-19**	**2019-20**	**2020-21**
No. of Departments mapped	12	16	12
No. of Programmes/Schemes mapped	88	88	90
Budget Estimate (₹ in crore)	2,894.65	3,150.67	3,337.37
Revised Estimate (₹ in crore)	2,791.83	3,156.41	3,184.87
Actuals Expenditure (₹ in crore)	2,326.08	2,633.73	5,468.38
% Growth of expenditure (Year on year basis)	0	13.23	107.63

Source: SDG Budget Allocation Reports

Appendix 9.3
(Reference: Paragraph 9.3.1; Page 231)
Statement of Department-wise Expenditure under SDG-3 during 2018-19 to 2020-21

Departments	Actual Expenditure (₹ in crore) during		
	2018-19	2019-20	2020-21
Health	**1,224.49**	**1,495.36**	**3,239.33**
Ayush	**28.90**	**67.16**	**213.25**
Family Welfare	200.63	205.31	212.24
Medical Education & Research	**24.54**	**677.69**	**1,584.85**
Woman and Child Development	636.92	0.92	0.11
Social Justice & Empowerment	18.22	23.82	3.78
Sports & Youth Welfare	74.11	64.88	59.61
Development & Panchayat	0	0	0
Revenue	5.74	0.75	140.14
Rural Development	21.00	0	0
Labour	0.09	0.02	0.02
Food & Drug Administration	0	0	15.04
Department of Economical & Statistical Analysis	0	0	0
Industries	0	0	0
Welfare of SC, ST & OBC	0	0	0
PWD (B&R)	91.44	95.25	0
Elementary Education	0	2.57	0
Total Expenditure for SDG-3	**2,326.08**	**2,633.73**	**5,468.37**

Source: SDG Budget Allocation Reports

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