

# NATIONAL RURAL HEALTH MISSION

## 2<sup>nd</sup> COMMON REVIEW MISSION

### STATE OF JHARKHAND

25<sup>TH</sup> NOV – 5<sup>TH</sup> DEC 2008

## TEAM MEMBERS

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## Index

Description	Page Number
1. Introduction	5-6
2. Observations from District 'Chaibasa'	6-10
3. Observations from District 'Hazaribagh'	10-22
2.a . Overall Strengths and Positive Observations	
2.b. Observations from PHCs, CHCs and SHCs	
2.c. Issues on MMU	
2.d.	
4. Issues on Pilot on Community Monitoring	22-24
5. SAHIYA Programme and Community Processes in the State	24-28
6. Relevant Observations from the field	28-32
7. Actionable recommendations	32-34
8. Annexure	35-52

### **MANDATE OF 2<sup>nd</sup> CRM**

The 2<sup>nd</sup> CRM was undertaken with the overall mandate of :-

- a) To review the changes in health system since launch of NRHM through field visits and spot examination of relevant records.
- b) To document evidence for validating the key paradigms of NRHM including decentralization, infrastructure and HR augmentation, communalization and others,
- c) To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM
- d) To recommend policy and implementation level adaptations which accelerate achievement of the goals of NRHM.

## **INTRODUCTION**

### **a. Introduction of the state:**

The state of Jharkhand has an area of 79,714 sq. km. and a population of 26.9 million. There are 24 districts, 212 blocks and 33500 villages. The state has population density of 338 per sq. km (as against the national average of 312). The decadal growth rate of the state is NA (against 21.54% for the country) and the population of the state continues to grow at a much faster rate than the national rate.

Common Review Mission was set up by the Government of India with the Focus of taking stock of the progress made for the implementation of the PIPs during the following years 2008-2009, highlights of key strengths in the health system in the state, along with the identification of key implementation bottlenecks and delineation of corrective measures needed as observed during the visit of the state as described in detail the report.

## **TEAM COMPOSITION**

**The Jharkhand CRM team consisted of the following members-**

### **Team Chaibasa**

Shri Amarjeet Sinha, (JS), MOHFW,

Dr. Jingle, Prof, Maulana Azad Medical College,

Dr.J.N.Sahay, Advisor, NHSRC

### **Team Harzibagh**

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**Process:** The process followed was as per the outlined TOR of the 2<sup>nd</sup> CRM, which was provided to shared with the team during 'CRM briefing' on 25 Nov. 2008 at MoH & FW, New Delhi.State provided an update on the overall implementation of NRHM. The State also involved in selection of specific facilities under each districts for the two teams for conducting field visits, and to capture perspectives from key stakeholders including local community & beneficiaries.

The facilities for Hazaribag district were chosen keeping in view the notification of one backward block, situated in remote area and another block connected by highway as informed by the state authority, Civil Surgeon cum CMO and Program management team in the district.

### **Reporting Sequence:**

The present report is sequenced in the following order;

1. Observations from District 'Chaibasa'
2. Observations from District 'Hazaribagh'
  - 2.a . Overall Strengths and Positive Observations
  - 2.b. Observations from PHCs, CHCs and SHCs
  - 2.c. Issues on MMU
  - 2.d. Issues on Pilot on Community Monitoring
3. SAHIYA Programme and Community Processes in the State
4. Relevant Observations from the field
5. Actionable recommendations
6. Annexure

## **OBSERVATIONS FROM DISTRICT CHAIBASA**

### **Sadar Hospital and other health facilities,Chaibasa**

**Infrastructure related :** Many of the sub centre's are functioning in the rented accommodation. One of the centres visited was functioning in a single small room without any ventilation. Many of the additional PHC and PHCs do not have proper infrastructure and some of the PHCs are without electricity connection. One of the PHCs visited was without generator on the pretext that the generator is not sold with receipt. There is no accommodation for medical officers. In Goel kera and Tanhnagar ,the medical officer in charge is residing in one of the health centre room to ensure 24x7 services to the patients. There is no accommodation for ANMs in most of the PHCs. Jhinkpani there is no boundery wall which is important for security of the nurse working at the centre during evening and night. In the district hospital also adequate number of accommodation are not available for the doctors and nurse.

The physical infrastructure and availability of human resources are grossly inadequate to provide required preventive and curative services to the population. During the visit it was observed that the sub centre at Kokcho is running in 6x8 feet space kaccha without window and other facilities . So also sub centre at Lupengutu is functioning in the verandah of a kaccha house . Both the centres are hired @ Rs. 100/- per month. In-charge referral hospital at Gail Khera and Tanhnagar PHC are residing in one room accommodation of PHC building. Facilities like labour tables, operation tables, operation theatre lights etc. needs to be planned and provided for all 24x7 PHCs. 100 bedded district hospital at Saraikeian is having only medical officers and no specialist to run the facility. At Saraikeia there was no provision of beds for patients. The list of inventories of the hospital and List of medicine available in the stores was not available. However on verbal enquiry the pharmacists reported that there were only 22 medicines.

Electricity and water supply needs to be provided in sub centers and PHCs. Location of AYUSH district hospital at Chaibasa is not proper as there were no directional Signage to guide the patient and in the close vicinity existed the with incinerator, mortuary and sulabh sauchalya. In spite of the above the daily attendance of patient in each system of Ayurveda, Unani and Homeopathy 40 to 60

**Care of Patients related:** The attendance of the patients in all the health facilities has increased many folds after implementation of NRHM Programs. Some of the Essential medicine are not available though they are procure to the funds available . At Saraikeia sadar hospital only twenty items of medicine were available. During last month at Sadar Hospital of Chaibasa 130 deliveries were conducted. At present no cesarean section is done even in the district hospital of Chaibasa. On the day of visit, there were 9 patients in the ward at Chaibasa. The ANC coverage in the district increased from 41% to 48%. During last month 78 NSVs were done. On the date of visit out of 86 beds in the district hospital of Chaibasa 76 beds were occupied. Average OPD attendance at PHC level is 60 patients per day and at sub centre 10 patients.

**Drug and Supplies:** The essential drug list of the State consists of 85 items. The number of items available were ranging from 22 to 75 at various health facilities. At Saraikeia District Hospital only 22 items were available. The procurement of drugs and equipments has been decentralized as the civil Surgeons and office i/c of district hospital were empowered to place supply orders and procure from the approved tenders finalized at state level. The local

community in rural areas, patients in health centres & hospitals expressed improvement in the availability of drugs.

**Empowerment for effective decentralization and flexibility for local action :** The Civil Surgeon of Chaibasa was not involved in the preparation of District Health Action Plan. However training has been imparted under guidance of mission director , NRHM for capacity building and developing district level plans.

**Facility related :** Facility like seating arrangement for patients and their relatives were not adequate. The patient and their attendants are compelled to stand in absence of the above.

**Process related:**

- ✓ **Registration & admission:** Two registration numbers are assigned on the same prescription making it difficult to follow the case. Duplication and registration also consumes valuable time of the clinician. Admission of patients to the hospital is not recorded properly.
- ✓ **OPD Management :** There is no system to direct the patients to required OPD from registration counter. The patients have to stand in queue and wait for their turn for attention by the doctors. This process can be made patients friendly by digital display system for calling patient.
- ✓ **IPD Management :** There is need for provision of Bed side locker, bowl , attendant seating stool and Stand for Mosquito net.
- ✓ **Signage management:** Lack of positional and direction signage leaves to in confusions to patients in accessing a particular service facility mostly in district hospital. Information about diagnostic facility are not displayed nor are there directional signage's to guide patient and to prevent harassment.
- ✓ **Sanitation management:** The status of sanitation is far from satisfactory. Toilets are unhygienic . The drains are not cleaned .There is no system of developing terms of reference or specification although sanitation services are contracted at district level hospitals.
- ✓ **Security Management:** Entry in the district hospital is unrestricted and there is no check to detect any unauthorized entry.
- ✓ **Cycle time management:** due to lack of coordination between various sections of the hospital patient have to wait for unduly long time for many other services.
- ✓ **Patients perceptions management:** There is no process to elicit patients opinion about the quality of services and other facilities available in the hospital.



- ✓ **Laundry management:** There is no scientific method adopted to Clean the hospital linen. The laundry services also does not take care of the body fluids, blood and other infected materials getting embed with the linen.
- ✓ **Waste management:** Biomedical waste management rule are not implemented. The waste is disposed in discriminately in the premises. Incinerator is not functioning.
  - ✓ **Death management:** No protocol is available in the hospital to handle, preserve and handover or dispose the dead body in event of death of patients.
  - ✓ **Universal precaution related:** The personal protective measures like use of gloves, mask etc. are not use uniformly across the hospital by the staff concerned.
  - ✓ **Regulation related:** Atomic Energy Regulatory Body (AERB) guidelines are not followed. Quality assurance committee is constituted recently.
  - ✓ **Maintenance related:** The process of getting repair done is cumbersome and needs to be addressed which may result in tangible improvement in hospital services. There is no system of having annual maintence contract for the equipments and machines
  - ✓ **ASHA:** In the district of West Singhbhum barring Chaibasa the training is in progress for fourth module. Most of the places incentives are disbursed to the ASHAs. However, at two of the sub centres visited, the release of incentives are delayed. TA/DA for attending training is not given to them. The ASHAs are having good knowledge of the work they are performing reasonably well. Community as well as health personnel are very happy with their performance and contribution. In the areas where payment got delayed the selected ASHAs have stop working. There is definite value addition by the ASHA towards improving health delivery system. To ensure their enthusiasm and motivation it is essential to provide all the due incentives in the time bound manner.
  - ✓ **HMIS and its effectiveness:** In chaibasa district there is need for improvement of data collection, proper analysis and transmission to appropriate level for decision making. In one of the sub centres, birth weight of the new born is recorded in pounds (picture) even though there is no such machine at the centre. Further, the new born weight is recorded in half kg. precision rather than accuracy of 100 gms. The analysis of birth weight data of Chiabasa district shows only 5% LBW children because of such inaccuracies. The records are not complete. Though, the area is highly prevalent for Pf Malaria, no death due to malaria is reported. On interaction, it was emerged that the deaths are not reported to avoid enquiry and filling up of lengthy proformas. The system needs monitoring and supervision in relation to HIMS.

- ✓ **Performance of Maternal Health, Child Health and Family Planning seen in terms of availability of quality services at various levels:-** ANC and ANC registration in the district increase from 64% to 81% within a period of last one year and which was in evidence during the visit at various sub centres/ PHC. There is rise in immunization coverage in West Singhbhum district.
- ✓ **Assessment of programme management structure at district and state level:-**the District and State Programme Managers are not having post graduate qualifications in public health.

### **OBSERVATIONS FROM DISTRICT Hazaribagh**

No of facilities visited

- i. 1 Dist. Hospital, Hazaribagh
- ii. 1 ANM Training Center , Hazaribagh
- iii. 1 District ICTC Services Centre, Hazaribagh
- iv. 1 AYUSH Centre, Hazaribagh
- v. 1 HFWTC, Hazaribagh
- vi. 4 Primary Health Centres(3 PHCs& 1 Add PHC)
- vii. 5 Health Sub Centres
- viii. 1 Mobile Medical unit
- ix. 1 Village for Pilot on Community Monitoring
- x. 1 AWC
- xi. 4 NGOs Involved in NRHM

### **Overall Strengths and Positive Observations:**

- Availability of drugs in the health facility
- Incinerator was working in a district hospital
- Unutilized fund in the HSC has reached and expenditure has also been done
- Certain health facilities are keeping good records
- ANMs are doing deliveries
- Annual maintenance grant has reached the PHCs
- Mobile Medical Unit is doing well
- Pilot on 'Community Monitoring' is a step in the right direction
- Sahiyas have a good knowledge and are involved in JSY and Immunization
- Weighing machine (adult) are available
- Sahiya have a Identity card with drug kit provided to them
- ICTC facilities are available in the health facilities
- IUD services are made available at some of HSC

- NSV conducted at one of the PHC
- Multi skilling of lady doctor has resulted in MTP and C-Section at District Hospital
- Blood bank services are available at the Dist Hospital
- Bed occupancy of Dist Hospital was found to be good
- GIS mapping of health facilities is available

**General issues that needs to be addressed:**

- Cleanness needs an urgent attention
- No toilet facilities are available at the health facilities
- Quality assurance committee at various health facilities not formed
- Electricity and water supply needs to be provided in HSCs and PHCs
- Proper Data collection and importance of data collection needs to be informed to the health provider
- District Health action Plan is nether shared with the team nor known to health officials
- Data analysis needs to be done on a regular basis
- Various Guidelines for Village Health Committee (VHC), Hospital Management Society (HMS), untied fund, Annual maintenance Grant, Waste disposal guidelines, infection control & waste management guidelines, Specification of pits needs to be disseminated and oriented
- Mosquito breeding in Water bodies needs to be looked into
- Bed occupancy is poor in all peripheral health facilities
- Rationalization of manpower (3LT in Chouparan)
- Eligible Couple Register (ECR) are not available
- IEC/BCC needs urgent attention including signages
- Total sanitation campaign launched by GOI has not been implemented
- Is there any correlation between TB and Crusher factories? A pilot needs to be initiated
- Condemnation of various articles needs to be done at the earliest
- Quality assurance committee for the sterilization and RCH activities has not been formed
- Constitution of Committee for HMS is not as per guidelines
- Certain new health facilities are located very far from the villages or outside the villages

- ANC record is not maintained properly (Wt. & Hb not done)
- No RTI/STI services are provided at 24X7 PHCs
- Counselors orientation & training is critical to the quality of counseling for pre & post test counseling for HIV
- No training or orientation given to Lab technician for ICTC centre for HIV.
- Analysis of data is critical as collected by lab technicians for Malaria, TB and HIV/AIDS
- No separate places of counseling for male and female at ICTC
- Referrals for counseling from ANC, STI/RTIs and voluntary counselling for youth friendly information services is not performed in the ICTC nor even reflected in the register
- Village Blindness registers are not available
- No Nodal officer for M & E
- No sahiya involvement in malaria and TB program
- Bio medical waste is not being segregated as well as the disposal of the waste is not properly maintained
- Salary system is not streamlined i.e. contractual staffs is not getting their salaries regularly. They are paid once after five months .
- No Job description is given to neither Lab Technician nor counselor since Aug. 08 IEC is missing.
- No signage system available to locate the various health facilities
- Centers which indicate counseling services are only provided to referral cases not for voluntary counseling.

#### **Issues related with Sahiyas:**

- Functional Sahiya coordination between ANM, AWW and MOIC needs to be strengthened
- Information about Integrated compensation package for Sahiya is not available with Sahiya, ANM, MOIC & NGOs
- JSY guideline still not clear to the health providers leading to delay in release of incentives to Sahiyas
- System of replenishment of drug kit is not in place
- Sahiya dairy along with compensation details should be made available to all Sahiyas
- Linkage with health system, Sahiyas related activities and NGO involvement in facilitation of Sahiya support needs to be streamlined

- Support system need to be put in place at the dist & sub-district level prior to the formation of 'Sahiya Resource Center' in the State

#### **Issues related with community processes:**

##### ***Hospital Management Society (HMS)/RKS***

- Members of HMS should be as per guideline
- Ensuring availability and orientation of HMS guideline for various health providers
- Sensitization of the Member on the scope of the functioning of HMS
- Fund utilization as per guideline, and periodic meeting with appropriate minutes and sharing of decisions taken to all the members

##### **Village Health Committee (VHC) and Village Health & Sanitation Committees**

- VHC & VHSCs should be constituted as per the guidelines
- ANM should involve in constitution and orientation of VHC & VHSC members
- Linkages of VHC & VHSCs with HSC and AWC with the involvement of sahiya
- Orientation of key stakeholders for strengthening of VHSCs

##### **Village Health & Nutrition Day (VHND)**

- Guideline should be made available to MOIC, ANM, AWW and NGO
- Orientation of VHND key stakeholder including Sahiyas
- Facilitation of intersect oral convergence through VHND

##### **Pilot on Community Monitoring**

- Objective and scope of community monitoring should be made available to the health functionaries at all level
- Interface between community monitoring team, health functionaries & NGOs
- Feasibility of impact of Community monitoring
- Involvement of Sahiyas in the processes of community monitoring

##### **NGO involvement**

- Involvement of NGO limited to Sahiya selection and training
- Govt. NGO cooperation in strengthening provision of Sahiya support system
- Rolling out of module - 5 involving NGOs
- Streamlining of incentive payment system and refilling of drugs and documentation of community based innovations

##### **Mobile Medical Unit**

- Various test are being conducted and diagnosis is made but the list of these patients should be shared with Sahiyas, and PHC IC of the respective area

- Monitoring visits need to be conducted by the PHC IC of the nearest PHC where the MMU is functionally located.
- Various data collected at the MMU needs to be analyzed with the involvement of MOIC of the nearest PHC and these data should be fed into district specific coverage with appropriate feedback on various diseases

### **Training Issues**

- Training needs assessments should be done prior to organization of any types of Training
- Identifying the training load and Training target should be assessed in terms of feasibility
- A comprehensive training plan needs to be prepared and periodically followed up with the training calendar
- Operationalization of the health facilities should be properly planned with the availability of equipments and drug
- Regular facilitation and handholding of on-going trainings
- Resource trainers from NGOs should be made available at the Training Centres and District Health Society for functional effectiveness and facilitation of Training support at the district level
- Involvement of Health functionaries and trainers from the Training institutes should be involved in training of Sahiyas, VHSC and related Community Processes under NRHM

### **Detailed observations from the district:**

#### District Hospital Hazaribagh

- 60 bedded Hospital. With ultra sound, X-Ray facilities.
- There should be a cleanliness drive for the hospital. However there was painting going on at the time of inspection
- Bed occupancy was good.
- **The Medical OPD attendance from 2006 to 2008 is reducing (from 33,000 to 29000 similarly the Gynae OPD and Child OPD also shows a drop in OPD attendance (from 35000 to 29000). Skin OPD from 12900 to 8,400, Dental OPD from 4100 to 1900. Eye OPD from 12600 to 1180.**

- Indoor attendance shows a little increase which does not correlate with the OPD attendance. Delivery shows a marginal increase. But data is available for 2006 and 2007.
- There is no signage visible showing where the emergency services or OPD services are available. Colored coded signage should be available to locate the various departments.
- There needs to be a proper case sheet for the patient.
- Bed Tickets should be available on the bed side of patient.
- There were number of articles like various vehicles, one non-functional X-ray machine was lying in the X Ray Room, they all needed condemnation

### **ANM Training Center**

- ANM training center is located in the premises of the District Hospital, Hazaribagh It started from 1968. Last inspection is held in 2004 There is three faculty only one principal, one sister tutor, one staff nurse. The suggested ratio of tutor is 1:10 by INC.
- There are 60 vacancies in the ANM training center however only 56 have been admitted. The team inspected the training center. Students are sent to the hospital for training after 3 to 4 months of theoretical training.
- Pre service IMNCI training has not been integrated in the curriculum.
- There is no full fledged MCH lab. The library is on the first floor and it appeared that the books have been recently kept.
- The teaching aid is only chalk and board. TV was functional but it was not in regular use.
- Kitchen was also inspected and found to be in bad condition.
- There is no boundary for the ANM training center which is a security concern.

### **Specific Observation**

- Bed occupancy is poor
- Cleanliness is critical issue with having no toilet facility and no water supply
- No sign board for details about services available.
- No sitting arrangement for Out door Patients
- No segregation of biomedical waste.

### **JSY**

- Inappropriate interpretation of guidelines
- Since the incentive is linked with BCG vaccination that payment may be made after a month or more
- Record does not reflect the payment of sahiya including beneficiaries for a particular Delivery
- Camp approach was used for payment to sahiya and others, which shows that administration is admitting the delay in disbursement of funds

### **T.B**

- Laboratory-Hemoglobin and urine routine not done
- No referral of TB/HIV co infections

### **ICTC**

- Collection to data with respect to the which category of sub group is counseling for
- Data does not show mapping of population diagnosis and treatment
- No indication of how many patients are defaulter
- Involvement of NGO / Involvement of PPP – neither for record nor the interaction
- HIV/AIDS awareness related IEC /BCC activities are negligible

### **RKS**

- RKS not constituted as per guideline at the moment it is health heavy weight
- There is no sensitization on RKS about functioning of members of RKS
- There is no regular meeting
- No orientation about RKS
- Poor utilization of fund
- Hospital Management resolution that Rs. 6.50/KM will be charged from the beneficiaries for transport and in case ambulance stay overnight additional Rs 300 will be charged

### **PHCs and SHCs Visited:**

#### ***Primary Health Center (PHCs)***

#### **Basaria Additional PHC**



**Positive Observation:**

- ANM is conducting the delivery at home
- Health educator is supporting in drug distribution and help in conducting OPDs with ANM
- Building has provision for ANM quarter
- Interaction of 3 Sahiyas. They know their roles and responsibilities .They know about the basic health issues fairly

**Other Observation:**

- No weighing machine
- No stethoscope
- In Hospital management Society Rs. 50,000 is not spend due to Chouparan MOIC is signing authority
- Weekly posting of one doctor (9.00 am to 3.00pm, Thursday ) starting from August 08
- Another building which is coming up near to existing PHC by March 2009.
- But no information on incentive for various services

**Berkhatta PHC**

- Fund transfer is done through Cash by BPO to ANMs at the Sub-Health Centers
- TB & Malaria register neither reviewed nor is feedback provided by the MOIC in the data collected every month
- Even MCH register is not maintained properly
- No formal communication received at the PHC regarding functioning of Sahiyas and related incentives attached to Sahiya activities under NRHM
- Confused statement by MOIC and NGO-NBJK on the Selection of Sahiyas within the coverage of 194 AWCs under this PHC
- The team observed that there are number of crushers in the area, Occupational health is critical
- There are number of water bodies in the entire Hazaribagh district

**Ichak PHC****Positive Obsevation:**

- Sahiyas were knowledgeable and aware of their roles & responsibilities
- NGO involvement on Sahiya training is good and productive

- Adequate care is taken in providing food and transport facilities for Sahiyas during Training organized by NGOs

**Other Observation:**

- Located 10 Kms from Hazaribagh catering 1,35,000 Population in 104 villages.
- 246 No of Sahiyas.
- Load of delivery is less (30 deliveries per Month)
- Interacting with the villagers it has been found that the villagers do not have confidence , so no delivery is conducted
- Interacted with five Sahiyas Maitri Devi 5<sup>th</sup> pass (Village-Kariyatipur), Yasado Devi (Furka),
- Sarswati Devi, 8<sup>th</sup> pass (Barkakhurd) Rekha Devi, Graduate (Barkakhurd), Kiran Devi Inter(Dhawaiya). Four Modules have been given to them Drug Kit have been provided, Understanding is good. Payment has been made for attending training. (Rs 25 per day excluding food), Mostly they are accompanying pregnant to sadar hospital for delivery due to this the amount due for ASHA is delayed.
- Appointed councilor at ICTC center is not trained since their joining Aug 2008. Nor any formal TOR/Job description is given to them. Cause of referral for counseling is not recorded in counseling Register.
- No RTI services are provided in PHC.
- No Ambulance service is available.

**Programmatic Suggestions**

- Sahlis Hemoglobin meter should be provided to the Lab Technician for doing Hemoglobin test.
- Reagent should be provided for testing urine for albumin and sugar.
- Urine Microscopic examination should also be done.
- Stock position of drug should be displayed for public.
- Bio medical waste is not being disposed as per the guideline. Pit to be formed for disposal of syringes and needles
- Toilet facility to be made available for staff and patients
- All data should be reviewed before sending to the district.
- Government-NGO cooperation needed to facilitate Sahiya Support for utilization of health services

- All guidelines relating to Sahiya, use of untied fund and VHSCs should be made available to the health functionaries

## **Health Sub-Center (HSC)**

### **Chaikela HSC**

#### **Positive Observations:**

- ANM are conducted delivery at sub centre level
- Good cooperation between ANM and AWW
- Sahiyas has good knowledge and record keeping of her daily activities

#### **Other Observation:**

- No passbook with ANM at the time of visit
- No payment for beneficiaries and Sahiya
- Record keeping is very poor
- Clarity regarding JSY guidelines is missing in the field
- JSY money is being distributed by MOIC Chouparan at PHC level and not distributed at sub centre level
- Delivery Table and mattresses are missing
- Bio medico waste is not being disposed properly
- Referrals for ICTC, counseling on HIV is mostly through camp but not camp approach, not a single referral from ANC cases send from same
- Minimum services are provided in VHNDs.
- No record keeping of meetings
- No sitting arrangements for patients. Role of Sahiya is neither known to AWW nor ANM even they attend some gathering at AWC level
- Weighing machine for child has not be provided
- No revolving fund with ANM
- No list of Sahiya with ANM. NGO should provide the list

### **Thuthi HSC**

#### **Positive Observation:**

- Good record keeping
- Untied fund spend
- Good maintaining the MCH register

**Other Observation:**

- 5 Km away from NH located in private one small room
- HSC, AWC new building constructed by MLA fund is one KM away from village, may not be used
- ANC registration is not done

**Kalahabad HSC****Positive Observation**

- Record keeping is good
- Delivery conducted at HSC level
- Untied fund has been spent

**Other Observation:**

- Weighing machine not functioning
- Needs strengthen through the provision of one more ANM
- In front of HSC there is newly constructed a labor room which will be handed over shortly
- Interaction with the local communities as well as MOIC reviled that they need a waiting space for people who are accompanying the pregnant lady from different places
- Local community has agreed to provide a land near by HSC
- She is recommend to SBA training and maintenance of buffer stock
- All the essential drugs should have a reorder level where it should be continuously replaced

**HSC Mahesara****Positive Observation:**

- Untied fund has been spent and record keeping of fund is also good. Cash Register is used to keep the bills.
- Stock register was checked and found to be in order
- White washing and paint has been done.
- There was emergency light also available.

**Other Observation:**

- Dr Ruby Lakra is visiting the center for 2 days in a week but her schedule should have been displayed and communicated to villagers in local languages
- List of Drugs with stock position is not in place.
- It is located on the highway, 10 kms from the District Hospital.
- The MPW has been working for more than 10 years, He got a training in 2006 does not have knowledge about Sahiyas.
- MCH register was incomplete.
- Display of staff availability was there.
- Hardly any knowledge of Sahiyas.

**HSC Silwar****Positive Observation:**

- Untied fund has been spent and record keeping of fund is also good. Cash Register is used to keep the bills.
- Stock register was checked and found to be in correct also signed by Medical officer in-charge.
- Interacted with 3 Sahiyas their Knowledge and understanding of the health issue is good. Handholding of Sahiyas is very much missing, aware of their responsibilities.
- White washing and paint has been done.
- There was emergency light also available.

**Other Observation:**

- Dr Ruby Lakra is visiting the center for 2 days in a week but her schedule should have been displayed and communicated to villagers in local languages
- No information available regarding the incentive package of Sahiyas.
- List of Drugs with stock position is not in place.
- It is located on the highway, 5kms from the District Hospital.
- MCH register was incomplete.
- The only concern is their functional relationship with ANM and health functionaries which is yet to be established

## **Mobile medical unit stationed at Chanda Village**

### **Specific Observations:**

The team went to Chanda for observing the functioning of Mobile Medical Unit which is run under Public Private Partnership (With NGO- Vikas Bharti). The team made certain observation which is follows;

- It came to our notice that investigation like X Ray, SGPT, Creatinine, Blood sugar, test for VDRL etc are being done.
- It was suggested that they provide the list of patient to Sahiyas at MOIC of the concern PHC especially people suffering from TB/ HIV Aids, Syphilis. Positive falcipareum cases etc. so that patients are tracked and integrated into the health system
- Chanda was around 5kms from ICHAK
- It was observed that the patients were standing in long queue. It was suggested that provision of drinking water and sitting arrangement should made.
- They were also told to display various IEC materials related to various programmes.
- They were told they should inform the villagers at least a week before about the MMU.
- Knowledge, understanding of Sahiyas involved in mobilizing local community are found to be good.
- Sahiya supports are being used to mobilize people with free of cost in majority of cases.
- Interacted with Sahiyas at the site of Mobile Medical Units operations are found to be aware of their knowledge and responsibilities. But their understanding about various schemes and incentives is yet to be established

### **Findings of Pilot on Community Monitoring at Saddan Village**

- Team examined the various aspect of community monitoring with NGOs, NBJK and Prayas.
  - It was observed that this is piloted in 15 village churchu, Katkam sandi, Ichak for 5 months
  - **Various Indicators used for assessing the village health are as follows- Maternal Health, Child Health, Disease Surveillance , Curative Service, Janani Suraksha Yojna, Untied fund, Quality of Care, Sahiya functioning, Adverse outcome.**

- **It came to our notice that on the basis of the above indicators they are grading the village to Red, Yellow and Green.**
- Low Sample Size, Scaling of plan is not in place, Official of the health is not involved after grading the various villages in to Red, Yellow and Green. There is no further plan to either go from Red to green and how to sustain the green indicators. Sahiyas is not getting the incentive for this activity.
- There is no linkage between Sahiyas, Health systems and the community monitoring
- There is no plan in place for scaling up of Community Monitoring pilot
- The team interacted with the villagers and found that the villagers do not have confidence on the recently upgraded 24X7 PHC Ichak. They as well as Sahiyas prefer to take the pregnant women to Sadar Hospital Hazaribagh.

### **Use of Larvivorous Fishes in Vector Control in urban Area, Hazaribagh**

The proposal mentioned above was operational in the early 80s to control malaria by use of Larvivorous Fish (Gambusia Fish). The team feels that there is a need to take up a similar scheme in the Hazaribagh area.

**Introduction-** During early 80s use of Larvivorous fish (Gambusia fish) was used in Hazaribagh town under urban Malaria scheme for vector control. The result was encouraging and the density of larvae was reduced subsequently mosquito density was also reduced tremendously.

### **Procedure Adopted.**

- a) Coordination committee was constituted involving-
  - a) DC – Chairman
  - b) District Malaria officer/Priologist-Secretary
  - c) District Fishery officer-Member
  - d) Executive officer (Municipalities)- Member
  - e) Ward Commissioner-Member
- 1. Mapping of perennial and seasonal water bodies were done by urban Malaria scheme staff.

2. At distance of 25 Sq Kms two mother hatcheries were developed under the supervision of Inspector, Urban Malaria scheme.
3. Distribution and redistribution of larvivorous fishes in different water bodies was carried out by Superior field workers.
4. At weekly interval larval density / humidity/ temperature was recorded by Insect collectors.
5. Guppies (*Poecilia reticulata*) were also introduced in many water bodies where more culicine breeding was found
6. Supervision was done by respective ward commissioners.
7. The committee to have quarterly review of the situation and suggest remedial measures in case of any problem.
8. No extra fund was provided, only regular staff was used to carry out the operation.

### **Disease Control Programme**

**RNTCP and NVBDCP** shows an increase in number of patients from 2005 to 2008

**NLEP** shows decrease in number of new cases from 2007 to 2008

### **SAHIYA Programme and Community Processes in Jharkhand:**

The concept of the SAHIYA as a village based health activist/change agent in the area of health is the key to the success of SAHIYA programme in Jharkhand. The primary responsibility of SAHIYA is to be the spokesperson of the village communities' right to health and access to benefits of health Care and health services. SAHIYA programme passed through the period of intense environment building in the villages through the formation of Village Health Committee with the help of NGOs as contracted by the Mission Directorate, NRHM.

#### **1. Training**

Sahiyas are trained and supported by a fulltime block training team of Block Resource Persons (1 per about 30-35 Sahiyas) and coordinated by 1 team & 3 District Resource Persons (NGO) per block. A range of training manuals and support material has been



prepared for the training of Sahiyas. CRM team observed effective training module during interaction with NGOs. In addition, periodic training needs to be done for Sahiya with appropriate training plan in place.

## **2. Drug Kit and Drug Distribution systems:**

Highest level of political commitment shown in the state, using the camp approach the Identity Card, and the Drug-Kit is supplied to the Sahiyas. However distributing re-filling the Drug-kit – is a special problem. As there is hardly any arrangement in place for drug distribution and replenishment of drug kit as responsive to changes in utilization patterns. The current system is to dispatch a fixed quantity of drugs to the peripheral facility irrespective of the pattern of usage based on the demand received from the periphery or sub health center. Even it is received on request from the Sub Health center on ad-hoc basis.

## **3. Involvement in Malaria Control -Blood Smear Examination**

Sahiyas are not involved in making and sending blood smear slides in fever cases. Even, there is no strategy in place to crack this problem as part of the village health committee nor Health Sub Center nor even MOIC at PHC level. This issue was noticed and discussed during our interaction with the Lab Technician, MOIC – PHC and as shared with SPM unit as feedback from field.

## **4. SAHIYA Referrals & Incentives**

SAHIYA refer cases to hospitals and often accompany them. However, often their referrals are known to any in Sub Health Centers or at PHCs unlike any other patients or cases. There is hardly any mentioning about Sahiya's referrals or feedback even JSY payments are given during camps organized by the MOIC for which they have to commute additionally. Payments relating to incentives are given by cash not through check and in most cases JSY payments are given to both beneficiaries and Sahiyas. Even the functionaries from health systems are hardly aware of any incentives details attached to services supported by Sahiyas. This is also equally applicable to the NGOs responsible for training of Sahiyas in the District. The issue of timely availability of compensation is critical and need immediate attention.

## **5. Sahiya and Immunization**

Sahiyas of hamlets where even half the children had not been immunized were expected to report this separately and the system is expected to take it up and hold a health and immunization camp in this village. In general the list of such hamlets was compiled with the help of AWW and ANM. Some chief medical officers interacted with during visit clarified that they have acted on this list when it was presented to them. This mechanism contributed to address the problems of immunization and its coverage as was expected to have risen after the involvement of district authority. The Sahiyas are even not aware of this aspect of their roles in respective hamlets or villages.

## **6. Cooperation between Sahiyas and ANM & AWW**

SAHIYA programme has not yet began to involve in training of ANMs and AWWs on the key roles and responsibilities of cooperation of Sahiya programme and even ANM & AWW are not involved as trainers. No doubt these efforts could have helped the capacity of Sahiyas, but there is still considerable room to improve their functional cooperation. The coming-up of Janani Suraksha Yojana and the immunization day incentive has made no change to this general pattern of lack of cooperation from the health department functionaries. There are similar problems in different aspects of coordination between state health department and the Sahiya. There is hardly any recognition or consideration of Sahiya effort by state health department's as at large felt by the team during their interaction with officials from the PHC, CHC and Districts health systems.

## **7. Role of NGOs in Sahiyas**

NGO involvement is limited in formation of VHC, selection and training of Sahiyas. Hardly any health functionaries are involved to support the Sahiya activities. The state health support system and most of the mother NGO neither take interest in Sahiya's problems nor listening their grievance in process of strengthening community process. Therefore, the benefit of community processes has been restricted to some extent with the training of Sahiyas only. It has not much contribution in facilitating support system at all level. This invite attention for larger cooperation of Government - NGOs for functional clarity which are essential to strengthening of Sahiya's roles in benefiting health care to the villagers under NRHM.

### **Critical challenges for SAHIYA programme:**

- In the current structure of the programme, increasing demands are made on Sahiyas to be accountable to the ANM for health programme achievements, whereas her original mandate was different as she was accountable to her village community. This largely creates confusion about her village level support system, handholding from the health systems and accountability within the health system.
- Understanding of ANM & AWW regarding role clarity of Sahiyas is critical. This is largely contributing in making her role into an unpaid assistant for the ANM which violates all norms of social health activist role as per the guidelines under NRHM.
- JSY incentives are given using camp approach, which creates a lot of confusion to trace out either the real beneficiaries or Sahiyas. As in most cases the guideline for JSY is hardly understood or interpreted correctly by the MOIC or the health functionaries responsible. This is also an issue of gender injustice as there is hardly anyone in the health system to respond correctly.
- The Sahiyas are also constantly undervalued by the professional health care staff, as there are any adequate steps taken to introduce health functionaries in the state/district/block/Sub-health centres regarding their roles and responsibilities in majority of cases. Nor, even any guidelines are available or reached on the use of untied fund, JSY or integrated compensation on various services. Even, MOIC was not aware of their training programmes as offered by NGOs in these blocks.
- Re-filling of Drug-Kits: Re filling of drug kit is not done in regularly basics. Many of the Sahiyas had received this only once since last 5-6 months when they received their Id card.
- Issue relating to incentives payment is also a major concern though the level of incentive currently reaching is not enough to keep the morale of Sahiya and that of the health systems effective support. Problems mostly relate to delayed payment, non payment, and reduced amount of payment to the beneficiaries of Sahiya scheme. In absence of clear strategies for facilitation of strengthening the payment process but this issue needs immediate attention of concerned health functionaries starting from District down sub centre level of functioning.
- A health and Nutrition day under the rubric of 'Immunization Day' is organized regularly with the coordinated involvement of Sahiya, ANM and AWWs. The challenge is to sustain this community process so that they do not become operate as one level of

functionaries of government in the village. Complementarily of efforts of Sahiya, ANM and AWW is suggested.

- All district hospital visited is having no Sahiya support system to help & assist Sahiyas with patient in reaching the specialist with the absence of initial counseling support. Failing which it was difficult to assess the cases referred by Sahiyas in the concerned hospital. This badly affects the morale of Sahiyas in sustaining their motivations.
- Orientation regarding Sahiyas effort in achieving benefits of general health services especially in the areas of involvement of community participation is yet to be understood to many among the health functionaries.
- Issue of recognition of Sahiya training effort involving government health functionaries is critical and this badly affecting the sustainability of community processes for contributing to the challenges of health systems support in the state is critical.

#### **Relevant Observations from the field:**

- The issue of provision of second ANM under NRHM was discussed and approved as observed during our visit. No sub-health center is having connected to electricity, water supply facilities. Mostly, sub health centers are located in the roadside or on the highways far from the proximity of villagers.
- Drugs and storage facilities are largely mismanaged. This account for the poor understanding and implementation of IPHS for 24X7 PHCs, FRUs and diagnostic facilities for quality care for delivery of health services in demand. Under Hospital Management Committees, the equipment and furnishing of peripheral health facilities is yet to be taken care.
- Community Processes contributed to the increase in institutional delivery, but absence of minimum standard of facilities as per IPHS standards, lack of Toilet for women, unclean Operation Theater, vacancy of staff nurse and physicians critically contributing to poor quality of care. Innovations of Public-Private partnership are yet to be streamlined under Hospital Management Committees.
- Utilization of RKS through Hospital Management Committee is implemented at all level under NRHM. It was felt seriously by the team that there is lack of appropriate monitoring and record keeping systems in place which account for ineffectiveness in

utilization of benefits of RKS in the state. Similarly, health department staff members need to be sensitized in this regard, the role of DPMU is essentially critical in this aspect. This contributes to large amount of fund transferred being unutilized.

- In most of the districts including Hazaribag is yet to prepare the District Health Action Plans based on inputs from the Block health action plans and Village level action plan. This process is yet to begin at present through NRHM support involving health departments. Involvement of other linking department is essential to initiate intersectoral convergence involving multiple stakeholders from concerned programmes /departments from various vertical programmes in the state. Even, no one in the district is aware of District Health Action Plan (DHAP) nor even had an opportunity to see last year's DHAP as discussed with us.
- The state has the tradition of involvement of NGOs in public health programmes. The role of NGOs in the state as facilitator for capacity building of Sahiyas is worth mentioning. This could lead to assessing multiple stakeholders' support at the grassroots for linking support from health systems. State level Sahiya (ASHA) Mentoring Group is formulated to take up the assessment of effectiveness in the 'Community Monitoring' under NRHM. Periodic stakeholder consultation is essentially envisaged under the present role of Sahiya Mentoring mechanism for the effective engagement of NGOs in the state & district especially in the areas of IEC/BCC strategies and community participation at large under NRHM.
- Programme Management structure is in place at the state as well as at the district level. The state has established SPMU at the capital and DPMU throughout the state. Continuity and retention of PMU personnel is critical to the success of contribution of DPMU to the implementation of NRHM. The coordination between SPMU and DPMU is facilitating the programme management in the state. But the strategic cooperation between NRHM team and DPMU is critical in building bridges that are essential in narrowing down existing challenges of governance of NRHM in the state. This in brief can contribute to;
  - Larger understanding of field situations by the DPMU team as well as SPMU
  - Optimizing the benefits of various vertical programmes through convergence from the field and establishment of District Health Society
  - Orientation of District Health Functionaries at Additional PHC, PHC and Sub-Health Centers on components of NRHM is critical to the functioning of DPMU and support system at the district level

- Exchange of information and strategies that are essential to reduce overlapping of capacity building measures at the field level for HMIS, Systems strengthening, Monitoring and initiating supportive mechanism & strategic supervision for mid-course corrective measures.
- Monitoring and coordination of Capacity Building activities starting from village, block and district level of operations with adequate involvement of DPMU in coordination with health functionaries
- Involvement and support from the government health functionaries in the capacity building on key components of 'Community Processes' under NRHM - ASHA, VHSC, RKS & NGOs
- Effective contribution to the operational issues involving role of NGOs in facilitation of support system, Sahiya Mentoring Group and provision of strategic measures for improvement in utilization of 'Sahiya Incentives' through availability of 'Integrated Compensation Package' for Sahiyas at the village, block and district level of operations
- Capacity building of DPMU and SPMU is critically essential for the effective coordination of implementation of NRHM in the state. Formation of Program Monitoring and Planning Committees at all levels of operations is worth mentioning starting from PHC, CHC to District and State. Review of district, block and PHC level MIS reports, integrated MIS formats and use of IT in tracking of reporting and documentation revealed that there is inadequacy in the hands on training input to these functionaries in this aspect of managing HMIS involving field level functionaries. Sensitization of stakeholders for the use of MIES format is critical. Establishing and operationalisation of feedback mechanism for mid course corrective measures are recommended by the team. Data disaggregating by gender and critically vulnerable group is suggested to be included in the integrated MIES formats.
- Identification of district specific issues and involvement in effective contribution to Sahiya programme, Village Health Nutrition Day, preparation of draft guidelines for VHSC, Hospital Management Committees, and operational guidelines on components of NRHM is critical. This can be facilitated by inclusion of 'District Coordinator' for Sahiya and relevant Community Processes under NRHM as a priority for the district. In a later stage the specifically identified district level support can be supported at the state level through already conceived 'Sahiya Resource Center' under NRHM.

- Additionally involvement in the capacity building initiatives for district support including facilitation of health planning can be provided under SRC support with well defined 'Terms of Reference' in a later stage. Even, research support in the areas of Intra-district and inter-district variations in health status can be included in the activities of SRC contributing to effectiveness of the 'Community Processes' in the state. Most importantly, IEC/Behaviour change communication intervention needs at community level can be identified and supported through SRC in the state.
- Mainstreaming of AYUSH initiative is largely suggested in the following areas with the contributions and active involvement of DPMUs;
  - Sahiya training design on home based herbal remedies
  - Support in development/modification of AYUSH Strategies in the district involving NGOs-Government cooperation in health services
  - District level planning on integration of AYUSH under NRHM involving DPMUs
  - Constitution of a separate AYUSH cell in the state for the provision of research and development under NRHM
- Convergence Initiatives in the state & District is suggested to be supported by DPMU team in coordination with SPM in the following areas of operations;
  - Coordination with WCD in capacity building of AWWs workers involving Sahiyas for effectively functioning of VHNDs
  - Coordination with UNICEF on IMNCI involving Sahiyas, School Health and Jointly organized IEC/BCC activities of AWWs and Sahiyas
  - Effective coordination with WCD, PHED, Total Sanitation Campaign and Women Self Help Group networks and VHCs
- 'Governance of NRHM'
  - Formation of District Health Society
  - Deployment and orientation of District Community Mobilizers for Sahiya and VHSCs
  - Development and sensitization of Village Health Sanitation Committee Guidelines
  - Facilitation of delegation of Financial Power with special reference to sanctioning, approving and signing authority for the effective functioning 'District Health Society'
  - Development of District Health Action Plan involving multiple stakeholders and DPMUs

- Use of computerization especially E-transfer through notification server
- Payment of incentives for Sahiyas through Bank account or through Post office account

## **ACTIONABLE RECCOMENDATIONS:**

### **Governance Issues**

- Issues of “Governance of NRHM” and ownership of health department are critical and need immediate attention of the state authority to address.
- Continuity of Mission Director in the state for providing strategic direction to SPMU and effective implementation of NRHM.
- Functional coordination between department of Health & NRHM with appropriate support systems for coordination of technical assistance within the state

### **Capacity Building of Support System**

- Capacity strengthening for effective utilization of IEC/BCC activities for use of health facilities needs to be streamlined
- Capacity Building of SPMU and DPMU along with State functionaries on Implementation Framework and Financial Management of NRHM
- Advocacy on NRHM Strategic Milestones with the effective engagement of multiple stakeholders from Government, NGOs and Private Sector involving intersectoral coordination within various programme managers of health department
- Capacity building on HMIS involving SPMU, DPMU and Concerned functionaries for effective monitoring, reporting and documentation
- Capacity building of state functionaries along with SPMUs on ‘Advocacy on intersectoral coordination under NRHM’ is suggested for maximizing convergence of services at the implementation level.

### **Programme Management**

- Establishment and operationalisation of ‘District Health Society’ and district management team including deployment of District Sahiya Facilitators need to be addressed in bridging the gaps between Community processes – Sahiya



Strengthening, VHSC functioning, use of untied fund, Rogi Kalyan Samiti/Hospital Management Committees and District PMUs for effective coordination of programme management operations. This will surely facilitate the field visit and field level input to the programme management in the state.

- Approval of pending commitments along with availability of guidelines on VHSC, use of untied fund, information on integrated compensation package for Sahiyas, functioning of VHNDs will ensure effective linkage between Sahiya operations, NGOs and government health functionaries. This will contribute to sustain the ongoing effort on Community Processes in the state.
- Establish mechanism for facilitation of Sahiya Support Systems as per the GOI guidelines for the states having more than 20,000 Sahiyas starting from Block level of Facilitation for 10-12 Sahiyas and Sahiya Resource Center at the State level.
- Fund transfer under various schemes needs to be done, bodies to be formed as per the GOI guidelines and regular meetings to be held.
- ANMs are conducting deliveries at the sub centre needs to be linked with the higher facilities, JSY simplified guidelines to be made available and payment systems for beneficiaries & Sahiyas need to be streamlined

#### **Assessments & Pilot**

- Undertake Pilot on linkage between crusher factories and TB
- Pilot on tackling the mosquito menace specially addressing the various water bodies in the district
- There needs to be an assessment on decrease Leprosy Cases
- Extension of Pilot on Community Monitoring for an adequate period with involvement of GO-NGO cooperation
- Integration of MMU into the health system functioning
- HIV/AIDS related counseling through ICTC services should be integrated into general health systems to address referrals from ANC and STI/STDs

#### **PIP Revision & Health Planning**

- Strategic planning and inclusion of suggested recommendations in the revised PIP is critical for Sustaining of ongoing effort under NRHM involving multiple

stakeholders and important to assess the effectiveness of NRHM at this stage of programme implementation in the state.

- Prioritization of system strengthening efforts needs to be executed along with strengthening capacities of support system for effective utilization of health services and health systems in the state. Key components under this should be placed as programmatic priority with appropriate budgetary request in the revised PIP.
- Emphasis should be given in the preparation of District Health Action Plan involving multiple stakeholder

# ANNEXURE

## Annexure 1

### Base line of Public Health System in the State:

**i) Infrastructure:** There are three medical colleges in district. There are 24 district hospital and 6 sub divisional hospitals. To cater to the needs of rural population following is the position of infrastructure required and its short fall.

Particular	Required	In position	Shortfall
Sub-Centre	7088	3958	3130(56%)
*Additional PHC	1005	330	675(67%)
*PHC 24 X7	188	31	157(52%)
FRU	NA	0	
Ayurvedic Dispencerries	NA	122	
Uniani Dispensaries	NA	30	
Homeopathic Disp.	NA	54	

It should be noted that there is no community health centre functioning in the state where as per norms different specialist are providing the health services. Construction is under process 425 CHCs and 83 PHCs. There are two homeopathic and 1 ayurvedic Hospital. There are 24 mobile unit 1 per district are functioning in the state through which more than 75 thousand patients are examined, 1825 Xray's done, 8115 Pathology test done, 828 ECG and 1057 Ultrasound were done from jan'08 to Sept'08.

**ii) HUMAN RESOURCES :** Following is the status of health manpower in the states.

Particular	Required(IPHS)	In position	Shortfall	%
Multipurpose worker	7088	1922	5166	73
ANM	14176	6437	7739	55
LHV	4331	278	4053	94
Paramedical Staff	4133	121	4012	97

Staff Nurse	4707	407	4300	91
Medical Officers	3686	1678	2008	54
Specialist	1316	188	1128	86

\*SAHIYAs working in the state 40764.

The above data in the table shows the shortfall ranging from 54 to 97 percent. At none of the sub centre there is an ANM and the Health facilities is managed with very little manpower of all categories. Under NRHM 1116 Multipurpose Workers are appointment on contractual basis and working for NVBDCP. Appointment of Medical officers through Civil Service examination is near to completion and appointment of lady medical officers for the PHCs is under process. Under NRHM all vacant positions of SPMU including State Consultants has been filled, all 24 DPMUs(24 District Program Manager), 24 District Accounts Manager, are in position. all 194 blocks accounts manager are in position.

### iii) Health indicators :

Indicator	Jharkhand	India	Goal(2012)
IMR	69(2006),48(2008)	57(2006)	Bellow 30
MMR	371(2006)	301(2006)	Bellow 100
CBR	26.1(2007)	23.1(2007)	
CDR	7.3(2007)	7.4(2007)	
TFR	3.3(NFHS 3)	2.7(NFHS-3)	
Sex Ratio 2001	941	933	
Antenatal Care	38(2006)	50.7(2006)	
Inst. Delivery	19.2(2006)	41(2006)	
CPR	36(2006)	56(2006)	
Full Immunization	51.9(2008)	44(2006)	
100 IFA Tab. Consumption(NFHS)	14.6	22.3	
Anemia in Mothers	57.9	68.4	
PNC 1	17	36.4	

**iv) Status of the PRI framework in the State :** Constitution of Rogi Kalyan Samiti (RKS) at Various level

Level	NO. OF FACILITIES	NO OF RKS	%
District	24	24	100
PHC (24X7)	194	165	85
APHC	330	231	70

Jharkhand has set up Rogi Kalyan Samitis as per the NRHM guidelines at different levels i.e in 24 district hospitals(100%),231 in additional PHCs(70%) and 165 PHCs(85%). These three sets of institutions have started receiving Rs. 5 lakhs, Rs. 0.50 lakh and Rs. 1.00lakh respectively every year as untied funds. Also, 3958 sub-centres (100%) have opened bank accounts for receiving untied funds; and many have received two remittances of Rs. 10,000 every year. ANMs at the sub-centre have been particularly benefited by inflow of untied funds every year. They have used this money to improve the condition of the sub-centre and to equip it better. With regards to formation of VHSC, the process of registration and opening of the account of the committee is going on.

**v) Others:**

- a. The social economic indicators of the states are as follows.

Item	
Scheduled Castes Population (in million)	3.19
Scheduled Tribe Population (in million)	7.09
Female Literacy rate (Census 2001)	38.9%

- b. Other program related information.

School health program is implemented through partnership. 40 thousand first aid box distributed in the school. There are 19 malaria endemic, 15 filairia endemic and 4 Kalazar endemic in the district. Cases of Filaria 44000 in 2005 to 8000 in 2007. Total cases of TB cases detection was upto 68%. Leprosy cases under

treatment by Oct '08 where 3580 and prevalence rate 1.1 per 10000. Under blindness control programme about 70000 cataract operation done achieving 94% target out of these 90% patient where given IOL.

**vi) Special Constraints :**

- a. For proper functioning of public sector health system adequate and efficient health manpower is required. In the state the no. of institutions producing various categories of manpower. Urgent and adequate measures of required to be taken to meet present and future needs.
- b. The health man power needs training for upgrading the skills. All the Doctors who are in-charges of various facilities don't have administrative and managerial trainings.
- c. For desired outcome of the programs officers handling different national health programme should be from public health specialty or public health background. The number of post graduate seats and the department of community in the states needs to be increase significantly and the department of community medicine needs strengthening.
- d. Many are the areas are inaccessible. There are no motorable roads and, it is very difficult to shift emergency cases to the health facilities where their problem can be attended. The road condition in the states is bad.
- e. There is no assured career progress option for medical officers due to which their motivation level is affected.

**vii. Complete list of facilities visited by the team:**

The State team was further divided into two sub teams. Team A consisting of Mr. Amarjeet Sinha, Dr. J.N. Sahay and Dr. G.K. Ingle visited West Singhbhum District and Saraikela District Hospital whereas Team B consisting of Dr. Dinesh Baswal and Dr. Manoj Kar visited Hazaribagh District. The complete list of the health facilities visited by the teams is given below:-

<b>Name of the state : Jharkhand</b>				
<b>Name of the Districts visited</b>				
<b>S.No.</b>	<b>Name</b>	<b>Dist. HQ</b>	<b>Name of the DM</b>	<b>Name of CMO</b>
1	West Singhbhum	Chaibasa	Mr. Sunil Kumar	Dr. Shyam sundar Prasad
2	Hazaribag	Hazaribag	Mr. V K Chaubey	Dr. B K Singh

### **Health facilities visited by Team A and Team B**

#### **Health facilities visited by Team A**

Health Facility Visited by Team A in West Singhbhum and Seraikela Districts (District profile of West Singhbhum is attached at Annexure \_\_\_\_)

S.No.	Name	District	Level
1	Sonua	West Singhbhum	PHC
2	Karaikela	West Singhbhum	APHC
3	Goailkera	West Singhbhum	Ref. Hospital (PHC)
4	Serikela*	Serikela	Sadar Hospital
5	Chaibasa	West Singhbhum	AYUSH DISP.
6	ANM School	West Singhbhum	ANM Training School
7	Tantnagar	West Singhbhum	PHC
8	Kokcho	West Singhbhum	Sub Center
9	Singh pokhria	West Singhbhum	Subcenter
10	Zikpani	West Singhbhum	PHC
11	Jodapokhar	West Singhbhum	AWC
12	Chakradharpur	West Singhbhum	Sub divisional hospital
13	Ghaghari	West Singhbhum	Sub Centre
14.	Narsanda	West Singhbhum	Sub Centre
15	Lupungutu	West Singhbhum	Sub Centre

16.	Hatgamaria	West Singhbhum	Addl. PHC
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Interaction with villagers from following villages:

1. Jodapokhar
2. Jamdhih
3. Balibandh
4. Indubasa
5. Gaogutu
6. Kumardungi
7. Baibeda
8. Hatgamaria
9. Bada Mirg Lendi
10. Manghari



**Team for Hazaribag:**

This team consisted of Dr.Dinesh Baswal and Dr. Manoj Kar who were accompanied by Chief Director, Health Department, Programme Director, Malaria & TB, Director-Training, Director-Immunization, DPM unit and State Facilitator, Community Participation, NHSRC.

The facilities in Hazaribag district visited as the review mission were as follows:

- District Hospital, Hazaribagh
- ANM Training Centre, Hazaribag
- AYUSH Centre, Hazaribag
- PHC Chouparan
- PHC Barakatha
- PHC Ichak
- Addl. PHC Basaria
- HSC Chaikela
- AWC Chaikela
- HSC Thuthi
- HSC Kalabad
- HSC Silvar
- HSC Mahesra
- HFWTC Hazaribagh
- Mobile Medical Unit, Chanda under PHC Ichak
- Community Monitoring , Sadan
- Civil Society representative (NBJK, Vikas Bharti, Prayas, RKSM)
- Sahiyyas (20) including Community members from locality visited for interacted.

As per briefing by state programme manager in presence of the Secretary (Health) & Mission Director (NRHM) and input to the draft report including feedback from the field along with major recommendations were shared and consensus achieved. On behalf of the State some assurances were given to the actions to be undertaken for the effective implementation of the activities in the end of CRM presentation, which was attended by the state officials, presided over by the Secretary Health.

**PHC Chouparan****Profile of Chouparan**

1	No of Villages	267
2	No of Panchayat	34
3	Population	196103
4	Additional PHC	2
5	HSC	18
6	Total No of Medical officer	6
7	Total No of Staffs	69
8	Total No of Anganbari	209
9	Total No of Sahiyas	339
10	Total No of Anganbari Session site	159

**Barkatta PHC**

1	Population	1,47,586
2	Total No of HSC	13
3	Total No of APHC	1

**Staff position**

		Sanctioned	Working	Vacant	
1	Medical officer	4	2	2	
2	Contractual Medical officer		2		
3	Supervisor	1		1	
4	Pharmacist	1		1	
5	Contractual Pharmacist		1		
6	Lab technician	1	1		
7	Supervisor	2		2	
8	Supervisor	8		8	
9	Female health Nurse	2	1	1	
10	ANM	15	11	4	
11	Contractual ANM		8		
12	Male Health worker	3	2	1	
13	Male family planning worker	3	2	1	
14	Health worker	3	1	2	
15	Clerk	2	2		
16	Computer	1	1		
17	Block extension	1		1	

	worker				
18	Driver	1		1	
19	Female ward helper	1	1		
20	Male ward helper	1	1		
21	Peon	1	1		
22	Health helper	4	4		
23	Sweeper	1		1	
24	Contractual A Grade Nurse		1	-	Deputed to sadar Hospital

**PHC ICHAK**

Sl No	Post	Sanctioned	Working	Vacant	On Contract	Remark
1	MO	4	3	1	2	
2	LHV	2	2	-	-	
4	Staff Nurse	-	-	-	-	-
5	ANM	16	12	4	18	
6	LT	1	0	1	1	
7	Assistant Medical Assistant	-	2	-	-	Deputation by DLO
8	Buniyadi Swasth Karyakarta	1	1	-	-	
9	Family Planning worker	3	3	-	-	
10	Clerk	2	2	-	-	
11	Health worker	3	-	3	-	
12	Sanganak	1	1	-	-	
13	Nigrani Nirikchak	2	-	2	-	
	Swakha Nirikchal	1	-	1	-	
14	Prakhand Prasar Prashik	1	-	1	-	
15	Misrak	1	-	1	-	
16	Dresser	1	-	1	-	

17	Nigrani Karyata	2	-	2	-	
18	Ac Manager	-	-	-	1	
19	Counciler ICTC	-	-	-	1	
20	Driver	2	1	1	-	
21	MPW	-	-	-	3	
22	Health Assistant	4	4	-	-	
23	Adeshpal	1	1	-	-	
24	Purash Kach Sewak	1	1	-	-	
25	Mahila Kacha Sevika	1	1	-	-	
26	Sweeper	1	1	-	-	

**Primary Health facility in Ichak**

SI No	Item	Amount Received	Spent Amount	Rest Amount	
1	Sub untied	150000 at 22.3.07	120000	30000	22.3.07
2	Untied fund	25000.00 25000.00	8463.00	41535.00	24.5.07 28.1.08
3	Annual Maintenance Grant	50000.00 50000.00	13736.00 25200.00	61064.00	24.5.08 28.1.08
4	PHC Hospital Management Society	1,00,000.00		1,00,000.00	7.1.08

**Salient findings of 2 blocks of Ranchi district, Jharkhand in 2<sup>nd</sup> CRM under NRHM**

Date of visit: 28.11.08

District: Ranchi

Key areas of discussion :

No of nursing staff in position, JSY disbursement, block accountant recruitment, VHC planning, RKS at PHC. Sahiya training and their involvement

**List of places visited**

Sl. no	Place of visits	Name of the Blocks	
		Ormanjhi	Kanke
1.	PHC	Yes	x
2.	FRU	Yes	x
3.	Sub center	X	Yes
4.	VHC	X	Yes
5.	AWC	X	Yes
6.	MNGO/Sahiya Training Center	Yes	x

**Ormanjhi PHC**

The PHC has 88 revenue villages, having 88 VHCs and 123 Sahiyas. The PHC in charge Dr. Bibha Rani told that all the sub center has 2<sup>nd</sup> ANM.

**Mukshya Mantri Janani , Sishu Surakshya Aviyan (MMJSSA) alias JSY**

The pregnant mothers receive money as per following norm from this fund.

On 1<sup>st</sup> registration at PHC/Subcenter, Pregnant Mother receives-Rs. 500.00 in cash from ANM.

After completion of 3<sup>rd</sup> ANC - a coupon of Rs. 250/- as Referral transport and

after hospital delivery a coupon of Rs 900/-was given by MOIC. The payments are made in cheques.

The Sahiya gets total of Rs.350/- per pregnant mother which is Rs.150/- after registration and Rs.200/- after hospital delivery.

3238 pregnant mothers received their 1<sup>st</sup> installment of Rs.500/- after registration in PHC on 5<sup>th</sup> Sept2008 in a health camp.

**RKS** is formed in the Ormanjhi PHC. The members are MOIC, BDO, MLA/MP NGO(KGVK), 2<sup>nd</sup> Medical Officer etc.

It was told that the meetings were held quarterly .They have spent RKS fund of 2 lacs in this year for repairing of OPD and Toilet, availability of Driver on demand, appointment of night guard on daily basis etc. The RKS meeting book was not shown as the person responsible was absent due to illness

**PPP The** FRU at Rukka run by the NGO KGVK. It is the FRU having all facilities like MCH Dept, X-ray and Pathology Dept, Blood storage Unit, HNE point. Etc. Under PPP the NGO received 2 ambulances, fund for running one ANMTC , etc from GOJ.

### **Sahiya Training**

In Jharkhand the Sahiya trainings were conducted by some identified NGOs named as District RRC , located in the district regions.

The Training Modules were developed by the state team which are also not following GOI developed ASHA books. The entire Sahiya training has 6 modules. The MT trainings were held on 4 modules till date, are as follows:

Module 1 -The introduction of Sahiya

Module 2 – Child health

Module 3 – Hygiene and sanitation

Module 4 – Safe motherhood

The concept of safe mother hood, child health etc were not very clear among the Sahiyas and also the MTs. Eg during interacting with the sahiyas in Garu village of Kanke block, all of them opined that using oil massage for the infant just after birth is good for child's health( it is a traditional belief in the area).



## VHCs

According to the coordinator, all the VHCs are registered and have their bank account. During visit it was found in Garu VHC, that the VHC did not receive its grant of Rs 10000/- as untied fund after six month opening of its bank account. The VHC has done their planning meeting and chalked out their plan of activities.

Name of the Panchayat	No of the Master Trainers (MT)	No of VHCs	No of Sahiya	Sahiya completed Non residential training
Patratu	10	180	271	3 <sup>rd</sup> module
Namkum	10	142	345	3 <sup>rd</sup> module
Angara	4	214	207	3 <sup>rd</sup> module

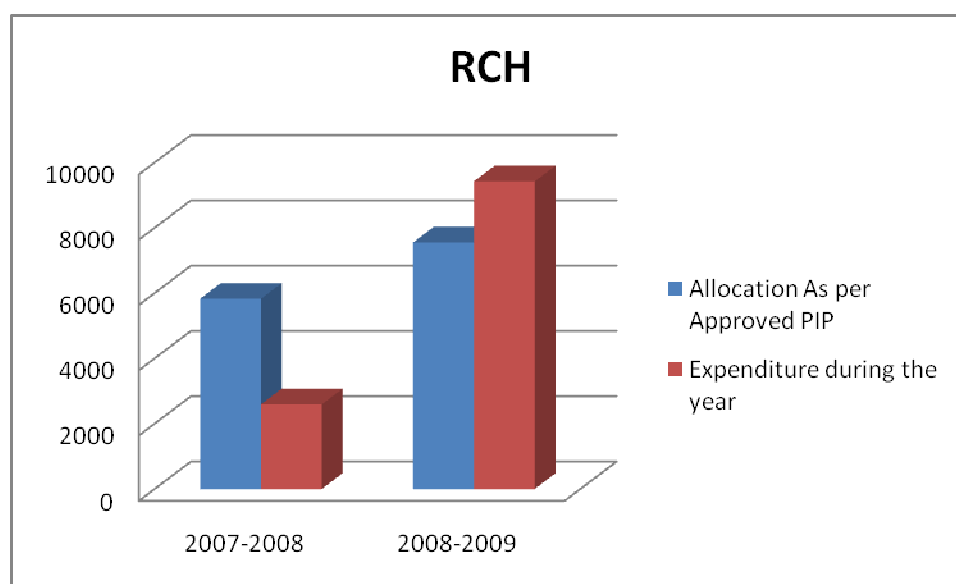
### Progress against the approved PIP of the state

General Trends of expenditure against the approved PIP is detailed below.

Graphitic Presentation of the financial progress report for the year 2007-2008 and 2008-2009.

#### A) RCH- Technical Strategies & Activities

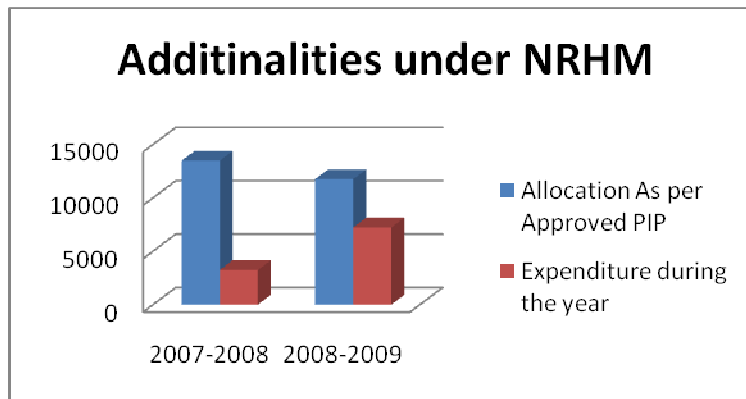
RCH	2007-2008	2008-2009
Allocation As per Approved PIP	5829.24	7552.15
Expenditure during the year	2594.09	9423.07*



\*The Expenditure has exceeded in JSY by 11.74%, Child Health by 3.08%, Procurement by 6.91% and urban health by 2.33%.

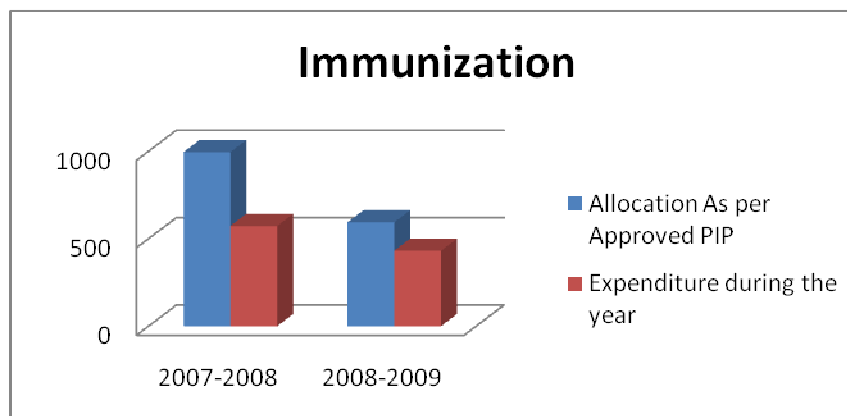
### B) ADDITIONALITIES UNDER NRHM

Additinalities under NRHM	2007-2008	2008-2009
Allocation As per Approved PIP	13483.89	11747.71
Expenditure during the year	3242.18	7228.81



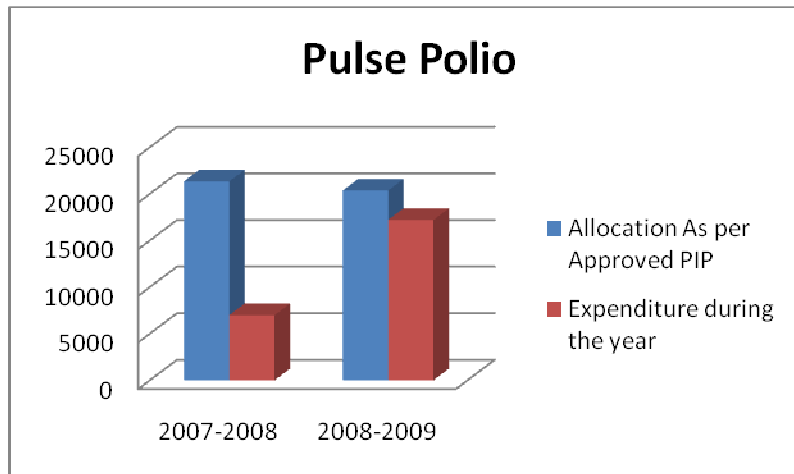
### C) IMMUNIZATION

Immunization	2007-2008	2008-2009
Allocation As per Approved PIP	995.52	593.81
Expenditure during the year	573.39	431.3



#### D) PULSE POLIO

Pulse Polio	2007-2008	2008-2009
Allocation As per Approved PIP	21343.9	20355.82
Expenditure during the year	6982.76	17203.7



#### E) OTHERS

Others	2007-2008	2008-2009
Allocation As per Approved PIP	280.9	232.3
Expenditure during the year	48.6	23.52

