National Rural Health Mission
Ministry of Health & Family Welfare
Government of India

2011

5th Common Review Mission

(November 8th – 15th)

Jharkhand

"HANDS FULL OF LIFE"

Districts Visited

1. Giridih
2. Deoghar

CRM Team - Jharkhand

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Contents

Abbreviations:

ABER	Annual Blood Examination Rate
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
APHC	Additional Primary Health Centre
API	Annual Parasite Incidence
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist (Sahiya in Jharkhand)
AWTC	Anganwadi Training Centres
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga Unani Siddha Homeopathy
BCC	Behaviour Change Communication
BHAP	Block Health Action Plan
BPM	Block Programme Manager
BTT	Block Training Team
CDPO	Child Development Project Officer
CHC	Community Health Centre
CRM	Common Review Mission
C-Section	Caesarean Section
CSR	Corporate Social Responsibility
DAM	District Accounts Manager
DDT	Dichloro-Diphenyl-Trichloroethane
DH	District Hospital
DHAP	District Health Action Plan
DHS	District Health Society
DMO	District Malaria Officer
DPT	Diphtheria Pertussis Typhoid
DTT	District Training Team
EAG	Empowered Action Group

EMRI	Emergency Management Research Institute
ERP	Enterprise Resource Planning (software)
ERS	Emergency Response Service
FMR	Financial Monitoring Report
FP	Family Planning
GNM	General Nurse Midwife
GoI	Government of India
HMIS	Health Management Information System
HQ	Headquarter
HR	Human Resources
HSC	Health Sub Centre
ICDS	Integrated Child Development Scheme
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In-Patient Department
IPH	Institute of Public Health
IPHS	Indian Public Health Standards
IRS	Indoor Residual Spraying
IUD	Intra-Uterine Device
IYCF	Infant and Young Child Feeding
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LS	Lady Supervisor
LT	Lab Technician
LWE	Left Wing Extremism
LWE IAP	Left Wing Extremism Integrated Action Plan

MIS	Management Information System
MMR	Maternal Mortality Rate
MMU	Mobile Medical Unit
MO	Medical Officer
MO I/C	Medical Officer in-charge
MP	Malaria Parasite
MPW	Multi-Purpose Worker
MTC	Malnutrition Treatment Centre
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NBW	New-Born Weight
NGO	Non Government Organisation
NLEP	National Leprosy Eradication Programme
NRDWP	National Rural Drinking Water Programme
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OCP	Oral Contraceptive Pill
OPD	Out-Patient Department
OPV	Oral Polio Vaccine
OT	Operation Theatre
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PMCH	Pataliputra Medical College and Hospital, Dhanbad
PMU	Programme Management Unit
PPI	Pulse Polio Immunisation
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
PTG	Primitive Tribal Groups
Pv	Positive Vivax
PWD	Public Works Department
RCH	Reproductive and Child Health programme

RDK	Rapid Diagnostic Kit
RI	Routine Immunisation
RIMS	Rajendra Institute of Medical Sciences, Ranchi
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
SBA	Skilled Birth Attendant
SC	Scheduled Casts
SDH	Sub Division Hospital
SDO	Sub Division Officer
SFM	State Finance Manager
SHS	State Health Society
SHSRC	State Health Systems Resource Centre
SNCU	Sick Newborn Care Unit
SOE	Statement of Expenditure
SRS	Sample Registration Survey
ST	Scheduled Tribes
TB	Tuberculosis
TFR	Total Fertility Rate
TOR	Terms of Reference
TSC	Tribal Sub Plan
UF	Untied Funds
VHC	Village Health Committee
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WCD	Women and Child Development

Chapter - 1: Introduction

Introduction of the state

Geography

Jharkhand (Hindi: झारखण्ड is a state in eastern India. It was carved out of the southern part of Bihar on 15 November 2000. Jharkhand shares its border with the states of Bihar to the north, Uttar Pradesh and Chhattisgarh to the west, Orissa to the south, and West Bengal to the east. The state has 24 districts, 251 blocks and over 32,615 villages in an area of 79,714 sq km 49,821 sq mi (129,040 km^2).

The industrial city of Ranchi is its capital and Dumka is sub capital while Jamshedpur is the largest city of the state.

This area in and around the districts of Chhota Nagpur and Santhal Parganas was formerly Southern Bihar and is forest-covered, mineral-rich, tribal dominated state. It is rich with vast biodiversity and beautiful landscapes. It has a diverse ethnic, cultural, and linguistic heritage; and has largely agriculture and forest based livelihoods. Mining and Steel are the key industrial activities.

History

There was a distinct geo-political, cultural entity called Jharkhand even before the period of Magadha Empire. The tribal rulers, some of whom continue to thrive till today were known as the Munda Rajas who basically had ownership rights to large farmlands. During the Mughal period, the Jharkhand area was known as *Kukara*.

Raja Jai Singh Deo of Orissa had declared himself the ruler of Jharkhand in the 13th century. After the year 1765, it came under the control of the British Empire and became formally known under its present title, "Jharkhand" – the Land of "Jungles" (forests) and "Jharis" (bushes).

Movement for separate State was initiated by various political / tribal parties. In August 1989, the Union Home Ministry formed a committee on Jharkhand Matters (CoJM) to look into the issue & in 1995 the Jharkhand Area Autonomous Council (JAAC) was set up

The state of Jharkhand became a functioning reality on 15 November 2000 after almost half a century of people's movements around Jharkhandi identity.

Despite having a presence in almost 7.80% of India's geographical area (home to 5.50% of India's population), the state of Jharkand is part of the "Naxal Belt" comprising 92,000 square kilometres, where the highest concentrations of the groups estimated 20,000 combatants.

The 28th state of the Indian Union was brought into existence by the Bihar reorganization Act on November 15,2000- the birth anniversary of the legendary Bhagwan Birsa Munda. Jharkhand is famous for its rich mineral resources like Uranium, Mica, Bauxite, Granite, Gold, Silver, Graphite, Magnetite, Dolomite, Fireclay, Quartz, Fieldspar, Coal (32% of India), Iron, Copper (25%of India) etc. Forests and woodlands occupy more than 29% of the state which is amongst the highest in India.

Demography:

Indicator	Jharkhand	India
Total population(In crore) (Census 2011)	3.29	121.01
Decadal Growth (Census 2011) (%)	22.34	17.64
Crude Birth Rate (SRS 2009)	25.6	22.5
Crude Death Rate (SRS 2009)	7	7.3
Natural Growth Rate (SRS 2009)	18.6	15.2
Sex Ratio (Census 2011)	947	940
Child Sex Ratio (Census 2011)	943	914
Schedule Caste population (in crore) (Census 2001)	0.31	16.67

Schedule Tribe population (in crore) (Census 2001)	0.70	8.43
Total Literacy Rate (Census 2011) (%)	67.63	74.04
Male Literacy Rate (Census 2011) (%)	78.45	82.14
Female Literacy Rate (Census 2011) (%)	56.21	65.46

Base line of Public Health System in the state

State Profile:

Rural Population (In lakhs) (Census 2011)	**250.37**
Number of Districts (RHS 2010)	24
Number of Sub Division/ Talukas	37
Number of Blocks	251
Number of Villages (RHS 2010)	32615
Number of District Hospitals	21
Number ofCommunity Health Centres (RHS 2010)	188
Number of Primary Health Centres (RHS 2010)	330
Number of Sub Centres (RHS 2010)	3958

There are 21 district hospitals, 188 CHCs (Block PHCs),SDH (6) 330 PHCs (Additional PHCs), and 3958 Sub-centres, most of them are serving a much higher number of populations as compared to the norms. The population of Jharkhand is 3.29 crores and sex ratio is 947 females per 1000 males (as per 2001 census). SC Population is 0.31 crores (census 2001). ST Population 0.70,(census 2001) overall Literacy rate 67.63% with a Female Literacy Rate of 56.21%. The state has MMR 261, IMR 44, and TFR 3.2.

There are three medical colleges in Jharkhand namely Rajendra Institute of Medical Sciences (RIMS) at Ranchi, M.G.M. Medical College at Jamshedpur and Patliputra Medical College and Hospital (PMCH) at Dhanbad. There are two institutes imparting education in the field of Psychiatry- Ranchi Institute of Neuro-Psychiatry and Allied Sciences and Central Institute of Psychiatry both located in Ranchi. There are three Dental Colleges- Awadh Dental College in

Jamshedpur, Hazaribag College of Dental Sciences and Hospital in Hazaribagh and Vananchal Dental College and Hospital in Ranchi. There are three Homeopathy Colleges and two Ayurveda Colleges as well.

Status of Health Indicators

Sl. No	Indicators	Jharkhand	India
1	Infant Mortality Rate (SRS 2009)	44	50
2	Maternal Mortality Rate (SRS 2007-09)	261	212
3	Total Fertility Rate (SRS 2009)	3.2	2.6
4	Institutional Deliveries (In Lakhs) 2011-12 (Upto June) (MIS)	0.65	32.98
5	Full immunization (In thousands) 2011-12 (Upto June) (MIS)	197	4651

Progress of NRHM

Sl. No	Activity	Status
1	24x7 PHCs	Out of 330 only 22 PHCs are functioning on 24x7 basis
2	Functioning as FRUs	17 DHs and 7 CHCs are working as FRUs.
3	ASHAs Selected	40964 ASHAs selected, 40115 have been trained up to 1st Module and 40964 ASHAs are trained up to 5th Module. No ASHA is trained in 6th & 7th Module.
4	Contractual appointments	478 Doctors, 576 Paramedics, 862 Staff Nurse, 31 Specialists, 4098 ANMs & 50 AYUSH Doctors are positioned under NRHM.
5	Rogi Kalyan Samiti	481 facilities (21DH, 170 CHCs, 36 Other than CHCs, 254 PHCs) have been registered with RKS.
6	Village Health Sanitation & Nutrition Committees (VHSNCs)	Out of 32615 villages, 30011 villages constituted VHSNCs.

Physical Progress of Institutional Deliveries and JSY

Year	No. of Institutional Deliveries (In Lakhs)	No. of beneficiaries of JSY (In Lakhs)
2005-06	0.52	0.00
2006-07	0.69	1.23
2007-08	0.82	2.52
2008-09	1.67	2.68
2009-10	2.96	2.15
2010-11	3.45	3.45
2011-12 (Upto June)	0.65	1.24

Services

Services	06-07	07-08	08-09	09-10	10-11	11-12
Male Sterilisation	6461	17380	12129	7198	14715	229
Female Sterilisation	94934	101636	114014	105735	105538	1552
Full immunization (In lacs)		6.42	5.47	6.18	6.03	1.97

Reproductive and Child Health Programme

a) Immunization Coverage

(***Figures in percentage***)

	NFHS-2	NFHS-3	Coverage Evaluation Survey		
Year	**1998-99**	**2005-06**	**2005**	**2006**	**2009**
Fully Immunized	8.8	34.2	45.7	52.1	59.7
BCG	44.3	72.7	76.5	83.8	87.4
OPV 3	36.4	79.3	53.0	57.3	69.5
DPT 3	21.6	40.3	57.8	57.9	68.7
Measles	18.2	47.6	58.0	62.2	67.5

b) Information on selected MCH indicators

Indicators	DLHS -2 (2002-04)	DLHS-3 (2007-08)
Child feeding practices (%)		
Children under 3 years breastfed within one hour of birth	14.5	34.6
Children age 0-5 months exclusively breastfed	NA	75.3
Children age 6-35 months exclusively breastfed for at least 6 months	7.8	49.5

Children age 6-9 months receiving solid/semi-solid food and breast milk	NA	53.6
Awareness about Diarrhoea and ARI		
Women aware about danger signs of ARI (%)	57.3	41.5
Treatment of childhood diseases		
Children with diarrhoea in the last 2 weeks who received ORS (%)	24.9	21.3
Children with diarrhoea in the last 2 weeks who were given treatment (%)	67.2	52.3
Children with acute respiratory infection of fever in last 2 weeks who were given advise or treatment (%)	58.4	56.0

Funds Released under NRHM

(In Crores)

Year	Allocation	Release	Expenditure[#]
2005-06	114.48	129.00	135.35
2006-07	216.20	158.64	91.89
2007-08	266.54	159.15	124.99
2008-09	294.00	247.27	299.30
2009-10	349.39	179.34	195.45*
2010-11	398.78	356.90	348.50*
2011-12 (Up to June)	458.88	107.30	33.99*
Total	2098.29	1337.60	1229.48

*Allocation and Release figures are excluding kind grants.
*****Expenditure figures for 2009-10, 2010-11 and 2011-12 are Provisional.
Expenditure is more than Release due to previous unspent balance and includes state share.

List of the facilities visited and officials met by the Team

5th Common Review Mission				
8th November to 15th November 2011				
Jharkhand				
S.No.	Name	District HQ	Name of DM	Name of CMO
1.	Deoghar	Deoghar	Mr. Mast Ram Meena	Dr. R.N.Prasad
2.	Giridih	Giridih	Shri Diprava Lakra	Dr.S.P.Singh
S.No.	**Name**	**Address/Location**	**Level**	**Name of Person in Charge**
1	Sadar Hospital	Deoghar HQ	District Hospital	
2	ANMTC	Deoghar	ANM School	
3	Block PHC	Palojori	CHC	Dr. Liyaquat Ansari
4	Block PHC	Madhupur	CHC	Dr. Gopal Prasad
5	Block PHC	Karon	CHC	
6	Block PHC	Mohanpur	CHC	Dr. Diwakar Prasad Paswan
7	Block PHC	Sarwan	CHC	Dr. Chittranjan Kr. Pankaj
8	Block PHC	Sarath	CHC	Dr. S.C. Jha
9	PHC	Madhupur	PHC	Dr. Om Prakash
10	PHC	Budhai	PHC	
11	HSC	Kushamaha	HSC	Meena Kumari
12	HSC	Lakhoria	HSC	Beena Kumari
13	HSC	Buscopia	HSC	Pratibha Mishra
14	HSC	Chulhia	HSC	Asha Kumari
15	HSC	Malahar	HSC	Anita Kumari
16	HSC	Bedia	HSC	Subash Teonudu
17	AWC	Lahore	AWC	
18	AWC	Buscopia	AWC	
19	AWC	Malahar	AWC	
20	AWC	Kherwas	AWC	
21	Sadar Hospital	Giridih	District Hospital	
22	ANMTC	Giridih	ANM School	
23	Block CHC	Pirtand	CHC	Dr. Govind Prasad
24	Block CHC	Bagodhar	CHC	Dr. Mithlesh Kumar
25	Block CHC	Bengabad	CHC	
26	Block CHC	Jamua	CHC	
27	Block CHC	Birni	CHC	Dr Ashok Yadav
28	Block CHC	Tesri	CHC	Dr. S.S Rana

29	Block CHC	Gandey	CHC	
30	Block CHC	Deori	CHC	Dr Satyendra Kumar Sinha
30	PHC	Barmasia	PHC	
31	PHC	Palganj	PHC	
32	PHC	Sariya	PHC	Dr. Haider Gfhani Unani
33	HSC	Khiuri	HSC	Ms Seema Ghosh
34	HSC	Lokai	HSC	Ms Nilu Kumara
35	HSC	Chandori	HSC	Ms Sunita Kumari
36	HSC	Chatro	HSC	Ms Bhiba Kumari
37	HSC	Nagar Keswari	HSC	
38	HSC	Bakshidih	HSC	
39	HSC	Chitradih	HSC	
40	HSC	Ojhadih	HSC	
41	HSC	Behradih	HSC	Ms Sunita Kumari
42	HSC	Chitki Khagariya	HSC	
43	AWC	Gapai-II	AWC	AWW Ms.Gudiya Rani
44	AWC	Ghatadih	AWC	
45	AWC	Basariya	AWC	AWW Ms Meghani devi
46	AWC	Chitadih-II	AWC	AWW Gulsan Parveen
47	AWC	Rukutand	AWC	
48	AWC	Mohandih	AWC	
49	AWC	Bandhawad	AWC	
50	AWC	Bharti Chalkari	AWC	
51	Village	Kala Pathar	Village	
52	Village	Amnari	Village	
53	Village	Jamua	Village	
54	Village	Loki	Village	
55	Village	Gapai-II	Village	
56	Village	Chitadih-II	Village	
57	Village	Bharti Chalkari	Village	

Chapter: 3 Theme based observations

Infrastructure Development

Type of Health Facility	Status		
	5th CRM	4th CRM	Remarks
No. of Medical College and Hospitals (Government)	3	3	
No. of District Hospitals (Capital Hospital,	21	21	
No. of Sub-Divisional Hospitals	6	6	
No. of Community Health Centres (including SDH)	188	188	
No. of Primary Health Centres (N)	330	330	
No. of Sub-Centres	3958	3958	
No. of A.N.M. Training Schools	22	10	(including 12 Pvt. institutions)

The State of Jharkhand has already established Engineering Cell in health department especially for construction of health facilities. Apart from their own state resource also receives funds under NRHM, Integrated Action Plan (IAP), Multi Sectoral Division Plan (MSDP), and Backward Region Grant Funds (BRGF) for health facility construction.

The health care facility in Jharkhand is provided by a network of 4476 health facilities consisting of 188 CHCs/Block level PHC, 330 PHC/Additional PHCs and 3958 Health Sub-Centres (HSCs).

Most of the visited HSCs in Giridih and Deohgar districts have no running water, electricity, toilet etc. Despite this many HSCs have been providing delivery services with support from local people and Sahiyas.

It is also observed that there was inadequate space for conducting deliveries at these facilities. At the CHC and PHC levels most glaring was the lack of residence facilities.

Moreover, where the residences are present conditions are not conducive for habitation.

Availability and Shortage of Staff Quarters at facilities

Facility Type									
	Doctors/ Specialists			**Nurses and Paramedics**			**Other staff**		
	Required (Sept 2011)	Available (Sept 2011)	Added during Mission period	Required (Sept 2011)	Available (Sept 2011)	Added during Mission period	Required (Sept 2011)	Available (Sept 2011)	Added during Mission period
District Hospitals (DH)	**24**	**21**	**-**	**-**	**-**	**21**	**-**	**-**	**21**
CHCs	**188**	**188***	**149**		**149***	**149**		**149***	**149**
PHCs	**1005**	**330***	**91**		**91***	**91**		**91***	**91**
Sub-Centres	**7088**	**3958***	**575**		**575***	**575**		**575***	**575**

Construction activities are underway in about 30 percent of the facilities but most of them were either found incomplete since 2 years or were not occupied. The reason given is that the newly constructed building has not been handed over to the District Health Society/Civil Surgeon. There is also no additional provision of human resources made in advance to utilize the available infrastructure. It would be appropriate to mention here that in Jamua CHC/Block level PHC in Giridih District, the building was constructed about 20 years back which was occupied after

almost 15 years in 2004, and renovation activity has been undertaken in 2010-2011. The contractor left the job in between after removing the utilities which converted the health facility almost non-functional at the time of the visit of the team It was also found that local health officials posted at the facilities were not involved at any stage of construction. This shows the planning, design and supervision are centralized at the state level. At state level, the construction activities are undertaken by an Engineering Cell within the Ministry of Health and Family Welfare. Apart from funds from NRHM, funds for construction are also received under, Multi Sectoral Division Plan (MSDP) and Backward Region Grant Funds (BRGF) and by the Health Department of the Jharkhand Government.

During the NRHM period considerable health infrastructure has been upgraded. Previously existing APHC were designated as PHCs whereas Block PHCs were designated as CHCs. There are a number of such facilities where new constructions are coming up in accordance with the new designation. However to deliver services matching the designation is still an issue.

Number of Facilities functioning	As on 01.04.2005	As on 31.03.2011	
	Total No of Facilities	Total No of Facilities	Functioning as per IPHS
DH	**12**	**21**	**12**
CHC & SDH		**194**	**-**
PHC	**194**	**330**	**-**
Sub centre	**3958**	**3958**	**-**

- **Number of 24x7 facilities** - 23 PHCs
  - 176 CHCs & SDH
- **Number of FRUs/CemONC** - 20 including DH

No proper biomedical waste management, as per the protocols, is being practiced in any of the visited facilities. Incinerator was not functional in the Giridih district hospital. Although the

colour coded bins were present in Deoghar district hospital, those were not used as prescribed. The staff was aware of the use of colour coded bins in the hospital.

Deoghar DH: ***Colour Coded bins present with protocols displayed, but inappropriately used***

The new buildings for CHC, APHCs and SCs are constructed in the districts visited, however the equipments and the furniture are deficient in the facilities. Some of the completed buildings are still not handed over to the health department (Manoharpur CHC). Manoharpur CHC is upgraded from PHC but still not performing as per the guidelines of CHC. Even the basic health services which are supposed to be at PHC are missing. CHC Sarwan is a huge complex that is still under construction. CHC Sarath was constructed two years back but not functional/operational (there is a big lock). APHC Madhupur is a newly constructed building that lacks adequate equipments required for the functional PHC.

Although a lot of new constructions are going on in the district but there is no consultation with the health department and actual users. OTs which are being constructed in the new facilities have iron grill windows which will hamper the sterilization process are against guidelines.

Even though District Hospital Deoghar is ISO certified, there is no paediatric ward, SNCU, PNC ward, emergency ward. As per the guidelines of FFF the hospital doesn't have ramp at the entrance and also the Labour room is on the first floor with no lift or ramp. OT is on the ground floor, there is only one OT for all the surgical procedures including LSCS. There is no new born corner in the OT. The USG machine at DH is not functional as there is no Radiologist/ Ultra-sonologist.

The earlier health infrastructure present in the state such as Additional PHC and Block PHC is now upgraded to PHC and CHC respectively. The upgradation which requires provision of resources to the facilities is only limited to documentation. The upgradation in mere designation and is not translating into the expected services. The exercise of upgradation was done years back but has still not taken place in the sense of the word. This irrational up gradation/designation is evident in the facilities such as CHCs and FRUs in the Districts (CHC Manuharpur, CHC Sarwan, SDH/FRU Madhupur).

PHC Barmusiya: ***Still lacking the infrastructure, HR & Services of a PHC***

New Constructions and renovations

Facility	No. of New buildings Completed in NRHM period	No. of New building Occupied and used	No. of Ongoing Works	No. of buildings with Quality Cerification
SC	19 NRHM 147 State Budget	7 NRHM 45 State Budget	54 NRHM 190 State Budget	-
PHC	1 NRHM 27 State Budget	16 State Budget	9 NRHM 64 State Budget	-
CHCs	15 State Budget	9 State Budget	23 NRHM 111 State Budget	-
DH	21 State Budget	21 State Budget	15 State Budget (up gradation)	-

PHC Burmusiya : ***Poor Service Provision***

Recommendations:

- The constructing agencies should be penalized if there are delays in the construction and handing over of building to the health departments.
- There should be active involvement of Health Departments in designing the OTs, wards, labour rooms etc.
- The Health Facilities should be assessed comprehensively for their service delivery as per IPHS.
- The up gradation of facilities with provision of necessary resources needs to be done in a time bound manner

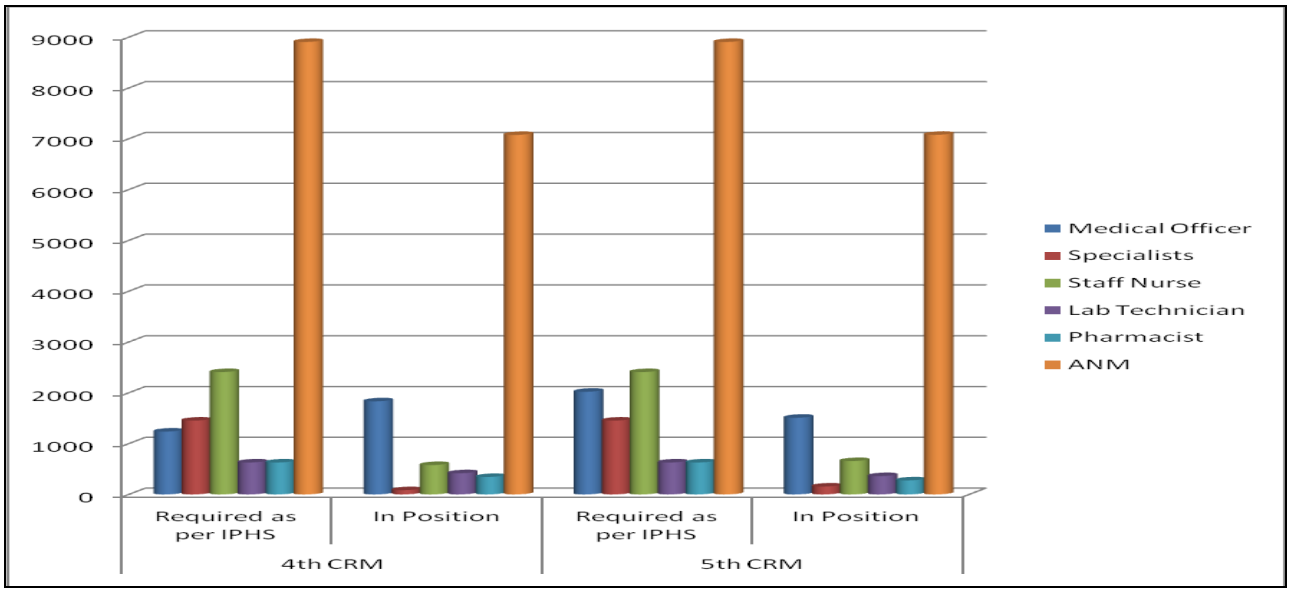
Health Human Resources

There is overall shortage of skilled human resources and difficulties in retaining them especially for hard to reach areas. Highest percentages of vacancies are noted in the posts of specialists. There is a huge attrition of contractual doctors. While Human Resources are inadequate with respect to the sanctioned posts, those available are not being used effectively. There is irrational deployment of doctors, and great need to improve the fit between Specialists posted and patient load, including Staff Nurses.

The status of Human Resource in the state presents a grim picture. If the current number is gauged on the IPHS standards, the shortage is to the extent of 1751 staff nurses, 1297 specialist, 512 Allopathic doctors and 353 pharmacists . Amongst the field staff 1904 MPW Male, 1828 ANMs, 188 Lab technicians and 955 AYUSH Paramedics are required

Comparative analysis of the Change in Human Resources over the year

HR positions	**4th CRM**			**5th CRM**		
	Required as per IPHS	Sanctioned	In Position	Required as per IPHS	Sanctioned	In Position
Medical Officer	1237		1833	2021	1870	1509
Specialists	1453		84	1453	84	**156**
Staff Nurse	2408		578	2408	304	657
Lab Technician	629		417	629	446	361
Pharmacist	629		344	629	501	276
ANM	8906		7076	8906	4666	7078



Comparative analysis of the change in HR status between 4th & 5th CRM

The state has acute shortage of Human resources in Health sector. The HR is, concentrated mostly in the urban centres. Moreover the situation is complicated by a high attrition rate of the technical HR. The Specialist positions available in the state are remarkably low as compared to the required number. The turnout rates for vacancies of doctors and specialists are also not encouraging. This situation can be attributed to a number of factors such as sluggish economic growth, poor residential facilities, difficult accessibility of facilities, low motivation levels, security issues, and above all improper cadre management . This was well evident in the districts visited by the team.

Giridih

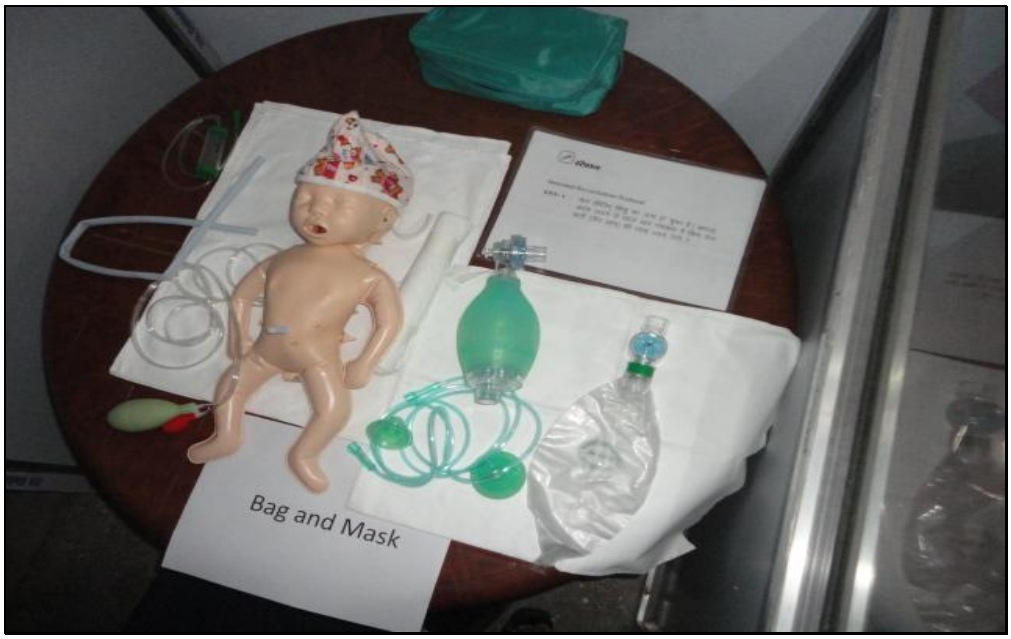
The HR status in the district Giridih is even worse than the Deoghar. The district is affected with Naxalism and is the most important reason for attrition.

54.4% post of doctors, 97.6 % of specialists 71.1 %, Staff Nurses 31.7, 31.7 % MPW and 23.8 % ANM post are vacant in the district.

Human Resources in management unit in the district is another gray area where more efforts are required. Only two staff in management unit at block level are recruited (Block Account Manager and Block Programme Manager) .There is no Data manager or a person dedicated for

data management. Presently Block Account Manager has dual responsibility of account management and data management. This is affecting the quality of work in both the areas. The financial powers of upgraded PHCs are still with MO/IC of CHCs .(PHC Sahiyya's financial powers with MO/IC of CHC Bagodhar).

There is an acute shortage of staff in ANMTC of Giridih. Having only two tutors Giridih ANMTC. This ANM training centre was closed since past 1 year which has recently started. 60 students per year is the total intake of this training centre. This 'Skill Lab' which an innovation at district level helps the trainee ANMs , ANMs and Nursing staffs to update their knowledge, micro conceptions and acquire better skills. This is proving to enhance their confidence level.The training status furnished by the district shows 65 % of ANMs and 55 % of Nurses are SBA trained. Only one doctor is EmOC trained in district. One Doctor is LSAS trained in district. Only 2 personnel are trained in FMNCI. Considering the work load the district needs more trained Doctors in EmoC and FMNCI. There is no plan of post training evaluation in the district.



Giridih ANMTC: ***Skills Lab – one of the 20 stations for training***

The posting of trained health staff in appropriate facilities are still matter of concern for the district. Few month back District authority tried for rational posting of ANM but there were resistance by ANMs. This problem needs to be addressed at State level.

Current HR Status

Category	Requirement as IPHS	In Positioned
Doctors(Allopathic)	114	52
Ayush Doctors	42	03
Specialists	42	01
Paramedics OT assent	13	0
Staff Nurses	90	26
MPW	180	123
ANM	390	297

Deoghar

Current HR Status

Category	Requirement as IPHS	In Positioned
Doctors(Allopathic)	75	57
Ayush Doctors	12	3
Specialists	84	8
Staff Nurses	279	25
MPW	186	67
ANM	373	315

In district Deoghar, the shortage of specialists like Obstetricians and Anaesthetists are obstructing the district plans to operationalise CHC as First Referral Units. The process of recruitment of Medical officers and paramedics is lengthy and takes about four to six months. There are only 2 X-ray technicians in the districts. There is frequent change of Data Manager at District level which effects the management Data and regular flow of HMIS. All the records

from the SCs are sent to PHC for uploading which takes more than one week. This limits the record keeping and maintenance at the SC.

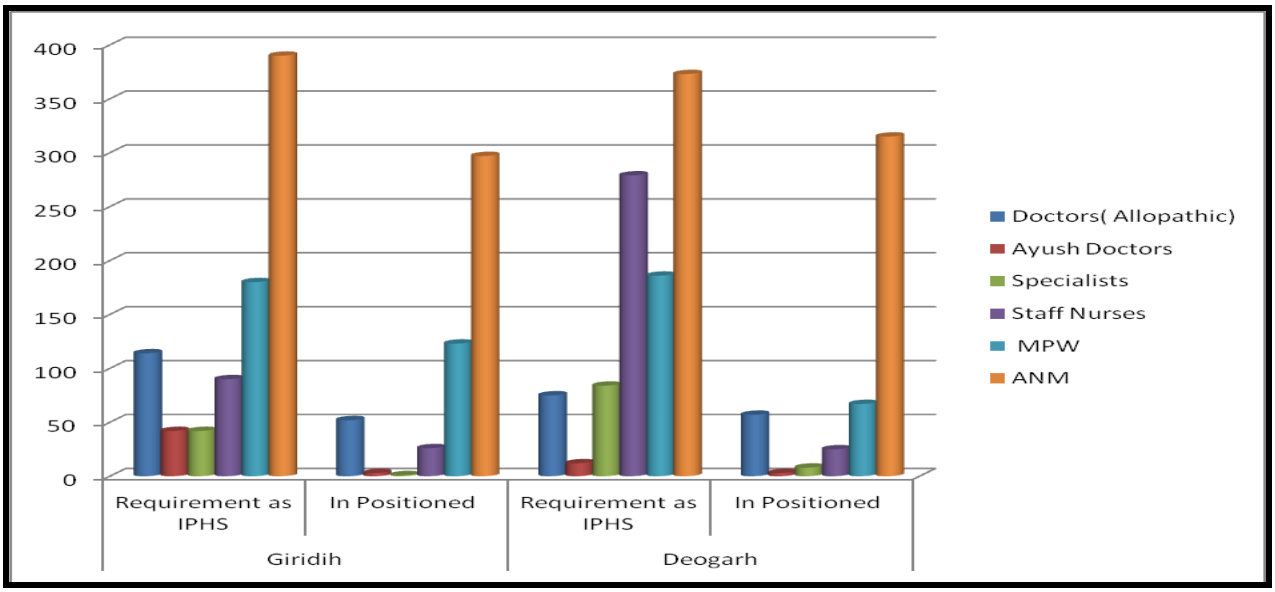
One of the reasons for low motivation levels is that although the APHCs have upgraded as PHCs but still the financial and controlling authority lies with CHC in charge or DMS under which the PHC comes (PHC Budhai, Block Madhupur). Most of the PHCs have only one MO which is limiting the supportive supervision role of the MOs as evident in the PHC Madhupur and CHC Manoharpur. There is variation of salary structures of contractual staff placed at Deoghar compare to the staff at Ranchi.

The underutilization of the deficient HR is another issue needs attention. The staff especially lab technicians at the facilities are underutilized. The Lab technicians appointed under programmes such as NVBDCP and RNTCP are performing tests required under their respective programmes. The other essential tests which are supposed to be done are not performed in the facilities. There are facilities having surplus (3-4) lab technicians, still the number as well as range of tests carried out being done are marginally low. Some of the blocks in Deoghar District have surplus ANMS while some blocks have inadequate numbers of ANMs.

The training plan of the district reflected that there is no induction training of DPM and BPM. The district did not have a training calendar/plan in place. The position of DPM was vacant for last three years; the new DPM has joined 20 days back. DPM has not received any induction or orientation on NRHM including TOR for her roles and responsibilities till date. All the SN in CHC & SDH, who are currently conducting deliveries have not received SBA training. The SBA trainings of ANMs are good and rely on hands on training and refreshers which are being conducted in nearby health facilities. The MOs placed at the PHC and CHC have not undergone EmOC training and LSAS training. There is no training calendar at the District level. IMNCI trainings have been conducted for MOs, ANMs and AWW. None of the MOs trained in BEmoC, CEmoC Minilap, NSV and laparoscopy, MTP, NSV, and ARSH.

SBA training conducted by Vistar, USAID is on track. ASHAs have undergone training on Module 5B on Nutrition and Disease. One of the MO/IC CHC Karon is undergoing EMoC training at Ranchi. The District is following the GoI guidelines for SBA training.

ANMTC: It is situated in old civil surgeon office having 2 faculties and one principal, residential training school has 6 rooms. In the hostel there are 14 rooms for accommodation. Currently 60 ANMs are undergoing training. ANMTC is equipped with TV, DVD and other training Aids like flip charts and model.



Comparative analysis of HR status in Giridih & Deoghar districts

Recommendations:

- Lab technicians should be provided integrated training for all the essential diagnostic tests rather than just programme specific tests.
- Proper mapping and rational deployment of ANMs is required.
- The ANMs should share carbon copies of data instead of sending registers to Block PHC for data entry (HMIS).
- The District should explore for PPP to augment RCH services
- The District should establish nursing college to augment the Staff Nurses status at the District level.

- The sanctioned position of X-ray technician to be increased.
- District should have a clear cut training plan on BEmoC, CEmoC, MTP, NXV, IUD, Minilap etc. with post training follow up and monitoring.
- District should have induction training program for DPMU staff.
- Impact assessment of MOs trained should to be done by Civil Surgeon.
- Rational deployment of trained staff at the facilities should be done by State.

Health Care Service Delivery- facility based- quantity and quality

The health care services delivery presents a progressive trend in the State particularly during NRHM phase. The number of OPD & IPD cases have steadily increased.

There is an increasing trend in the number of OPD cases (13.1% in 2006-07 to 27.4% in 2010-11 including safe abortions and MTPs

Similarly the IPD cases has increased over the years (From 4.8% in 2006-07 to 11.1% in 2010-11). The trend of C- sections at public health facilities is limited to 2-3 % of total number of deliveries..At the district level RTI /STI case diagnosis is multiplying fast as 24 RTI/STI clinics exits in the state this reflects the increase in the demand for services in general but largely depends upon the facility specific factors. There are facilities showing remarkable increase in the case loads whereas some of them showing decline in the performance levels. The observation by team members are prominent factors responsible for such a differential is the motivation & efficiency of the facility in charge.

Years	Total Annual OPD in the State	Percentage increase of OPD over previous year	Total annual In-Patient admissions in the State	Percentage increase of IPD over previous year
2005-06	**4090644**	**-**	**265266**	**-**
2006-07	**4628342**	**13.1**	**278067**	**4.8**
2007-08	**5442304**	**17.5**	**300244**	**7.9**
2008-09	**6656808**	**22.3**	**330821**	**10.1**
2009-10	**8248853**	**23.9**	**367180**	**10.9**
2010-11	**10506760**	**27.4**	**408148**	**11.1**

The emergency services across the state register a very minimal presence. Presence of Emergency Trauma centers at the district head quarters is need of the hour. The new initiative of the state for maternity referrals in the name of ***Mamta Vahan*** is an appreciable step. The response from the public is also encouraging. The scheme requires further strengthening in terms of technical and back-up support.

The current status of emergency referrals and maternity cases referrals is as follows.

Emergency Care Arrangement

Emergency and Referral Transport Services	
No. of Emergency Transport Services Vehicles and types	**167 Govt. Ambulances**
Referral Transport (Mamta Vahan) stared since July 2011	
No. of Mamta Vahan Operating	**1822 through PPP till date**
No. of Mamta Vahan Beneficiaries	**10890**
Average response time of the vehicle	**30 minutes to 1 hr**

The available diagnostic services in the facilities have provision for limited tests. Although the number of lab technicians present in the facilities is reasonably better as compared to other services, still the case load and the number of tests are minimally low. Essential hematological and pathological tests are not performed. ECG and ultra-sonography services were rarely witnessed across the state. The status of diagnostic services and laboratory facilities in the district needs attention and strengthening.

Pathology lab: ***Underutilized Resources***

Giridih

The number of sanctioned beds at Giridih District Hospital is 180 whereas functional beds are 120 and the bed occupancy was only 20%. There are 2 FRUs in Giridih District. At other hospitals out of two FRUs with bed strength of 30 each only one is functional whilst the one at Dumri is not functional. There are 15 PHCs in Giridih District .This PHCs are 6 bedded. Among these none of the PHCs are functional. Hence out of 384 sanctioned beds in the district 204 are functional. Total Population of the district is 24.45 lakhs hence the bed population ratio is as follows:-

- **Sanctioned bed per 1000 population 0.15**
- **Functional Bed per 1000 population 0.083**

The bed occupancy rate of district hospital is 34% for the preceding year and during the visits other facilities with bed showed a similar and rather a lower trend.

The number of OPD patients in Giridih district has shown a distinct decline of 30% (Source: as per the state authority) and that at Giridih District Hospital is over 31.4 % . In

Giridih district hospital itself the OPD patients show over 30% decline during the year 2010-11. At Giridih district hospital the increase in institutional deliveries is 13.4%.

The emergency services need augmentation in terms of a separate department as the present Emergency is not operational round the clock and it is operated from the dressers room in the OPD area and space adjacent to office of DS.

At Pirtand PHC, a notice mentions that the emergency operates from 3 pm to 9 am but it is non operational due to availability of only one doctor at the facility who does not reside in the vicinity of the PHC.

Laboratory and Diagnostic Services at district are basic. Ultrasound machine at District Hospital is not working since last eight months. Whilst AERB clearance has been applied for lead aprons and TLD badges are not in use at Radiology department of District Hospital. Use of Personnel Protective Equipments by laboratory personnel was not evident.

The essential Drug list was available at most of the facilities visited however the availability of the drug was to the extent of 50% and at some PHCs and HSCs where delivery is conducted the attendants have to buy their own medicines and gloves etc. increasing the out of pocket expenditure of the beneficiaries. Essential drug list booklet and the standard treatment guidelines issued by the state in the year 2004 were not available of any of the facilities visited. There is no evidence of measures taken to ensure rational use of drugs.

Ancillary services like laundry, diet, sanitation and housekeeping are carried out without clear cut objectives and there is no institutional mechanism to monitor the same. However Check-sheets at district hospital for cleaning of toilets were available. Availability of drinking water was there at district hospital and upto PHCs however many of the labour rooms did not have the facility of toilets.

Running water and power were predominantly absent at the sub centers although power lines were available in the area near the facility.

Management of Bio-medical Waste across the state as well as Giridih District hospital is either nonexistent or in early state of operation. The district hospital does have an incinerator which is

not operational due to technical reasons and efforts are being made to start its operations. The other issues are lack of adequate bins, Training of personnel involved in outsourced segregation, Intramural transport carrier, Puncture proof boxes, Non standard deep burial pits, Liners and disinfectant, Maintenance services are outsourced in piecemeal fashion. e.g the outside cleaning of the District hospital is done by the own staff whereas inside cleaning is done by outsourced party. Patient related information in the hospital -Citizen Charter was visible only at the district hospital.

Privacy of patients is compromised in absence of curtains. Giridih District hospital has a formal close loop complaint management system in place, whereas no such provision at other peripheral level facilities.

The RKS meetings are not held regularly. PRI Participation is variable. The utilization of RKS funds, untied fund is at the level of 50%. The state had undertaken 3 hospitals for ISO certification beside 1 which stands certified but its functioning is not upto the desired level due to shortage of human resources and facilities. 7 DH have undertaken family friendly Hospital Initiative. Whilst the state have a formal quality assurance cell the district level quality assurance cell .No meeting of district level and state level monitoring cell has taken place .

Records of patient and beneficiary have scope for improvement. The bed occupancy across the facilities in the district is 25 to 50 %. Predominantly the beds are occupied by delivery cases .Drugs availability is 50 to 70% of essential drug List. Generic Drugs were available at all the facilities. In the PHC/CHC there was a display board depicting the medicines.

Deoghar

Three CHCs in the district Sarwan, Sarath and Karon have a high case load of OPD and IPD. All the 3CHCs conduct more than 1000 deliveries annually. There is a steady increase in the number of deliveries (CHC Sarwan) from 57 deliveries in 2004 to 1060 in 2011. The MO I/c of these three CHCs are quite motivated and ensure that the CHCs provide a wide range of RCH services. However most of CHCs in the district are not providing safe abortion services. The CHC/SDH designated as FRU Madhupur does not perform the FRU functions as there is no gynaecologist in the facility. No LSCS are performed at FRU.

Even though the OPD of District hospital is 1, 23,297 in a year, the In-patient load is very low 19, 453 in a year. There is no pediatric ward and SNCU. The average number of C-Section done in the DH is less than 3 per month. It was observed that some of Sahiyyas are directly referring Obstetric cases to Private facilities for C-Sections. Similarly despite having 2 pediatricians & a Sick new born unit at the DH, patients are referred to the private clinics. .

In most of the facilities little emphasis is given on Family Planning methods. There has been reduction in the number of NSV & tubectomy conducted in the district. There is poor distribution of OCPs and condoms by ANMs. IUD insertions are significantly low at all the facilities in the district.

There is limited data available on RTI/STI treatment at the facilities. The Syndromic Management Approach is adopted by all the facilities.

The ILRs and Deep freezers are functioning well in all the facilities visited by the team. Temperature is maintained and regularly monitored by MO. Two backup generators are present in the facilities. Vaccinations are available as per prescription. Phototherapy unit is not functional.

The labour room was neat and tidy with attached toilet and water supply. Standard Protocols displayed in the labour rooms, Partograph are practiced at sub centres but not filled in accurately. ANMs doing deliveries have undergone SBA training; however the SN had not received SBA training. There was no emergency drug tray available in the labour room. The ANMs are not filling the ANC data meticulously which is leading to data insufficiency and inaccuracy.

ORS and IFA are available at the facilities while Zinc tablets were not available. Chloroquine was exhausted. Labs are functioning reasonably well but the tests are limited to Hb and urine only besides Malaria (per day 40 slides including periphery) and TB exclusively. Leprosy drugs were adequate at the facilities.

ARSH clinics in DH are still in evolving stage. No RKS records visible at the facilities even the list of RKS members to be displayed at the facility was missing.

The Mamta Vahan Scheme is getting a very encouraging response from the community. The initiative needs further strengthening and support from the State. There are few pockets in the district where the number of empanelled vehicles under the scheme was substantially low. The documental and administrative procedures for registration are creating impedances in empanelment of the vehicles.

Deoghar DH: Male Ward

It was very nice to find new bedsheets, mackintosh, trays, equipment, curtains, paintwork , printing on walls etc in almost all the facilities visited in these two districts but at the same time little surprising, too. The local resident beneficiaries and media people informed that the present scenario was only temporary and was done a few days before the arrival of the CRM Team and requested to have central Team Visit every three months.

Recommendations:

- The quality of ANC provided by ANMs need to be improved. ANMs should be mandated to check BP and Hb levels of all registered ANCs.
- The Staff Nurse placed at the health facilities to be provided with SBA trainings.
- The RKS meeting to be conducted regularly with proper documentation and action taken reports.

- Training of ANMs should be conducted for maintaining registers and entering accurate data(HMIS).
- All MO/ICs to undergo EmOC training.
- Calcium supplementation to be provided to all registered pregnant women to prevent Pregnancy induced Hypertension (PIH).

Outreach services

The state has 96 functional MMUs (Mobile Medical Units) and over 13.7 lakhs beneficiaries which includes 1.10 lakhs from Giridih District utilised the services. In the current year within six months over 26.7 lakhs patients have been benefited which includes over 61000 from Giridih district. The state has 167 Govt. Ambulances (Giridih 7) and 822 Mamta Vahans (Giridih -85).

Mobile Medical Units (MMUs)	
No. of Mobile Medical Units	**103**
No. of Functional Mobile Medical Units till date	**96**
Number of patients examined at these MMUs	**13,77,193 In 2010-11**
	26,79,685 In 2011-12

All the Sub Centres visited by the team are performing well in outreach work, immunization services and conducting safe deliveries. More than 50% of SC are conducting deliveries. Each of the SC has developed micro plans for immunizations and VHND.

Deoghar VHND site: *Blooming Buds*

ANMS coordinate well with ASHA/Sahiyya and AWW. There is exemplary interdepartmental convergence for the VHNDs and immunization. The tickler bags are kept at the AWCs. The MMUs are functioning well in the district in partnership with NGOs. On an average 150 cases are treated on monthly basis.

AWC Palojori, Deoghar: ***Community Support***

Recommendation

1. 23 vacant posts of MPWs to be filled at the earliest to enhance the outreach services.

ASHA Program

ASHA is known as Sahhiya meaning 'friend' or 'companion' in Jharkhand. The NGO facilitated the selection of Sahhiyas who were selected prior to Panchayat election in Jharkhand. As a result PRIs were not involved in the selection of Sahhiyas. There were about 40964 Sahhiyas selected and most of them were trained in Module 5B. However, only about 3/5th of Sahiyyas were found to be active (in Giridih particularly). The major activities in which Sahiyyas are involved are JSY, RI, FP, Malaria, DOTS, referral of malnutrition children to MTC/MTEC. Some of the reasons for the non-existence of Sahhiyas were that they were not selected in some villages, while in others many of them got elected as PRI members in the local body election held later and left the job. On an average incentive received by active Sahiyya was about Rs.2000 per month. Sahiyya is supported by Village committee Sahiyya Resource Centre (VSRC) at the state level. On the other hand, at village level about 15 Sahiyyas are supported by a Sahiyya Sathi.

There is Block Training Team (BTT) consisting of 4 BTTs per block and State Training Team (STT) consisting of 2 STTs at state level to assist, supervise and train Sahhiyas. As a good practice we found that the state has created a Sahhiya Help Desk at the district hospitals to redress the grievances of the Sahhiyas. The state has also created Village Committee Sahhiya Resource Centre (VSRC) in 2007-2008 and all trainings subsequently were given by VSRC. Before 2007-08, the training of Sahhyias was undertaken though NGOs.

Most of the ASHA were provided drug kits in the first instance but there was no refilling and replacement of kits later on. This has hindered the good work of Sahhiyas. Sahhiyas were found doing work in assisting institutional deliveries particularly escorting the pregnant women to the health facility and arranging transport. They are also helping the mobilization of the children for immunization at the VHNDs and working as DOTs providers. However, Sahhiyas were hardly involved in family planning activities.

At the community level many Sahhiyas have earned goodwill and respect in the community and have been a source of help and strength to the expected mothers. However, many of them reported that they are not getting their incentive money on time.

Deoghar

There are 2900 Sahiyya in the district across 2358 villages. Initially Sahiyya were selected by the NGOs, however recently selection has been made by the PRI and community members. All the Sahiyya have been trained till 5th A Module and training on 5th B Module is going on in the district. About 20% of selected Sahiyya are inactive in Deoghar district. Sahiyya help desk at DH is effective. Sahiyya kits have been partially distributed and not replenished till date. Some of the Sahiyya have been provided with OCPs and condoms for distribution at the community level under social marketing project. However they have not been trained in contraceptive counseling. Main emphasis of Sahiyya is on routine immunization. There has been delay in payment of incentives at many places.

Deoghar DH Sahiyya Help Desk: ***Extending the helping hand***

Districts	Number of ASHA required	Number of ASHA Selected	Number of ASHAs dropped out	Number of ASHAs in place	Number of ASHA trained up to following Modules till date			Number of ASHAs with drug kits
					5th	6th	7th	
	40964	40964	3%	40964 (Reselection of drop out ASHA)	5th - 39000 5B - (31312)	DRP Training initiated & roll out in process		36659

Giridih

There are 2502 Sahiyyas in the district. The support structure consists of 134 sahiyya saathi, 48 BTT and 2 STT. Only about 3/5th of Sahiyyas were found to be active (in Giridih particularly). In the field visit of Giridih district, in many villages Sahhiyas were not present. Some of the reasons for the non-existence of Sahhiyas was that they were not selected in some of the villages, while in others many of them got elected as PRI members in the local body election held later and left the job. Rewards and recognition system for Sahiyya has been initiated in the district. Block level training on Menstrual Hygiene Scheme has been completed.

Recommendations

- The selection criteria for Sahiyya should be made stringent and consensus of community should also be taken.
- Timely payments should be made to the Sahiyya to increase their motivational level.
- Grievance redressal mechanisms for Sahiyya to be put in place.
- Sahiyyas to be motivated to take up the activities such as FP and new initiative of the Government such as Menstrual Hygiene Scheme, Social Marketing of Contraceptives scheme.

RCH II (Maternal Health, Child Health & Family Planning Activities)

Indicators	2010-11	2011-12 (Upto 30th Sept) / yearly target
ANC (%) registration of estimated pregnancies	80.8	41.6
Institutional deliveries (%) of estimated deliveries	36.4	18.6
% of institutional deliveries hospital stay of > 48 hrs	16.8	9.9
% of delivery conducting institutions having a Newborn Care Corner	-	-
No. of districts with at least 1 neonatal intensive care unit	-	-
% of post natal mothers with post natal follow-up	70.2	85.1
% of children (12-23 months) with complete immunisation	70.2	41.9
C-section rate	1.34	3.76

The RCH services have improved over last year in terms of the institutional deliveries from 1.59 lakhs in 2010-11 to 1.68 lakhs in 2011-12 (Oct 2011). ANC registration of the estimated pregnancies was about 80% percent in last year and is up to 41 % in the current year (till Sept.2011) which indicates that the achievement rate has not improved significantly. The post partum stay for more than 48 hrs in the hospital has not shown improvement in this year also which is 9.9% of the total institutional deliveries till Sept'11. (Last year-16.8%). There is an improvement in cases of C-Section in the current year which has increased from 1.34% to 3.76% till Sept'11. The tertiary care services for neonates are virtually absent in the state. At present there are only 1NBSU and 2 SNSCU in the state. Even the new born corners have been rarely seen. Although the state has launched the JSSK in all 24 districts, most of the facilities do not ensure the provisions under the scheme. Mamta Vahan scheme has been launched recently to fill in the long felt need of a referral system in the state. The scheme has recieved a lot of appreciation. Most ANMs conducting deliveries are SBA trained. The SBA training across the state has been conducted by UNICEF and USAID/Vistaar Project. JHPIEGO/MChip of USAID has started a well maintained Skills Lab at Giridih DH with all technical and manpower support.

Giridih, Pirtand PHC New Born Corner: ***a rare site in the state***

Parameter	Expected Outcome	Outcome of the Mission in the State
Maternal Mortality Ratio	100 per 100,000 live births	400 per 100,000 live births in 2001 (SRS) 371per 100,000 live births in 2006 (SRS) 261 per 100,000 live births in 2011 (SRS)
Infant Mortality Rate	30 per1000 live births	72 per 1000 live births in 2001 (SRS) 49 per 1000 live births in 2006 (SRS) 41 per1000 live births 2011 (AHS)
Total Fertility Rate	2.1	3.2 in 2009

Malaria Mortality Reduction Rate	60% by 2012	58 % in 2010
Kala Azar Mortality Reduction Rate	100% by 2010 and elimination by 2012	55 % in 2010
Dengue Mortality Reduction Rate	50% by 2010 and sustaining that level until 2012	100 % in 2010
Cataract operations	Increasing to 4.6 Million	4.25 lakhs (22568 Cataract Operations done till Sept. 2011 in the FY 2011-12)
Leprosy Prevalence Rate	Reduce from 1.8 per 10000 in 2005 to less than 1 per 10000 thereafter	1.4 in 2006-07 0.98 in 2009-10 0.65 in 2010-11
Tuberculosis	Maintain 85% cure rate through entire mission period and also sustain planned case detection rate.	Achieved the twin objectives since last 2 years

Deoghar

The maintenance of labour room was satisfactory in most of the facilities visited. No MDR (Maternal Death Review) Committee has been set up in the district. There is one blood bank at District Hospital. There is no blood storage facility at CHC/FRUs. There has been no EMOC and CEMOC training for the MOs. The safe abortion services are nonexistent in the district. ARSH services are not visible across the facilities in the district.

Most of the health facilities in the district are lacking in terms of New Born Care Corners. There is no SNCU facility at the DH also. The protocol on new born resuscitation was not displayed at the facilities. There has been problem in procurement of Radiant Warmers. Phototherapy units were not functioning in most of the facilities. NSSK training has not been carried out at the

District level. IMNCI training has been conducted for MOs and ANMs. School health programme activities were not visible at the district level.

Across the facilities visited it was found that the approach towards the family planning services is seasonal and target oriented activity. There has been reduction in the number of NSV, tubectomy conducted in the district. There is poor distribution of OCPs and condoms by ANMs. IUD insertions are significantly low at all the facilities in the district.

The response to the Mamta Vahan which has been introduced as part of JSSK is good and institutional delivery is already showing a remarkable increase. The Mamta Vahan Call Centre has been established at the District Hospital and is getting significant number of calls. It was reported that 80% of the calls have been translated into free transportation of pregnant women to the health facility in Deoghar. A complaint box at the facility and a toll free complaint number for grievance redressal is in place for improving service delivery.

Giridih

Jamua CHC Giridih*: Institutional Delivery* - despite infrastructure deficiencies & no power supply

Recommendations:

- The quality of ANC provided by ANMs needs to be improved. ANMs should be mandated to check BP and Hb levels of all registered ANCs.
- All MO/ICs undergo BEmOC and CEmOC training.
- Maternal Death Review Committee to be set up at the District level.
- New born care facilities to be introduced across all health facilities where deliveries are taking place.
- At least one SNCU to be operationalised at the District level.
- NSSK training to be prioritised for the MOs, ANMs and SNs.
- IEC/BCC activities to be strengthened for creating demand for OCP, ECs and condoms.

Preventive & Promotive Health Services including Nutrition and Inter-Sectoral Convergence

The state exhibits a good example of inter sectoral convergence in the form of the services provided through Aganwadis where ANM provides immunization and maternal health check-ups. The distribution of 'Take Home Ration' (THR) has been staggered in last few months. Supplementary Nutrition is not provided at any AWCs visited since September- October 2011. Adolescent Girls are given IFA tablets once per week. The Village Health Nutrition & Sanitation Centre requires better involvement of PRI members. The awareness level among the PRI members regarding the functions and responsibilities of the VHSNCs is poor in the districts visited. This can partly be attributed to the recent formation of the Panchayat Committees in the state. The state has increased the number of Malnutrition Treatment Centres from 58 in 2010-11 to 65 in 2011-12. Every district hospital has MTC, however large number of severely underweight children in the district, number of admissions of such children were poor. Therefore, facilities available at MTCs need to be popularized and promoted in the community.

Malnutrition treatment Centre – Deoghar : *Poor Number of Admissions*

However, the MTC at Giridih district was exemplary in services and service delivery by the trained staff. The No. of admissions was low, which needs strong IEC & advocacy

State Government has launched Vitamin-A supplementation for children between 9 months to 5 years and conducted massive campaign in the months of February and September. State laboratory for NIDDCP had not been established. Five persons for State laboratory were recruited but did not join/continued due to lack of availability of funds. Funds of Rs. 18 lakh approved and released by MoHFW, Government of India in 2008-09 had been revalidated and in the process of getting State approval for IDD programme.

Mother and Child Protection Cards (MCPC) were not available in any of the villages visited in Giridih except in one village where 10 MCPCs were provided. On a sample check in this village, it was seen that one lactating mother had the MCPC. However, one part of MCPC is being retained by ANM. ANMs also need orientation for proper filling up of MCPC. There was no health check up for school children and AWCs. The team observed cases of new born babies not breastfed within 2 hours of delivery and also witnessed cases of bathing new born babies NGO involvement for malnutrition programme in Giridih was negligible, however MTC in Giridih district is functioning well. Staff has requisite knowledge, understanding and skill for rehabilitation of severely mal nourished children. There were AWWs aware of MTCs and referring children for treatment to MTCs. follow-up services of MTCs is weak. Keeping this in view, the state has launched financial incentive scheme to promote post follow-up. Salt testing kits were not available and henceforth not in use in VHND. All Civil Surgeons in the state were trained in February 2010 on salt testing. Similarly all Sahiyas were also trained and were to be supplied 10 salt testing kits supplied by MHFW, GOI. However, these kits were not supplied to Sahiyya as expiry date for these kits was January 2011. From sample testing of salt in villages visited, it was observed that around 60 per cent of households were using iodised salt. PRI members are not actively participating in NRHM programme. District IDD survey proposed to be done in 2-3 months. There is inordinate delay in JSY payment to beneficiaries (Since September 2011).

- Community reported that mostly doctors were not available in working hours in health facilities and gave priority to their private practice.
- PRI members were not actively participating in NRHM programme
- Community also reported that health functionaries demand money for providing services from Government health facilities.
- VHSNC notification process initiated.

Recommendation

- The take home ration (THR) supply should be ensured through inter-department coordination by the state and district authorities.
- The use of salt testing during VHNDs should be ensured along with consistent supply of salt testing kits.
- Ensuring better cooperation from the Women & Child development Department for support to the mal nourished children admitted in the MTCs.
- The new nomenclature of Village Health Nutrition Sanitation Committee (VHNSC) to be universally implemented with its status as a subcommittee of Gram Panchayat.
- Special focus of School Health Programme is required.

Gender issues & PCPNDT

There are 58 registered USG centers in the public sector in the state. State PCPNDT cell is the authority responsible for implementation of Act. Monitoring of the implementation is done by state inspection and monitoring committee.However, in the district Deoghar there is no evidence of districts enforcing PC&PNDT Act or undertaking advocacy against sex determination. District doesn't have monitoring/inspection protocols for USG clinics. No training workshops have been conducted on the PCPNDT Act. The display board is not as per guidelines of PC&PNDT Act

There is no privacy provided to the pregnant women during ANC examination at some of the SCs. Conduct of Maternal Death Review is inconsistent and unrelated to instilling accountability.

Recommendation

1. There is need for IEC on PC& PNDT Act services
2. The districts should have a dedicated PNDT cell.

National Disease Control Programmes

STATE

Malaria

- All 24 districts of the state are malaria endemic. All districts are highly affected by malaria except , district Jamtar, Koderma and Deoghar
- State has achieved target for malaria mortality reduction to 58% in 2010 against the target of 60% in 2012 taking base line of 2005.
- Surveillance has improved as Annual Blood Examination Rate (ABER) has been scaled up from 7.12 in 2006 to 10.51 in 2010. It is attributed mainly to use of Rapid Diagnostic Test (RDT) and deployment of contractual Male MPW supported by GoI under NVBDCP.
- Due to improved surveillance and better case detection, there was increase in cases during 2008 and 2009 and thereafter it showed decline during 2010 and further decline in 2011.
- Plasmodium falciparum which may lead complication and deaths contributes about 40% of total malaria cases. Deaths due to malaria have been also declined in 2010 to 16 from 28 in 2009. During 2011 up to Sept 7 deaths have been reported as compared to 8 during the comparative period of 2010.
- Sate action plan and PIP is prepared based on districts action plan and district PIP
- Under vector control activities high risk population are identified and spray is being done by involving VHNSC Since 2009. But the coverage after involvement of VHNSC has decreased as low as 30% against the minimum desired level of 805%.
- There 3958 sub-centres but only 1463 posts of surveillance workers have been sanctioned of which only 248 are in position. Out of 2304 contractual male MPW sanction by GoI under NVBDCP only 1889 have been filled up. The support from GoI is only for XI plan. It should be taken seriously or surveillance will collapse.
- State has inadequate anti-malarials stocks as decentralized items have not been procured

- There is also shortage of RDT and ACT. The 25% of total requirement of RDT and ACT were to be procured by the states for bridging gap, through NRHM additionality, same has not been procured.
- The Microscopy centers are at block PHC level, which covers on an average 1.6 lac population against the norms of maximum 30,000 for one microscopy centre. A total of 197 LT posts sanctioned only 44 are in position. There are 52 posts of Contractual LTs sanctioned of which 16 are in position. It indicates that there are huge gaps in requirement and sanctioned position of LTs.
- Out of 40,964 ASHAs 26,000 are trained in Malaria in diagnosis and treatment. In high endemic inaccessible areas ASHAs are equipped with RDT , ACT and other antimalarials
- The allocated budget to the programme being released in time through JRHMS .During 2011 funds under NRHM additionality have not been released to the programme.
- Malaria situation in the Sate during 2006 to 2011 is as under

Year	Blood Slid Examined (in lac)	Total Positive Case	Pf. Cases	Pf. Proportion (%)	Annual Blood Examination Rate (ABER)	Annual Parasite Incidence(API)	Death due to Malaria
2005	28.60	200804	53030	26.41	10.13	7.11	38
2006	20.95	193888	48388	24.96	7.12	6.69	4
2007	20.00	184878	45926	24.84	6.68	6.17	31
2008	25.48	214269	73531	34.32	8.29	6.97	25
2009	33.47	230686	91194	39.53	10.64	7.3	28
2010	33.83	199842	89357	44.71	10.51	6.21	16
Up to Sept 2011	24.16	101245	38288				7

Kala-azar

- Only four districts Dumka, Godda, Sahabganj and Pakur are endemic for Kalazar
- Due to inexpension of use of RK 39 rapid diagnostic test kits, and deployment and involvement of contractual MPW the case detection has increased.
- ASHAs are involved in detection and referral of suspected cases to the diagnostic centers and treatment of confirm cases by providing incentives.
- For vector control indoor residual spray is being carried out by involving VHNSC.
- The status of Kala-azar situation is given below.

Year	Cases detected	Cases Treated	% Treated	Death
2005	5989	5978	99.82	11
2006	7508	7489	99.75	11
2007	4803	4779	99.50	20
2008	3689	3679	99.73	5
2009	2875	2855	99.30	12
2010	4305	4288	99.61	5
Up to Sept 2011	4738	3744	79.02	3

Lymphatic Filariasis

- 17 Districts are endemic for filaria and being covered under filariasis elimination programme.
- Annual Mass Drug Administration (MDA) is done by preparing District action Plan.
- Annual MDA for filarial elimination programme is being carried out since 2004 but ASHAs are being involved since 2006 in MDA
- A total of 95885 lyphoedema and 37580 hydrocele cases have been line listed.
- A total of 5707 hydrocele cases have been operated.
- Coverage of MDA has been ranging from 70% to 89% since 2005.

- Out of 17 MDA districts 12 districts have already achieved micro filarial rate of less than 1 which is criteria for elimination

Dengue and Chikunguniya

- Dengue has been reported in the State during 2011. The total of 17 confirmed cases have been reported from 6 districts namely Ranchi, E. Singhbhum, W. Singhbhum, Chatra, Dhanbad and Garhwa.
- 341 Lab. Confirmed Chikunguniya cases have been reported from 7 districts namely Ranchi, E. Singhbhum, W. Singhbum, Saraikela, Latehar, Dhanbad and Garhwa for the its time during 2011.
- 3 Sentinel Surveillance hospitals have been identified and functional.
- There need to be kepp visil and community should be mobilized for early reporting of cases to the health system.

Japanese Encephalitis

- Till 2010 only sporadic cases of JE were reported in the state but during 2011 a total of 46 confirmed cases from 12 distrcts have been reported. There were 5 deaths due to JE. Most affected districts are Chatra, Hazaribagh, Palamu and Ranchi.
- This disease has high case fatality rate. Effective preventive and control measures need to be taken State should plan for vaccination programme in the affected districts.
- 3 Sentinel Surveillance hospitals have been identified but the sentinel surveillance hospital PMCH Dhanand should be made functional.

Information with regard to checklist pertaining to Vector Borne Diseases

- **Surveillance** for malaria is being carried out through both male and female worker as well as ASHAs. For Kala Azar surveillance quarterly fortnight survey for active case search are being carried and suspected cases are being referred by ASHAs, MPWs to the detection centre on regular basis. For Dengue, Chikungunya and JE, Surveillance is carried out by 4 Sentinel Surveillance Hospitals identified in the state, For Filarial detection is done passively in the PHC, CHCs and hospitals.

- **Vector Control measure**s are being carried out as per districts micro-planning with the help of Village Health and Sanitation Committee and often untied fund are also used for meeting spray wages in case of shortage of operational cost. Spray wages for Kala-Azar vector control is supported by GoI. The coverage is only 30% against the target.

- **National Drug Policy** is being followed up for treatment of malaria and Kala-azar cases in the health facilities.

- **Rapid Diagnostic Test (RDT)** is available and being distributed to Peripheral Health Institutions and Community level facilities , to be used by health workers and Sahiyas (ASHAs) specially in areas not readily accessible to microscopy Centres. RDT is also being used in PHCs, CHCs and Hospitals in emergency and odd hours. During Field visit such practices were witnessed

- The involvement of VHSC, ASHAs, MPW male and female optimal but involvement of MOs, needs to be enhanced specially for monitoring and supervision, data analysis and actions

- **Performance based incentive to ASHAs** is being paid for Malaria, Kala-Azar, MDA filarial as per the programme norms

- **Sentinel site hospitals for** surveillance have been identified, for indoor malaria cases 3 medical colleges and all districts hospitals have been identified. For dengue / Chikungunya 3medical clogs have been identified and functional and adequate test kits have been provided. Out of 3 Centinel hospitals for J.E one site PMCH Dhanbad is not functional.

- **During facility visits** it was found that all functionaries including community based are involved in the VBD control activities.

Deoghar

- Out of 6 Vector Borne Diseases under NBVDCP only malaria and filaria are prevalent in the district
- Though the districts is low malaria endemic but it is surrounded by high endemic districts like Giridih, Dumka , of Jharkhand and Banka and Jamui of Bihar.
- Surveillance has improved as Annual Blood Examination Rate (ABER) has been scaled up from 5.2 in 2006 to 11.7 in 2010. It is attributed mainly to deployment of contractual Male MPW supported by GoI under NVBDCP.
- District reports around 250 cases annually. During 2011 up to Oct 119 cases have been detected as compared to 155 during the corresponding period of previous year.
- Around 50% cases are amongst the population who return from other states and districts. In addition to reported cases in the districts large numbers of case of other districts are detected, treated and cross reported.
- District also reported deaths due to malaria which are mainly amongst migratory populations and reported late to hospital.
- There are 181 Sub-centres while the sanctioned posts of Male MPW (Surveillance Worker) are 25 and only 2 are in position.
- District has prepared micro-action plan. The population to be covered with Indoor Residual Spray is of adjacent areas of other high endemic district.
- District has adequate anti-malarials, rapid diagnostics etc. The Microscopy centers are at block PHC level only. There are only 17 Laboratory Technicians (regular 6 + contractual 11)
- Out of 2961 ASHAs 1575 are trained in diagnosis and treatment of malaria. However only few ASHAs have been provided with RDT and ACT depending on their education, capacity as well as endemicity.
- The allocated budget to the Districts is being released in time through Districts Health Society..
- Malaria situation in the districts during 2006 to 2011 is as under

Year	Blood Slid Examined	Total Positive Case	Pf. Cases	Pf. Proportion (%)	Annual Blood Examination Rate (ABER)	Annual Parasite Incidence	Death due to Malaria
2006	29971	137	26	18.2	2.6	0.1	0
2007	62340	230	43	20.5	5.2	0.2	3
2008	85570	286	182	63.6	6.4	0.2	0
2009	120016	266	161	60.5	8.8	0.2	0
2010	150733	227	158	69.6	11.7	0.2	4
Up to Oct 2011	157875	190	80				0

Filaria

- District is endemic for Filarial . District action Plan for anuual Mass Drug Administration (MDA) has been prepared. Training of the staff done.
- Annual MDA for filarial elimination programme is being carried out since 2004 but ASHAs are being involved since 2006 in MDA
- Line listing and mapping of lyphoedema and hydrocele cases are done
- Lyphoedema cases are managed and hydrocele cases are operated
- Coverage of MDA has been >90%

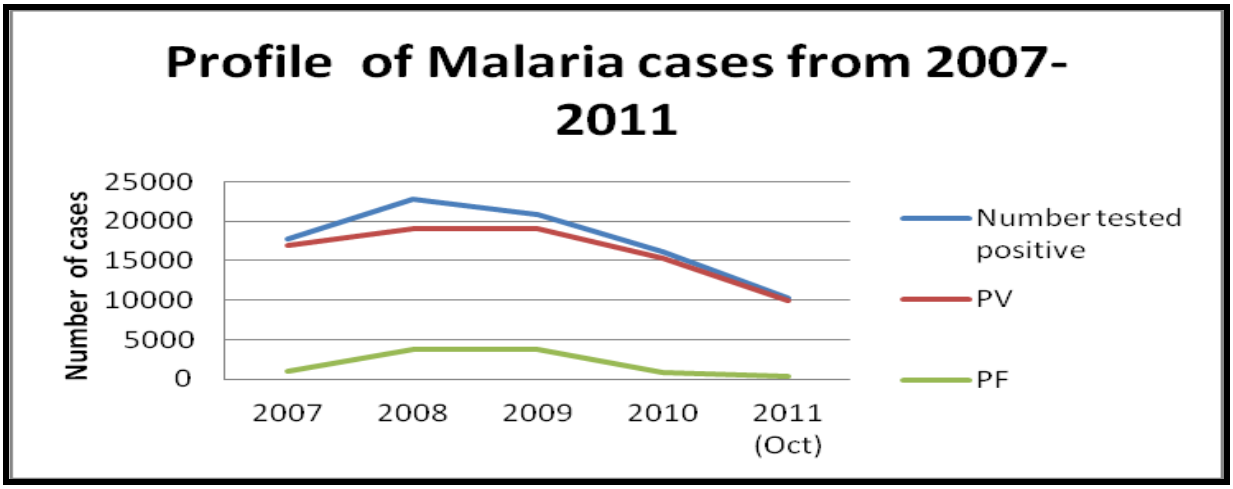
Information with regard to checklist

- Surveillance for malaria is being carried out through both male and female worker as well as by few ASHAs.
- Filaria surveillance is also being carried out by filarial unit.
- National drug policy for malaria is being followed and accordingly drug is available up to PHCs ACT has not been provided to Sub-centre and ASHA, as very few Pf. cases are being detected.

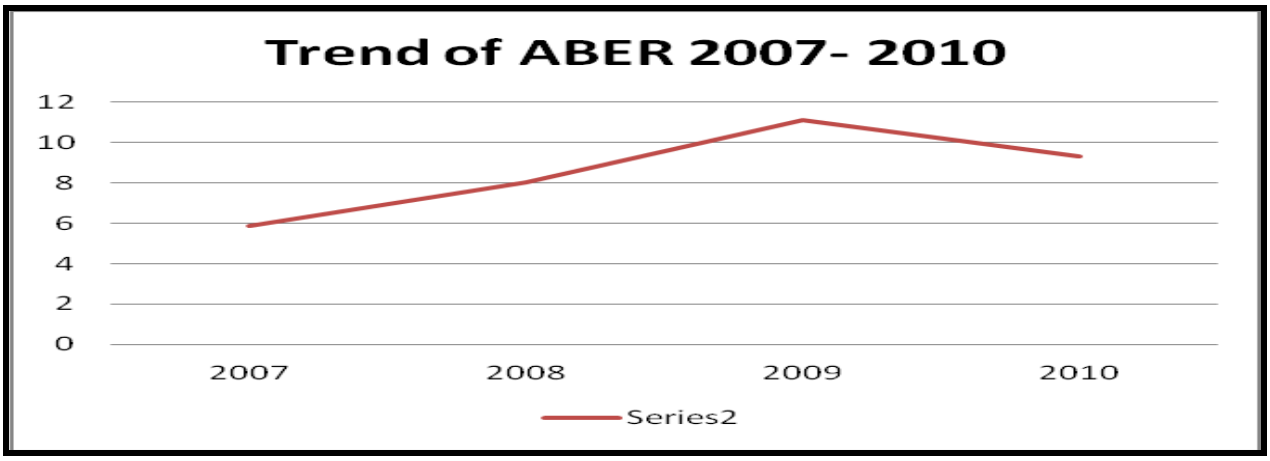
- CHC/ PHC Medical Officer, ASHA and VHNSC are involved in case detection treatment of malaria and mass drug administration in Filaria Elimination Programme
- Rapid Diagnostic Test (RDT) is available but only few Peripheral Health workers and ASHAs are using it.

Giridih:-

- District is equipped to do surveillance of all VBDs, however major focus is on Malaria.
- Major HR constraints especially of MPWs affecting the quality of surveillance and also supervision.
- Full time dedicated Malaria officer is in place.
- National Drug policy on Malaria 2010 is not uniformly followed in the facilities visited
- PHC MOs, ASHA are involved , in the prevention and control of NVBDCP this was evidenced while visiting
- Sahyas are trained to prepare slides, and they acknowledged the incentives for the same are paid on time. Few of selected sahyas are also given training in malaria management.
- RDT Kits were reported to be unavailable since 2-3 months in the facilities visisted.
- VHSNSC is involved in IRS, however the quality of coverage is suboptimal. Adequate quantity of spraying machines not available. Malaria officer requested for more funds for vehicle maintenance as he finds the current allotment is inadequate and this is affecting his supervision.



Performance of Malaria programme in Giridih 2007-2011



National Leprosy Elimination Programme:

STATE

- State has dedicated State Programme Officer for NLEP
- Annual New case Detection Rate (ANCDR) has been declining consistently for the last five years and it has been brought down from 2.6 in 2006 to 1.3 in 2010 .During 2011 it is also showing a decline as till Sept recorded ANCDR is 1.1
- Prevalence Rate (PR) is also showing consistent decline for the last five years and it has been brought down from 1.4 in 2006 to 0.65 in 2010. However during 2011 there seems increase in PR as it has been recorded as o.74 till Sept'11
- Treatment completion rate in all the districts during 2010-11 was found to be good as all have achieved above 90% except district Chatra. Over all , the achievement of the state in the past five years has been good.
- Anti- leprosy drugs for MBA (15501), MBC (686),PBA (8312) and PBC (645) are adequately available.
- Manpower needs to be given focus as for 24 districts only 15 DLOs are in position, 11 Non Medical Supervisors (NMS) ,7 Physiotherapists, and 5 Health Educators.
- Under disability prevention 7 medical rehabilitation (DPMR) are there.

- In the state, till September'2011, 226 L-Reactions cases were managed, 692 patients have been provided with footwear, 225 patients have been provided with self care kits and reconstruction surgery was done in 11 patients
- State has 4 RCS Institutions, 54 leprosy colonies and 33 self care groups have been established

Year	New Cases detected	ANCDR	Cases on record	PR	Grade II Disability	Disability Rate %
2006-07	7672	2.6	4236	1.4	220	2.2
2007-08	6799	2.2	3460	1.1	182	2.7
2008-09	5181	1.6	2941	0.95	152	2.9
2009-10	5345	1.64	3183	0.98	183	3.4
2010-11	448	1.34	2158	0.65	84	1.9
Up to Sept 2012	2135	1.1	2443	0.74	25	1.2

District Deoghar

- All 8 Block PHCs areas detect leprosy cases
- Annual New case Detection Rate (ANCDR) has been declining consistently during the last five year period and it has been brought down from 3.30 in 2006 to 1.58 in 2010 During 2011 it is also showing a decline till Sept'11 as recorded ANCDR is 0.94 .
- Prevalence Rate (PR) is also showing consistent decline during the last five years and it has been brought down from 2.41 in 2006 to 1.34 in 2010. During 2011 there is also further decline and PR is 0.91 till Sept'11
- Treatment completion rate in all the blocks has been nearly 100%
- Status of Leprosy in the district is given below.

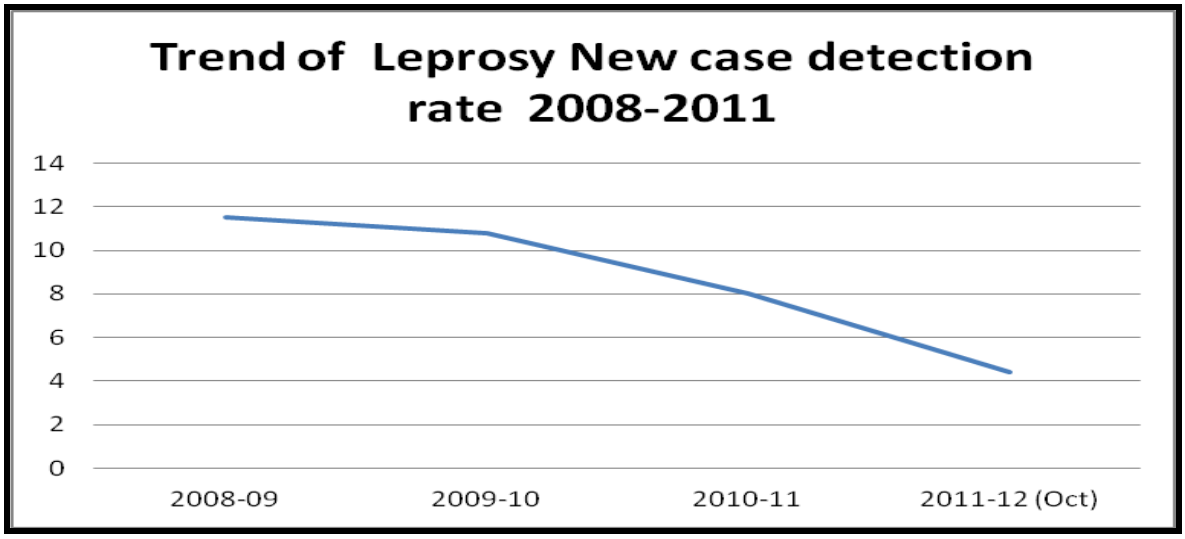
Year	New Cases detected	ANCDR	Cases on record	PR	Disability	Disability Rate %
2006-07	510	3.30	520	2.41	77	10.52
2007-08	372	2.77	511	1.57	25	6.72
2008-09	237	1.84	431	1.32	16	6.85
2009-10	235	1.58	405	1.34	4	1.70
2010-11	264	1.88	434	0.92	6	2.27
Up to Oct 2012	132	0.94	254	0.91	3	2.27

Information with regard to checklist

- Funds availability has been adequate. As on Oct'11 there is a balance of Rs. 1.5 Lakhs
- Anti- leprosy drugs for MBA (193), MBC(34),PBA(21) and PBC(1) are adequately available and supply from state is regular. Drugs are adequately available at periphery also and utilization is optimal
- Manpower needs to be given focus as DLO is designated, only 9 out of 26 Non Medical Supervisor (NMS) posts are filled up, both Physiotherapist posts are vacant, and Health Educator post is also vacant
- DPMR guidelines is being implemented as ;

  1 RCS done, 12 Reactions cases managed, 122 patients have been provided with Footwear, 100 patients have been provided with self care kit
- At CHC / PHC and Sub-centres are involved in case detection and treatment. Case follow up and IEC activities are being done by ANM, MPW and Sahiya - ASHAs.

Giridih:-



- Leprosy control programme is well integrated with the health system
- All the facilities have medicines and records were available
- Reconstitution surgeries are being done in the district .This year 5 surgeries were conducted and NGOs are supporting this activity
- ANMs and sahays are supporting in the default retrieval, and IEC activities.

Revised National Tuberculosis Control Programme

STATE:-

- A dedicated full time STO is present
- State has achieved the targets of case finding and treatment success rate as per the programme targets
- Suspects examination rate is less (129/ lakh/quarter) compared to National 169/lakh/quarter
- The monitoring and evaluation at the state level is good, which is evident by the regular state level review meeting and Internal Evaluations done
- The State's progress in DOTS Plus implementation is commendable. Jharkhand is now in a position to support the neighboring states for MDR TB diagnosis

Giridih:-

- Full time DTO present
- DMC LTs are in position, RNTCP LTs are trained in other disease lab services and are supporting other programmes as well, and this is an example of optimal utilization of available human resource.
- Suspect's examination is substantially low 98/lakh/quarter when compared to State average of 129/lakh/ quarter; this probably is a reflection of low reference subsequent to the unavailability of Medical Officers.
- Regular monthly review meeting is happening; however these meetings are not attended by higher officials or District Magistrate.
- Medical Officers in the visited facilities are trained in RNTCP
- 90% ANMs & MPW are not formally trained in RNTCP among the visited facilities , however they are departing RNTCP functions and getting proper timely support from RNTCP Key staff (STS /STLS)
- District/ Sub district level monitoring was not evident in the field. The treatment cards were not updated and the ANMs were not clear about the administration of DOTS. Practices of unsupervised drug administration's were reported.
- TB- HIV activities are not routinely offered to TB patients
- Financial management and liaising with NRHM is good.
- Only one private institution involved in RNTCP, even though 11 major private institutions are present in the District.

Year	Sputum Examination/lakh/Annum	Annualized total Case detected /Lakh	Annualized New Smear Positive Case detection rate	Treatment success rate
2006	321	107	60%	88%

2007	346	98	64%	92%
2008	381	95	64%	92%
2009	434	103	70%	93%
2010	415	91	69%	92%
Up to Sept2011	450	85	70%	91%

Deoghar

- Regular full-time DTO is in place
- All 8 Block PHC have Designated Microscopy Centre, except Devipur where only collection, fixing and examination are done but staining is done at DTC.
- Cure Rate has been achieved more than 90% since 3rd quarter 2008.
- Success Rate (treatment completion) has been sustained above 90% since 2005.
- Conversion rate has been above 90% since 1st quarter 2006

Year	Sputum Examination	Sputum Positive Case	Sputum Negative Case	Total Cured	Treatment completed	Death
2006	6540	702	416	617	453	33
2007	5594	815	354	664	420	45
2008	6350	868	364	783	447	27
2009	7269	856	329	789	404	23
2010	7831	895	327	645	291	10
Up to Sept2011	5950	676	172	-	-	

- Funds availability has been adequate. However funds for salary from October, 11 onward are yet to be received.

- Anti TB drugs are available and supply from state is regular. Drugs are adequately available at periphery also as per norms and utilization is optimal
- Data Entry Operator (DEO) post is vacant since 9 months. DEO and Sr. TB-HIV Supervisor have been recruited and appointment is under process.
- At DTC and in all 8 Block PHCs Microscopes, Microscopist, reagents etc are available
- Financial Management Guidelines of NHRM are available at the district
- In District Review, RNTCP is also regularly reviewed.

Integrated Disease Surveillance Programme:

Deoghar:

- IDSP was established in 2008. District level Officer for VBDs and IDSP is same.
- Epidemiologists, LT and Accountant posts have not been filled up till now. Only Data Manager and Data Entry Operator are in place.
- Space for Data Centre and training Centre has been identified but yet to be established.
- Internet Connection yet to be provided.
- Reporting : Syndromic reporting is being done by 2 out of 8 units
- : Reporting on P and L form is being done from 8 out of 9 units
- Training: out of 63 MOs only 10 are trained
  : out of 450 Health workers only 20 are trained
- Rapid Response Team is in place
- Budget for allocation for site preparation and training is inadequate
- OPD data collection is being done (P form)
- Value addition due to epidemiological date is not yet visible as reporting is not complete

Giridih:-

- Full time epidemiologist is in position.
- 14 reporting units are in place and 12 (86%) are reporting on time, however only 50% hard copies and soft copies are being received through the proper mechanism, rest the epidemiologist is making efforts by making phone calls to the concerned staff in PHC/CHC.

- Syndromic reporting is non-existing in the district
- The hard copies of P/L forms were not available in the facilities visited. The hard copies of the P/Lforms are in the process of printing only. Private sector is not reporting cases.
- The purpose and importance of reporting is not well understood by the field workers and MOs in the visited facilities. In all the institutions pharmacist was doing the task, and no copies of the previous reports were available for verification.
- Epidemiologist requested financial support for maintaining the telephone as he is making efforts to get the reports by making phone calls. The mobility support for outbreak investigation is inadequate.
- Media alerts received are promptly handled. No media alert in 2011.

National Blindness Control Programme:

- Under this Programme only eye check and refraction test are done in the schools.
- IOL cataract operations are being carried out. Target and Achievements since 2005-06 are given below;

Year	IOL cataract operations		Screening of school Children		Vision defect	
	Target	Achievement	Target	Achievement	No. of Children	Refraction Correction
2005-06	3000	3035	37000	24957		
2006-07	4500	2677	50000	51521		
2007-08	4500	4509	37000	50197		
2008-09	4500	4609	59000	45812		
2009-10	5200	5466	60000	57136	3600	1155
2010-11	5500	5650	59000	48367	3540	986
2011-12	6000	605 (up to Oct)	59000	31378 (upto Oct)	3540 (up to Oct)	547(up to Oct)

Giridih:-

The surgeries are being done in the district and the OT is in the Sadar hospital of Giridih which is being prepared, however the microscope and other equipment for surgery are not in place. The last camp was done by using the ophthalmologists' personal instruments. NGOs (Rotary and Lions Club) are supplementing the gap and the trend of cataract operations shows that the district had achieved beyond the targets.

Iodine Deficiency Disorder Control Programme:

Giridih:-

- It was reported that testing kits are distributed to sahyas, however reagents and testing kits were not available with them..
- The team tested samples from the field and found that only 60% of them are iodized.

Deoghar:-

- Reagent was supplied one time only for testing salts for iodine content

The TB and Leprosy programmes are functioning well in the district. The ANMs and Sahiyas are TB DOTS providers. The Blindness Control Programme is performing well. The surveillance of Malaria and Filaria has improved in the district. The sahiyas and MPWs are involved in case detection and treatment of cases. There is acute shortage of surveillance workers across the district. The IDSP program is at evolution stages and Epidemiologist position is still vacant.

Tuberculosis Lab CHC Jamua Girdih

Recommendation

1. The vacant positions to be filled in at the earliest.

Program Management

K. Information on Programme Management Units				
Level	No. of Regular Staff	No. of contractual Staff in important positions like Programme managers and Consultants who have been employed for their technical expertise	No. of contractual **support staff** such as programme assistants/ DEOs/ typists/ peons	Total Number of Staff in SPMU
SPMU	0	30	Executive Asst-5 Comp Asst -35 Other Support Staff -13 Driver - 40 Peon - 17	140
DPMU	0	117	Comp Asst (RI) - 24	141
BPMU	0	388	0	388
Total	0	535	134	669

State has a functional Programme Management Unit. There are different programme cells headed by Health directorate officials. This is a good initiative for integration and co-ordination between programme management unit and Department of Health and Family Welfare at state level. State has not made effort for administrative and capacity building of programme management unit. Training for District Data Manager and Accounts Manager has been recently introduced. There is no training programme for programme managers. Lack of infrastructral provision to programme management at District and Block level. Co-ordination between various levels of management units need to be strengthened in the districts. State has supervision and monitoring schedule in place though adherence to this is an issue. State has appointed administrative and management personal for every district for supervision and monitoring. SHSRC is still in nascent stage. Recently performance evaluation of management unit is done by SHSRC and is also involved in data analysis and state health planning.

Giridih

Programme management unit in the District has a profound presence with its effective involvement in programme implementation. 2 posts of account manager are vacant (Block Deori and Rajdhanmar). Integration with administrative structure of health and programme management unit is week. In Giridih District Block managers were not aware about some programmes (Promotion of Menstrual Hygiene). No orientation and training has been provided to the newly appointed district data manager. District does not have any capacity development plan for Block programme managers. Block account managers are handling additional responsibilities of data managers. There is no provision of Block data manager position and is leading to delays in data uploading of MCTS and HMIS. Co-ordination between district and block programme management unit is weak also Supervision and monitoring activities by programme management unit needs strengthening.

Deoghar

The Program management unit is weak as the position of DPM was vacant for past 3 years. The BPMUs are non functional in most of the blocks due to lack of human resources. PMU Staff unaware of job responsibilities and accountability. The last meeting of DHS held six months back. There is lack of co-ordination at District level which results in output and impact adversely. No induction training provided to newly recruited PMU staff. The infrastructural support provided to PMU is inappropriate.

Recommendation

- The roles and responsibilities of PMU staff should be well defined
- The DHS meetings to be held on monthly basis.
- A training to understand administrative process is required.
- State should have capacity building programme for DPMU and BPMU

Procurement System

State

There is no specific procurement unit for NRHM at the State and District level. A purchasing committee at state level looks after procurement under NRHM. The procurement is done as per Jharkhand State purchase rule. The rates are fixed centrally and are procured by district. State provides funds to districts according to their demands and requirement. The needs are assessed on the number and type of cases, case load, and the existing number of institutions in each block. Present procurement system cannot be compared with the transparency, efficiency and drug safety benchmark of TNMSC model. State has a procumbent manual. State also issued EDL and Standard treatment guideline but are not present in the facilities. Financial audit of procurement is in place but physical monitoring of procurement is absent at state level. Pro-MIS has been initiated in the state and will take time in full swing operations.

Giridih

Drug purchasing committee is present in District and decides the amount of drugs to be purchased. Under NRHM centralized rate fixation is done at State level and procurement is done by District authority. Drugs are mostly procured from PSU. There is lack of inventory management system in Sadar Hospital. Transparency is subject of concern in district for procurement. Giridih District has ProMIS manager and data is regularly entered by the manager.

Deoghar

A technical committee is constituted at the district level and decides the amount of drugs to be purchased. The quantity of drugs to be purchased is done as per requirement and the budget allocation under different programs of NRHM. The budget is approved by the civil surgeon and drugs are purchased from the agency approved by the state. The procurement cell exists in the district and is fully functional. The ProMIS (data entry) is operational at the district and drugs flow is managed as per FIFO. Though the district has a fully functional drug store, it does not satisfy the norms of a drug store.

Recommendation

- A new fully functional warehouse be established at the district level to maintain drug safety.
- Renovation /construction of drug stores at the block level.
- Timely release of funds to purchase the required drugs

Effective use of Information Technology

Currently SRCH officer is state Nodal officer for MCTS and State System Analyst is looking after MCTs at State level being a nodal person.

ANMs are collecting mother and child data in MCTS, 80 column sheet for online entry. They are trained to collect data. And submit the sheet to the PHC and block programme manager (BMP) enters data into MCTS Server. Many BMP post are vacant. There is no dedicated personal at PHCs for MCTS data entry. Presently more than 15 CHCS started work plan generation process.

Jharkhand started MCTS application with a new name E JANANI .

MCTC team is in regular touch with all DDM /DPM to ensure online entry at blocks. There is problem of electricity and internet bandwidth in almost all block of the state. State has provided invertor to all the blocks for uninterrupted MCTS data entry but blocks are facing severe issues in internet bandwidth. State system analyst is always in touch with district as well as blocks to resolve issues of online data entry. Many Letters to District and block officials regarding MCTS has been issued by MD. So far a total of 223528 mothers and 192022 children have been entered as on 11.11.2011.

1. Reporting of HMIS data is lacking behind in the entire state due to HR crunch
2. The data do not reach on the schedule date that is 5th of every month of the preceding month
3. Data from private health service provider is not captured consistently
4. The level of out layering of data is high due to double entry for the same person for which state health society data annalist has developed a system of using options of “Migrated in and Migrated out” but data entry personal at peripheral level are not aware of it
5. **Shortage of data entry operator** , poor internet connectivity and troubles in logging due presumably to server problem are working as bottleneck
6. Zero element error where data is not available is quite prevalent.

7. After entry of data in draft mode in server, unduly long time is taken before it is forwarded to enable the data to be visible to others
8. Between April to September 2011, ANC registration against expected pregnancies is 13 % and reported deliveries against expected deliveries is 4.9 %
9. The institutional deliveries against estimated deliveries is 2.3 % (April to September 2011) where as institutional deliveries against reported deliveries is 47.2%

The MCTS data entry points at the District level are less than 10%. Only one PHC/ CHC in the District (Karon PHC) was reporting on MCTS portal. There is a contractual computer operator who is uploading the data from 22 SCs. Currently only 50% of SCs are sending data, however data submitted by the SC needs validation and quality check.

The data entered at the block level is not accurate as there is no Data Manager in place. The post has been vacant for last three months; in addition to that there is delay in uploading of data at the Block level. The ANMs are submitting the registers for a period of one week to BPHC for data entry in HMIS. This leads to haphazard and inaccurate collection/collation of data at the SCs.

Recommendations:

1. Hands on training for the district and Block level use of HMIS need to be prioritized.
2. The Civil Surgeon should be oriented in the use of information from HMIS for planning, programme monitoring and Management.

Financial Management

Finance is one of the important means for the operation of any project and its management has always been the key area of attention at any level and across the sectors, hence, is utmost important. Management of finance should be such that it ensures maximum and optimum utilization of all other organizational resources, in order to achieve the organizational objectives.

Finance Personnel:

State

Key posts are held as follows:

Director Finance- Shri. K.K. Bhagat

State Finance Manager- Shri. Pratap Ranjan Prasad

State Account Manager- Md. Naseem Akhtar

By making the appointments of key posts of finance division, state has complied with the findings of the 4th Common Review Mission (CRM).

Giridih

District Account Manager (DAM)- Mr. S.C. Mahto.

Block Account Manager (BAM)- 10 out of 12 sanctioned post are filed and the post of BAM posts at PHC Deori and Raj-dhanuwar are vacant.

Deoghar

District Account Manager (DAM)- Mr. Ravindra Kumar

Block Account Manager (BAM)- all 08 sanctioned posts are filed

Electronic Fund Transfer

State

Funds are transferred from state to district electronically through RTGS.

Giridih

District transfers fund to CHC/PHC through the Bank Cheque.

Deoghar

District transfers fund to CHC/PHC through the Bank Cheque.

Customised version of Tally ERP.9

State

At state level customized version of Tally ERP.9 is used for maintaining Books of Account.

Giridih

District is maintaining Books of Account through the customized version of Tally ERP.9.

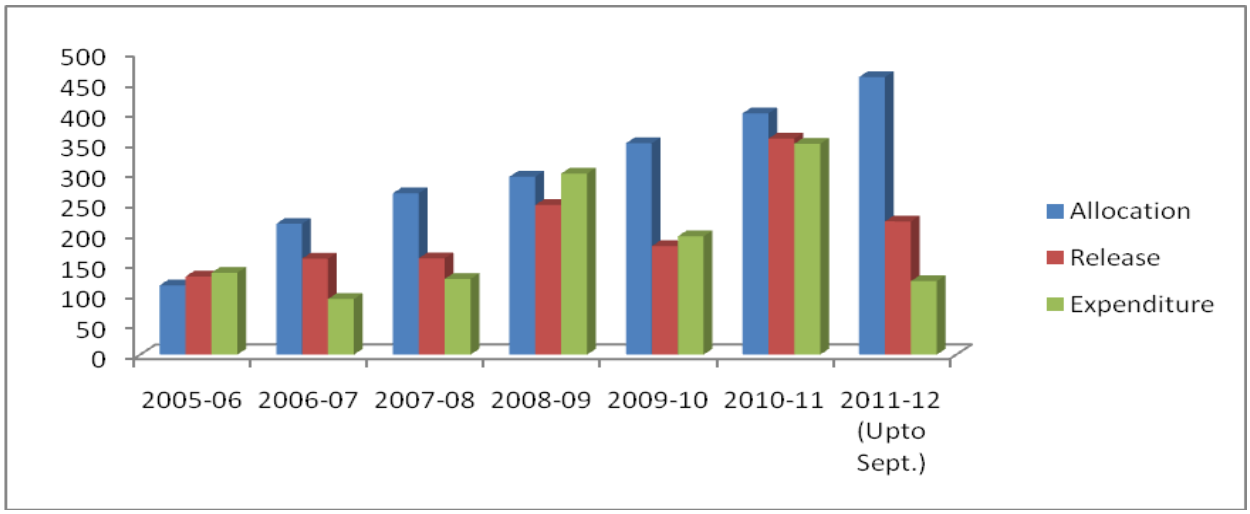
Deoghar

Customized version of Tally ERP.9 has not been installed although DAM has taken training . Beyond the district level, books of accounts are maintained manually in both the districts. As far as the response of Tally solution is concerned, it was noticed that Tally ERP.9 was recently installed and financial personnel have never called for the trouble shooting help.

Funds Utilization:

Funds released are utilized for the activities for which the same has been approved under State PIP.

Fund Utilisation- Jharkhand



Auditing Procedure:

State

Appointment of Statutory Auditor is made at state level. Statutory audit for the 2010-11 has been completed and report has been submitted. Concurrent Anuditor has been appointed in 18 districts out of 24 districts for the audit of 2011-12.

Giridih

Concurrent auditor for the audit of 2011-12 has not been appointed. Further, it was observed during the visit that, concurrent auditor was appointed for the audit of 2010-11 no report has been submitted by the auditor.

Deoghar

Concurrent auditor for the audit of 2011-12 has not been appointed till the date of visit (i.e. 13th Nov., 11).

Delegation of Financial & Administrative Power:

State

Financial & Administrative power has been delegated. Bank accounts of the State Rural Health Society are operated by the Mission Director, Director-in-Chief and the State Account Manager.

Giridih & Deoghar

Financial & Administrative power has been delegated to Civil Surgeon, District Account Manager at district level.

Training on Financial Management:

No training measures have been adopted by the state to improve capacity building of finance personnel of the state. However, training on Tally ERP.9 has been given to the District Account Manager (DAM) at state level in the month of October,11.

Giridih & Deoghar

District level financial personnel (i.e. DAM) has taken training on Tally ERP.9 but block level financial staff (i.e. BAM) have not been provided any training.

Financial status under HMIS:

Financial data are updated quarterly under HMIS.

Submission of financial reports:

State

State submits financial report like Financial Monitoring Report (FMR), Statement of Fund Position (SFP) quarterly to the Government of India. State had submitted FMR for the 2nd Quarter of 2011-12.

Giridih & Deoghar

Financial report is submitted by district to state on monthly basis in the form of Financial Monitoring Report (FMR).

Integration of Financial Management Process with NDCPs:

State

Societies relating to various National Disease Control Programme (NDCPs) have been integrated with the State Health Society (SHS).

Giridih

Societies related to various National Disease Control Programmes (NDCPs) have been integrated with District Health Society (DHS). Expenditure is reported by the various NDCPs division to the DHS on monthly basis.

Implementation of Model Accounting Handbooks:

Model Accounting Handbooks for sub-district level finance staff has not been implemented so far in both the districts

Procurement Manual:

The procurement manual has been framed and the procurement is done as per the guidelines mentioned in the manual.

Pendency of UCs:

UC of Rs. 46.53 crore under RCH Flexipool and Rs. 89.20 crore under Mission Flexipool is pending for the amount sanctioned during 2010-11. State has informed that the collection of UCs from the district shall be given due priority..

Longstanding advances:

There are some long outstanding advances which are to be settled.

Expenditure of Untied Fund/AMG:

State

State releases fund to the district against untied fund and Annual Maintenance Grant (AMG) as per the specified rate.

Sr.No.	Particulars	CHC	PHC	DH	VHSNC	NPHC	Sub Center
1	AMG	1,00,000	1,00,000	-	-	50,000	10,000
2	RKS	1,00,000	1,00,000	5,00,000	-	1,00,000	-
3	UF	50,000	50,000	-	10,000	25,000	10,000

Note- AMG is provided to only those Sub-centers, which are in Govt. Building and not in rented building.

Giridih

District releases fund regarding Untied Fund and AMG as per the DAP. Release is treated as advance and the same is recorded as expenditure after the submission of utilisation certificate

Allocation, Release and Utilisation of fund

District- Giridih

Year	AMG			United Fund		
	Allocation	Release	Expenditure	Allocation	Release	Expenditure
2005-06	0	0	0	0	0	0
2006-07	600000	600000	0	2100000	2100000	0
2007-08	1200000	1200000	0	3200000	3200000	0
2008-09	750000	750000	122411	375000	4935000	1350985
2009-10	3910000	3910000	505576	2775000	14585000	697103
2010-11	3910000	3910000	4377788	1885000	13705000	19620067
2011-12 (upto Oct. 11)	2650000	3620000	1123391	2775000	2725000	10375864
Total	13020000	13990000	6129166	13110000	41250000	32044019

Deoghar

District releases funds (Untied Fund and AMG) as per the DAP. Release is treated as advance and the same is recorded as expenditure after the submission of utilization certificate (UC)

Fund adequacy:

Fund release is adequate and commensurate with the needs of the programme and utilization of fund more than the approved PIP has not been noticed.

Low Utilization of fund:

There is low utilization of funds on some activities like family planning, ARSH, referral transport and routine immunization (RI). Reason given for the low utilization is that number of health facilities are in remote areas.

RKS constitution and fund utilisation :

Rogi Kalyan Samiti (RKS) is not constituted at state level but the same is constituted at district, CHC/PHC level. RKS has been constituted in both Giridih and Deoghar district at health facilities, with the health personnel, administrative officer like BDO and Community representative like MP /MLA. There are 7 members of RKS at the district level and 7 at Block level. The allocation of RKS funds is done as per NRHM norms (i.e., 5 lacs to districts, 1 lac to PHC and CHC each). The funds are mostly used for:

- Salaries of housekeeping staff, security guards, ambulance drivers, generator operators etc.
- Cleaning materials
- Referral care
- Minor repair of the building.

Separate books for the RKS are required to be maintained but only a few facilities are maintaining separate book for RKS and backlog in updating of RKS books of account is ranging from 3 to 6 months as was observed in Girdih District.

Allocation, Release and Utilisation of fund

District- Giridih

Year	RKS		
	Allocation	Release	Expenditure
2005-06	0	0	0
2006-07	0	0	0
2007-08	0	0	0
2008-09	1800000	1800000	0
2009-10	0	500000	1383468
2010-11	0	3200000	2023117
2011-12 (upto Oct. 11)	3200000	3100000	1722982
Total	5000000	8600000	5129567

State share contribution:

State contributes its share and the same is utilized for the activities commensurate with the NRHM activities. State has contributed Rs. 156.82 crore since the inception of programme and Rs. Rs. 90.46 crore is outstanding still.

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Year	Amount to be contributed	Amount contributed
2007-08	28.08	11.25
2008-09	43.64	40.00
2009-10	31.65	51.57
2010-11	62.98	54.00
2011-12 (Till October,11)	80.93	0
Total	247.28	156.82

Compliance situation:

State is making compliance of the income tax like deduction of TDS. However, state has not filed TDS return since 2 years and has hired M/s A.K. Kejriwal & Associates, Chartered Accountant firm for the filing of return. State has Rs. 1.94 crore unspent balance under RCH-I which have to be refunded.

In Giridih district provision of Income Tax are complied with and TDS is deducted, deposited and TDS returns are filed.

Suggestion & Recommendation

Though in principle, the state should monitor the activities on a monthly basis, it never happens in practice. It is recommended that instead of a monitoring committee, a special monitoring cell be established at the state as well as district level for regular monitoring of the progress of activities

The Model Accounting Handbook should be in place at the earliest in order to make full utilization of funds. In addition the block as well as the district level accounts managers should be provided appropriate training on the general financial regulations of GoI as well as Jharkhand state

Training and capacity building programme for finance personnel at state and district level should be organized periodically. A concurrent auditor should also be involved in such programme. For this purpose service contract may be outsourced.

As an effective internal control, duties of the staff should be segregated and the person who maintains the books of account or having access to the books of accounts should not be signatory to bank account. Accordingly, at state level SFM should be signatory of bank account instead of SAM. Though, custodianship and preparation of cheque by the SAM may be continued.

Fund disbursement should be as per the approved action plan and not activity wise. Sometimes late disbursement of fund creates bottleneck in performing such activity.

Concurrent audit mechanism should be effectively implemented. Monitoring of concurrent audit should be made by the state. During the interaction with finance personnel, it was observed that presently state has not put much emphasis on current audit. As far as possible local level firm should be appointed as concurrent auditor, in order to provide a handholding support.

At district level account assistant should be appointed to support the District Account Manager.

Decentralized Local Health Action

At village level, there is an existence of VHSNC but it is not found functional. It was also found that VHSNC does not consist of PRI members because it was formed prior to panchayat election in Jharkhand. At village level, a bank account was found to have been opened and jointly operated by Sahhiyas and Chairman of VSHC for managing the untied funds. However, how money is spent is not transparent. Many Sahhiyas, however, reported that they are spending the money on insecticides, in the repair of hand pipe etc but the issue of utilization of untied fund is never discussed and reported at the VHSNC. Because of this, in many villages, some villagers expressed resentment about the way untied funds are being spent at the village level. At the HSC level also , there is no involvement of PRIs. As such the Bank Account at Sub-centre level is jointly operated by ANM and Aganwadi Worker. However, the team found better utilization of untied funds at the Sub-centre level. The untied funds at the sub-centre level were spent in purchase of tables, chairs, almirah, solar lamps and drugs etc. However, the money of untied fund is not reaching the sub-centre on time. Team found that they have not received money every year as per the norms. On inquiry from the Block Management Unit it was informed that the main reason for the non-availability of untied fund was non-submission of unitization certificate (UC) on time.

At the PHC/CHC and also District Hospital levels, the Rogi Kalyan Samitis (RKS)/Hospital Management Committees were found in existence but meetings were held occasionally. In the meetings of RKS, discussion was only on routine matters and hardly any strategy for fund generation and future improvement were formulated. There has been a misunderstanding that RKS is meant to decide only the RKS funds received under NRHM. This has hindered this institution in evolving as an overarching committee looking after the overall administration and management of health facilities. At state level, the meeting of the state health society chaired by Principal Secretary is being held regularly but the meeting of State Health Mission chaired by the Chief Minister has not been held for the last one year. Overall, there has been a total lack of involvement of elected members both at the local, district and state levels.

The planning and supervision of NRHM activities at the local level is very weak. There was no District Level Vigilance and Monitoring Committee (DLVMC) in place in spite of order issued

by Govt of India dated 15th September 2010. Although Block and District Health Plans are being prepared, that too, only recently, but this was only for getting funds from the central government. Later on this is not used to assess the progress of work. This was evident from the fact that at block level, although Block Level Health Action Plan was prepared, there was no copy kept for future reference and monitoring. Further the Block and District Health Action Plan is not discussed and approved by the Block and District Health Societies. This is taken as a routine matter by the respective MOICs and CSs.

A good practice of *Jansamvad* is found to exist to redress the grievances of all concerned and general public, but not on a sustainable basis.

Recommendation

- Active involvement of PRI members in the functions of VHSNC should be ensured by the state and district authorities.
- In Preparation of DHAP, the PRI members should be involved.
- Capacity building of VHSNC members for appropriate funds utilization.
- RKS planning should be done with involvement of PRI members.

Actions taken on the recommendations of the previous CRM

4th CRM Recommendation

Infrastructure:

Recommendation-

- Increase resources for infrastructure, especially in hard to reach areas
- Enhance resources from other sources- Tribal sub plan, MSDP, BRGF, District funds, LWE IAP, Finance Commission
- Invest in staff quarters up gradation and transition measures
- Further improve Coordination between Health Dept, District team to expedite and areimprove civil works
- State to coordinate with the Electricity dept
    - Expedite operationalisation of IPH Namkum
    - Preferential lines for District and block level health facilities
- State to mobilize support from TSC, NRDWP for ensuring access to safe drinking water and sanitation

Action taken-Engineering wing initiated at state level is monitoring and mentoring the all infrastructure development both through NRHM and through State funds**.**

STATUS OF INFRASTRUCTURE DEVELOPMENT

Facility	**Existing**	**Complete 2011**	**Under Construction 2011-12**	
			By State	**By NRHM**
DH	21	-	-	-
SDH	6	-	-	-
RH	31	-	-	-
CHC	188	15	126	18
PHC	330	28	81	5
HSC	3958	176	337	73

Human Resources:

Recommendation:

- Develop a comprehensive and sustainable HR policy
- Improve cadre management (including revision in remuneration)
- Provide an Incentive package for hard to reach areas
- Expedite operationalisation of the Namkum IPH
- Expedite Proposal for Arogyashala Itki Training Centre
- Expedite sanction of ANMTCs especially challenging districts
- Expedite operationalisation of 5 sanctioned, existing ANMTCs
- Review and development of a need based training plan
- Greater emphasis on competency based training with hands on practice, linked to performance outcomes.

Action Taken:

- Study has been covered for developing the HR road map with the objective of development of comprehensive HR policy and also plan for bridging the future requirements of desired clinical Human Resource.
- An incentive scheme 'Jharkhand Swathya Protsahan Yojana' is under submission with Ministry of Health & Family Welfare, GoI. The scheme proposes to provide incentives to the health human resources working in hard to reach and naxalite affected areas.
- IPH Namkum is operational.
- Arogyashala Itki training centre is functional, MTC training conducted.
- 10 ANMTCs functional.

Healthcare services delivery – facility based – quantity & quality

Recommendation

- Accelerate Institutional deliveries- especially in hard to reach areas and scattered tribal populations
- Staggering promotional activity and contact prior to VHNDs in hard to reach areas
- Improve security arrangements in hard to reach areas
- Standard treatment guidelines should be displayed in CHCs /PHCs.

- Establish SNCU (Level II) in District Hospital Gumla
- Promote better information sharing between GOI/ states and districts on Kit A, Kit B supplies
- Expedite procurement of Long Lasting Insecticide treated Bednets
- Enhance support for referral transportation.
- Provide diet for patients and attendants- including MTCs
- Improve biomedical waste disposal - especially in District Hospitals
- Strengthen teamwork and role clarity of regular and contractual staff
- Strengthen response to local health needs, with improved disease surveillance

Action Taken

1) **Outreach services**
    - New women panchayat members mobilised for community based monitoring. But needs strengthening.
    - Quality of ANC attended to, But needs to be improved, and specifically ANC at AWCs during VHNDs
    - There is action but a great need to increase IEC related to VHNDs- especially through folk media, also involving ICDS mata samitis.
    - VHNDs have Immunization, Child nutrition & THR and child education activities done but there is need to expand the services provided at VHNDs to include IYCF counselling, linked to distribution of THR
    - RCH and tribal area camps and MMU schedule could use a fixed day approach
    - Improve microplanning and coordination between ANM, Sahiya, AWW at places in Palamu

2) **ASHA programme**

    - Enhance incentives and connectivity (eg. mobiles) for Sahiyas (ASHAs), especially in hard to reach areas
    - Strengthen the existing mentoring network for ASHAs
    - Enhance incentive for trainers eg. BTT, DTT

- Strengthen linkages of Sahiyas with new PRI members
- Strengthen linkages of Sahiyas, AWWs, ANMs in Palamu
- Replicate Sahiya shelters as in Chainpur CHC
- Provide opportunities for education /training to those interested and recognition for good performance.

Action taken

- 2149 Sahiya Sathi has been selected and trained.
- Sahiya Sathis are conducting regular monthly cluster meeting to Sahiyas.
- Sahiya Sathi paid Rs. 100 x 15 days per month.
- The training budget for Sahiya per day increased from Rs. 200 to Rs. 265 per day and BTT honorarium increase from Rs. 250 to Rs. 300 per day for 4 days as supportive supervision along with the training days.

3) RCH-II (Maternal Health, Child Health and Family Welfare)

- MTCs seem to be underutilized in Palamu (3 cases in Hussainabad PHC, 2 of which were grade-II children). But in Gumla MTC at DH is optimally utilized.
- Tracking of severely malnourished children and planning of capacity at MTCs needs improvement
- Sahiyas' role in nutrition component needs to be strengthened
- Less focus on promoting infant and young child feeding practices
- Linkage of VHNDs with THR distribution in Gumla is effective
- Mother and child new NRHM ICDS cards are yet to be introduced

Action taken status -Not provided by the State

4) Nutrition

- Strengthen lactation management support in MTCs for mothers of infants less than six months
- Strengthen comprehensive preventive approach to undernutrition- in addition to Malnutrition Treatment Centres
- Expedite rolling out of new WHO child growth standards,
    - Release the new joint NRHM ICDS mother child card (prototype)
    - Procurement and replenishment of child weighing scales

- Utilise the Mata Sahayta Samoohs for NRHM and ICDS
- Create a common block training platform, for both ICDS NRHM
- Promote the concept of Malnutrition Free Panchayats
- Improve mobility of CDPOs, LS of ICDS in hard to reach areas and mobile connectivity of AWWs.
- Joint counselling IEC campaign for health and nutrition – using a life cycle approach, focusing on preventive family based care
- Strengthen the system of referral and follow up of cases to MTC through ICDS
- Strengthen Nutrition component in ASHA training modules
- Strengthen supply chain management of Kit A supplies, for addressing micronutrient malnutrition. These include IFA, Vitamin A supplements and zinc supplements with ORS for diarrhoea management

Action taken status -Not provided by the State

5) National Disease Control Programmes

- Increase integration in NRHM and priority to NDCP – especially NVBDCP (Malaria and Elimination of Kala azar)
- Operationalise two hospitals as sentinel sites for NDCP
- Strengthen Disease surveillance for GIS mapping of Hot spots
- Focus on high endemic areas with matching human resources
- Prioritise villages/HSCs for Micro-planning for IRS activities
- Streamline Reporting and Investigations of deaths.
- Strengthen Capacity Development with hands on practice
- Improve inventory management system at field level
- Integrate IEC activities in State PIP/ DHAP/BHAP
- Ensure mobility to DMOs-new vehicles with WB support

Action taken status -Not provided by the State

6) Institutional Mechanisms and Programme Management

- In view of panchayat elections, revisit constitution of District Health Missions
- Extend existing NRHM Village Health and Sanitation Committee to include Nutrition and ICDS; this could be recognised as a sub committee of panchayat

- Build on the strong management support function in the state - PMUs and plan for institutionalisation in next plan
- Build on the ongoing initiative for developing District Health Action Plans through participatory processes, with need based Block Health Action Plans
- Enhance management training opportunities for health programme managers, including visits to best practices
- Introduce a system of recognition and motivation for high performing district teams- including both regular and contractual staff
- Strengthen hands on training on the use of HMIS
- Improve the use of HMIS for decision making, and integrate hospital based indicators
- Inventory management needs strengthening – especially with regard to stock outs and reordering level
- Integrated data based management in IDSP needs to be used for early warning signals of outbreak
- Validation of data being generated needs to be ensured

Action taken

- SPMU has been restructured. Inclusion of more regular staffs under SPMU.
- Job profile has been defined and performance management system has been introduced.
- Positions have been completed under SPMU/DPMUs/BPMUs.
- Functionalization of SHRC to support in strengthening the SPMU.
- HIMS is being used in more efficient way in district level planning and being used for Informed decision making, capacity building of Block, District and State level functionaries are being done. The corrections of data uploaded had increased.
- PROMIS has been introduced in all 24 districts and at state level. Capacity of district and block is being developed for improvement inventory management.

7) Financial Management

- Expedite Concurrent Audit in Districts, where auditors are appointed
- Strengthen Internal Control System through integration of physical and financial indicators in regular reviews

- Increase the frequency of DHS/ RKS Meetings and involvement of public representatives
- Guidelines on best practices re effective use of RKS Money to be shared
- Strengthen orientation of State/District/ Block teams (including treasury officers)
- Decentralisation of Financial Powers and simplification of formats
- Orientation of VHSCs and HSC committees on untied funds
- Ensure e-transfer of funds through lead banks.
- Timely allocation of funds flexi pool wise as per approved District ROP.
- Display of fund status of major NRHM programmes in Health Facilities, with monthly updation
- Uploading of FMR in HMIS portal on regular basis by all the 24 Districts
- Point of JSY payment should be closer to the female ward

Action taken

- Expedite concurrent audit in the districts is going on in some districts.
- FMR is being uploaded in Tally by all 24 districts.
- State level post of Director Finance is filled up.

8) Decentralised local health action

- Requirements at facility level and local needs should be reflected through differential flexible planning
- Link with ICDS Mata Samitis, Mata Sahayta Samoohs
- Community monitoring needs to be prioritized in hard to reach areas.
- Share best practices of VHSNC utilisation of untied funds

Action taken status -Not provided by the State

Chapter 4: Success Stories

An Integrated approach in Birhor Community Giridih District Jharkhand

The *Birhors* are a nomadic hunting and gathering tribe. They are numerically a small population located chiefly in the *Chotanagpur* plateau and sporadically found in Orissa, West Bengal, Madhya Pradesh and Chhattisgarh. They move about in small groups snaring the monkeys, tracking hare , deer other games and collecting rope –fibers , hone and bees wax. Their habitat is called *Tanda*.

CRM team visited two ***Tandas*** ; *Kala Pathar* and *Amnari*.

Total population of Kala Pathar is 67 persons in 16 families and total population of Amnari is 103 persons in 27 families. The integrated approach of different departments; trusts and NGOs has helped them to settle at one place and mix with the local community so as to come in mainstream of the society.
One Mini Anganwadi centre is in Kala Pather Tanda is providing services to the community.

Jaago Foundation has appointed one person who knows the local language, for facilitation to access health, education and livelihood services provided by the government and others.

There is one school present for education, *Adim Janjati Trust* is providing livelihood programme to the community residents.

One ANM visits this Tanda every week for regular services.Birhor community is well aware about JSY benefits. Immunization is well accepted whereas Family Planning is discouraged due to the National Policy for the Tribal Population.

The Government as well the health department has been instrumental in protecting this small tribal community without harming their tribal legacy. To make such communities accept modern health care means is an achievement in itself. This becomes a shining and encouraging example for a state where a large tribal population exits.

These convergence efforts of the Health department should come to light and be recognized for replication elsewhere.

Skills Lab

Giridih District health department with the technical support of USAID-MCHIP (JHPIEGO) started a new capacity building / development programme in ANMTCs.

This is a periodic hands-on training programme to improve the skills of health care providers. The basic objective of the programme is to build the capacity of the ANM students, ANMs and Nursing staffs on the basic and critical skills for Skilled Birth Attendance, Newborn Care, Child Health and Infection Control Measures.

This Skill Lab consists of 20 stations related to maternal health, newborn and child healthcare and infection control with biomedical waste management.

Assessment of the existing skills of each trainee is done first and during assessment every candidate has to pass through each skill station. The gaps in the skills are then addressed by hands-on individual training.

Sufficient time to practice the skills over and over again is done to each trainee in the next session by demonstration & presentation.

After completion of this exercise a short presentation/demonstration follows with answering of questions and clarifying the doubts raised by any trainee.

Skill evaluation is done simultaneously for all the trainees.

The entire programme is for 1-2 days for each batch of 20-30

The Skills Lab has a well equipped Class Room with all technical facilities and each station has a well organized supportive material in the form of equipment, dummies, instruments etc.

USAID-MCHIP (JHPIEGO) provides all technical support in the form of materials, in-station trainers and visiting faculty

This is a good initiative and may be scaled up to all over the state and may be for all over India, after evaluation of programme.

Chapter: 5 Recommendations

Infrastructure development

- The constructing agencies should be penalized if there are delays in the construction and handing over of building to the health departments.
- There should be active involvement of Health Departments at state and districts levels in designing the OTs, wards, labour rooms etc. as per the local needs
- The Health Facilities should be assessed comprehensively for their service delivery as per IPHS.

Health Human Resources

- The Lab technicians should be provided integrated training for better and optimal utilisation of services as multi-skilled service providers
- Proper mapping and then rational deployment of ANMs is required.
- The ANMs should share carbon copies of the data instead of sending registers to Block PHC for data entry (HMIS)
- The Districts should explore for PPP to augment RCH services
- The Districts should establish nursing college to augment the Staff nurses requirement at the district level.
- The sanctioned positions of X-ray Technician needs to be increased.
- District should have a clear cut training plan for BEmoC, CEmoC, MTP, NXV, IUD, Minilap etc. with post training follow up and monitoring.
- Districts should make induction manuals for the DPMU staff.
- Impact assessment of MOs trained should be done by Civil Surgeon.
- Rational deployment of trained providers at the facilities should be prioritized by Civil Surgeon.

Health care service delivery- facility based- quantity and quality

- The quality of ANC provided by ANMs needs to be improved. ANMs should be mandated to check BP and Hb levels of all registered ANCs.
- The Staff Nurses placed at the health facilities to be provided with SBA trainings.
- The RKS meeting to be conducted regularly with proper documentation and action taken reports.
- Training of ANMs should be conducted for maintaining registers and entering accurate data (HMIS).
- All MO/ICs should undergo EMoC training.
- Calcium supplementation to be provided to all registered pregnant women to prevent Pregnancy Induced Hypertension (PIH).

Outreach services

- 23 vacant posts of MPWs to be filled at the earliest to enhance the outreach services

ASHA Program

- The selection criteria for Sahiya should be made stricter and consensus of community should be taken.
- Timely payments should be made to the Sahiyas to increase their motivational level.

RCH II (Maternal Health, Child Health & Family Planning Activities)

- The quality of ANC provided by ANMs need to be improved. ANMs should be mandated to check BP and Hb levels of all registered ANCs.
- All MO/ICs undergo BEMOC and CEMOC training.
- Maternal Death Review Committee to be set up at the District level.
- New born care facilities to be introduced across all health facilities where deliveries are taking place.
- At least one SNCU to be operationalised at the District level.
- NSSK trainings to be prioritised for the MOs, ANMs and SNs.
- IEC/BCC activities to be strengthened for creating demand for OCP, ECs and condoms.

Preventive & Promotive health services including Nutrition and Inter- Sectoral convergence

- The take home ration (THR) supply should be ensured through inter-department coordination by the state and district authorities.
- The use of salt testing during VHNDs should be ensured along with consistent supply of salt testing kits.
- Ensuring better cooperation from the Women & Child development Department for support to the malnourished children admitted in the MTCs.
- The new nomenclature of Village Health Nutrition Sanitation Committee (VHNSC) to be universally implemented with its status as a subcommittee of Gram Panchayat to be established.
- Special focus on School Health Programme is required. The select staff may be sent to other state/s where a well established & productive School Health Program is functioning

Gender issues & PCPNDT

- There is need for IEC on PC& PNDT Act services
- The district should have a dedicated PNDT cell.

National Disease Control Programmes

- Surveillance activities should be strengthened through recruitment of Surveillance workers which are only 248 in-position against 1463 sanctioned posts.
- There is a huge gap in required and sanctioned position of LTs in the state which needs to be filled in a time bound manner.
- Effective preventive and control measures for Japanese Encephalities need to be taken. State should plan for vaccination programme in the affected districts.
- Human resources under DCPs need special attention . Posts of non medical supervisors, physiotherapists and health educator needs to be filled.
- Participation of private institutions in RNTCP activities should be encouraged. Only 1 out of 11 major private institutions is involved in the program.

Program Management

- The roles and responsibilities of PMU staff should be well defined
- The DHS meetings to be held on monthly basis.

Procurement System

- A new fully functional warehouse be established at the district level to maintain drug safety.
- Renovation /construction of drug stores at the block level.
- Timely release of funds to purchase the required drugs

Effective use of Information Technology

- Hands on training for the district and Block level for use of HMIS need to be prioritized.
- The Civil Surgeon should be oriented in the use of information from HMIS for planning, programme monitoring and Management.

Financial Management

- Though in principle, the state should monitor the activities on a monthly basis. It is recommended that instead of a monitoring committee, a special monitoring cell be established at the state as well as district level for regular monitoring of the progress of the activities
- The Model Accounting Handbook should be in place at the earliest in order to make full utilization of funds. In addition the block as well as the district level accounts managers should be provided appropriate training on the general financial regulations of GoI and Jharkhand state
- Training and capacity building programme for finance personnel at the state and district level should be organized periodically. A concurrent auditor should also be involved in such programme. For this purpose service contract may be outsourced.

- As an effective internal control, duties of the staff should be segregated and the person who maintains the books of account or having access to the books of accounts should not be signatory to bank account. Accordingly, at state level SFM should be signatory of bank account instead of SAM. Though, custodianship and preparation of cheque by the SAM may be continued.
- Fund disbursement should be as per the approved action plan and not activity wise. Sometimes late disbursement of fund creates bottleneck in performing such activity.
- Concurrent audit mechanism should be effectively implemented. Monitoring of concurrent audit should be made by the state. During the interaction with finance personnel, it was observed that presently state has not much emphasis on concurrent audit. Preferably local level firm may be appointed as concurrent auditor, in order to provide a handholding support.
- At district level account assistant should be appointed to support the District Account Manager.

Decentralized Local Health Action

- Active involvement of PRI members in the functions of VHSNC should be ensured by the state and district authorities.
- In Preparation of DHAP PRI members should be involved.
- Capacity building of VHSNC members for appropriate funds utilization.
- RKS planning should be done with involvement of PRI members.

Chapter 6: State Specific Issues

Concluding Meetings held with:

i. **Collector Deoghar Shri Meena, (on 13.11.11.)**
ii. **Principal Secretary-Health Shri K. Vidyasagar and Mission Director Ms.Aradhana Patnaik (On 14.11.11.)**

Meeting with District Collector of Deoghar District:

The team members called on the District Collector Shri Meena. As advised by the team leader, the points were consolidated and presented to the Collector by the visiting team and the following matters were highlighted:

- The monthly meetings of the District Health Society under the Chairmanship of the Collector had not been held during the financial year 2011-12 which had affected the progress of activities that were awaiting clearances. The meetings were held regularly during the years 2008 and 2009. Shri Meena informed that he had been away on a training programme and thereafter the district authorities were all preoccupied with the annual Shrawani Mela. He indicated that he would be holding monthly meetings hereinafter.
- The District Program Management Unit had not had a Program Manager for the past three years and the new DPMU who had joined recently had received no orientation and appeared unequipped to do justice to the NRHM programmes.
- The district hospital was very short of specialists and complaints were voiced that patients who had been brought by the *sahiyas* were asked to go to private facilities in stead. There was also a need to look into the shortage of specialists in the district hospital in order to improve the quality of services being offered to the public.
- Critical infrastructural deficiencies were also pointed out e.g. absence of a ramp or lift for pregnant women to access the first-floor labour room. The Collector stated that he had sent a proposal for this and other requirements to the Mission Director but approval had

not been conveyed. The team offered to reiterate the need for the ramp to the Mission Director which was welcomed by him.

- It was highlighted that the visits to various health facilities had shown that there was considerable variation in the quantum of work undertaken by the Medical Officers posted at different CHCs and PHCs ; some doctors were undoubtedly attending to a large number of patients while others were seeing a sub-optimal number of patients in the OPD . Besides deliveries, the in-patient load was next to negligible. The Collector was informed that the deployment of doctors and their regularity in visiting the sub-centres needed his attention.

The Collector indicated that he would be placing a direct recruit IAS - SDO working under him to specially address the managerial problems that were brought to his notice concerning the medical and public health work being done under the umbrella of NRHM in Deoghar district.

Meeting with Principal Secretary (Health) and Mission Director-NRHM

On the final day the team leader made the de-briefing presentation before the Mission Director and the state health officials. The Principal Secretary - Health joined at a later stage during the presentation. After the meeting concluded, the team briefed the Mission Director and the Principal Secretary - Health in detail, to emphasize the cross-cutting issues which were militating against the overall performance of NRHM. Certain local as well as policy related factors were reducing the impact of excellent work being done at the community level.

The morale of the doctors was very low. They constantly compared their salaries with their counterparts in the states of Bihar and West Bengal. They were dissatisfied because their career progression and service conditions were not being looked into. The Principal Health Secretary agreed that this was in fact a major constraint and he was already attending to it.

It was also pointed out that there was an absence of leadership and a line of command and control in the Deoghar district where the prevailing conditions left a lot to be desired. Coordination between the heads of various vertical programmes and the DPMU was not in evidence and the civil surgeon was not playing a focal role as expected. Due to this, the synergy

that was expected was missing and the goals of NRHM were getting diffused. The Principal Health Secretary indicated that he would be personally looking into the question of filling up the doctors' vacancies and would also try and have a cadre of specialists created. 500 posts of doctors were also being filled soon.

The issue of district hospitals being taken up for ISO Certification was discussed and need for giving priority to basic facilities first, was emphasized.

The issue of nomination of many PHCs as CHCs was pointed out. Because the facilities so nominated were not fulfilling criteria of PHC even.

The issue of Private Practice done by Medical officers was discussed at length because this was affecting the health care. In most of the places it was pointed out by local media and community members that most of the medical officers were not attending government facility but having private practice during office duty hours. The principal Secretary-Health assured necessary action by state in this regard.