

7TH COMMON REVIEW MISSION- JHARKHAND

11TH NOVEMBER- 17TH NOVEMBER

2013-14

MinistryOfHealth&FamilyWelfare,
GovernmentofIndia

Table of Contents

Team Composition	2
Facilities visited	2
Profile of the State	3
Summary of Findings	7
TOR 1. Service Delivery	13
TOR 2. Reproductive and Child Health	24
TOR 3. Disease Control Pgrammes	38
TOR 4. Human Resource & Training	42
TOR 5. Community Process & Training	47
TOR 6. Information and Knowledge	53
TOR 7. Health Care Financing	58
TOR 8. Medicine and Technology	63
TOR 9. National Urban Health Mission	65
TOR 10. Governance and Management	67
NUHM FGD1	71
NUHM FGD 2	73
NUHM FGD 3	76

Team Members

District Bokaro	District Sahebganj
Mr. Dilip Kumar, Director (NRHM)	Mr. Vikas Arya, Director (EPW)
Mr Sanjay Kumar, Deputy Director (MCTS)	Dr. Bhattacharya, NVBDCP
Dr. M Jalis Subhani Deputy Advisor (AYUSH)	Mr. Samarjit Chakraborty, State Director PFI
Dr Sachin Gupta, USAID	Dr. Sovesh Dass, Consultant MoHFW
Dr Mithila Dayanithi Consultant MoHFW	Ms. Monica Chaturvedi, PHFI
Mr Prabhash Jha, Consultant MoHFW	Dr Shalini Singh, Consultant NHSRC
Ms. Shraddha Masih, Consultant MoHFW	

Facilities Visited

District Bokaro	District Sahebganj
SDH Chas	Sadar Hospital, Sahibganj
CHC Nawadih	SDH Rajmahal
CHC Peterwar	CHC Taljhari
CHC Chas	PHC Udhawa
APHC Chalkari	PHC Mirzachoki
HSC Chapri	HSC Koyla Bazar
HSC Harladih	HSC Khorikhotana
HSC Partar	HSC Tertaria
HSC Bijulia	HSC Madansahi
Bokaro General Hospital	HSC Maharajpur
UHC Yadohadih More	HSC Sakrigali and Sahiya meeting
AWC Pindrar	VHND HSC Karalh (Khorikhotana)
MMU Umari	MCH, MTC, Mamta Vahan

1. Profile of the State

Rural Population (In lakhs) (Census 2011)	250.37
Number of Districts (RHS 2012)	24
Number of Villages (RHS 2012)	32394
Number of District Hospitals	21
Number of Community Health Centres (RHS 2012)	188
Number of Primary Health Centres (RHS 2012)	330
Number of Sub Centres (RHS 2012)	3958

Status of Health Indicators

Sl. No	Indicators	Jharkhand	India
1	Infant Mortality Rate (SRS 2010)	38	42
2	Maternal Mortality Ratio (SRS 2007-09)	261	212
3	Total Fertility Rate (SRS 2011)	2.9	2.4
4	Under-five Mortality Rate (SRS 2011)	54	55
5	Institutional Deliveries upto June 2013 (HMIS)	102763	3303609
6	Full immunization (In thousands) upto June 13 (HMIS)	157	4863

Sl. No	Activity	Status
1	24x7 PHCs	Out of 330, only 86 PHCs are functioning on 24x7 basis.
2	Functioning as FRUs	47 (21 DH, 7 SDH and 19 CHC) are working as FRU.
3	ASHAs Selected	40964 ASHAs selected, 40115 have been trained in 1 st Module and trained upto 4 th Module, 40964 ASHAs are trained upto 5 th Module and 33779 ASHAs trained in Round 1 & 26687 trained in Round 2 & 366 trained in Round-3 of the 6 th & 7 th Modules.
4	ANMs at SCs	Out of 3958 SCs, 2355 are functional with 2 nd ANM.

5	Contractual appointments	21 Doctors, 359 Paramedics, 509 Staff Nurses, 192 Specialists & 5185 ANMs are positioned under NRHM.		
6	Rogi Kalyan Samiti	557 facilities (21DH, 170 CHCs, 36 Other than CHCs, 330 PHCs) have been registered with RKS.		
7	Village Health Sanitation & Nutrition Committees (VHSNCs)	Out of 32394 villages, 30012 villages constituted VHSNCs.		
8	MMU	100 MMUs are operational in 24 Districts		
9	VHNDs	103058 VHNDs were held during 2013-14.		
10	Infrastructure Strengthening	Facility	New Constructions	
			Sanctioned	Completed
		CHC	28	19
		PHC	11	10
		Sub Centre	438	83
11	New Born Care Units established	Sick New Born Care unit (SNCU)		2
		New Born Stabilization Unit (NBSU)		7
		New Born Care Corner (NBCC)		203

Demographic Profile

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 2012)	24.7	21.6
Crude Death Rate (SRS 2012)	6.8	7.0
Natural Growth Rate (SRS 2011)	18.1	14.7
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

Physical Progress of Institutional Deliveries and JSY

Year	Institutional Deliveries	JSY beneficiaries
2005-06	52293	0
2006-07	68900	123910
2007-08	82000	251867
2008-09	167000	268661
2009-10	296000	215617
2010-11	345000	386354
2011-12	353583	559507
2012-13	432667	199064
2013-14	102763	51338

Reproductive and Child Health Programme (RCH)

a) Immunization Coverage

(Figure 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 the last 2 weeks who were given advice or treatment (%)	58.4	56.0

c) Information on selected FP indicators

Indicators	DLHS -2 (2002-04)	DLHS-3 (2007-08)
Couple Protection Rate : Any modern method (%)	31.1	30.8
Total Unmet Need (%)	34.2	34.7

Summary of findings

Strength

State has added substantial new infrastructure during the NRHM period: 12 DHs, 188 CHCs. Currently all CHCs and more than 90% of PHCs function through government buildings. While recognizing its constraints of huge geographic dispersion and challenges of left wing extremism that limit access to higher facilities, state has consciously planned strengthening its peripheral facilities and provision of staff quarters have been made in majority sub-centres designated as delivery points.

Overall for the state there is a consistent increase in figures for OPD and IPD in the last three years. OPD service utilization increased by 35% from 2009 -10 to 2012-13 and for the same period a 46% increase in utilization for institutional delivery is noted. This can be attributed to increased utilization of free services for maternal and new born care offered under JSSK. State focus of strengthening delivery points with adequate manpower and infrastructure also led to an increased utilization for IPD services and a substantial increase of 135% is noted on this aspect.

Initiative of Referral transport in the form of "Mamta Vahans" has definitely contributed in increase in institutional delivery across the districts. Government of Jharkhand has established a referral network in all the 24 districts of the State. Call centres have been established at the district level. The call centres are operational round the clock with trained operators working in 8 hours shifts. Vehicles have been arranged through local providers at the panchayat level and all vehicle owners have a Memorandum of Understanding (MOU) signed with the State Government. The entire initiative runs in PPP mode with the call centre operators and logistics being facilitated through State funds and the vehicles being privately owned.

State shows a strong commitment to develop a State-specific Communication Strategy for Maternal and Child Health using a life-cycle approach. A functional Social and Behaviour Change Communication cell exists with experts for Research and planning, skill building and Monitoring and Evaluation. A wide range of expertise from Mass and Alternate media, Creative art design, Consultant media/IEC, Technical expert capacity building has been incorporated. The State is using a media mix approach and there is a shift in methodology from IEC to SBCC. A transition from adhoc IEC to more structured thinking with emphasis on IPC along with mass media is now seen.

Concept of observing quarterly New Born Week through Sahiyas is a positive move. Eleven districts with high IMR observed new born week from 15th -21st November, 2013. This aimed to improve detection of high risk new-borns through Sahiyas. As per the reports of the first three days- 10716 new-borns were visited, 578 were identified as high risk, 283 were referred and 66 infant deaths were reported. In districts where systems capacity is already geared to handle sick new-borns the combination of facility care and home based care through Sahiyas will definitely yield positive outcomes.

Malnutrition treatment Centres have been established across all the districts and a need based planning has been done in terms of placing NRCs in high prevalence areas. All Sahiyas have been trained in identifying malnourished children and this has increased referrals to MTC by ten times from FY 2010-11.

Strong handholding and high level of commitment by the team of Village Health Sahiya Resource centre has ensured continuous strengthening of community process. A strong Sahiya programme, well established VHSNCs, training of PRIs and members of VSHNC in community based monitoring are positive initiatives. Streamlined mechanisms have been created for -training of Sahiyas and supportive supervision is systematically undertaken using the protocols of performance monitoring.

Workforce management for human resources for health is gaining focus and implementation of online HRMIS for HR data base is a promising step. Recruitment of regular doctors was adjourned since statehood but it was reinitiated in 2012.

A new initiative in the form of State Review Mission every quarter to strengthen programme monitoring and ensuring supervision by programme experts. The team for this review is an eight member team comprising of programme managers and consultants from SPMU, public health experts, representatives of disease control programmes, SHSRC, development partners etc.

Mobile Medical Unit running in PPP mode with local NGOs has been providing regular services as per micro plan in difficulty/inaccessible terrain.

Weakness

The state needs to strengthen and upgrade the existing infrastructure. Designated facilities are not having adequate infrastructure as per the service delivery norms (bed strength).

Infrastructure up grading, and constant supply of drugs and new born care equipment like mucous suckers needs to be planned for high case load

delivery points particularly HSCs conducting more than 40-50 deliveries in a month.

There is irrational deployment of medical officers in the districts and LSAs and EmOC trained MOs are not being used in strengthening FRUs. There was only one obstetrician and gynaecologist Specialist who was posted as a District TB Officer is also working as a Blood Bank Officer. Similarly there was only one paediatrician who was in charge of an MTC wing of the hospital.

In the Bokaro district there was no blood bank and no functional blood storage unit due to lack of transformer.

Drug Procurement System- State needs to strengthen the Drug Procurement System. There was no clarity on the procurement of drugs at all the levels. There were inadequate drugs available at the facilities visited. Central rate contracting for only 112 drugs has been done. Action taken by State Headquarters not conveyed at the district level and district level procurement of the same drugs being done. Essential drug list not known at the district level and medicines tendered at the State and District level not known to field staff (MOICs or DS).

Availability of drugs and equipment as per 5X5 RMNCH+ A matrix is missing across the facilities. Unavailability of either equipment or reagents for routine diagnostics such as urine albumin and Hb% leads to incomplete ANC for pregnant women right from DH to HSCs. Lack of distribution of Maternal and Child Protection Cards severely hampers tracking of ANC status and immunization services for mother and child. There was no IFA supply in the facilities in Bokaro from the last one and half year which leads to increased out of pocket expenditure of patients.

Staff sensitization is missing on standard protocols. Facility based new born care needs to be strengthened; need to ensure creation and optimal utilisation of SNCUs and NBSUs through adequate posting of staff trained in NSSK and F-IMNCI. Drugs availability and equipment supply also to be improved and provided free to sick new born.

Out of pocket expenditure still reported on drugs and some diagnostics in spite of rolling of JSSK; awareness on JSSK entitlements and free provision of drop back low. Backlogs of JSY payments still reported in certain blocks.

Weak systems for maternal and infant death review which need to be improved through greater action on facility and community based reporting with verbal autopsy for all cases so that the time, place and cause of death can be identified and corrective actions can be planned.

Consolidation of achievement in malaria made so far, ABER has decreased to sub optimal from 7.1 % to 6.9% this year and needs to be maintained at >10%. Sahiyas to be involved in case detection & treatment of Malaria to further reduce the API and balance quantity of LLIN should be procured at the earliest. Entomological surveillance activities to be started in full earnest.

Recruitment in district level is in abeyance for the past several years and adhoc/ looking after arrangements are in vogue; (53%) posts of MOs have been filled so far against the target of 2983. Also the State does not have a specialist cadre, which makes it difficult for the planners to identify Medical Officers with post-graduation and post them in the identified FRUs. Finding specialists willing to join and serve in the designated FRUs remains a major hurdle and could be responsible for ineffective delivery of services.

State to operationalize more FRUs in the District Bokaro as per the norm there should be 4 FRUs. Skill building of Medical Officers on EmOC and LSAS is urgently required to operationalize more FRUs.

IEC/BCC needs to be strengthened to create the awareness on National Programs and Schemes such as JSY/JSSK.

Maternal and Child Health registers were not available in the districts. There was no uniformity in the record maintenance.

Delayed payments for Sahiyas for as much as six to nine months and drug kit unavailability are two persistent challenges for the programme since the last several years and need immediate action.

Standard treatment protocols to be followed for quality of care maintenance. Proper upkeep and adequate number of ambulances to be deployed for utilization of transport facilities.

Capacity building of the district and block level officials need strengthening to increase the demand generation of services. Proper advocacy and social mobilization planning are required to reach hard to reach population pockets.

The overall maintenance of the facilities and provision of services like food for the patient to increase the duration of stay at the facility after institutional delivery.

Postpartum Family Planning services need strengthening especially PPIUCD In terms of immunization services, record keeping, tracking of the left-outs and dropouts, and AEFI reporting needs to be strengthened.

Quality of service provision at VHNDs need to be strengthened along with convergence and action on social mobilization activities.

The state needs to initiate activities planned for urban health what have been proposed to the GOI through NUHM PIP FY 2013-14

A grievance redressal cell needs to be established at all the facilities at the district level to address the issues related to the treatment of the people.

E-transfer of funds up-to Block Level, but no computerized system for the maintaining the records. Tally recently been installed in CHC&PHC but not operational. District, Block and PHC accountant not trained in Tally ERP-9. Need for more training and support from the state level to make the system operational. Although the finance and accounts staff are trained in financial procedures regarding NRHM, they lack clarity with regard to the guidelines and procedures of NRHM.

Vacancies in the district and block programme management unit affects management of the programmes. Dedicated program officers are missing and Medical officers are being given additional charge. Programme managers find it difficult to discharge their duties due to limited capacities as except for adhoc orientation on certain schemes, no induction training or orientation has been conducted so far. There is also no existence of public health cadre

Findings of 7th CRM

TOR 1: Service Delivery

A. Adequacy and access to health care facilities

The state did substantial addition in the number of facilities through the creation of new CHC and PHC in the first two years of NRHM, However from 2007 till now the number of facilities at all levels remain unchanged and progress is noted in infrastructural strengthening and enabling these facilities through government buildings.

Table 1 -Change in Public health facilities from 2005-2013

Type of health facility	RHS 2005		RHS 2007		Total number of functional facilities	RHS 2012		
	Total number of functional facilities	Facilities In Govt Building	Total number of functional facilities	Facilities In Govt Building		Facilities in Govt Building	Facilities in rented building	Rent free Panchayat/Vol Society building
Sub Centre	4462	NA	3958	1736	3958	1969	1066	923
PHC	561	NA	330	117	330	252	30	48
CHC	47	NA	194	170	188	182	0	0
SDH	10	10	10	10	10	10	0	0
DH	21	21	21	21	21	21	0	0

**there is a reduction in the number of centers functioning at the end of the 10th plan as compared to those functioning at the end of the 9th plan due to the division of the state.*

The facility planning was done according to 2001 population and needs to be increased as per the 2011 Population Census.

Table 2- Required Facilities as per 2011 census population

Facilities	Functional Facilities as per RHS 2012	Required facilities as per population (Census-2011)	Shortfall	% shortfall
SC	3958	6043	2085	35%
PHC	330	964	634	66%
CHC	188	241	53	22%

State guidelines for establishing health care facilities follow IPHS norms for tribal and geographically dispersed areas and the population density per facility is found to be lower in districts like Sahibganj.

Table 3-Facilities in Tribal Areas

Jharkhand	Total number of functional facilities	Facilities in Tribal Areas
Sub Centre	3958	2053
PHC	330	123
CHC	188	90

Source: RHS 2012

One notices wide variation in the density of the population covered by CHCs, PHCs and HSCs in district Sahibganj. The distribution pattern shows that there is a substantial load on HSCs and CHCs while the population burden for PHCs is low. Though 61 HSCs out of total 139 cover a

population of less than 5000, there is 77 of them which cater to a population of more than 5000. Of this a substantial number of 21 actually cover more than 10000 population. (IPHS require only 1 sub-centers per 3000 population in hilly, tribal areas). Population density for 6 out of 10 PHCs is less than 10,000. Most CHC covers a population of more than a lakh except CHC Pathna which has a population of 86,861. Even this is clearly above 80,000 norm of IPHS. DH is at 5 lakh population. Distribution of facilities is clearly adhoc and there is a need to redistribute the population and increase the caseload at PHCs and if still not sufficient increase in number of HSCs could be planned for.

In Bokaro there is no District Hospital. A new hospital building has been recently constructed which is yet to be operationalized. Currently Bokaro General Hospital and SDH Chas are covering major service delivery of the district.

Access is a big challenge for both Sahibganj and Bokaro. Geographic barriers, cultural factors, illiteracy and overall highly poor condition of general infrastructure such as roads and public transport are limiting factors.



Road conditions in Sahibganj



Tribal group in Sahibganj



Route en route to CHC Nawadih, Bokaro

B) Infrastructure

Table-4 Health Infrastructure in the District Visited

	Jharkhand		Bokaro		Sahibganj	
	No. of facilities	Facilities functioning in govt. building	No. of facilities	Facilities functioning in govt. building	No. of facilities	Facilities functioning in govt. building
Sub Centre	3958	1969	116	72	139	126
PHC	330	320	16	12	10	10
CHC	188	188	8	8	7	7

*12 PHCs running in HSC **9PHCs running in HS

Table-5 Status of Infrastructure completion in Jharkhand using NRHM funds

Type of Facility	Sanctioned	Ongoing Construction	Completed	Hand Over	Work Stopped
CHCs	22	16	5	4	1
PHCs	11	7	4	3	0
HSCs	438	262	157	109	19
Total	471	285	166	116	20

As per the data in above table work is in progress in 60% of sanctioned facilities which have been taken for infrastructure development. It has been completed in 35% of facilities but actual handing over has been done for only 24% facilities which is very low. If we see the table below, slow progress is also noted for infrastructure work being sanctioned through state funds and only in 29% facilities actual handing over of sanctioned projects has taken place.

Table 5- Infrastructure status from State Budget

Type of Facility	Sanctioned	Ongoing Construction	Completed	Hand Over	Work Stopped
DH	23	12	11	9	0
SDH	12	5	5	4	2
MCH	26	15	6	3	5
CHC	133	89	37	28	7
PHC	110	63	44	37	3
HSC	416	146	255	130	15
Jharkhand	659	298	336	195	25

There is gradual progress in infrastructure development as pace of completion of construction activities is slow. Most PHCs and CHCs in Jharkhand now function through government buildings. But about 55% sub centres are still operating through rented buildings.

In comparison to the Bokaro pace of infrastructure development is slightly better for Sahibganj. Sahibganj has all CHCs and PHCs functioning through government buildings. On the other hand Bokaro has no district hospital so far, a new District Hospital has been constructed but is yet to be operationalized. SDH Chas is functioning as District Hospital. The district still has four out of sixteen PHCs and about 60% HSCs operating through rented buildings.

No MCH wing has been made in the Bokaro whereas it is functional in District Hospital Sahibganj.

Infrastructure planning in both districts is also not done as per the comprehensive need based approach. Some HSCs having a delivery load of 60-90 per month are functioning in one room. This was particularly noted in HSC Tetihari in Borio block of Sahibganj district. APHC & CHC visited were not as per the IPHS standard. Infrastructure and bed strength of the facilities were not as per the IPHS norms. APHC was functioning in two room building with 2-4 bed strength.

These gaps noted in both the places are due to lack of strategic planning, no monitoring of activities by the district health administration and limited supervision.

C) Utilization of Facility Based Services:

Table 6- Service Delivery Improvement in Jharkhand:

Service	2009-10	2012-13
IPD	230821	542949
C-sections in public	3782	5545
Institutional Delivery	223908	326049
OPD	8248853	11126524

Data Source: HMIS for Jharkhand

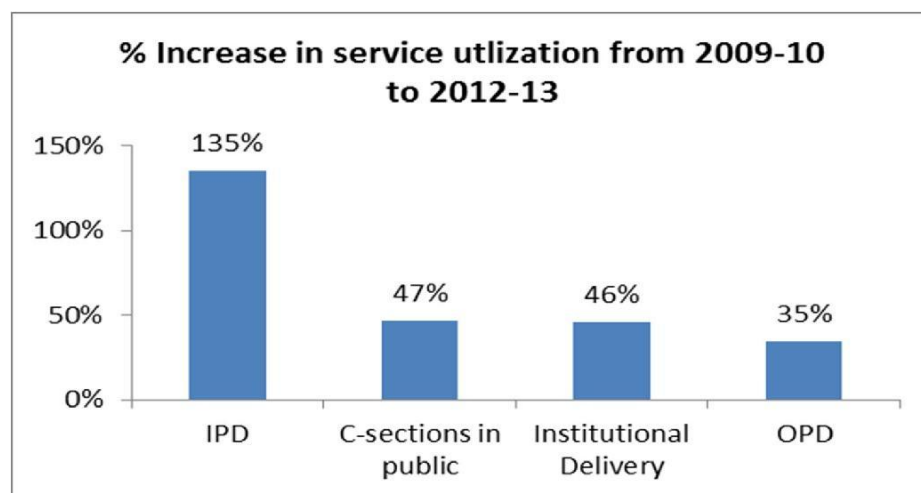


Table-7 Pattern of OPD and IPD utilization in districts visited

	2009-10			2010-11			2011-12			2012-13		
	State	Bokaro	Sahibganj	State	Bokaro	Sahibganj	State	Bokaro	Sahibganj	State	Bokaro	Sahibganj
OPD	8248853	376410	425325	10506760	408435	354833	10807109	443142	337094	11126524	474744	382229
IPD	230821	12528	13112	408148	9278	18117	543206	10118	204567	542949	11,488	37098
Bed Occupancy Rate	NA	17.69	21.77	NA	12.41	22	NA	12.41	23	NA	4.31	44.79

Data source-HMIS

OPD and IPD figures for the state in 2012-13 show a marked increase from FY2009-10. Though IPD increase is a maximum of 135%, a substantial increase for OPD and institutional delivery by 35% and 46% respectively is also observed.

Last three years data for Bokaro and Sahibganj both shows a positive trend in the utilization of OPD and IPD services as demonstrated by the table above. As per the observations during the facility visits – in Sahibganj CHCs had a range of 50-200 OPD per day and PHCs 20-50 per day.

In Sahibganj increased case loads are reported particularly from the delivery points, which have been strengthened with infrastructure and manpower and hence attracting high caseloads for deliveries. IPD figures shown above are primarily from the CHCs and District Hospitals which were found crowded during the visits, but very low in the PHC level. This arises from the fact that majority PHCs do not have adequate manpower or infrastructure to handle IPD cases.

In Bokaro low Outpatient and Inpatient services were found in all the facilities visited. Service delivery is limited to RCH services. The OPD visit per capita population is 0.3 for Sahibganj and 0.2 for Bokaro. The difference in IPD as a percentage for OPD is larger as it is 9.7% in Sahibganj and only 2.4% for Bokaro. One reason for this is higher availability of private sector options in Bokaro.

No Blood Bank in the District Bokaro and no functional blood storage unit in the FRU due to power deficient.

AYUSH

Colocation of AYUSH facility with district hospital has been done only at District Hospital Sahibganj and one medical officer has been posted. The monthly OPD of AYUSH clinic reaches to approximate average of 40 cases in a month. The whole programme of co-location of AYUSH facilities in CHCs and DH has not been initiated on the ground at CHC or District. Hospital in Bokaro.

CRM team flagged an issue with the state officials that state has not been able to utilize funds worth Rs.20.44 crore which were released during the FY-2008-09 and UC of Rs.27.78 crore are still pending. As per the state officials the funds are available with the state health society and were to be released for renovation/ publication/advertisement for the programme. The funds could not be utilized due to a State Government circular which stipulate the requirement of the approval of cabinet for any programme figuring an estimated expenditure of above one crore rupees . The issue was raised in the state level debriefing and it was clarified that funds are now a part of NRHM and can be utilized as per the scheme provisions.

D.) Quality of Care

Clinical Quality of Care: A trend to write outside prescriptions was particularly not followed by the doctors but clearly they were compelled to write on account of drug unavailability in the hospitals. Standard treatment protocols made by the state are not readily available indicating the current non - use of these essential tools of clinical quality of care.

Biomedical waste management: There is no unit for Centralized Sterile Services Department is in place in almost all facilities visited. Preferred choice of Bio-medical waste disposal is deep –pit burial and is being used.

Cleanliness and hygiene. Overall cleanliness in the hospitals was reasonable for Bokaro while facilities in Sahibganj still have a long way to go in attaining adequate standards of sanitation and hygiene.

Signage: Signage's were found to be in plenty but Citizens charter, JSSK entitlements were not prominently displayed in Bokaro and Sahibganj.

Security Was not an issue as the facilities had compound walls and larger facilities had security arrangements. There were no problems of stray animals.

Water & Electricity: There was a shortage of water in some of the facilities visited in Bokaro. Also there was a problem of electricity in some of the facilities visited in Bokaro.

Patient Satisfaction level: There are no mechanisms to assess patient satisfaction level. Grievance Redressal mechanism has not been established. Exit interviews and discussion with the community highlighted instances of the rude behaviour of the doctors at the public health facilities.

A system of quality assurance was not in place in Sahibganj and Bokaro thus monitoring the same is not defined and there is no action plan or action taken on these issues.

E.) Referral Transport:

An initiative of Referral transport in the form of “Mamta Vahan” has definitely contributed in the increase in institutional delivery across the districts. The tie up with the Panchayat for implementation of this is highly appreciated.

Government of Jharkhand has established a referral network in all the 24 districts of the State. Call centres have been established at the district level. The call centres are operational round the clock with trained operators working in 8 hour shifts. Vehicles have been arranged through local providers at the Panchayat level and all vehicle owners have a Memorandum of Understanding (MOU) signed with the State Government. The entire initiative runs in PPP mode with the call center operators and logistics being facilitated through State funds and the vehicles being privately owned.

Toll free number was displayed in the facilities. The Sahiya's were well versed with the numbers.

Till date 2438 vehicles have been contracted under the scheme and referral services rendered to around 2, 80,243 pregnant women from the start of the initiative in July 2011 till October 2013 with more than half the referral services having been availed by the marginalized population groups.

There are 161 Mamta Vahan empanelled in Bokaro and 77 in Sahibganj to cater the referral services under JSY and JSSK scheme. Mamta Vahan were not GPS fitted. There are two ambulances in district Sahibganj which are not functional. Bokaro has 21 ambulances (6 Govt+ 15 MLA fund) which are placed at 3 SDH and 8 CHCs which helps in inter facility transfer.

The state plans to launch 108 Emergency Referral Services by the end of FY 2013-14.

Table 8- District wise details of service delivery by Mamta Vahan are as follows:

		Home to facility			Facility to Home			
	District	Call Received	Service Provided	%	Call Received	Service Provided	%	% Utilizing Mamta Vahan in Return Service
1	Sahibganj	4746	4727	100	2793	2793	100	59
2	Bokaro	1847	1847	100	1487	1487	100	81
	Jharkhand	44643	42490	95	28935	28537	99	67

One reason for the low drop back rate is lack of awareness in the community regarding this provision and also many patients who deliver at sub center prefer to return on their own.

F.) Mobile Medical units:

The state has 103 MMUs out of which 97 are functional in the 24 districts operated by different NGOs.

An annual contract is done with the local NGOs to provide the OPD and diagnostic services. All the arrangements are made by an NGO which includes the hiring of requisite staff and providing free drugs to the patient.

MMU have been planned to provide outreach services in all the villages particularly to tribal groups residing in inaccessible areas.

MMU field visit plan is made at the district level. Each MMU covers one village per day and conduct camps at fixed places on fixed days.

In Bokaro there were 4 MMUs placed which covers 2 blocks each. In Sahibganj there are 5 MMU to cover 9 blocks.

In Sahibganj there was an operational challenge to run huge MMU vehicle in devastated roads of the district. It is suggested to supplement this with a smaller vehicle which is easy to manoeuvre and can actually ensure better reach to those in need in difficult areas.

Its functioning could not be observed and could not be validated by discussion with the community.

In the MMU visited in the Bokaro X-ray machine was not functioning from last 2-3 months.

Table 9- Services offered by MMU in Jharkhand state.

Financial Year	No. of MMUs	Total no. of Patient observed	Total X-ray	Total Patho. Test	Total ECG Conducted	Total Cases referred
2012-13	103	1847414	2544 4	26930 3	13307	6155 9
2013-14 (Sept.)	103	627724	8777	95390	3657	1573 7
GPRS is installed in 39 Vehicle of 10 districts – Dumka, Dhanbad, Ranchi, Hazaribagh, Simdega, Khunti, Deoghar, Gumla, Giridih, Lohardaga						



MMU In Sahibganj



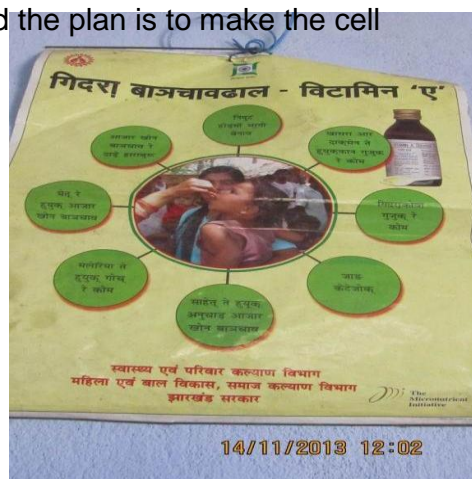
MMU at Umari, Bokaro which needs maintenance

G.) IEC/BCC

The state has a functional Social and Behavioural Change Communication (SBCC) cell which has been established through a Government Order. The cell is being supported by UNICEF for a period of 2 years and the plan is to make the cell self-sustainable once the UNICEF support is withdrawn.

The state is in the process of launching State-specific Communication Strategy for Maternal and Child Health.

The State is using a media mix approach and there is a shift in methodology from IEC to SBCC. There is a transition from adhoc IEC to more structured thinking with emphasis on IPC along with mass media. In Bokaro, there was good display about the health programmes. There was IEC displayed about Filaria day observed on 11th November 2013.



Challenges	Way forward
Lack of training and proper direction	Roles and responsibilities as per qualification and designation
Lack of clear roles and responsibilities assigned	A service manual with detailed promotion guidelines with clarity
Lack of acknowledgement/recognition of work by other staff	Acknowledgment of work
Non participation in program	Knowledge and participation in all National and state health programs
No promotion	Mainstream HE and BEEs work
Work environment risky and hostile (Naxal affected)	Transportation facility for the field visit
Lack of job aids, resources and support from authorities (CS, MOIC)	Capacity building and training Opportunity for imparting training down the line
Payment delay in program implementation	Certificate course in IEC/BCC Strengthening district IEC cells
Process delay in program implementation	Support and assistance in performing duties

Recommendation

There is a need to have a good- articulated plan for both- the unreached tribal population and also for the migrants from neighbouring West Bengal in Sahibgnaj. As a first step district should map and allocate these migrant settlements under the designated area of Sahiyas so as to improve their access to health care. The greatest action is also needed to counter access and awareness issues in PTGs. One effective way is by expediting the implementation of Participatory Learning and Action through Sahiyas for increased social mobilization, as has been done in other districts of Santhal- Pragna region.

State may also consider increasing the number of HSCs as per the Census 2011 population.

Intense follow up is needed to commence work on up gradation projects taken up the year 2011-12. Immediate attention is required in strengthening the infrastructure of Sub Centres especially, which are delivery points and have high case loads. The facilities need to be provided with adequate equipment for the essential service deliveries.

Construction activities need to be streamlined with quicker completion, better quality, faster handing over to DHS.

As per IPHS norms provision of AYUSH facility should be made at PHC, CHC level.

As per IPHS norms provision of AYUSH facility should be made at PHC, CHC level. Considering the fact that the State is facing major challenges to deploy requisite HR in many facilities, the State may consider recruiting AYUSH doctors and utilizing their services after appropriate capacity building in other health interventions like RBSK, screening for non-communicable diseases, ARSH clinic etc. SBA and NSSK trainings to AYUSH doctors/paramedics can also be thought of.

An AYUSH wing can also be established in each District Hospital to cater to the specific demands for AYUSH care.

ICE chart/poster on AYUSH systems of medicine may be displayed in DH/CHCs, PHCs, Health centres etc. as part to generate the public awareness and facilities available.

A grievance Redressal mechanism needs to be set up.

Jharkhand has placed District Hospital Managers across all the districts who should be more effectively used to monitor and improve all the determinants of quality of healthcare such as-drugs, equipment, human resources, diet, security, etc.

There is an urgent need to build a system to assess patient satisfaction level. The feedback from this mechanism should form a part of regular reviews and should be used to devise strategies for improvement.

Better Signage, Citizen Charter and IEC materials for beneficiaries to be displayed at all the facilities to create the awareness about National Schemes/programs.

The state is on the verge of launching advance communication strategy using a life cycle approach. However to make the strategy more robust and for effective implementation state may consider taking wider technical inputs from national agencies.

TOR 2: Reproductive and Child Health

Table 10 –Delivery Points in Jharkhand State

Health facility	Delivery Status	Numbers in 2011-12	Numbers in 2013-14
Sub-centers	>3 deliveries per month	487	649
Primary Health Centers	>10 deliveries per month	25	59
Non-First Referral Units (FRU) / Community Health Centers (CHC)	>10 deliveries per month	138	150
FRU-CHC/Sub District Hospital (SDH)	>20 deliveries per month	31	27
District Hospital/ District Women Hospital	>50 deliveries per month	21DH	21 DH
Medical colleges	>50 deliveries per month	3	3
Accredited PHF	>10 deliveries per month	42	42

Table 11- Delivery Points in the districts visited

SNo.	Type of Facility	Bokaro			Sahibganj		
		Total number	Designated Delivery points	Functional Delivery points*	Total number	Designated Delivery points	Functional Delivery points*
Level I facility							
1	Sub center	116	86	86	139	45	45
2	Other PHC	9	7	7		3	2
Level II facility							
3	24*7 PHC	7	7	7		7	5
4	Non FRU CHC	7	1	1		7	6
Level III facility							
5	FRU CHC	1	1	1	1	1	0
6	SDH	3	3	3			
7	DH	0	0	0	1	1	1
Total							

A. Planning

Considering the geographic dispersion in Sahibganj or problems of LWE in Bokaro, the strategy of district for facility development to cater to institutional delivery has been to strengthen the peripheral facilities. One can notice emphasis on strengthening HSCs as access to higher centers is actually difficult in both the contexts.

For instance in Sahibganj, there are 64 delivery points out of which 59 are functional. 45 of these delivery points are sub centres and show good functionality in terms of institutional delivery. The district has made extra efforts for the provision of ANM accommodations because of which they are able to stay in these facilities and are providing services on a 24X7 basis. A direct outcome of this initiative plus added support through Mamta Vahan has allowed

Sahibganj to attain a figure of 65%¹ institutional delivery which is comparatively better than the state average of 45%. In the context of Sahibganj this strategy appears to work well and can be retained. However the scope of improvement remains in increasing manpower, training, strengthening infrastructure and ensuring a regular supply of equipment and drugs to the level one facility with high delivery load. For instance five sub-centres that undertake 40-90 deliveries in a month have only one ANM, function through single room and also lack equipment for essential newborn care (none of the HSCs had mucous suckers). The numbers of sub-centres also appear inadequate considering the population coverage and extent of utilization.

In Bokaro there are 105 functional delivery points of which 86 delivery points are at SC. Case load is at the periphery level facilities as there is no functional District Hospital.

The number of CHCs and PHCs are adequate. Functionality of PHCs is a concern as out of ten PHCs in Sahibganj, only 5 are providing services on a 24x7 basis and have BEmOC and NSSK trained staff. The remaining so called L-II PHCs do not have capacity of BEmOC, also do not function as 24x7 and in clinical capacity they are effectively Level I. Thus complicated cases referred from the periphery are attended only at CHCs or district hospital.

Immediate planning in Sahibganj and Bokaro is to increase the number of FRUs in both the district. Only one is functioning in Sahibganj and two in Bokaro due to unavailability of EmOC trained MO or Specialist. HR shortage is a major challenge in improving effectiveness of RCH care at the facilities. The planning for HR is weak and one can see the irrational deployment of medical officers. For instance one senior obstetrician and gynaecologist MO in Sahiganj has been made in-charge of RNTCP and also has the responsibility of blood bank. Many facilities are unable to function at full potential on account of unauthorized absenteeism on the part of MOs as well as paramedics.

Bokaro has no district hospital. There are only 2 FRUs in the district with no functional blood storage unit. There is no monitoring of the trained personnel. There was varied level services at the CHCs visited. Partograph was not maintained in all the facilities visited. In Sahibganj Safe abortion is provided only at the district hospital and at three other CHCs. So far, the district health team does not have concrete plans to extend safe abortion services in PHCs. For instance in PHC Mirzachowki there are two doctors who are MTP trained but are not functional on abortion care due to unavailability of MVA equipment.

Sahibganj's emphasis on improving newborn care services at facility level was found to be low and provision of sick newborn care was nearly negligible. There is one NBSU at the district hospital and only four NBCCs are currently operational in four CHCs.

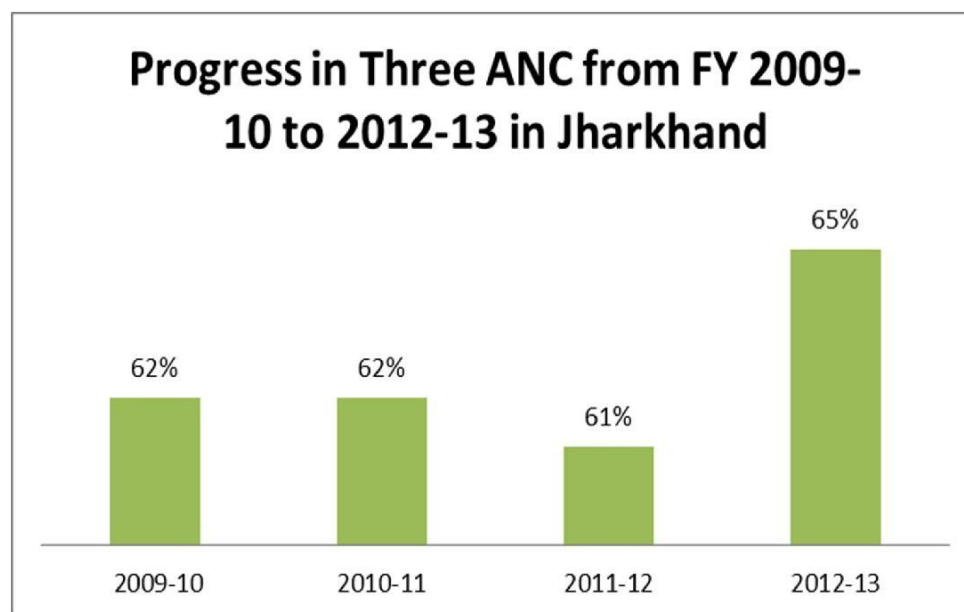
There were no SNCU in the Bokaro district. Two functional NBSUs are present, one at FRU, Jainamore and the other at SDH, Chas. Both NBSUs are well equipped.

Improvement needed in terms of record maintenance.

¹ Source District HMIS-2012-13

B. Care of mother and child:

Antenatal care



Achievement of three ANC remained more or less stagnant between FY 2009-2011. However a four percent increase is noted from the period of last CRM

As per HMIS full ANC coverage for the state of Jharkhand is at 71.4%. The numbers of pregnant women who are registered in the first trimester is only 21% for Sahibganj and further less at 15% for Bokaro. Sahiyas and ANM mentioned that very few mothers reveal their pregnancy status in first three months due to prevailing myths. Thus first ANC for many happens only second trimester onward.

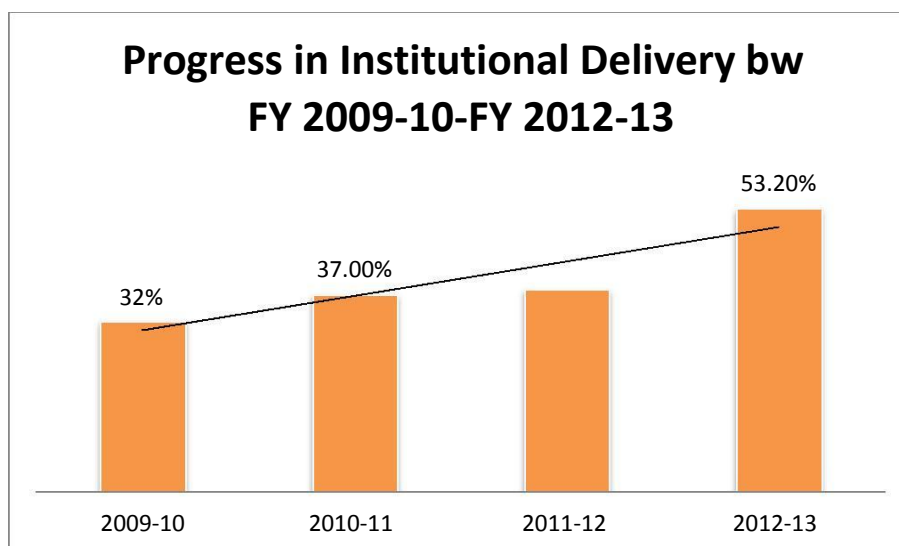
In Sahibganj the provision of all components of the ANC was largely inadequate even at the district hospital level. Women are referred to private facility for the urine albumin detection due to stock out of dip sticks and reagents. Even at the periphery (HSC and VHND) ANC is limited to weighing, BP measurement and tetanus immunization. Many women who finally agree to go for ANC check-up withdraw when they discover reaching an HSC that for certain tests (urine albumin and HB%) they will have to go higher centers. This is expected considering- the distances they have to travel, difficult access for those residing in hilly areas and bad conditions of roads. All this results in limited tracking of severe anaemia in pregnant women and low detection of cases of eclampsia and preeclampsia. If we see it against the HMIS reported known causes of maternal deaths for Sahibganj it correlates as 50% deaths are due to severe hypertension/fits.

In Bokaro due to unavailability of iron folic supply from the last one and half year, beneficiaries were asked to buy from the private shop.

Delivery and Intrapartum Care:

Table 12- Institutional Delivery in Districts visited

Name of the facility	Institutional Deliveries conducted in Bokaro		Institutional Deliveries conducted in Sahibganj	
	2012-13	2013-14 (till september 2013)	2012-13	2013-14(till Sept 2013)
HSC	3026	1579	2927	2954
PHC	1040	499	3228	1961
CHC	6583	2799	8056	4667
FRU-CHC	611	959		
SDH 1+ SDH2	611+423=1034(C-sections 13)	959+421=1380		
DH	NA		5458 (159 C-sections)	2353 (118 C-sections)



Though institutional delivery against estimated deliveries is still 53% in Jharkhand and is low compared to other high focus states. But the good news is a faster improvement is being noted since FY 2011-12. There has been a 15% hike since the period of last CRM.

As per HMIS of the total reported deliveries in 2012-13- share of Public sector in Sahibganj for institutional delivery is about 74% and only 4% deliveries happen in a private facility. The remaining are home deliveries. The rate of C-sections viz a viz normal delivery was only 1.9%. It was noted that majority of C-sections were performed in a private facility in Sahibganj. In both the districts major load of delivery services was at the periphery and CHCs. In Sahibganj many HSCs with high caseloads function in not so well maintained labor rooms, which raise doubts regarding the quality of care provision. However skill demonstration and identification of complications by SBA trained ANMs was noted to be good in both the districts.

The capacity of Sahibganj to manage complications was low mainly due to unavailability of BEmOC or EmOC trained staff. Nurses in Sadar MCH, were able to describe PPH management well and were confident about AMTSL.

In Sahibganj though magnesium sulphate was present in all the facilities, every delivery point which the team visited showed either shortage or stock outs of essential drugs like misoprostol and oxytocin. Lack of essentials like oxygen cylinder and functional resuscitation unit for the new born raised serious concern about the functioning of OT of the only functional FRU present in the district and highlighted the lack of preparedness to handle emergency cases. The photograph was seen being maintained for all labor patients only at the MCH wing of the DH.

In Bokaro, major load of delivery services were at HSC, APHC and CHC. Labor room was clean and well maintained but there was the irrational deployment of HR which was posed as a big challenge for ensuring RCH care. In CHC Petarwar avg 70-90 deliveries take place per month managed by 22 ANMs whereas in CHC Nawadih 40-90 deliveries per month were managed by 2 GNMs.

All the ANMs in Bokaro were SBA trained, but very few maintain the photograph. In CHC Petarwar in the last year only 15 photographs were made and in 24X7 PHC Harladih, ANM had no knowledge about photographs and they were not being maintained for any patient. In Bokaro, average duration of stay after the delivery is 5-6 hours.

Only ANMs and GNMs are staying in staff quarters. Doctors are not reported to be staying at hospitals.

In both districts at most of the facilities charts with standard protocols for PPH, AMTSL, Eclampsia and breast feeding were also not displayed.

Post- partum Care:

Early initiation of breastfeeding was noted.

Limited beds and lack of amenities such as toilets, electricity etc. limits 48 hours stay of mothers at the facility.

Average duration of stay after the delivery is 5-6 hours for both the districts. No patient is staying for 48 hours. The reason for this, as explained by the ANMs at the CHC is mainly lack of facilities for the patient and patient's attendants at the CHC as no food facility (for attendants) and other commitments of the mother like looking after other children at home etc.

Home Deliveries:

There are still 35% home deliveries in Sahibganj and can largely be attributed to limited access to referral transport during night hours.

Bokaro reports a higher proportion of home deliveries at 58% . One of the reasons as reported by district officials is low reporting by private nursing homes due to income tax issues.

New born care:

Inter district variations were noted with care for the sick newborn and greater efforts and concrete actions were noted in this regard in Bokaro. For example – Though the district is yet to operationalize SNCU the FRU Jainamore, has a fully established NBSU. It was seen to be functioning as per the norms, and all essential equipment was present. 48 cases were managed

at the NBSU during the last 3 months. However, there was no record of inborn vs. outborn patients. Also date of discharge in the NBSU register was missing. The other NBSU at SDH Chas was well maintained but the number of cases managed was less (53 cases since Jan 2013).

There is one NBSU in Sahibganj at the DH and NBCC is in four CHCs. Even with this lack of equipment remains a big challenge and affects operationalization. One paediatrician in the district is posted only to manage the malnutrition treatment center and attend cases of paediatric OPD, which even during the busiest days do not go beyond 20. Out of the ten C-sections done at the FRU last month, he attended only two new-borns. No SNs and only one ANM posted at NBSU have been trained in the protocols of F-IMNCI. As per the district hospital data of Sahibganj, NBSU has dealt only 35 cases of sick new-borns in the last nine months. Total IPD for infants at district hospital was 69.

Home Based Newborn Care

The Home Based New born care through Sahiyas has been initiated and functionality of Sahiyas met in both districts was noted to be reasonable. Visit to new born households with Sahiya showed good skills of weighing and wrapping. However unavailability of thermometers is an issue and limits their functionality on this aspect.

In comparison to the Sahibganj functionality of Sahiyas in Bokaro on newborn care is better.

As per district officials in Sahibganj one reason for low functionality is that 20% Sahiyas belonging to PTG or 10% older Sahiyas from Santhal community have language barriers and were unable to absorb the content of Module 6 and 7. However, the state is trying to address this issue by organizing separate training for these Sahiyas.

Status of HBNC by Sahiyas was noted to be reasonable in Bokaro where the HBNC checklists were being filled and all protocols were being followed. However, Sahiyas informed that their payment is pending since last six months.

In districts such as Bokaro where system capacity is already geared to handle sick newborns this combination of facility care and home based care through Sahiyas will yield positive outcomes earlier. On the other hand more time, greater on the job mentoring of Sahiyas and increased focus to strengthen support systems will be needed to attain similar outcomes in districts like Sahibganj.

<p>New Born Week by Sahiyas: Eleven districts with high IMR including Sahibganj started observing new born week from 15th -21st November, 2013. This aimed to improve detection of high risk newborns through Sahiyas. As per the reports of the first three days- 10716 newborns were visited, 578 were identified as high risk, 283 were referred and 66 infant deaths were reported.</p>

Nutrition Rehabilitation Centres:

Table 13- Position of NRC in Jharkhand

	IN FY 12-13		In FY 13-14 (upto Sept.)
No. of functional NRC/ MTCs	66		69
Total admissions	7529		3279
Children Treated	6514		2813
Death	16		1
Up referral	151		52
Defaulter/ LAMA	482		689
Total no. of children under follow up	F1	3269	780
	F2	2377	534
	F3	1915	475

Table 14- MTC Referral Sheet

Year	Total Admission	AWW	Sahiya	OPD	Own	Other
2009	441	262	64	45	5	65
2010	2017	1177	473	140	41	186
2011	4331	2436	1440	125	61	269
2012	6585	2697	2976	221	402	289
2013 till June	648	160	331	52	51	54

Malnutrition treatment Centres have been established across all the districts and a need based planning has been done in terms of placing NRCs in high prevalence areas. Sahiyas have been trained in identifying malnourished children. Jharkhand introduced a separate state specific Module 5B on disease and nutrition in 2011 and the number of referrals in MTCs has shown a marked increase since then (see MTC referral

sheet and table below). Sahiyas involvement also led to an increase in community initiated referrals to MTC.

Bed occupancy was 6/16 in the MTC at Sadar Hospital in Sahibganj while it was higher (8/10) in the second MTC at Rajmahal CHC. There was adequacy of staff and diet provision was as per the guidelines. Children showing weight for height less than - 3.D were admitted. As per the paediatrician at the MTC malaria is the most common co-morbidity seen in such children and was noted in 50% of the cases. Out of the 414 cases that were admitted in Sahibganj MTC since 2010, paediatric tuberculosis were detected in 6% cases.

Table15- NRC.



Incentive of Sahiyas for mobilising cases to Malnutrition centre was not proposed in the PIP 2013-14 and thus has been discontinued.

	No. NRCs in 2011-2012 Apr11-Mar12	Number of cases admitted in 2011-2012	No. NRCs in 2012-2013 Apr12-Mar13	Number of cases admitted in 2012-13
Bokaro	2	182	2	286
Sahibganj	3	194	3	280
Jharkhand	59	3131	66	6248

C. ARSH & School Health

About 194 ARSH clinics have been established in the state since the inception of the program in 2009. However 188 are functional and out of this 114 are reported regularly. In both the districts visited there were no separate counsellors for adolescent health and ARSH clinics are being managed by ICTC counsellors at the District Hospital and CHCs. Though all these counsellors have received a separate training on adolescent health issues.

Sahibganj has nine medical officers and 41 ANMs who have been trained on ARSH. In Bokaro eight MOs and 21 ANMs have received this training. Clinic happens during the afternoons and medical officers are given duty on a roster basis. Avg. Case load as per register is 7-8 patients at DH Sahibganj and two to three patients at CHCs.

Though the overall state has trained 73 peer educators of Nehru Yuva Kendra they have neither been selected nor trained in Bokaro and Sahibganj. As per the records case load in ARSH clinics has been substantial. Average case load in Bokaro was 858/ month in the first three quarters of 2013. However case load was less, between 150/month in case of Sahibganj. One reason for this could be that facilities in Sahibganj were seeing adolescents for specific adolescent, reproductive and sexual health complaints while in case of Bokaro all individuals in the age group of 10-19 years were referred to ARSH clinics irrespective of the nature of the complaint.



WIFS program is yet to be implemented in both Sahibganj and Bokaro. However state launched the scheme on 27th February 2013. State level Convergence under WIFS has been undertaken and the WIFS advisory committee has been formed and meets regularly. Even at District Level WIFS advisory committee has been formed under chairmanship of Deputy Commissioner however regular meetings are an issue. Orientation of State, District and block level officials of Health, Education and Social Welfare department done.

Scheme for promotion of menstrual hygiene is operational in Bokaro since 2011 and has been accepted well by the community

RBSK implementation is still in its nascent stage and state is in the process of recruiting medical officers to form the block teams. The result of 172 MOs has been declared. Posting is expected in the end of November.

The state is planning to establish 5 DEIC centers any further action on this is yet to be taken.

Merging of RBSK has been done with the existing school health program under which health check-ups have been conducted for 26.21 lakh students from 26696 schools in Jharkhand during this financial year.

In the Visited School in Bokaro, eye check-ups are being done regularly. The adolescent girls get the sanitary napkins from the neighbouring Sub Centre. Records were checked of the health cards were checked. Children who require spectacles were referred to the CHC, Nawadih

D. Family Planning:

Jharkhand has high fertility with a high TFR of 2.9 as per SRS 2011. As per DLHS-3 (2007-08) Jharkhand has a Contraceptive Prevalence Rate (any modern method) of 30.8 and Unmet need of 34.7. Female Sterilization accounts for 24.6 %, Male Sterilization for only 0.4%, IUCD for 0.5% and Pills for 3.3% among the Family Planning methods used in Jharkhand. As per HMIS data as on 4th November 2013, out of the total sterilization, Mini lap Sterilization accounts for 62.10%, Laparoscopic sterilization for 11.84%, 11.63% of postpartum sterilization and Male sterilization for 14.42%.

There was a good display of information about Family Planning Methods in the facilities visited in Bokaro.

In the facilities visited there was no strategy of post-partum family planning as the postpartum patients do not stay for up to 48 hours. From the feedback from the patients, it is learnt that there are no proper facilities for the relatives to stay. Free diet & medicines were provided in the ward.

Mini Lap was the preferred method for conducting Tubectomy in both the districts.



The preferred method for usage of family planning methods was sterilization rather than limiting methods in Bokaro. In the facilities visited, SDH, Addl PHC and CHCs though there was high case loads of 50- 60 deliveries per month, the GNMs were not inserting IUCDs. In Bokaro, even in the SDH, Chas functioning as a District Hospital, there were only 6-7 intervals IUCD inserted per month.

CHC, Nawadih & Chas was the only 2 facilities inserting PPIUCD though having only 2 GNMs with 50 deliveries per month, which is really appreciable. The Nurses at other facilities with high case load need to be trained in PPIUCD. Supportive supervision required for facilitating PPIUCD.

The Subcentre visited do conduct deliveries, however, for an IUCD insertion patient is taken to the Addl PHC/CHC and not inserted at the HSC.

There was no strategy for Fixed Day Static (FDS) services available in SDH & Addl PHC. There was no display of Fixed Day Static Services mentioned in any of the facilities visited. Clients preferred to have the surgeries done in winter rather than any time during the year.

As per the Government of India guidelines under the Home Delivery of Contraceptives (HDC), the free supply of contraceptives namely Condoms, OCPs & ECP were to be withdrawn from PHC and HSC. Likewise the same was seen in the field visit, which is really appreciable. However, the clients were not ready to pay to the ASHAs for the contraceptives as the commodities were supposed to be government supply, as told by the ASHAs.

In both the districts visited there was a lack of clarity about the Ensuring Spacing at Birth Scheme. ASHAs are having problem in getting the registration of Marriage. Social marketing scheme for distribution of contraceptives has picked up well in Sahibganj however there is limited clarity amongst Sahiyas and officials on the newly implemented scheme for ensuring birth spacing. Many Sahiyas reported not getting any incentive of Rs 1000 for ensuring couple to adopt a limiting method of contraception after two children. Block officials insist on the birth certificate of children and not producing the same devoid Sahiyas of this incentive. Pregnancy Testing Kits were available in the HSC visited and were used by the ASHAs and the ANMs in the HSCs. Stocks were available.

In both the districts there were no RMNCH + A counselors. Among the 27 counselors approved in ROP 2013-14 only 8 were appointed. (Godda, Latehar, Simdega, Dumka, Khunti, Dhanbad, Jamtara & Ramgarh).

However cascade training initiation of post-partum IUCD services is yet to be implemented in the district. Only one MO and one SN at the Sahibganj DH was trained on PPIUCD and this explains for low insertions to just six percent of targeted cases this FY in Sahibganj.

In CHCs and DHs family planning services were given on all day basis. There was no strategy for Fixed Day Static (FDS) services available in SDH & Addl PHC in Bokaro. There was no display of Fixed Day Static Services mentioned in any of the facilities visited in Bokaro.

Safe Abortion: Three PHCs visited in Sahibganj was designated for providing safe abortion services. Two doctors posted in PHC Mirzachowki were MTP trained but were not undertaking MTP due to lack of MVA equipment. Tablet mifepristone was also not available. As per HMIS abortion rate in Sahibganj is 1.5% which is normal and of the total reported cases a 6% were conducted at private facilities, 25% were MTPs in public facilities and remaining 69% were spontaneous cases. The rate of abortion is higher in Bokaro at 2.9%, even here 89% were spontaneous. The share private facility abortion was 25% but that of public facility was far less at 7%.

E. Janani Surakhsha Yojna and JSSK:

All beneficiaries met in both districts were aware of Janani Suraksha Yojna. There was good display of IEC material in the facilities visited.

Direct Benefit Transfer through account payee checks has been started and JSY payment is done at the facilities.

In Sahibganj for some beneficiaries (20%) facilities are issuing bearer's checks as they do not have a bank account.

The district data shows 70% utilization of funds but discussion with beneficiaries in Rajmahal CHC revealed delays or backlogs in payments. Similarly in Bokaro there was delay in payment to JSY beneficiary at CHC Nawadih and PHC Petarwar

JSSK has been rolled out in all the districts and timely budget release has been done by the state to the districts.

There were no "Prasooti kits" being prescribed for women who have come for institutional delivery.

In Sahibganj the failure to get drug logistics systems has led to periodic shortage of drugs, reagents and equipment leading to out of pocket expenditure on drugs and diagnostics. An out of pocket expenditure ranging between 100-300Rs is reported by patients for routine tests like urine albumin and haemoglobin. This was ascertained from exit interviews with ten beneficiaries.

No out of pocket expenditure was reported in Bokaro district. In case of unavailability of drugs at the facility, the drugs were purchased from the drug fund available at the facility.

In Sahibganj many patients were not aware of the free drop back facility and were incurring costs for the same. All patients reported provision of free diet on the day of the visit. In Bokaro, beneficiaries were not using drop back facility as they left the facility before 48 hrs. The free Diet facility was available at SDH and CHC but for APHC and HSC beneficiaries were given Rs. 100 per day for diet.

In comparison to JSY, awareness about JSSK in the community was low and highlights a need to more focussed IEC/BCC.

Sahibganj has only one functional blood bank based at the district hospital. On an average 50 units of blood is needed in a month but on the day visited it had just four units. Blood availability is a challenge and the number of camps organized to meet the requirement are also less. Facility relies on replacement blood to comply with JSSK norms. In Bokaro there were no blood bank and no functional blood storage unit.



F. Maternal and Infant Death Review:

Maternal and infant death review is a weak area. The big problems are that community reporting was almost non-existent in both the districts visited and even the facility based reporting is neither closely monitored nor effectively analysed.

The Sahiyas and the ANM are unaware of the -new incentive and criteria of reporting all woman deaths in the age of 15 -49 years. The facilities reporting maternal deaths were the DH and CHCs and not a significant number is being reported from the peripheral facilities.

No review of maternal and infant deaths is being conducted by the district and block officials and there are no provision that has been made for a community based review. Though the state

level orientation for maternal and infant death review was completed for District RCH officers in June this year the mechanisms for audit are yet to be implemented.

G. Immunization:

Immunization in terms of session planned vs held has been reasonable for the state and shows an achievement of 94%. Adequacy of sessions ranges between 90-92% for Sahibganj and Bokaro.

Sahibganj district reports 102% BCG coverage and 82% of full immunization coverage in 2012-13. The BCG Measles drop out is 12%. The district has reported 85 cases of measles in 2012-13. Last year (2012-13) Jharkhand reported a high proportion (3102) cases of Measles. The number of cases of measles was less for Bokaro at 56. Full immunization coverage in Bokaro was better at 89% and its BCG to measles drop out was far lower at just 1%.

Low emphasis on monitoring in response to drop out and left out cases in Sahibganj explains for lesser achievement in full immunization. One finding that emerged out from field observation of VHND was that Maternal and Child Health Protection Cards have not been printed and distributed to mothers. ANMs are filling details of immunization in a slip of paper and giving to mothers. On many occasions they lose the slips and make tracking of immunization status almost impossible.

Another constraint in achieving 100% immunization in Sahibganj was- difficult access in hilly areas which are inhabited by PTGs and outreach by ANMs does not happen regularly. A high prevalence of myths in these tribal groups and even in the Muslim population is noted and calls for stronger and intensive community mobilization. As per DRCHO there is no separate staff such as a District Immunization Officer for monitoring the program. The DRCHO has to see all the RCH interventions and immunization which affects monitoring of services for all. Sahibganj is on the bank of the Ganges and is affected by floods for two months in a year. During this time many families migrate to neighbouring districts as a result many children are left out during immunization rounds.

An AEFI committee has been formed in Sahibganj and reports of AEFI are shared regularly. In last FY-105 cases of abscess and 81 other minor cases were reported. Amongst the major ones there were two child deaths after measles round.

Table16- Percentage immunization out of the estimated live births

District	BCG	DPT 3	OPV 3	Measles	Full Immunization	Measles	Diphtheria	Pertussis
Bokaro	93%	82%	58%	81%	75%	85	0	0
Sahibganj	92%	93%	87%	92%	89%	56	0	0

HMIS Data 2012-13

The cold chain maintenance was found to be adequate in Sahibganj.

The logistics, infrastructure, HR and quality gaps affecting mother, child and new born care in Sahibganj are consequent to the larger issue of lack of strategic planning, monitoring and near total absence of coordination between the districts and block team. A greater thrust is needed by district health management to resolve these issues following which many of these gaps would be addressed effectively.

Recommendation

I) Planning:

- a) Making peripheral facilities functional is a good strategy however state should plan to increase the number, strengthen the infrastructure and increase the number and capacity of staff of HSCs which have huge case load of institutional delivery.
- b) State should aim to equip its PHCs with adequate and skilled manpower who is BemOC and NSSK trained so they are able to contribute effectively in handling complicated cases referred from the HSCs.
- c) Planning in Sahibganj so far has been centred around provision of institutional delivery across the facilities. District should urgently plan to train and deploy manpower resources, drugs and equipment for comprehensive RCH services in terms of sick new born, safe abortion and family planning services.

II) ANC/VHND/ Outreach

- a) Supply ANC equipment (Hb meter, dip sticks, BP instruments) to enable ANC check-ups with full complement of services and improve the quality of outreach. Intensive action is also needed on community mobilization through Sahiyas, IEC and BCC is needed to increase early registration of mothers and ensuring complete ANC.
- b) There is a need to supply and ensure distribution of Maternal and Child Protection Cards to enable tracking of ANC status and immunization services for mother and child.

III) Intra-partum Care:

- a) The adherence to protocols such as use of partographs should be emphasized and monitored by state level team.
- b) There is an urgent need to equip delivery points with essential drugs such as oxytocin, misoprostol and supply equipment like mucous extractors.
- c) Prioritize training and increase the number of service providers in EmOC so that the designated FRUs can be made functional on an urgent basis. There is also a need to increase monitoring of FRUs for stock outs of essentials drugs and equipment so that issues of equipment dysfunction and drug shortages could be addressed immediately.

IV) New born Care:

- a) There is an urgent need to establish SNCUs especially in high focus districts with high IMR like Sahibganj. State may consider roping in additional technical capacities to meet the purpose as has been done in other states like MP.
- b) Sahibganj should take immediate measures to effectively use the services of the paediatrician at DH in providing essential new born care for high risk new borns. He is currently just being involved in consultation for severely malnourished and OPD cases.
- c) Initiation of Home based new born care through Sahiyas is positive step but district and block ASHA teams should undertake refresher training and increase on the job mentoring for those Sahiyas who are not functional on this aspect. Inputs from Village Health Sahiya Resource Centre

are needed in terms of a separate module for PTG and illiterate Sahiyas to support this refresher training.

MTC- State to propose incentive of Sahiyas for referring cases to Malnutrition Centres.

V) Family Planning:

- a) There is a need to increase the number of staff that has been trained on PPIUCD particularly at high case load facilities which are CHCs and HSCs in case of Jharkhand.
- b) Ensure regular supply of contraceptives, condoms and emergency contraceptive pills by regular monitoring of stock consumptions and sending timely requisition of supplies to the state level.
- c) Currently there are no fixed day services for family planning. State should implement fixed day services both for sterilization and IUCD at the facilities and widely disseminate the schedule at the community level.

VI) Safe Abortion:

There is less emphasis on safe abortion practices and state should ensure that these services are provided at the designated facilities by deploying trained staff and ensuring supply of MVA equipment and mifepristone tablets.

VII) JSY/JSSK:

- a) Greater monitoring is needed to ensure timely payments to JSY beneficiaries.
- b) Increased IEC at the facility level and more efforts on building awareness regarding JSSK entitlement through Sahiyas at the community level should be done.

VIII) MDR/IMR:

State has undertaken training of medical officers on maternal death review at the facility level. Considering the fact that Jharkhand has an MMR of 261 as per AHS 2011 there is an urgent need to operationalize maternal death review both at the level of facility and community. State endeavour should be such that every maternal and infant death reported should undergo a verbal autopsy so that the time, place and reason for death can be identified and corrective actions can be planned accordingly. Immediate action is needed on dissemination of the guidelines to Sahiyas on reporting of maternal deaths.

TOR 3 : Disease Control Programs

A. Malaria:

Malaria has been historically endemic in Jharkhand. However, during the last two years there has been a spectacular improvement in Malaria situation. During the period, the numbers of cases and deaths have reduced to 2.4 times and 3 times respectively. During 2011, thirty six CHCs out of total 194 had >10 API with the highest (56) being in Gopikander CHC. With robust control activities through the supply of diagnostics and drug (RDT & Act), IRS, LLIN and strengthen Supervision 15 CHCs had reported >10 API during 2012. A total of 6,60,000 LLINs was distributed during December 2011 against the state's requirement of 55,46,000.

In Sahibganj district 2838 cases have been reported so far during 2013 with 95% being Pf cases. Surprisingly no Malaria death was reported. RDT stock is 6935 in district HQs. But in PHCs about one month's stock is available. From NRHM Flexi pool ACT pack has been procured. Though API has marginally reduced from 3.70 in last year to 2.38 this year (up to October), the ABER has further reduced from suboptimal 7.40% to 6.39% till October 2013. The district has distributed 100,00 LLIN in 2012. The reported IRS coverage of first and second round during this year was 86% and 80% respectively. Sahiyas (ASHAs) are found to be less involved in Malaria cases detection and treatments which are the responsibilities of MPWs. Entomological surveillance is non-existent.

Action Points:

1. Consolidation of Achievement made so far.
2. ABER should be increased to >10%
3. Sahiyas to be involved in case detection & treatment of Malaria to further reduce the API.
4. Balance quantity of LLIN should be procured at the earliest.
5. Entomological surveillance activities to be started in full earnest.

B. Japanese Encephalitis.

The development of JE endemicity has been recent in the state. The first case was reported from Pakur district during 2010. Presently it is reported from 13 out of 24 districts. During 2013 a total of 82 cases and 5 deaths have been reported till 30th October with the highest number of cases (19) from East Singhbhum districts. Three medical colleges of the state are working at Sentinel Surveillance Hospital. The MPWs have been trained about JE and they do active surveillance for early case detection.

C. Dengue

First case of Dengue was reported from East Singhbhum districts of the state during 2010. Currently 16 out of 24 districts are reporting for Dengue. During 2013, a total of 85 cases with no death have been reported from the state so far.

The district of Sahibganj does not have JE & Dengue as Public Health problem at present. First JE case was reported in 2012 from Barhait block and diagnosis was confirmed from RIMS Ranchi. No JE case is reported this year. Out of 5 suspected dengue cases last year, 2 samples were tested and found negative in Dhanbad Medical college. This year, out of 22 suspected cases diagnosis was confirmed in 4 cases by Dhanbad Medical College. However, no death has been reported so far due to JE or dengue this year.

Action points :

1. Both these serious viral diseases are knocking at the door and strong vigilance needs to be maintained to detect any out-break at the earliest.
2. Immediate vector surveillance to be initiated.
3. Training of man power, provision for early diagnosis and tertiary level treatment facilities with proper referral system should be in place.

D. Kala-azar:

Kala-azar is endemic in four districts of the state viz: Sahibganj, Godda, Pakur and Dumka. In Sahibganj 6 out of 7 blocks, in Godda all 7 blocks, in Pakur all 6 blocks and Dumka in 8 out of 10 blocks are endemic. During January to September 2013, a total of 2031 cases with no death have been reported. All patients were treated with Miltefocine for 28 days. An adequate stock of drug for six month is available and treatment completion rate is >95%. KTS are actively involved in tracking and ensuring drug compliance.

Sahibganj district reported 740 cases within no death in 2012. During 2013, a total of 436 have been reported till October. Barhait block had highest number of cases (257) last year. This year also it has reported 100 cases till date. The main problem was lack of motivation, even refusal, to take Allopathic Medicine. The district HQ, has no drug but was to be brought from Ranchi within 2 days. An amount of Rs. 8,82,445 has been spent during the year so far to compensate for wage loss and transportation of patient as well as incentive to Sahiyas.

Action Points:

1. Irrespective of a claimed high IRS coverage, this important vector control activity needs a real monitoring and supervision to explain how so many cases have occurred in spite of high IRS coverage.
2. Some innovative approach to be adopted for the patients who refuse allopathic treatment.

E. Lymphatic Filariasis :

Lymphatic Filariasis is endemic in 17 out of 24 districts of Jharkhand. ELF Programme with annual MDA has been in operation since 2004. The state missed 2009 and 2012 round of MDA. The latest one being due to delay in procurement of DEC tablets. During past MDA rounds only twice coverage of >80% was reported. The state has observed MDA-2013 round during 11-13 November 2013. So far 16 districts have achieved overall <1% Mf rate out of which six have achieved <1% Mf rate at each site. The state has a backlog of about 5000 hydrocele operation.

The reported coverage of MDA-2013 round in the Sahibganj district on 11 & 12 November is about 30%.

Though MDA started in 2004, the district is still having Mf rate of >1%. As per latest Mf

survey report, one sentinel site (Pathna) has Mf rate of as high as 6.1% which has nullified the achievement made on other sites of the district.

Action Points:

1. The state should ensure that no more MDA is missed in the future.
2. Concerted efforts need to be given with strong social mobilization to achieve 85% of supervised drug consumption.
3. To clear the backlog of hydrocele operation through "Camp Approach".

F. Elimination of Lymphatic Filariasis (ELF) & Kala-azar:

Government of India is committed to eliminate these two diseases by 2015. The ELF will be achieved when <1% antigenemia will be found in 6-7 years old children. Kala-azar elimination will be achieved when there will be <1 cases/10,000 population with no death. Current situation, as observed in the review, is not encouraging. WHO has categorized these two diseases under "Neglected Tropical Disease" as these are not given due importance by administering.

Action Points:

1. Authorities at state and districts level may like to monitor these two diseases with special care considering the national commitment of elimination by 2015.

G. Entomological Zones:

The state has two entomological zones in Ranchi and Hazaribagh. The posts of Zonal Entomologists and Insect Collectors are vacant in both the zones. As such the Entomological Zones are non-functional. Sahibganj district is under Ranchi zone which is about 500 KM away. This gross gap in entomological activities can lead to disastrous situations in the future so far Vector Borne Diseases are concerned.

Action Points:

1. All the posts of Zonal Entomologists and Insect Collectors should be filled-up immediately.
2. Mechanism for continuous entomological surveillance should be initiated with the sharing of data at different levels.

H. Tuberculosis:

The state reports on an average 40,000 TB cases per year. There are about >8000 DOT centres in the state. One Integrated Referral Laboratory is operating in Itki TB Sanatorium Ranchi. Treatment completion rate of patients is >80%. The state has somewhat adequate supply of anti-TB drugs. However, category-2 of 1st line drugs & Box-B of 2nd line drugs are stocked out at the State level. Supply is expected from central. Three centres to deal with drug resistant cases are functional at Dhanbad, Ranchi and Dumka. Serological test has been banned in the state and the disease has been made notifiable also.

Currently 1473 cases are registered in Sahibganj district. Drugs are distributed through 3 TB Units (Located in District Hospital and Barhait & Raj Mahal CHCs), Public Health Institutes and 334

DOT centers. At Sahibganj, individual files are maintained for 9 private doctors to ensure “Case Notification”. Monthly reports (including ‘Nil’ reports) are also collected from them regularly. So far 55 cases were notified by private doctors. There are 13 functional designated microscopic centres in the districts. The defaulter rate in last Qr was 2%. Treatment completion rate in last Qr was 89%.

Action Points:

1. Consolidation of achievement made so far through continuation of activities as have been done.
2. Proper supply chain management of drugs.

I. Leprosy:

Annual New Case Detection Rate (ANCDR) of Leprosy has reduced from 16.7 to 10.8/100,000 between 2009 and 2012 at the state level. The overall (urban + rural) treatment completion rate is $\approx 95\%$. Saiyas (ASHAs) are given monetary incentive to keep track of patients. Only Deoghar, Latehar and West Singhbhum districts have achieved ANCDR of $< 2 / 100,000$ so far, whereas National Programme stipulates achievement of $< 1 / 100,000$. The state has to go a long way for achieving elimination.

During the current year up to October, 74 cases have been registered in Sahibganj district. The ANCDR and treatment completion rate are 7.75 / 100,000 and 97.5% respectively during the same period.

Action Points:

1. More emphasis should be given for new case detection.
2. Consolidation and maintenance of high Treatment Completion Rate.

J. Non Communicable Disease:

The National Programme for Prevention & Control of Cancer, Diabetes, Cardio-vascular Disease & Stroke (NPCDCS) was started in three districts (Bokaro, Deoghar and Ranchi) of the state during 2012-13. An amount of Rs. 3,99,73,000 was provided for the Programme from the centre. The amount was distributed among the districts on 13.07.2012 for utilization as per the Operational Guidelines. Over and above, the state also received 19.85 lakh of ‘Glucose Strips’ for conducting community survey in the identified three districts and Deoghar. The estimated prevalence of high blood sugar was found to be 6%.

Sahibganj district is not covered under NPCDCS. In Bokaro district NPCDCS register was found in the CHC Chas. The newly inaugurated District Hospital at Bokaro has NCD cell and was observing World Diabetes Day on the day of the visit (14th November 2013). The AYUSH services may be implemented for reduction in risk factors in the district hospital for a holistic approach to the NCD problems

Action Points:

1. The importance of NCD as a public health problem needs to be disseminated and demand for care should be generated.
2. Necessary infrastructural, logistics and HR supports should be provided to counter these silent killer diseases.

TOR 4: Human Resources for Health

Till early part of 2011, Jharkhand followed the Bihar Service Code and did not have its own HR policy. Jharkhand Public Service Code for Health, Medical Education and Family Department (only for Medical Officers) was published in the same year, and norms were established for remuneration, recruitment, promotion & posting etc.

Table 17- Generation of Health Human Resources

	Name of the Institute	No. of Seats	Remarks
Medical	Colleges (3)		
1	Rajendra Institute of Medical Sciences (RIMS), Ranchi	150	
2	Mahatma Gandhi Medical College (MGM), Jamshedpur	100	
3	Patliputra Medical College & Hospital, (PMCH), Dhanbad	100	
	Total	350	
BSc	Nursing College (1)		
1	College of Nursing (RIMS Campus), Ranchi	50	Basic
		30	Post Basic
	Total	80	
GNM	Schools (3)		
1	Rajendra Institute of Medical Sciences (RIMS), Ranchi	50	
2	Mahatma Gandhi Medical College (MGM), Jamshedpur	30	
3	Patliputra Medical College & Hospital, (PMCH), Dhanbad	30	
	Total	110	
ANM	Training Schools (10)		
1	ANM TC, Ranchi	60	Local Area Selection criteria is a must for ANM Training Centers
2	ANM TC, Simdega	60	
3	ANM TC, Deoghar	60	
4	ANM TC, Dumka	60	
5	ANM TC, Giridh	60	
6	ANM TC, Jamshedpur	60	
7	ANM TC, Chaibasa	60	
8	ANM TC, Hazaribagh	60	
9	ANM TC, Dhanbad	60	
10	ANM TC, Palamu	60	
	Total	600	

In addition there are about 15 private institutions which have an annual intake of 845 for ANMs and GNMs and three private nursing colleges with an annual intake of 60. The state has plans to increase annual intake in its 3 Medical Colleges.

Table 18- Recruitment

Category of Staff	Jharkhand (Sanctioned/ Working)	Regular		Contractual		
		Bokaro	Sahibganj	Jharkhand	Bokaro	Sahibganj
Medical Officer	2983/1561	99/56	80/57		/30	4/1
Medical Officer (AYUSH)	509/126	21/06	14/04	42/33	NA	/3
Medical Officer (Dentist)	38/24	1/0	1/0	NA	NA	NA
Medical Officer (MMU)				103/100	04/04	05/04
Staff Nurse	395/310	16/9	12/10	900/408	55/33	17/08
Pharmacist	464/170	31/02	14/02	97/97	10/10	3/3
Radiographer	73/26	4/3	3/1	80/80	5/5	11/11
ANM	4617/3427	178/80	165/112	5500/3679	140/132	207/111
Lab Technician	464/103	28/4	20/2	223/223	17/17	11/11

Public health workforce in Jharkhand is recruited through three channels. Regular Medical Officers are recruited by Jharkhand Public Service Commission and are managed by the health secretariat. The establishment of regular paramedical workers is located at the medical directorate. While NRHM contributes in appointing contractual doctors and paramedics, a small proportion of contractual appointments are also done through the state treasury route. The process of recruitment of regular staff was adjourned in Jharkhand till 2009. This left huge vacancies both in the position of doctors and paramedics. However a clear change over last CRM has been re-initiation of regular recruitment during 2012. Since 2012- there have been two rounds of recruitments and 1561 (53%) posts of MOs have been filed so far against the target of 2983. Though gradual but it is definitely a positive step towards addressing HR challenges.

However decision on policy for appointing paramedics through a regular cadre is yet to be undertaken and recruitment for regular paramedics has not occurred since statehood. The State does not have a specialist cadre, which makes it difficult for the planners to identify Medical Officers with post-graduation and post them in the identified FRUs. Finding specialists willing to join and serve in the designated FRUs remains a major hurdle and could be responsible for ineffective delivery of services and compromised outcomes. Issues such as- why are specialists being deployed and remunerated as “Medical Officers” were voiced out during field level interaction. FRU Rajmahal in Sahibganj could not be made functional only on account of the unavailability of an EmOC trained doctor or specialist.

In Sahibganj under regular posts- except for Staff Nurses, 30-33% vacancies exist for the position of doctors and ANMs. The number of vacant posts is even more for the Pharmacist and Lab Technicians.

However in both the districts NRHM has been leveraged for filling the contractual posts of paramedics such as- Staff nurses, pharmacists, Lab technicians and ANMs. So far in the last seven years only one medical officer and three AYUSH doctors have been appointed through NRHM in Sahibganj.

HR gap mitigation through NRHM was better in Bokaro. There was recruitment of 30 medical officers and except eight all contractual posts of ANMs have been filled. However, Sahibganj had only 50% posts of contractual ANMs filled so far.

Actual delivery of health services is also affected by unauthorized absenteeism or long leaves of the doctors in Sahibganj. For instance for the Sub-Divisional hospital of Rajmahal (visited by the CRM team) 8 post of medical officers has been sanctioned, out of which 7 medical officers have already been posted. However on the day of the visit the CRM team found that it was being managed by two medical officers (including one Incharge & one medical officer being deputed from other block). The rest of all other medical officers (6 in no's) were absent unauthorized or were on long leave. On the day of the visit the two doctors had already seen about 250 cases in OPD.

Many paramedics and contractual doctors raised concerns that there is no scope for promotions of contractual staff. They are given one year contracts, to be extended after a process of annual appraisals against their terms of reference (TOR), which are held at state and district levels. The increments are also to be decided during these appraisals. Interactions with the three ANMs in the field revealed that they have not received any salary increase since the time of inception.

Payment delays of as much as three months were reported by ANMs from Borio and Tallijhari Block in Sahibganj.

Since there is no clearly defined transfer policy at the state level many doctors posted in remote districts such as Sahibganj take transfer. Instances of random reshuffling of PHC-MOs were also quoted by doctors in Sahibganj that is demotivating and affects their performance.

Though the state has designed a detailed format for performance evaluation, to be used during the annual appraisal of contractual doctors, it is long overdue in Sahibganj.

Human Resource Information System: A promising step towards streamlining human resources for health:

The state established computerized information under the iHRIS of Medical Officers in all the 24 districts. Intra health provided technical support for this initiative. The database captures personal, educational, training and service history of the medical officers posted across all the districts. This is operational in the state for the last one year and information is updated in the MIS on a quarterly basis. This information is still not being effectively used for HR Planning and rational deployment.

iHRIS is a promising model but process of handing over by Intrahealth is yet to be initiated and this also creates gaps in access of information by the HR planners.

Training and Capacity Building:

The Training Cell has 3 consultants who help the state in planning and implementation of training calendars under NRHM for both the regular and contractual service providers. A comprehensive and integrated training plan is drawn up every year and the numbers trained so far are as follows:

One can see that except for Staff nurse training in IUCD insertion the progress of training as per the planned calendar appears to be reasonable. In Sahibganj 40/57 doctors have been trained in skills like NSSK, IMNCI, CTU, FBMD and MTP. A concern for Sahibganj was that so far-LSAS training has been given to just 2 doctors, and only one doctor has received EmOC training.

HR retention mechanisms:

There has been improvement in residential facilities for the staff in Bokaro. However doctors in Sahibganj had issues about the quality of accommodation facilities.

Other mechanisms such as preferential admissions in PG courses for the doctors who have served more than three years in remote areas are not being followed. State is also not providing any difficult area incentive for MOs serving in districts such as Sahibganj and LWE infested blocks of Bokaro.

Under the “Jharkhand Swasthya Protsahan Yojana”, the state government had proposed Financial incentives for both regular and contractual staff for serving in remote areas, linked with performance. But the proposal was not approved by the central government in 2012-

13.”

Recommendation

Urgent release of salaries to contractual service providers – who have not been paid for many months

Process for contractual appointments of specialists, doctors, nurses & paramedical staff to be with the districts – and state should recruit only when districts are unable to find candidates.

Ensure all obstetricians, anaesthetists, paediatrician and Amos & LSAS trained MOs are posted in designated FRUs. Ensure all MOs with PG qualifications are posted in CHCs, block PHCs or higher centres.

Accelerate implementation of incentive programs for difficult areas. Notify all difficult PHCs on declaring criterion.

Sustain and strengthen iHRIS – a promising initiative. Use of iHRIS in feedback as an adjunct for planning trainings of public health workforce and their rationale deployment should be done more frequently by the state.

Monthly advertisement for filling vacancies of regular posts be undertaken till recruitment is completed in each region. .

The state should introduce preferential admission of ANMs/Staff Nurses from under-served areas in the nearest ANM / Staff Nurse Training Schools.

Increase sanctioned posts of doctors under NRHM and create a specialist cadre

The state should also try to reduce the salary gap between contractual and regular staff.

Measures to attract and retain doctors in rural areas- the graded monetary incentive, the graded increased eligibility for post-graduation, the preference given to the locality for postings- are all to be expanded and maintained.

Deploying Bachelors in Community Medicine is now another option for states like Jharkhand which are facing extreme shortage of HR in health.

TOR 5: Community Processes and Convergence

a. Panchayati Raj Institution:.

There were no Panchayats in Jharkhand till 2010 and elections were held in the later part of the year. Panchayats were still finding its roots during the time of previous CRM and clearly one can see greater involvement of Panchayat in health now.

Both the governing and executive body of committees like District health Society, RKS have representatives from Zilla Panchayat. The state has conducted two day orientation of 41032 PRI members on a separate module for PRIs. This was to increase their knowledge on various facets of NRHM and increase their involvement in functioning of VHSNCs. Thus most active involvement of PRI in health is seen in the village health sanitation and nutrition committees.

In about 40% VHSNCs Mahila ward Panch is the chairperson.

b. Village Health Sanitation and Nutrition Committees:

Sahiya and her support structures are playing the leadership role in functioning of VHSNC. Composition of the committee is representative of the village population. As per the district data about 50% of VHSNCs in Sahibganj have appointed head of the Tribal Council as the chairperson of the committee. Sahiya is the member secretary for all VHSNCs.

The other remaining VHSNCs function with women ward Panch being the chairperson. Sahiyas have been provided with a VHSNC register in which they maintain the record of minutes, key decisions taken and capture fund utilization details very comprehensively. The meetings are well facilitated by Sahiyas and Sahiya Sathis who also decide the topic of discussion during the meeting. Sahiya and her support structure in the form of Block trainers, district trainers provide day to day mentoring and support to VHSNC.

VHSNC untied fund were utilized in the following heads: Hand pump repair, Renovation of well used for drinking water, Referral transport in emergency cases , ASHA Maitri baithak, constructing soak pits besides hand pumps, Cleaning village periphery, ANC table for HSC, curtain for AWC. Role of VHSNCs in source reduction and vector control activities was seen to be minimal and reflects that district has failed to use the potential of VHSNCs and Sahiyas in control of vector borne diseases.

State initiatives of capacity building of VHSNC members on roles and responsibilities and fund management is a promising step and has provided a good foundation to VHSNC to undertake its function. A separate training of PRI members has also ensured their active participation in VHSNCs.

VHSNC have been formed in 1407/1407 revenue villages in Sahibganj Utilization of funds in Sahibganj was nearly 60% for the FY 2012-13 which improved from 55% in 2011-12 and could be attributed to training of members. One reason for low utilization in Sahibganj is the fact that bank accounts for 28% VHSNCs are yet to be opened. As per the district programme coordinators these villages are highly remote and do not have access to bank services.

A direct correlation is also seen between functionality of Sahiyas on holding village level meetings and fund utilization. For instance fund utilized was better for Bokaro at 90% which also has high functionality of Sahiyas in VHSNCs

Except for few members who have undertaken training on community based monitoring of health facilities and services, capacity of other members to understand village health priorities was observed to be limited. Nevertheless state has laid foundations for strengthening VHNSCs and members are now prepared to learn more complex skills of village planning and monitoring of health services for improving health outcomes.

c. Village Health Nutrition Days and Convergence:

Organizing successful VHND is a key role of VHSNC members; though they were aware about it they showed low functionality on this aspect in Sahibganj. It highlights the fact that there is a need for more focussed capacity building of members of this aspect. Convergence with ICDS existed but was ineffective as no take home rations were being distributed and growth monitoring for under five was also not being done by the AWW. This was true for all VHND sites visited in Borio and Raj Mahal block of Sahibganj. These gaps existed because of limited skills of AWW in growth monitoring and lack of replenishment of stock for take home rations for the last six months. The problems seen in the field are a part of the larger problem of lack of convergence and monitoring of activities at the district level itself. The understanding and action of district officials in Sahibganj on social determinants of health was near negligible.

In Bokaro VHNDs were held regularly with the ANM and AWW. There was a good convergence with ICDS. Home ration was available and was distributed on time.

d. Sahiya Programme: (ASHA)

Selection:

The state follows a selection norm of one Sahiya per 800 population and has achieved the primary target by placing 40964 Sahiyas. Considering the geographic scatter of the state, districts have been provided flexibility to relax population norms and undertake hamlet based selection. Selection of Sahiyas in both the districts preceded NRHM and was done by NGOs. The number of Sahiyas currently working in Sahibganj is 1400 and 1416 in Sahibganj and Bokaro respectively. Originally 1638 were selected in Sahibganj but it is observed that about 250(13%) Sahiyas have dropped out over the last seven years from the programme.

Proposed number of Sahiyas was as per the 2001 population norm. As per the district data base of both the districts there will be about 15% villages which are not covered by any Sahiya in Sahibganj. Also population has increased and there are villages with population above 1200 which need selection of another Sahiya on account of geographic scatter. Sahiyas have difficulty traveling long distances resulting in many peripheral households to be inadequately covered. Efforts to reach the marginalized are observed and Sahibganj has selected Sahiya for PTG groups residing in hills. To address inadequate coverage arising due to drop outs, geographic scatter, a detailed cluster wise mapping by Sahiya Sathis has been planned by District and block support team. This would allow reallocation of households or selection of new Sahiya in these areas.

Training:

State shows good progress in training of Module 6 and 7. 95% Sahiyas have been trained in Round 1, 85% in Round 2 and 25% in Round 3. Both Sahibganj and Bokaro have completed

training 95% Sahiyas in first two rounds of Module 6 and 7 and about 80% and 70 % have also been trained in the third round in Sahibganj and Bokaro respectively.

More than 60% of Sahiyas who were met had better knowledge retention and recall of key messages such as-identifying danger signs during pregnancy and delivery, colostrum feeding, identifying high risk newborn, hypothermia management etc. Demonstration of skills was found to be adequate and reflects at the good quality of training. The district had distributed equipment kit to all Sahiyas who attended training in module 6 and 7.

Support Structures:

The presence of a common support structure for Sahiyas and VHSNCs at all four levels is a positive aspect of the program in Jharkhand.. Performance monitoring mechanism to assess Sahiya functionality has been initiated. As per programme officials it is proving as a useful tool to identify non-functional Sahiyas is helping in taking right steps towards supportive supervision of Sahiyas working in the community. Sahiya Sathis are now able to identify low performing Sahiyas and take specific corrective action.

Both the districts reported creating a database for Sahiyas.

Streamlined mechanisms for Sahiya training periodic systems of review between the state, district and block Sahiya team and initiatives to enable supportive supervision are exemplary and worth appreciating. These are a direct impact of the intense focus and commitment shown by the state team and Village Health Sahiya Resource Centre. These efforts have made Sahiya program emerge out as the most heartening features of NRHM in Jharkhand.

Drug kit: All Sahiyas met had essential drug kit. The last time replenishment of drug kit was done in 2011. The state doesn't streamline mechanisms for drug kit replenishment and the root cause for this is the drug logistics problem being faced across the state and is hampering availability of drugs at facilities across all levels.

ASHA Payment- More than 90% Sahiyas in both the districts now have bank accounts but payments through e-bank transfer have not been made fully operational. For instance in Sahibganj only two out of seven blocks are doing e-transfer. Average take home for Sahiyas was reported to be 1000-1500 rupees payment delays are a key challenge for the state and all Sahiyas reported delay of about six months. Bottlenecks for payments were mainly seen at the block level. Main reasons for this was unavailability of black accountants in many areas, no mechanism of monthly PHC level review meeting with all sahiyas, delay in submission of vouchers by Sahiyas and strict adherence to conditionalities by block officials for payments. For instance, asking Sahiya to submit the birth certificate of the newborn for HBNC payment.

ASHA functionality and Outreach: Field observation revealed a reasonable functionality of Sahiyas on key aspects of promoting institutional delivery, immunization, providing HBNC, and on follow up of malnourished children and undertaking nutrition counselling. Recognition and action needed to reach the marginalized was visible in the field and could be attributed the training by Sahiya Sathis on "Reaching the Unreached" which is given during their monthly cluster meetings. If we compare Sahibganj and Bokaro, functionality was seen to be low in Sahiyas from Sahibganj. About 20% Sahiyas in Sahibganj belonged to PTGs and 30% from

Santhal community have low literacy levels and have language barriers. As per ASHA Facilitators this makes assimilation of training content difficult for them and contributes to their low functionality. Apart from the inputs of training and support, functionality of Sahiyas also correlates with the emphasis given by district health functionaries on a particular task. The lower programmatic emphasis so far to involve Sahiyas in providing community level care for sick newborn and sick children and lack of essential drugs like ORS, paracetamol seems to be the cause of their limited functionality and effectiveness on this aspect. District officials also perceives the Sahiyas role to be predominantly in RCH care and this has led to their decreased involvement in malaria control activities and explains for their low activeness. One of the factors for the comparatively low functionality of Sahibganj Sahiyas was weak health systems support which is demotivating for many Sahiyas and affects their performance. *(Few Sahiyas did mention that even if we identify high risk newborns where do we take them? Even the DH does not admit sick newborns and refers them to Bhagalpur. How would poor patients travel so far?).*

Other support mechanisms for Sahiyas: ASHA help desk has been established across all the district hospitals and CHCs in high priority districts and helps in easy navigation of Sahiyas and beneficiaries across the facility. The state has created a corpus fund and instituted a health insurance mechanism for Sahiyas from this financial year. Distribution of bicycles to Sahiya has also been started.

However many Sahiyas expressed a desire for having a designated ASHA Room or ASHA Gruha at the facilities. It would be very useful support as many of them travel huge distances while escorting patients to healthcare facilities and often have to stay with them for more than a day.

Community Monitoring:

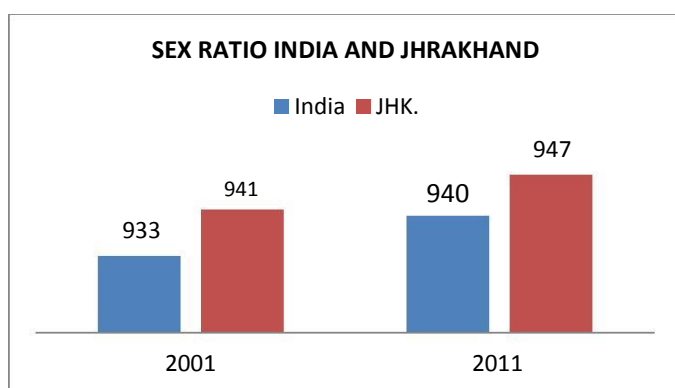
CBM process was initiated in all the 24 districts of Jharkhand A team of 3 per village (revenue village) is created and involves One VHSNC member/one PRI member/one village volunteer selected by Gram Sabha. Equity concerns are addressed by mandating that at least two members be women or those belonging to marginalized community. Orientation of stakeholders is done which involve representatives of DHS at district level, MOIC, BPM, BAM, ANM at block level and some PRI members.

One day training at the block level is organized on Quesionairre, Process and Report card which is based on accessibility, quality, behavioral issues for services being provided at health facilities.

Presentation of findings by the CBM team is done first in Gram Sabha.

In FY 2012-13 out of 96 blocks selected for CBM, training for 77 has been completed. “Jan sunwais” at block level has been completed in 42 blocks and while district sunwais have been held only one district so far. In Sahibganj four blocks with 50 villages each was selected for CBM and about 135 members from each block were trained and Jan Samvads up to district level have been completed. In Bokaro no community hearings have happened so far but training of members for CBM is over.

PCPNDT and Gender:



The sex ratio at birth for Jharkhand as per AHS 2011 is 928 and the child sex ratio is 938. Figures of consecutive census show a drop in child sex ratio by 23 points. However when we compare data from AHS a marginal increase of one point is noted for child sex ratio while a substantial improvement of five points is seen in sex ratio at birth in this period of one year. **The state is committed towards implementing PCPNDT across the districts and the improvement described above validates this point.**

Table:

Indicator	Census 2001	Census 2011	AHS 2010-11	AHS 2011-12
Sex ratio (All Ages)	941	947	942	944
Child Sex Ratio (0-6 Yrs)	966	943	937 (0-4 yrs)	938 (0-4 Yrs)
Sex Ratio at birth			923	928

At the state level Jharkhand has formed Statutory Bodies in the form of the State Supervisory Board, (SSB), the State Appropriate Authority (SAA), State Advisory Committee (SAC), State Inspection & Monitoring Committee (SIMC) to take action PCPNDT. At District Level there are District Appropriate Authority (DAA), District Advisory Committee (DAC) and District Inspection & Monitoring Committee (DIMC)

The SIMC and DIMC meet every six months. The last meeting of SIMC was held in July 2013.

The number of total inspected clinics or visited till June 2013– 766 (Some clinics are visited/ inspected twice). Of this the registered clinics till June 2013 are 730.

A separate one month long campaign called Save the Girl Child Awareness Campaign was organized in FY 2013-14 with key objective of intensive social mobilization and improving close monitoring of ultrasound clinics. Under this campaign 480 clinics were inspected and June 2013-license for 43 clinics were cancelled. Legal action in terms of total Cases filed till June 2013 was done in **19 cases**.

Regular meetings of DIMC were reported from Bokaro and in 2013-38/65 registered clinics were inspected; five of them were sealed, legal action was taken against one.

Sahibganj reported no meetings of DIMC. So far under Save the Girl child Campaign - 4/8 clinics were inspected and one of them was also sealed.

Recommendation

A persistent problem of delayed payments to Sahiyas is observed in Jharkhand. There is an immediate need to clear the backlogs and implement streamlined mechanisms of payment through single window payment on the fixed day basis and through e-bank transfer. The state should abide with its plan and implement this in the next six months. Since the major payment delays are noted at the PHC level, the state should leverage block support team for Sahiyas to monitor Sahiya payments more closely and immediately address specific issues in coordination with the DPC.

To address drug kit unavailability of Sahiyas, state team should coordinate with districts to check delays in drug procurement and address inadequate estimation for drug requirement. To ensure drug availability with Sahiyas, guidelines for periodic replenishment of Sahiya drug kits should be prepared and disseminated at the district, block and sub-block levels on a priority basis.

There is a need to sensitize district and block officials such as-CMHO, Block medical officers on Sahiya and VHSNC so as to build their understanding about the programs. This would help them leverage these programmes more effectively in achieving health outcomes.

The state has several initiatives to support Sahiyas, however the creation of ASHA-Gruha in healthcare facilities would be helpful as many Sahiyas have travelled huge distances while they escort patients and have often have stay overnight or for than a day.

Concerted action is needed for convergence with ICDS, Rural Development and water and sanitation at district and block level so as to improve the status of social determinants of health.

TOR 6: Information and Knowledge

A. Health Management Information System (HMIS):

Districts are doing facility wise reporting on HMIS portal. The monthly reports from the facility-HSCs, PHCs are prepared manually for all the programmes and hard copies are submitted to the block data managers, BPM, BAM for entry.

Monthly feedback is sent to districts by SPMU on reporting quality and discrepancies (if any) on the basis of data available on the portal, however, use of available data at the district level observed to be minimal across the programs where the team visited.

There are rampant power failures (approximately 10 hours during working hours) which hinder the operation of the system in the State. The system suffers due to low bandwidth. Therefore the State had to install vsat/ymax to make the systems functional, which is also posing a challenge. Although the blocks have been provided invertors, but due to long power cut the invertors do not recharge. Acute shortage of skilled manpower obstructs the effective functioning of HMIS.

It has been observed that the reporting of deaths in the field are not being captured very well. A major proportion of infant and maternal deaths are going unreported. This could be reporting gap or an indicator that a substantial proportion of the population is actually getting left out.

The team noticed that the use of data by the district and block level programme managers was minimal. The block and district level health managers need to ensure analysis and use of physical and financial reports for close monitoring of the programme.

Out of 24 districts only 4 districts have received block level trainings, however Block Program Managers (BPM) have received a 2 day orientation and the training of Block Data Managers is planned for 26th and 27th November 2013 for 8 districts.

B. Mother & Child Tracking System (MCTS):

Mother & Child Tracking System (MCTS) is an IT enabled Name based Tracking System implemented by the Government of Jharkhand for strengthening the health care service delivery system by improving service delivery coverage and the monitoring system.

The progresses of MCTS implementation in the visited districts and the State as well have sufficient scope of improvement in terms of registration and timely service updating. Data reported on MCTS Portal depicts that:

Implementation status at Bokaro- Jharkhand is

- ❖ During 2013-14, only **42.07%** pregnant women and **38.4%** children have been registered on the system so far on pro rata basis (status as on 23rd November, 2013).

- ❖ It has been observed that **2480** pregnant women were registered in MCTS with LMP in November, 2012 of which only **19.75 %** of pregnant women received ANC 2, only **8.95%** received ANC 3, only **4.35%** received ANC 4 and 0% received all four ANC services. The district has shown poor performance in delivering of All ANC services.
- ❖ Similarly, it has been observed that **2360** children were registered in MCTS with DOB in **September**, 2012. Ideally all the vaccinations should have been received by the children by now, out of which only **56.35%** received all doses of BCG whereas only **14.06%** received all doses of OPV, only **14.23%** received all doses of DPT and only **2.92%** received the full immunization.
- ❖ Uploading of validated phone number of ANMs and ASHAs on MCTS portal is also a major concern. Total **309** ANMs are registered in MCTS. Out of which **272 (88.02%)** ANMs are registered with Phone number and only **17.8%** ANMs are registered with validated phone numbers. Similarly, Total **1,414** ASHAs are registered in MCTS. Out of which **534 (37.76%)** ASHAs are registered with Phone number and only **7.95%** ASHAs are registered with validated phone numbers. It is suggested to optimally use the call center set up to achieve the targeted 100% validation of records of ASHA and ANM data verification.

Implementation status at Sahibganj –Jharkhand is

- ❖ During 2013-14, only **44.22%** pregnant women and **35.85%** children have been registered on the system so far on pro rata basis (status as on 23rd November, 2013).
- ❖ It has been observed that **2443** pregnant women were registered in MCTS with LMP in November, 2012 of which only **26.60 %** of pregnant women received ANC 2, only **6.63%** received ANC 3, only **4.35%** received ANC 4 and **0.20%** received all four ANC services. The district has shown poor performance in delivering of All ANC services
- ❖ Similarly, it has been observed that **2537** children were registered in MCTS with DOB in **September**, 2012. Ideally all the vaccinations should have been received by the children by now, out of which only **81.59%** received all doses of BCG whereas only **11.90%** received all doses of OPV, only **16.79%** received all doses of DPT and only **1.41%** received the full immunization.
- ❖ Uploading of validated phone number of ANMs and ASHAs on MCTS portal is also a major concern. Total **306** ANMs are registered in MCTS. Out of which **229 (74.83%)** ANMs are registered with Phone number and only **14.71%** ANMs are registered with validated phone numbers. Similarly, Total **998** ASHAs are registered in MCTS. Out of which **370 (37.07%)** ASHAs are registered with Phone number and only **6.61%** ASHAs are registered with validated phone numbers. It is suggested to optimally use the call center set up to achieve the targeted 100% validation of records of AHSA and ANM data verification.

ANM and Sahiya “the lowest health functioning staffs” are well aware with MCTS system. Maternal and Child Health registers were not available in all the facilities of the districts. However

the Registers and Formats distributed at the health sub facilities are being maintained properly by ANMs at most of visited the health sub centers.

Work plan (services due list) are not being generated periodically at the data entry point (block PHC level) and distributed to ANMs for providing of due services to the beneficiaries on time. Also the delivered services are not getting updated regularly on MCTS Portal. Services due list is being prepared by ANMs in coordination with Sahiya at the Sub Centre for providing services due to the beneficiaries.

MCTS generated reports are not being used by the State as the single source of information to review the implementation progress of various schemes related to RMNCH. MCTS is considered as a data entry portal only. The system is used by the official to check the feeding status of registration and services delivered to beneficiaries only not for the strengthening of the program.

It has been observed that effective implementation of MCTS is not the priority area of the State. Health coordinators and managers at block and district level having very limited knowledge about MCTS Portal. Most of them are not well aware about the vision, objective, various features and functionalities of the MCTS Portal.

Official's in-charge at blocks and districts (BMOs' and CMOs' and other program officers and coordinators) are not taking ownership and realizing the requirement & impact of MCTS. Also they don't have any robust strategy and fixed time frame for its effective roll-out and a timeline.

Apart to above, some other major constraints (observed at field level) that restricts the effective execution of the project are :

- Unavailability of Block Data Managers at lowest entry point (CHC Level)
- Poor electricity at block level
- Lower internet bandwidth
- Training / Sensitization of the functionaries at different levels
- Limited monitoring and supportive supervision
- Unavailability of an Offline facility for child's entry under MCTS.

However, few initiatives have been taken by the state for improving the pace of implementation of MCTS which are as follows:

- New guideline has been provided to the district regarding recruitment of the Block Data Manager (BDM). 34 BDM appointed till date.
- The inverter is being provided to all blocks for uninterrupted MCTS entry.

C. State Health System Resource System (SHSRC):

The SHSRC was registered in 2010 in the State but as on the date the Executive Director has not been appointed. The team is led by a Deputy Director who holds the additional charge.

- There are 8 new staff positions which have been sanctioned in the State PIPs, however only 2 appointments have been done so far.
- Organizational mechanism is not able to discharge its duties due to Human Resource bottleneck.
- Meetings of the Executive Committee are held regularly. Last executive committee meeting was done in April.
- State Program Management Unit (SPMU) takes care of the planning process with support from NGOs, Development Partners (DPs) and key nodal persons. Role of SHSRC in providing policy inputs and as a knowledge resource center is minimal and these functions are largely in purview of staff in SPMU and are led by directorate. .

SIHFW does not exist in the state. Institute of Public Health has been identified as a State nodal agency for providing leadership training and undertaking capacity building on technical aspects. The IPH is led by a Director and there are 2 Deputy Directors. These are regular posts and filled from the Medical Officer Cadre. Currently, the other positions are contractual – 7-8 program associates, training coordinator etc. But a proposal for creation of regular posts for these positions has been submitted to the government.

Recommendation

A. Strong Point:

HMIS and MCTS are the two web enabled IT system have been introduced by the State of Jharkhand for strengthening the health care service delivery system by improving service delivery coverage and the monitoring system.

ANM and Sahiya “the lowest health functioning staffs” are well aware and convergent with both the system. Registers and formats are being maintained properly and disseminated by the ANMs at the health Sub Centre level.

Services due list is being prepared by ANMs in coordination with Sahiya at the Sub Centre for providing services due to the beneficiaries.

B. Key Concerns for improvement:

A village wise integrated RCH Register has been designed by MoHFW and shared with States/UTs. State is advised to ensure for its implementation in next three months.

State is advice to ensure:

- ❖ Complete and accurate mapping of all the health facilities & health service providers including urban those belonging in urban areas.
- ❖ 100% Registration and update of Services Delivered to Pregnant Women & Children on MCTS Portal.
- ❖ Timely generation and distribution of work plan to ANMs at the sub centres/ vaccinations site for tracking of beneficiaries for timely delivery of their due services and near real time updation of the same on MCTS Portal.
- ❖ Capturing **Aadhar Number & bank details** of all the pregnant women & health workers (ANM, ASHA) in the MCTS portal for availing the JSY benefits & payments.

Monthly review/ orientation meeting at BMO's level to review the performance of ANMs based on MCTS generated reports, identifying & addressing of gaps/ challenges related to MCTS and programs and decide the further course of action.

Use MCTS data for periodic reviewing and action-to follow up on various schemes and programs related to RMNCH services. Also the corrective action from the State level, CMHO and BMO level should be regularly carried out based on the analytical reports generated from MCTS portal.

TOR 7: Health Care Financing

Observations of the team on the basis of relevant accounts/finance records on various issues of accounts and financial management and recommendations are given below:-

1. Status of Humans Resource:

In the state, Director (Finance), State Finance Manager and State Accounts Manager are in place.

2. Status of Maintenance of Books of Accounts:

Books of Accounts are not being maintained properly as per Finance and Accounts Manual at SHS/DHS/PHC/CHC/SB Level. They are maintaining books of account manually and are not updated till 11th November, 2013. So our observations related to the maintenance of books of accounts are based on manual accounts as follows:-

Cash/Bank Book

Cash book is maintained in Tally ERP9 as well as manual (DHS only)

The closing balance has not been maintained at District level on a daily basis.

There are 11 Bank Accounts for NRHM programmes in Bokaro District and 7 in Sahibganj.

Bank Reconciliation

Bank reconciliation has been prepared by the District Health Society Bokaro and Sahibganj for RCH and MFP as on 31st October 2013:

There is a difference in the bank Reconciliation Statement of Rs. 2.34 crore and Rs. 77 lakhs (cheque issued) at the State level since 2005-06, which is not reconciled yet. Bank reconciliation has not been prepared by the most of the CHC/PHC, even though the bank statement was not available.

It reflects that District is not preparing its MIS report from books of accounts. Which is a serious lapse as far as the reporting and the maintenance books of accounts is concerned, it is recommended that all financial MIS reports should be prepared on the basis of the books of accounts at state and district level.

Advance Register

The District Health Society (**Bokaro**) has not maintained Advance Register under any programme.

The advance balance under RCH and MFP as on 31st October 2013 is given below:

RCH : 627.90 lakh

MFP : 185.85 lakh

RI : 43.89 lakh

Total 857.64 lakhs

3. Advances and Unspent balance:

An amount of Rs. 7.80 lakhs given to previous State Finance Manager in the F.Y. 2009-10 is not settled yet.

On analysis of the Statement of Fund Position of the State for the quarter ending Sep. 2013, the following observations may like to see:-

(Rs. In Lakhs)

Pools	Unspent Balance (As on 30.09.2013)	Advances (As on 30.09.2013)	% of Advances against Unspent
RCH Flexi pool	18740.68	17742.91	94.67%
Mission Flexi Pool	25411.27	20875.49	82.15%

4. JSY Payment:

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

Facilities	Date of Deliveries	Date of Payment
CHC- Nawadih	18-06-2013	04-10-2013
PHC-Peterwar	23-04-2011	13-06-2011

Salary Register

The District Health Society has not maintained the Salary Register under any programme.

Vouchers

The vouchers of cash/bank transactions are properly maintained at Addl. PHC Chalkari and Sub Centre Kurra only, but at CHC and PHC level vouchers of cash/bank transactions are not properly maintained. Printed Vouchers are not being used.

Journal

DHS has passed journal entries in the tally but not in manual books of accounts for the Statement of Expenditure received from CHC/PHC.

No Journal entries are passed in the manual books of accounts but in case of tally it is in place in the case of bill received from Parties at DHS Bokaro & Sahibganj.

Supporting documents of journal entries are maintained at DHS/FRU/CHC level where the actual expenses are incurred.

5. Status of e-transfer:

State Health Society, District Health Society and CHC/PHC have maintained bank accounts with Punjab National Bank, IDBI Bank and others. The State Health Society is sending funds to DHS through e-transfer, DHS to CHC/PHC through e-transfer and also down the line PHC it sends through e-transfer only.

The funds are being released by the SHS to DHS according to ROP and activity wise, DHS to CHC/PHC according to DHAP and activity wise.

6. Status of Tally ERP9:

The District Health Societies have not been using a customized version of Tally ERP9 and at the PHC/CHC level Customized version of Tally ERP9 is yet to be implemented. At DHS, they have some problems in Customized version of Tally ERP9. However, as of now the DHS has already complained to Tally solutions for the same.

7. Statutory Audit and Concurrent Audit

Statutory Audit

The State has submitted the audit report for the year 2011-12. As per the audit report, District Health Society has not maintained such records which are required as per the guidelines.

The State has not submitted the Statutory Audit Report for the F.Y. 2012-13 to the Ministry.

Concurrent Audit

The Concurrent Auditors have been appointed for 2012-13 by the SHS and DHS. First quarter concurrent audit is in process at DHS.

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

8. Pending Utilization Certificates:

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

Programme	Amount in Crores
RCH Flexi Pool	
2010-11	0.00
2011-12	28.59
Mission Flexi Pool	
2007-08 to 2011	0.00
2011-12	19.22

9. Income Tax Issues:

It has been observed that, most of the CHCs and PHCs have not followed rules of Income Tax under tax deduction at sources. Some PHCs are not deducting TDS on salary of staff. District Health Society Bokaro has not deducted the TDS of MMU payment of Rs. 22 Lakhs last year, also the return of TDS has not filled till 2012-13. However, the return of TDS for the F.Y 2013-14 is being submitted on time as per Income Tax Rules.

10. State Share Contribution

There is no shortfall under the State share till date. Against the desired contribution of Rs. 451.50 Crore, the State has contributed Rs. 552.80 Crore as on date.

11. FMR Reconciliation

On analysis of the Statement of Fund Position & FMR of the District Health Society Bokaro for the quarter ending June 2013, the following observations may like to see:-

			(Rs. In lakhs)
Pools	Expenditure as per SOE reported by DHS Bokaro to SHS, Jharkhand (As on 30.06.2013)	Expenditure as per FMR reported by DHS Bokaro to SHS, Jharkhand (As on 30.06.2013)	Difference
RCH Flexi pool	68.73	76.06	-7.33
Mission Flexi Pool	48.41	57.75	-9.34

11. Submission of MIS reports from CHC/PHC to DHS

The Monthly Statement of expenditure reports are not being submitted on time by the CHCs and PHCs to DHS. The dated of submission of reports is 1st to 7th of the following month and the DHS submits expenditure reports to SHS on 7th to 10th of the following month.

12. Model Accounting Handbooks

The Model Accounting Handbooks have not been sent to DHS to sub-districts so that there is no status on implementation of the Model Accounting Handbooks.

Recommendation

Advance Register should be maintained at state & district level.

Bank Reconciliation should be prepared on monthly basis at PHCs and CHCs.

Unspent balance should be reconciled on monthly basis between State and DHS, DHS and CHCs/PHCs.

Journal Entry must be passed in the journal and supporting vouchers should be kept as per journal vouchers.

Action and Taken report should be prepared at the DHS level for concurrent auditor observations.

Low/Nil expenditure should be maintained at District and State level. The reason of Low/Nil expenditure may be clarified

Income Tax provision for deduction of TDS must be followed by the DHS as per Income Tax rules and regulations.

Bank account should be separate for each programme.

State should not divert funds from one programme to another programme as per the Gol guidelines. Monitoring visits should be organised.

TOR 8: Medicine and Technology

Procurement Process:

Free Drug Policy not implemented in the state.

EDL and facility wise EDL notified by the state.

Standard Treatment Guidelines available in the state.

Mechanism of procurement of drugs and equipment in Jharkhand is through central rate contracting. The essential drug list has been adopted with no modifications and rate contracting of 30/908 items (304 Essential Drugs) has been done so far.

Procurement process is adhoc in view of the fact that the districts also have the flexibility to undertake a local level procurement.

One reason for this is that the agencies which bid for tender at state level have a high turnover ranging between 12-13 thousand crores and do not comply with the rates set by the state and bid only for 30 items. This value is high in comparison to TNMSC where agencies show an annual turnover of only one crore. Thus the state has issued guidelines to districts to undertake local procurement for the remaining items.

The concept of central procurement of drugs and equipment for consumption has been non-existent or discontinued since the last four or five years on account of certain vigilance cases in the past at district and state authorities.

Consequent to these constraints, the systems to assess the total requirement of drugs and equipment are totally redundant.

The present system of rate contracting which is done for 30 odd items also severely compromises on the quality issues as inspections are done only once pre-purchase and thereafter supplies are obtained on a need basis by the districts.

The essential drug list was not known at the district level in Sahibganj. Even at the sub-district level one notices communication gaps and medicines tendered at the State and District level are not known to field staff and MOICs.

Thus as of now only 17 drugs were being supplied at DH Sahibganj for OPD and it has also led to stock outs of not only emergency drugs and ambulatory equipment but other essentials mentioned in 5X5 Matrix (Oxytocin, misoprostol, IFA and even MVA equipment etc.).

However despite all this the bright spot is high willingness of the state to set up Central Procurement agency for undertaking procurements on the lines similar to Tamil Nadu.

Infrastructural facilities:

The state has recently constructed central warehousing facilities in RCHO Office Complex in Namkum.

There are six distinct storage facilities with one completely dedicated to cold chain of vaccines. This infrastructure is in good shape and well maintained. If the central procurement is initiated then this infrastructure can be prudently utilized.

The present stock keeping is completely manual and state showed no inclination or plan to move towards an IT enabled inventory management.

Storage and Supplies:

Presently a pull system is in practice rather than a push system. The basic concept of central procurement of essential drugs and equipment has been done away with and a system of rate contract has been put in place where Firms are Shortlisted on the basis of tenders to supply open ended quantities as per the requirement of various districts.

Supplies are also affected due to delayed indenting from the facilities.

These procurement issues described above have resulted in shortage or stock outs of essential drugs as mentioned on RMNCHA 5X5 Matrix in many facilities.

District warehouse in Sahibganj is functioning out of 10x 15 size room.

The state has done a rate contracting of the drugs to allow central procurement. Drug procurement is to be done at the district level following the same norms. Issues such as - delays in indenting for procurement by facilities across all levels and an inadequate estimation of drug requirement, which does not match the actual need and lack of awareness of district officials about the drugs that can be procured through central rate contracting has resulted in shortages and stock outs.

Review Process:

A state level procurement committee has been formed and comprises of members such as-Director in Chief, rug Controller, Joint Secretary to Health Mission, Director Finance, Representative of the state finance department as a nominated member, Health Administrative Officer, representatives of ministry of industries, vigilance department and program cell in charge respective NRHM cells for which the procurement has to be done. This committee meets more than three times in a year.

District level review process for procurement seems to be ineffective at least in the case of Sahibganj.

Recommendation

To address drug stock outs and streamlined mechanism for drug and equipment logistics measures for centralized procurement should be instituted immediately.

Steps towards essential free drug delivery are encouraged however to overcome challenges of drug requirement estimation state should seek technical support and build capacities on utilizing C-DAC.

TOR 9 : National Urban Health Mission (NUHM)

The state has proposed 14 cities to be taken up in 2013-14 under NUHM. The state has prepared and submitted the city PIP for all 14 cities based on some secondary data and consultation with the district health officials. Data related to urban areas is not available in the state and therefore a detailed baseline survey, mapping of cities with all existing facilities & gap, vulnerability assessment of the people living in slum or slum like situations would be essential.

Involvement of urban local bodies in the planning process would be required. For e.g. in Sahibganj, local municipality was not consulted and was not involved while preparing the city PIP for NUHM. As a result, the plan lacks realistic approach. At the same time newly elected ward representatives who do not have any idea on health and its determinants related issues needs to be capacitated on these interventions. Discussion with some of the counsellors of Sahibganj Municipality and with the Chairman reveals that the counsellors do not have any idea on various issues related to urban health and its determinants like water, sanitation and nutrition. Planning in isolation done by the health department resulted in a mismatch in even total urban population. There is no water supply in the entire Sahibganj municipality which is one the major areas of concern and open defecation is widely practiced. City PIP what has been submitted to the state to develop the state PIP of Jharkhand for NUHM is therefore not able to depict the actual picture.

There are some urban health post (54) in the state what basically takes care of primary health need of the urban people . Sahibganj does not have such health post. These health posts are run by the ANM only. There is no dedicated Medical Officer to manage the OPD in such posts. To reduce the load of the district hospital it is necessary to create PHCs in urban areas having at least 50,000 populations as per NUHM norm. Sahibganj city PIP has proposed one PHC for its 88,000 population as they are already having one. It is recommended to have at least one delivery point in one of these PHCs as district hospital (sadar hospital) is not able to manage to huge demand of the urban people.

In Bokaro there are 6 Urban Health Centres staffed with 3 MOs on deputation and 6 ANM (3 regular+ 3 deputation). Urban local bodies such as municipal corporations were included in the planning process of City NUHM PIP.

Because of absence of the referral system, as there is no SAHIYA in urban areas and AWC (Aanganwadi center) do not refer cases to any facility, no one in the district hospital takes care of the patient. If someone knows any person in the hospital, then only it becomes easier for them to get the treatment. Otherwise, they are being treated very badly and have to wait for a longer hours to reach the doctor.

People in slums are living in extremely unhygienic condition like water logging, open defecation, no drainage facilities and no garbage disposal system. Lot of flies and mosquitoes were seen during day time what is the main cause of Malaria and is one of the major diseases in Sahibganj urban areas. There is no facility for destruction of Malarial larva's in water logging points and bleaching powder etc. are not being sprayed or supplied by the health department.

MCH card is not being given to the mothers as there was a shortage of supply what DRCHO has said.

As a result, tracking of mothers & children is not happening properly. Most of the pregnant

women have not received the second TT, IFA tablets and there are a significant number of children have not received all scheduled vaccines. This is something very striking as these slums in Sahibganj are located within the distance of 2-3 kms from the district hospital. Home deliveries are still taking place in urban areas as observed in Sahibganj urban slums. There is no NGO working in urban slums or in urban areas in Sahibganj city. There is no community based organization (CBO) too. But most of the women have agreed to have CBO like Mahila Arogya Samiti for their benefit.

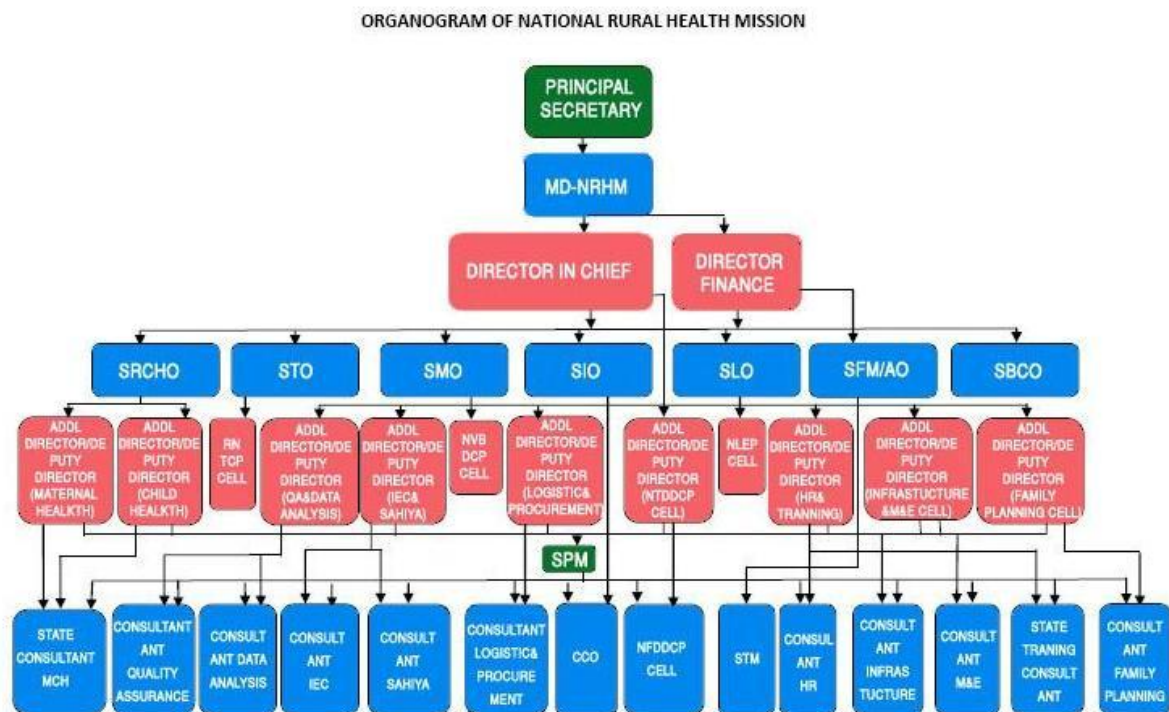
State preparedness for NUHM:

State PIP for NUHM has been prepared based on 14 city PIPs prepared for the year 2012-13 and sent to GOI for approval. PIP has been approved by the JRHMS (Jharkhand Rural Health Mission Society)

JRHMS has given approval for:

Re-designation of the Mission Director as Mission Director, National Health Mission. The appointment of Additional Mission Director for National Urban Health Mission Urban Health Cell under JRHMS. Technical support from the Health of the Urban Poor Program , being implemented by the Population Foundation of India/ Plan India with the support of USAID, India. Integration of NUHM component in the district health mission for its implementation. State share for NUHM i.e. 25% i.e. 10.35 crores of the total budget of 41.39 crores in which central share is 75% i.e. 31.04 crores will be required.

ToR 10: Governance and Management



State management structure for National Health Mission is based within the Programme management Unit. Mission Director heads both the National rural and urban Health Mission. Apart from the MD-NHM, the mission also works under the strategic guidance of Director in Chief and Director Finance. An urban health cell has been created and is headed by a designated Nodal Officer from Directorate of Health Services. Positions of consultants have been sought for implementing NUHM in supplementary PIP-2013-14.

Jharkhand demonstrates good integration of the Programme Management Unit with the Directorate of Health Services. Different domain areas (Maternal Health, Child Health, Adolescent Health, Village Health Sahiya Resource Centre, Programme Management, Human Resources, Training, infrastructure etc.) under NRHM are implemented through a designated programme cells which are headed either by Deputy Director, Directors or Additional Directors who are supported by a team of three to four consultants.

The SPMU consists of 4 persons: State Programme Manager (SPM); State Finance Manager (SFM); State Accounts Manager (SAM) and State Data Officer (SDO).

Recruitment of HR for programme management has been delegated to State Administrative Officer, while all decisions of fund release and expenditures are undertaken by Director Finance. Delegation—

A major concern noted in management structure was insufficient manpower in many programme cells.

For example the position of State Programme Manager is vacant for one and half years and is currently being seen by State ASHA Programme Coordinator in VHSRC. This

further limits operationalization of the VHSRC team which is now limited to just three members.

Likewise management of human resources under NRHM is managed by single consultant. There is also an issue of minimal coordination between Jharkhand Public Service Commission, Treasury and HR management team of NRHM, thus making the problem of limited human resources for health even more complex.

District Level

The DPMU at each district consists of 3 persons: District Programme Manager (DPM), District Accounts manager (DAM) and District Data Manager (DDA).

Many districts have also appointed hospital managers. The district health society is chaired by District Magistrate and civil surgeon is responsible for overall implementation of the programme. CS is supported by Additional Civil Surgeon and District RCHO officer looks after the implementation of all RCH program and is supervises training for clinical care. In addition to this District Programme Coordinators look after community process interventions and report to Village Health Sahiya Resource Centre. Regular Medical Officers have been given the responsibility to manage different programmes such as malaria, TB etc. Jharkhand is yet to take action on the creation of a public health care. However, about 18 districts have trained and placed hospital managers.

Block Level:

The BPMU at each district consists of 3 persons: Block Program Manager (BPM), Block Account manager (BAM) and Block Data Manager (BDA).

One of the findings of our discussion with the district team in Sahibganj was that out of the 21 posts of BPM, BDM and BAM in the seven blocks of Sahibganj only 8 are functional. No induction training or orientation has been conducted for Program managers. Many Block Programme Managers have received only one day orientation at induction which appears to be highly inadequate in terms of enabling them to play program management roles. This affects the management as well implementation of various programme activities.

Dedicated program officers are missing and Medical officers are being given additional charge. The incoordination between contractual and regular staff further makes it difficult for personnel from BPMU and DPMU to discharge their duties.

There is no existence of public health cadre at any levels.

Supervision and Monitoring: From the financial year 2013-14 state started a new initiative in the form of State Review Mission to strengthen programme monitoring and ensuring supervision by programme experts. The team for this review is an eight member team comprising of programme managers and consultants from SPMU, public health experts, representatives of disease control programmes, SHSRC, development partners etc. The allocation of districts and travel plan is done in such a way that every team gets to visit one district once in three months. This exercise has been envisaged on the same lines as Common Review Mission and involves an exhaustive field work of five days. Post field visit the team shares follow up actions and recommendations with the district officials and action taken report is sought by Mission Director from the district health society. The tools and checklist that are being used for this mission are in complete conformity with the Supportive Supervision tools that have been developed by MOHFW, Government of India. (Action Taken Report of SRM)

In addition to SRM other mechanism of programme review involves the periodic Divisional Review conducted under the leadership of Principal Secretary Health.

Mechanism for district programme review is through the meetings of District Health Society. However it was seen that meeting of the executive body of the District Health Society in Sahibganj didn't happen in the last nine months.

District Level Monitoring Vigilance Committee: Most districts have established DLVMC as per NRHM order under the chairmanship of district MP in the FY 2012. However regularity of these meetings is a concern. For instance in Sahibganj no meetings have been reported so far. One meeting in Bokaro was held on 5th January 2013.

Clinical Establishment Act: The Act desires to improve public health by providing registration and regulation of clinical establishments in the state and prescribing minimum standards of facilities and services that may be provided by them. Jharkhand has adopted the 'The Clinical Establishment Registration and Regulation Act, 2010' completely with no modifications. Few steps that the state has taken in this regards are- -

1. Establishment of the State Council for Clinical Establishment (Notification: 7 (A) 06-03/10 62 (7A))
2. Notification of names from the State for the various sub-committees to be constituted at the National Council for Clinical Establishment.
3. Initiation of the process for establishing District Registration Authority in each district of Jharkhand. Districts like Ranchi, Kodarma etc. have already established the District Registration Authority.

Teresa @ Titaria



The Local Teresa – Nibha Naomi Soren

Little did we know that the morning of November 14th 2013 will bring with it the most incredible experience of our lives. We were in Jharkhand for the 7th CRM visit. Totally devastated and crestfallen by the all-pervasive poverty, human sufferings and complete collapse of public systems that we had been experiencing throughout our visit to the Sahibganj district. Oblivious of what lay in store for us we expressed eagerness to visit the Subcentre at Titariya. You might wonder what triggered that thought?

During our analysis of the data that was being shared by the district authorities, one figure intrigued us and caught our attention – 556 deliveries at a sub-centre in 9 months, more than the deliveries conducted at the District Hospital.

We were excited not because we were about to explore a heart-warming experience rather that we'll catch some sort of malpractice. Next day morning we set out on our journey and in some time we were at the doorstep of the subcentre of Titaria village, catering to a population of 12,000. We were welcomed with simplicity by a middle-aged woman by a smile exuberating warmth. Upon enquiry she humbly submitted that she has conducted 556 deliveries in 9 months. We couldn't believe our ears and expressed the desire to meet the beneficiaries. All our doubts just vanished in seconds when we saw words being spoken in praise of The Local Teresa – Nibha Naomi Soren. She was a Goddess in the garb of an ANM for the local women in distress. Though we were awestruck by her unbelievable service to mankind our mean Indian mentality took better of us. We didn't waste even a second to leave room for a subsequent thought and wanted to reconfirm if at all what we saw had truthfulness or was it just a farce. We went inside a small room to meet the beneficiaries. There were 3 new mothers who had delivered in the last one day and fourth one was expected to deliver any moment. We had not even stopped admiring the ANM when we had more surprises in store. Soon we saw yet another pregnant lady washing her utensils, which captivated us yet again when we whispered in her ears to know as to how much do they pay for food etc. We felt ashamed at our mentality when we heard the response of the beneficiary- a marginalised Santhal whose husband was a migrant labour and was out for work- "I live in the adjoining village and experienced false labour pain two days back and came to consult didi. Since my delivery date is near didi didn't allow me to go. She cooks and feeds me and doesn't charge a penny. She is GOD to me."

The tale of this middle-aged woman is embossed on our minds and heart forever.

NUHM FGDs:

FOCUS GROUP DISCUSSION 1

City: Sahibganj

Name of the Slum: Methar Toli of Rasulpur

Dehla Ward Number: 5

Total Population: 250 (approx) Category

of people: SC, Mushlim, OBC

Main Occupation: Rickshaw chalak, Drivers, shoe making, sweepers Composition of

groups: Men and women of all age groups (Men 12 , women 7)

Facilitators: Mr. Smarajit Chakraborty, Member 7th CRM team & Dr. Murmu, DRCHO-Sahibganj district Date : 13th November, 2013

About the slum and the group: Methortoli is one of the unauthorized slums of Rasulpur Dehla area coming under ward number 5 of Sahibganj Municipality. This slum is 1 km away from the district hospital. This is one of low land areas of Sahibganj city where water logging is one of the major concerns in regard to sanitation & hygiene which was observed during a transact walk before the FGD. There is one samiti named “ Handi Bhang Jati Samiti” formed by the residents of the slum 5 months back. The purpose of the Samiti is to mitigate the conflicts amongst slum dwellers and social development. Resident of this slum lives in an unacceptable unhygienic condition. Malaria is very common according to the residents of the slum and there is no action being taken either by the Municipality or by the health department for cleaning the drains. Municipality supplies bleaching powder before rainy season which is insufficient against the need. There is no individual toilet facility. Only one community toilet has been constructed by the municipality with 4 seats which cannot cater the huge need of the slum. Open defecation is widely practiced. There is one AWC (Aanganwadi Center) which is about 50 meters away from the slum and is the immunization site for the women and children of the community. ANM comes to this AWC once in a month but do not visit this slum. AWW too do not come to this slum for home visit although this is one of the catchment areas of this AWC.

1.2 & 1.3 About Health Issues and Health services and about access to other services and relationships: Following diseases and health issues are common in the area:

Malaria

Jaundice

TB

Cold, cough & fever

Malaria and water borne diseases are the major public health problems in the slum which are bothering the slum dwellers throughout the year. District hospital is just 1 km away from this slum and for any minor and major health problems they go to this hospital for treatment. They need to pay Rs 30-40 to rickshaw to reach to the district hospital. Some of them go to the private practitioners for major health problems like TB, cancer, heart disease what according to them is a costly affair. In the district hospital they have to wait for a long time to get a chance to reach to the doctor. There is a railway crossing in between the hospital and the slum which sometime becomes a barrier to take a patient to the hospital especially for deliveries. Although most of the deliveries are being conducted at the district hospital but there are cases of home deliver by SBA. Mothers after delivery do not stay in the hospital till 48 hours. They stay there for a maximum period of 24 hours because of limited beds and facilities. Main source of drinking water is tube well and there is no supply water. Lack of knowledge and practice in regard to infant feeding practices like early initiation of breast feeding, exclusive breastfeeding, proper weaning of food are challenges observed in the slum. Most of the mothers do not have immunization card of their children.

1.4 About Community's Expectations on Services: Waiting time for treatment in the hospital should be minimal, medicine supply should be ensured in the hospital, supply of IFA tablets should be regular with

prescribed quantity, more community toilets and provision of individual toilets, financial assistance for local health action, visit of ANM in the slum at least once in a month.

1.5 % 1.6 about the organization and efforts made by themselves to get better health and NGOs in Action: One Samiti has been formed in the basti which is the only community based organization what basically takes care of conflict resolution but they do not have wider vision to improve the health condition of the community. Upon probing women had shown interest to have a group of their own in line with Mahila Arohya Samiti (MAS).

FOCUS GROUP DISCUSSION 2

City: Sahibganj

Name of the Slum: Kabutar

Khopi Ward Number: 25

Total Population: 5000 (approx)

Total number of voters: 1667

Total number of families: 500 (approx)

Composition of groups: All women of reproductive age, 16 women

Facilitators: Mr. Smarajit Chakraborty, Member 7th CRM team & Dr. Murmu, DRCHO-Sahibganj district Date : 13th November, 2013

About the slum and the group: Kabutar Khopi is one of the unauthorized slums of Sahibganj city of Jharkhand located on the bank of the river Ganges. There is no formal group exist in the slum. This area was under rural part and in the year 1996 this has come under the town area of Sahibganj. First municipal election was held in this ward in the year 2008 according to Ms Ranjita Debi who is the councilor of ward number 26 and was present during discussion. The slum comes under the ward number 25 of Sahibganj Municipality. The slum is 2.5 kms away from the district hospital. There is one AWC (Aanganwadi Center) which is approx 60 meters away from the slum and is one of the immunization sites in Sahibganj city. Women take their children to this AWC for immunization. ANM does not visit this slum neither AWW (Aanganwadi worker) comes for home visit. According to the women, supplementary food is not being distributed to them from this AWC. There is no drainage system exist in the slum.

1.2 & 1.3 About Health Issues and Health services and about access to other services and relationships: Following diseases and health issues are common in the area:

Kala Azar

Malaria

Filaria

Anemia among
women Lucoria

Gastro entities

Water borne diseases like diarrhoea, jaundice,

Women said that water borne diseases like diarrhoea, jaundice, cold, cough & fever are the most common diseases what is being seen throughout the year. Most of the time they go to the govt district hospital as they do not have the capacity to afford the cost of private facilities. District hospital is 2.5 kms away from the slum and the only means to go to the hospital is rickshaw. Rickshaw fare is Rs 50/- for one way to the district hospital. Fees of private doctor ranges from Rs 150/- to Rs 200/- and this is the reason they do not go the private doctors. However, some of them go to the private practitioners as they do not have trust on the govt facility/ doctors.

Women in this slum have lot of grievances against the health system especially against the district hospital which is the only option for them whether it is a common ailment or RCH services. All of them said very aggressively that they are being treated like cattle by the hospital staffs (verbatim: **ldhar maat aao, dur hato, jao yahan se** etc). No one in the hospital talks to them properly and let them wait for a long time for any normal or emergency services. Pregnant women at advance stage need to wait for hours and sometimes even for the whole night for admission. One of the examples they cited: One of the mother in law told that once she had taken her daughter in law to the district hospital for delivery. She had to wait the entire night and was told that the position of the baby was not proper and therefore they cannot deliver the baby. Her daughter in law was with labour pain and ultimately she along with few women conducted the delivery in the hospital itself that night and no one in the hospital helped them. She said that they have lost the trust on the govt facility but as they do not have the capacity to afford the private facility they do not have any option left. Women have also said that they need to pay the hospital staff Rs 300/- to Rs 500/- after delivery as tips and they cannot get the JSY cheque without paying Rs 200/- to ASHA. They

know that Rs 1400/- is being given to the mothers out of JSY scheme but for receiving the cheque they need to pay at least Rs 200/-.

In the group there were two pregnant women and none of them have received the MCH card (Jaccha baccha card) . One of them is with 8 months pregnancy and has received only one TT before 3-4 months in the district hospital. No one in the hospital had told her to come again for the second TT and the poor lady does not know about the TT doses and its duration. She was not given the IFA tablets from the hospital and does not know the EDD. The other pregnant woman who is 7 month pregnant too has not received the MCH card and the second TT. She is also not aware of the second dose of the TT and no one in the hospital has told her about this. She has received only 2 stripes of Iron tablets and not aware of the EDD.

Almost all women said that supplementary food is not being distributed at the AWC which is 60 meters away from the slum and preschool education is not being imparted to the children. AWW doesn't come to the slum for home visit but sometime she comes for household survey. This AWC is the immunization site for this slum and some of the mothers take their children to this AWC for immunization. Some of them go the district hospital. They feel that if ANM comes to their slum it would be very much helpful for them and the status of immunization will be improved. So far as sanitation is concerned, nothing is happening. Most of the slum dwellers do not have individual toilet facility and there is no community toilet. Open defecation is widely practiced what aggravates the situation without drainage system in the slum. Residents collect some bleaching powder from the municipality before the rainy season and spray on water logging points. This is also very insufficient for the area.

1.4 About Community's Expectations on Services: First and foremost expectation of the community is a human behavior from the service providers. They had been complaining against the health providers of the district hospital throughout the discussion. They said that no one comes to them and when they go to the facility they are not being treated properly. They expect that officials should come to them, listen to them and understand their problems. They should get proper treatment in the facility, no one should harass them for money and they should get medicine from the hospital. Most of the time they are compelled to buy medicine from open market. There is no supply water in the slum and they expect that water should be supplied to them on regular basis as soon as possible.

1.5 % 1.6 about the organization and efforts made by themselves to get better health and NGOs in Action: As mentioned, there is no such community based organization (CBO) exist in this slum neither any NGO is working in this area. Upon probing, they said that a CBO like Mahila Arogya Samiti may be very much helpful for them and they would go for if someone helps them.

FOCUS GROUP DISCUSSION 3

City: Sahibganj

Name of the Slum: Launchghat

Basti Ward Number: 14

Total Population: 500 (approx)

Total number of families: 65

Composition of groups: All women of reproductive age, 20 women

Facilitators: Mr. Smarajit Chakraborty, Member 7th CRM team & Dr. Murmu, DRCHO-

Sahibganj district Date : 14th November, 2013

Time: 11 AM to 1 PM

About the slum and the group: This is a slum which is located on the bank of the river Ganges and beside the road of the city. This is an unauthorized slum in ward number 14 of Sahibganj Municipality. Ms Shila Devi is the ward councilor who has been recently selected and was present during the discussion. There are 3 AWC (Aanganwadi centers) in this ward and the nearest AWC is about 1 km away from this slum. There is no water supply and one tube well which is on the bank of the river Ganges is the only source of drinking water. No one of them is having individual toilet facility. There is a sulabh sauchalaya which is the only toilet facility and is chargeable. Rs 5/- is being charged for one time use and women face lot of problems as Rs 5/- is also very much high for them. Some of the women have said that if someone suffers from Diarrhea then it becomes very difficult for them to use the paid toilet. Main occupation of the slum dwellers are rickshaw pullers, daily wagers and coolie. Most of the pregnant mothers are having 4-5 children and average age at marriage is 13-14 years for girls.

1.2 & 1.3 About Health Issues and Health services and about access to other services and relationships:

Following diseases and health issues are common in the area:

Typhoid

Malaria

Gastroenteritis

Cold , cough ,

fever Hypertension

Diabetes

During the discussion it was found that most of the women have gross complains against the govt health system. They being poor cannot afford private facility and at the same time they are not being treated properly by the staffs of the govt hospital. They have to wait for a long time to reach to the medical officer of the hospital with an average 7-8 hours of waiting on the Que. There were 3 pregnant women present during the discussion and none of them has received the second dose of the TT and IFA tablets. None of them has received the MCH card and are not aware about the ANC and child immunization. There was a nursing mothers in the group who has a 3 months old baby received only one dose of Immunisation (BCG). All of them said that the hospital staffs are very much rough and rude towards them and no one listen to them and understand their problems. There was a malnourished children found who is 9 months old and according to the mother that child was refused to be admitted in the MTC at the district hospital. District hospital is 2.5 kms away from the slum and they have to pay Rs 100/- to reach to the hospital as rickshaw fare. They are not aware of free transportation facilities initiated by the govt through Mamta Bahan. They said that they have lost their trust on the govt health system but poverty does not allow them to go the private hospital.

1.4 About Community's Expectations on Services: All of them unanimously said that they should be treated as human being at the govt hospital and medicine should be supplied at the hospital as they do not have the buying capacity to buy medicine from open market. They expect that the medicine should be made available for them. Supply water, toilet facilities, regular availability of supplementary food at the AWC, drainage facility are major expectations of the community. They said that these discussions are also of no use as nothing is going to happen. They requested facilitators to take up these issues at the appropriate level so that their voices are heard.

1.5 % 1.6 about the organization and efforts made by themselves to get better health and NGOs in

Action: There is no community based organization exist in their community neither any NGO is working in this area When probed they said that they are interested to form their own group like MAS for their interest.

In-depth Interview

Interviewee: Mr. Rajesh Prasad Gond, Chairman- Sahibganj

Municipality Date of Interview: 13th November, 2013

Place: Sahibganj Municipality

Interviewer: Mr. Smarajit Chakraborty, member CRM team- Jharkhand and Dr. Murmu-DRCHO, Sahibganj According to the Chairman Major health related issues in Sahibganj Municipal area are:

Time: 10 AM to 11 AM

- Lack of Specialist doctors in the district

- Unavailability of medicine in the hospital

- Selection process of medial and paramedical staffs is questionable

- People do not have trust of the public health system

- Referral of cases like malaria, fracture to the districts of West Bengal

- No steps are being taken by the health department after floods which is a regular phenomenon in the city as the city is on the bank of the river Ganges

- Chemical contamination of water from Arsenic, fluoride is a serious health concern

Suggestive actions / strategies:

- Treatment of water for chemical and bacteriological contamination

- Destruction of Malarial larvas on stagnant water to prevent malaria

- System strengthening: Joint Planning, monitoring & review of health

- programmes Identification of urban poor

- Mapping of vulnerable pockets,

- families Construction of more

- community toilets Political will

- People's participation in planning and monitoring of the program

Chairman said that they are willing to support the health department in micro planning and promised that all 28 councilors of Sahibganj Municipality would be engaged in planning and monitoring of health programme in the city if district health authority wants. Chairman said that he attends the meeting of district health society being one of the members but his suggestions are not being taken care of and this is the reason he does not take much of interest in health activities.