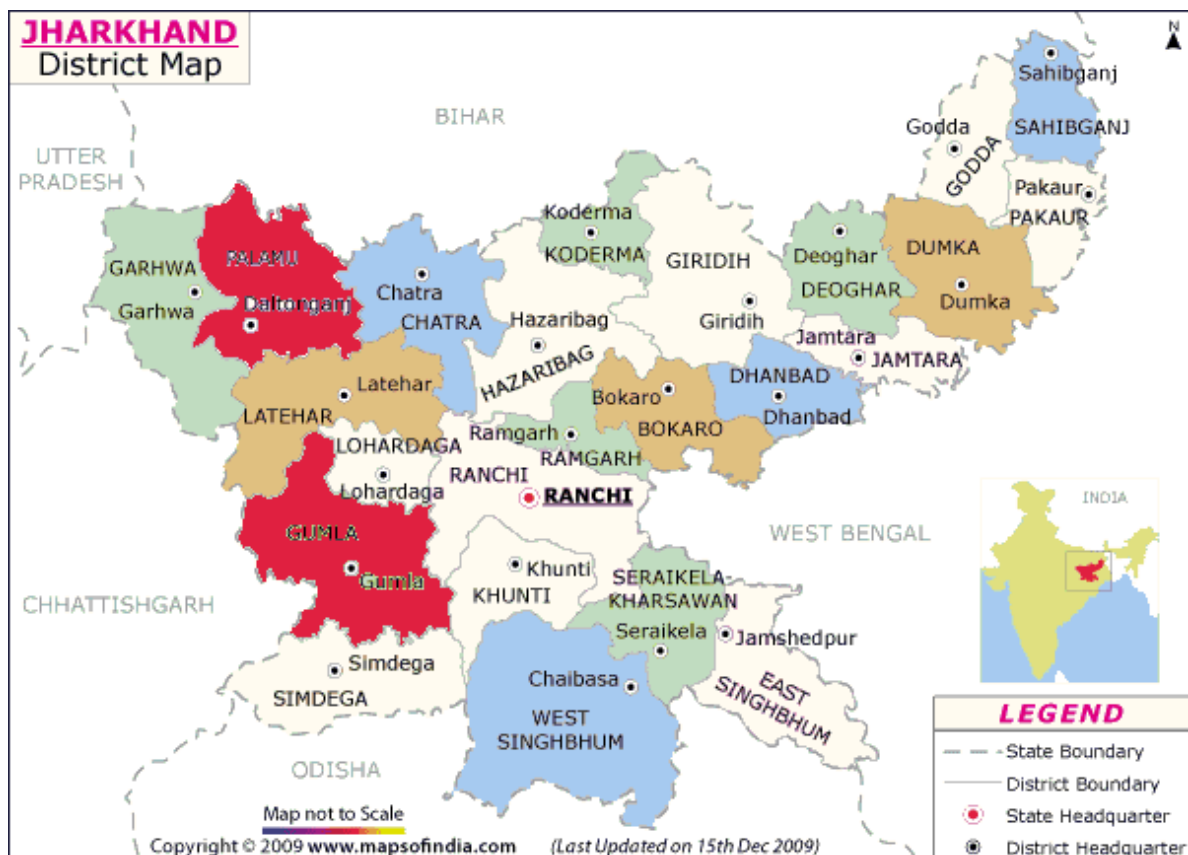


2010

National Rural Health Mission (NRHM),
Ministry of Health & Family Welfare,
Govt. of India



4TH COMMON REVIEW MISSION (DECEMBER 16-22, 2010) JHARKHAND

4th Common Review Mission (CRM): JHARKHAND
under
National Rural Health Mission (NRHM)
(16th-22nd December 2010)

Organised by:
NRHM Division
Ministry of Health & Family Welfare
Government of India

CRM Team for Jharkhand:

- 1. Dr. S.N. Sharma**
Joint Director (NVBDCP)
22 Sham Nath Marg, New Delhi – 110005
Phone (Off): 011-23990007; Mobile: (0)9810538795
E-mail: drsnsharma@sify.com
- 2. Dr. D.K. Saikia**
Deputy Director (NIPCCD)
Ministry of Women & Child Development
Jawahar Nagar, Khanapara, behind Kendriya Vidyalaya, Guwahati – 781022
Phone (Off): 0361-2301519; Mobile: 9435349626
E-mail: dsaikia8@yahoo.com
- 3. Ms. Deepika Shrivastava**
Officer on Special Duty – WCD & Nutrition
Planning Commission
459, Yojana Bhawan, Parliament Street, New Delhi
Phone (Off): 011-23096765, 23042487; Mobile: 9811260888
E-mail: deepika.s@nic.in; deepikashrivastava21@gmail.com
- 4. Mr. V. Ramesh Babu**
USAID
Embassy of USA, Chanakyapuri, New Delhi
Phone (Off): 011-24198226; Mobile: 9873004702
E-mail: vbabu@usaid.gov
- 5. Mr. Gautam Chakraborty**
Advisor – Financing of Health Care
National Health Systems Resource Centre (NHSRC)
NIHFW Campus, Baba Gangnath Marg, Munirka, New Delhi – 110067
Phone (Off): 011-26108982/83/84/92/93; Fax(Off): 011-26108994; Mobile: 9971002391
E-mail: gchaks72@hotmail.com
- 6. Dr. Mona Gupta**
Program Management Support Group (PMSG)
RCH-II (Ministry of Health & Family Welfare)
Mobile: 9377819831
E-mail: mona.hrd@gmail.com
- 7. Mr. Jayanta Kumar Mandal**
Finance Analyst (Finance Management Group – NRHM Division)
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi
E-mail: jayant.fmg@gmail.com

Content

Chapters/Sections	Page
Abbreviations	3
Chapter 1: Introduction	6
1(a) Jharkhand: an introduction to the state	6
1(b) Public Health System in Jharkhand	6
i. Infrastructure	6
ii. Human Resources for Health and NRHM	7
iii. Health and Performance Indicators	7
iv. Status of the PRI framework in the state	8
v. Special constraints	8
vi. List of facilities visited by the CRM team	8
Chapter 3: Findings	10
3(a) Change in key aspects of health delivery system	10
i. Infrastructure Upgradation	10
ii. Human Resource Planning	11
iii. Health Care Service Delivery – Facility Based – Quantity & Quality	12
iv. Outreach Services	15
v. ASHA Program	16
vi. RCH-II (Maternal Health, Child Health and Family Welfare)	17
vii. Nutrition	17
viii. National Disease Control Programmes	17
ix. Institutional Mechanisms and Program Management	18
x. Financial Management	19
xi. Decentralised local health action	20
3(b) Progress against approved PIP of the state	21
Chapter 4: Recommendations	24
Chapter 5: State Specific Issues	28

Abbreviations

CHC	Community Health Centre
PHC	Primary Health Centre
SC	Scheduled Casts
ST	Scheduled Tribes
MMR	Maternal Mortality Rate
IMR	Infant Mortality Rate
TFR	Total Fertility Rate
RIMS	Rajendra Institute of Medical Sciences, Ranchi
PMCH	Pataliputra Medical College and Hospital, Dhanbad
ANM	Auxiliary Nurse Midwife
GNM	General Nurse Midwife
IPHS	Indian Public Health Standards
EAG	Empowered Action Group
ANC	Ante-Natal Care
PRI	Panchayati Raj Institution
LWE	Left Wing Extremism
CRM	Common Review Mission
HSC	Health Sub Centre
APHC	Additional Primary Health Centre
VHND	Village Health and Nutrition Day
MTC	Malnutrition Treatment Centre
NGO	Non Government Organisation
PPP	Public Private Partnership
AWTC	Anganwadi Training Centres
ANMTC	Auxiliary Nurse Midwife Training Centre
TOR	Terms of Reference
PWD	Public Works Department
SOE	Statement of Expenditure
MO I/C	Medical Officer in-charge
LHV	Lady Health Visitor
RCH	Reproductive and Child Health programme
MO	Medical Officer
PMU	Programme Management Unit
MPW	Multi-Purpose Worker
SDH	Sub Division Hospital
AWW	Anganwadi Worker
ASHA	Accredited Social Health Activist (Sahiya in Jharkhand)
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
SBA	Skilled Birth Attendant
IPD	In-Patient Department
OPD	Out-Patient Department
DH	District Hospital
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
C-section	Caesarean section
BPM	Block Programme Manager
HQ	Headquarter
JSY	Janani Suraksha Yojana
IUD	Intra-Uterine Device

OCP	Oral Contraceptive Pill
ABER	Annual Blood Examination Rate
API	Annual Parasite Incidence
MP	Malaria Parasite
NLEP	National Leprosy Eradication Programme
PTG	Primitive Tribal Groups
OT	Operation Theatre
LT	Lab Technician
IEC	Information Education Communication
MMU	Mobile Medical Unit
IFA	Iron Folic Acid
RI	Routine Immunisation
FP	Family Planning
SDO	Sub Division Officer
SRS	Sample Registration Survey
NBW	New-Born Weight
DPT	Diphtheria Pertussis Typhoid
OPV	Oral Polio Vaccine
NRHM	National Rural Health Mission
ICDS	Integrated Child Development Scheme
NVBDCP	National Vector Borne Disease Control Programme
RDK	Rapid Diagnostic Kit
Pv	Positive Vivax
IRS	Indoor Residual Spraying
RNTCP	Revised National Tuberculosis Control Programme
TB	Tuberculosis
SHS	State Health Society
IDSP	Integrated Disease Surveillance Programme
HMIS	Health Management Information System
MIS	Management Information System
SFM	State Finance Manager
DAM	District Accounts Manager
RKS	Rogi Kalyan Samiti
HR	Human Resources
DHS	District Health Society
VHSC	Village Health and Sanitation Committee
UF	Untied Funds
PPI	Pulse Polio Immunisation
ERP	Enterprise Resource Planning (software)
DHAP	District Health Action Plan
GoI	Government of India
FMR	Financial Monitoring Report
VHC	Village Health Committee
DDT	Dichloro-Diphenyl-Trichloroethane
LWE IAP	Left Wing Extremism Integrated Action Plan
WCD	Women and Child Development
BHAP	Block Health Action Plan
IYCF	Infant and Young Child Feeding
PIP	Programme Implementation Plan
ARSH	Adolescent Reproductive and Sexual Health
AYUSH	Ayurveda Yoga Unani Siddha Homeopathy

BCC	Behaviour Change Communication
SHSRC	State Health Systems Resource Centre
IPH	Institute of Public Health
TSC	Tribal Sub Plan
NRDWP	National Rural Drinking Water Programme
SNCU	Sick Newborn Care Unit
BTT	Block Training Team
DTT	District Training Team
CDPO	Child Development Project Officer
LS	Lady Supervisor
DMO	District Malaria Officer
ERS	Emergency Response Service
EMRI	Emergency Management Research Institute
CSR	Corporate Social Responsibility

Chapter 1: Introduction

1(a) Jharkhand: An Introduction to the state

Jharkhand, the 28th state of Indian union carved out of erstwhile Bihar on 15th November 2000, is a forest-covered, mineral-rich, tribal dominated state. It is rich with vast biodiversity and beautiful landscapes. It has a diverse ethnic, cultural, and linguistic heritage; and has largely agriculture and forest based livelihoods. Mining and steel are the key industrial activities. The state has 24 districts, 224 blocks and over 32,000 villages. Population density in the state is 274 per sq. km, as against the national average of 312. There are 24 district hospitals, 194 CHCs (Block PHCs), 330 PHCs (Additional PHCs), and 3958 Sub-centres, most of them are serving a much higher number of populations as compared to the norms. Most of its districts are under political turmoil and insurgency, due to Maoist extremist activities. The population of Jharkhand is 2.69 crores and sex ratio is 941 females per 1000 males (as per 2001 census). SC Population is 12%, ST Population 26%, overall Literacy rate 53.6% with a Female Literacy rate of 38.9%. The state has MMR 312, IMR 46, and TFR 3.31.

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

1(b) Public Health System in Jharkhand

i. Infrastructure

The health infrastructure in the state of Jharkhand is a legacy from the unified Bihar days, which are now being adjusted to the specific needs of the state. The number of health institutions at various levels is shown in the table 1.1 below.

Table 1.1: Health Infrastructure in Jharkhand

Health Sub Centres	3958
Primary Health Centres (Additional PHCs)	330
Community Health Centres (PHCs)	194
Referral Hospitals	32
District Hospitals	21
Medical Colleges	3
Nursing Colleges	1
Paramedical Training Schools	0
ANM Training Centres	10
GNM Training Centres	3
Ayurveda college	1
Homeopathy college	1

As per the above mentioned number of health facilities, compared against the population norms, the state of Jharkhand is short of 3130 Sub Centres and 675 PHCs. Also, considering the national norm of one medical college for 50 lakhs population, the state would need at least two more medical colleges.

ii. Human Resource for Health

The position of human resources for health in the state of Jharkhand, along with the requirement (as per IPHS norms), is shown in table 1.2 below.

Table 1.2: Human Resource for Health in Jharkhand

Category	In position			Requirement as per IPHS	Shortfall
	Regular	Contractual	Total		
Medical Officer	1376	457	1833	1237	---
Specialists	84	0	84	1453	1369
Staff Nurse	216	362	578	2408	1830
Lab Technician	85	332	417	629	285
Pharmacist	100	244	344	629	212
ANM	2978	4098	7076	8906	1830

It can be seen from the above table that there is no shortfall (as per IPHS norm based requirement) requirement of Medical Officers, but the shortfall in other staff category is substantial. There is 94% shortfall in Specialists, 76% shortfall in Staff Nurses, 45% among Lab technicians, 34% among Pharmacists/Compounders, and 20% shortfall in ANMs.

iii. Health and Performance Indicators

Jharkhand has one of the poorest health indicators among the EAG states. Some of the key indicators of Jharkhand are shown in tables 1.3 and 1.4 below.

Table 1.3 Key Health Indicators of Jharkhand

Indicator	Jharkhand			Target for 2010-11	India	Goal
Year	2001	2006	2008	2010-11	2009	2012
IMR	72	69	46	35	53	<30
Full Immunisation	8.8%	34.5%	54.1%	80%	54.1%	100%
MMR	400	371	312	175	254	<100
TFR	2.8	3.3	---	2.7	2.6	2.1

The state seems to have achieved more than the all-India levels for IMR and “Full Immunisation” but had lagged behind the national average in terms of MMR. But compared to what targets the state had set itself, it is far behind and not likely to achieve it by the end of Xth Five-Year Plan.

Table 1.4 Key Health Performance Indicators of Jharkhand

Indicator	Jharkhand			Target for 2010-11	India		Goal
Year	2001	2006	2009	2010-11	2001	2006	2012
3 ANC (%)	24.5	36.1	43.5	70	66	51	100
Institutional Delivery (%)	13.9	19.2	31.2	45	34	41	80
Safe Delivery (%)	17.5	28.7	---	60	42	48	100

The state is evidently lagging far behind in terms of ANC coverage and Institutional Deliveries, showing serious lack of capacity in both outreach and facility based services.

iv. Status of PRI framework in the state

The state of Jharkhand held the Panchayat elections in December 2010, for the first time after creation of Jharkhand in 2000. Hence the institution of PRI is at its nascent state and needs nurturing before it can be employed effectively of planning, administering and monitoring development activities at the grassroots.

v. Special constraints

Instability in the state government had caused delays in decision making regarding reform issues like cadres, service conditions, and also affected civil works being taken up for many health facilities. This had adversely affected the upgradation of the state health system in general, and the state had lagged behind other EAG states.

The Left Wing Extremism (LWE) had also adversely affected the outreach and peripheral healthcare services, resulting in increased absenteeism, lack of supervision, etc. It had also affected emergency and referral transportation as many times dug-up roads had delayed access to appropriate health facilities.

vi. List of facilities visited by the CRM team

4 th Common Review Mission				
17 th December 2010 to 23 rd December 2010				
Name of State		JHARKHAND		
Names of Districts visited				
S.No.	Name	District HQ	Name of DM	Name of CMO
1	Palamu	Daltonganj	Ms. Pooja Singhal Purwar	Dr. M.P.Singh
2	Gumla	Gumla		
Health Facilities visited				
S.No.	Name	Address / Location	Level (HSC / PHC / CHC/other)	Name of the Person in Charge
1.	Civil Surgeon, Palamu	Daltonganj	District Headquarter	Dr.M.P.Singh

2.	Civil Surgeon, Gumla	Gumla	District headquarter	
3.	Sadar Hospital	Daltonganj	Dist. Hosp	
4.	District Hospital	Gumla	District Hospital	
5.	Block PHC	Chhatarpur	PHC (designated SDH)	Dr. Aggarwal
6.	Block PHC	Patan	PHC	Dr. Dilip Kumar
7.	Block PHC	Chainpur	PHC	Dr. SKP Yadav
8.	Block PHC	Hussainabad	PHC	Dr. Anil Kumar
9.	Block PHC	Palkot	CHC	
10.	Block PHC	Basia	CHC	
11.	Block PHC	Dumri	CHC	
12.	Block PHC	Bishunpur	CHC	
13.	PHC	Nawdiha Bazar	Additional PHC	Dr. Alok Anand
14.	PHC	Kishanpur	Additional PHC	Dr. Rajiv Kumar
15.	PHC	Hydernagar	APHC	
16.	PHC	Jairagi	PHC	
17.	Sub Centre	Nowdiha	Sub Centre	Sister Horo
18.	Sub Centre	Nawadih	Sub Centre	Ms. Mary Teresa Kujur
19.	Sub Centre	Chawkri	Sub Centre	Ms. Damayanti (ANM)
20.	Sub Centre	Nadiain	Sub Centre	
21.	Sub Centre	Manihatoli	Sub Centre	
22.	Sub Centre	Moreng	Sub Centre	
23.	Sub Centre	Solabera	Sub Centre	
24.	Sub Centre	Salem	Sub Centre	
25.	VHND	Tenpa	Anganwadi Centre	Mrs. Sumita Kumari (ANM)
26.	VHND	Nawdiha Bazar	Anganwadi	
27.	Anganwadi Centre	Dumri	Anganwadi	
28.	Anganwadi Centre	Karmadon	Anganwadi	
29.	Anganwadi Centre	Salem	Anganwadi	
30.	MTC	Chainpur	PHC	Dr. Kesri
31.	MTC	Hussainabad	PHC	Dr. Anil Kumar
32.	Mobile Medical Unit	Rampur	CHC	
33.	Mobile Medical Unit	Bishunpur	CHC	
34.	Vikas Bharti	Bishunpur	NGO	
35.	Mission Hospital	Mander	PPP	Sr. Joan
36.	Dipti Hospital	Nawadih	PPP	
35.	AWTC	Bishunpur	Anganwadi Training Centre	
36.	ANMTC	Daltonganj	ANMTC	Mrs. Kanti Mishra

Chapter 2: Findings

3(a) Change in key aspects of health delivery system

The CRM team for Jharkhand split into two teams. One team comprising of Deepika Shrivastava, V Ramesh Babu, and Jayanta Kr. Mandal, went to Gumla district. The other team comprising of Dr. SN Sharma, Dr. Saikia, Dr. Mona Gupta and Gautam Chakraborty, went to Palamu district.

The teams had the following observations regarding the eleven issues identified under the TOR for CRM, for the state of Jharkhand, based on what they observed in the two districts.

1) Infrastructure upgradation

- Major gaps in infrastructure (44 % in the case of HSCs)
- Backlog of construction under NRHM & State funds
- Civil works delayed in several instances –
 - Palamu : Patan PHC, Chattarpur PHC- through PWD (Delays in Payments, SOEs)
 - Gumla : CHC Bishunpur - delays in release of state funds
- Need to strengthen coordination between Health Dept. and District implementing agency
- Inadequate staff quarters – major constraint in 24 hours availability
 - Gumla: CHC Dumri, CHC Palkot, CHC Bishunpur
 - Palamu; PHC Patan, PHC Chattarpur, HSC Naudiha
- Irregular power supply and lack of connectivity in some PHCs /HSCs
 - No electricity in Gumla – PHC Jairagi, Palamu – Kora HSC, Navadih HSC
- Lack of functional toilets and safe drinking water
 - No toilets in PHC Chattarpur, HSC Kora
 - No piped water supply or handpump in APHC Naudiha Bazar
- Some initiatives for stay of Sahiya like at Chainpur PHC, stay of attendants -shed Gumla Dumri hospital

Some of the other specific observations made by the teams are as follows:

- There is an engineering wing at the state level which takes the decision on the architectural, development and financial aspects of the new constructions under state or NRHM Budget.
- The construction of the CHC/PHC Patan and Chhatarpur was started during 2008. It was told that the MO I/C is not aware and involved in the process of planning, designing or monitoring of the construction activities. Four residential quarters of medical officers and 6 staff quarters (Patan) were demolished and the new construction is coming up on that place. The financial support and overall architectural planning is being done through state engineering cell under NRHM.
- It was informed that the construction work has been stopped for last one and half years in Patan and Chainpur, and since last 8-9 months in Chhatarpur. The fund release was stopped as SOE was not provided by the agency. A total of Rs. 3.58 crore was sanctioned for the building in Patan.
- A total of Rs. 1.59 crore was approved in 2008 for the construction of new building of CHC Chainpur. The construction is incomplete and stopped.

- The Medical Officers and paramedical staff is residing in rented houses at Patan Chainpur and Chhatarpur PHCs, as their quarters were demolished.

2) Human Resource Planning

- Overall shortage of skilled human resources and difficulties in retaining in hard to reach areas. As per IPHS, in respect of existing facilities- for the State
 - Staff nurses: shortfall is 1830 out of 2408 ie 76%
 - ANMs : Shortfall is 1830 out of 8906 ie 20%
 - Lab technicians: shortfall is 45 %
 - Pharmacists/ compounders: shortfall is 33 %
- High vacancies were observed, as in
 - Gumla MOs (48/ 97- 50%), LHV (11/24 ie 50 %), ANMs (102/292 ie 35 %), LT (67%)
- Doctors' service conditions, remuneration stagnant, not at par with other EAG states such as Bihar, Odhisa
- Disconnect between regular and contractual staff
- Delays in state recruitment processes
- Service providers, have reasonable knowledge and core skills – especially for RCH. But motivation is a key issue
- Fragmented Training- overload on MOs, ANMs, where high vacancies exist
- Vibrancy in health system through newly recruited ANMs, Sahiyas, PMUs
- Overall supply capacity low – For MOs –highly inadequate, for ANMs also- 10 ANMTCs govt and 8 ANMTCs (pvt.) not enough

Other issues observed by the teams are as follows:

a. Availability of Human Resources & Gap analysis

- Out of 1348 total sanctioned posts for all categories, 603 post are filled up in the district Palamu.
- Out of 227 sanctioned posts for MOs, 97 posts are filled up
- In Patan PHC, there is adequate manpower available except need for a female doctor, Malaria Inspector, MPWs and ANMs. But in PHC Chhatarpur, there is only one MO in place, and the MOs from nearby APHCs are posted/ deputed on a rotation basis to provide 24x7 services.
- There is need for the specialists doctors at PHC, which are being converted to CHC/SDH (30 to 50 bedded facilities)

b. Pre-service Training capacity

- No planning and time line for the training were observed
- MOs, ASHAs, AWWs and ANMs need regular orientation.
- Palamau has an ANM training Centre attached to district hospital. The ANMTC was functional till 2006 and has trained batches of 90 ANMs in each term. However it has only one teaching faculty (the Principal) now and is being used for pre-service IMNCI and SBA trainings.

c. Recruitment and Cadre Management

- Interviews for all categories have been conducted and the results would be declared after the Panchayat elections

- There is shortage of medical graduates in the state which are passing out from the medical colleges as per the state requirement. At the present rate, it will take approximately 20 years to fill up all the positions (as per IPHS staff norms) provided all the pas out doctors are absorbed in service.

d. Skill quality of Health Human Resources

- Quality of lab technicians leaves a lot to be desired, especially in detection.
- Doctors and field staff need orientation in upcoming diseases like mental health (said to prevalent among women in Chhatarpur block) and Diabetes (many cases, on insulin, in Hussainabad block)

3) Health Care Services Delivery – Facility Based – Quantity & Quality

- Increase in IPD at District Hospital
 - Gumla - by 2% (from 08-09 to 09-10) and 8% (from 09-10 to Nov 10)
- Decrease in OPD at District Hospital
 - Gumla – decreased by 0.5% (08-09 to 09-10) and by 18% (09-10 to Nov 10)
- Stagnation in hard-to-reach areas (PHC Bishnupur, CHC Dumri in Gumla; APHC Hyder Nagar, Kishanpur)
- Patient load found to be concentrated on district level hospitals and less at PHC/Block level in Palamu
 - average monthly deliveries in DH – 350, in PHCs – 150, 2-3 at HSC/APHC level.
- Very few HSCs (15%) conducting deliveries in Palamu
- Mother and child not staying in facility, especially at PHC/APHC level, even for 24 hours (mainly because of lack of facilities to stay)
 - Large stock-outs of drugs and consumables (in Palamu 80% items stockout at DH, 50-60% at APHC level, 10-25% at PHC level) – stockouts lasting 1-4 months

Other facility specific observations made by the teams are as follows:

District Level:

- On an average OPD is 600 per day.
- IPD is 60-70% of bed occupancy
- Overloaded for institutional deliveries and insufficient number of bed.
- 7 maternal deaths reported so far and audit conducted through verbal autopsy.
- Payments are not given at the institution of delivery but the patients are asked to collect funds from Civil Surgeon office, 10-15 minutes walking distance.
- Induced deliveries are not encouraged.
- MTPs up to 12 weeks by MVA performed by trained doctors posted in DH (April-Dec 18, 2010 total MTPs =111). Above 12 weeks MTP done only with tube- ligation. MTP registers being maintained properly. Training including refresher training being conducted regularly with support from Ipas. Wall painting at DH about free MTP seen.
- 10 Ambulance services vans.
- No telephone facilities for ambulance services

- Toilets for general ward were dirty, there was no light and no water. Ladies toilets maintained by Sulabh were away from the female wards. A patient who has undergone C-section cannot be expected to walk so far. There was no water.
- The monthly consumption rates for drugs have not been worked out.
- There is need for the monitoring of stocks in and stock out. Drugs from Various sources (directorate, RCH and local purchases) are maintained in separate registers. Some
- Outsourcing has been done but, Pathological investigations are not being monitored by Pathologist doctor for quality checks of the technicians.
- The team was given to understand that the Boyle's Apparatus in DH is on rent.

CHC/ PHC

- No specialists posted in Patan or Chainpur, hence no c-sections. However the CHCs are functional 24x7 and are conducting normal deliveries.
- There was no annual plan available with PHC. MO I/C was not able to explain any activities being undertaken at the PHC but, was totally dependent on the Bock Programme Manager (BPM).
- Ambulance services are being mostly used by the MO I/C for meeting and delivery of medicines from Civil Surgeon office and for bringing surgeons from district HQ for sterilizations. It is being not adequately used for referral services.
- Money for some of the patients under JSY not paid, though cheques were signed by the medical officer in advance.
- Maternal deaths audits were done for 10 patients (in Patan) but no measures were taken up to find out the reasons and to take steps for improvisation.
- In Patan, 4578 pregnancies were registered and 3146 normal deliveries have taken place. 1951 deliveries have been home based. (2009-10)
- In Patan, indoor residual spray has been quite poor without proper training and monitoring.
- In PHC Chainpur, the infrastructure, human resource, facilities, drugs availability and management capacity for the health care was found to total contrast to PHC – Patan. This PHC can be a role model for other health facilities in the state.
- In Chainpur, there were 3474 registrations for ANC till Nov. 2010. Out of 2698 deliveries so far, about 50% are home based deliveries. The number of NSV, Tub., IUD, OCP and Nirodh has been 46, 127, 421, 3561 & 11099. The Child immunization has been about 82% till Nov. 2010. OPD was 30939 and IPD number was 1361. ABER is 8.9 %, API – 10% & Pf % - 7%
- The diagnostic facilities are very poor at the PHC.
- The quality of slide preparation, staining and examination for malaria is very poor and unsatisfactory. The technicians are not well versed with the microscopy and record keeping. MOs are not monitoring the treatment protocols of malaria treatment. Cross checking of the slides is not being done. Patients got examined for MP from outside are not being re-examined with microscopy.
- A total of 7565 school children were screened and 253 children were enrolled at Vision Centre for treatment.

- 126 patients are under treatment under NLEP.
- 129 positive cases were detected out 1311 sputum check ups.
- Till August 2010, no RCH camps and Outreach & PTG Camps were held as funds were not made available.
- On the day of visit on 19.12.2010, three deliveries took place at Chainpur PHC and three beneficiaries were discharged after payments through cheques and birth certificates.
- The Labour room, OT, Cold chain, OPD are well maintained. However, no patient was found in IPD.
- There is a backlog of Rs. 1,05,445/- in JSY at Chainpur PHC.
- A total of Rs. 61,44,198/- was received from district and there is 61.24% of the expenditure of the total funds received till Nov. 2010
- At PHCs drug availability is relatively good with less than 30% items stock-out during the time of the visits. Drugs are being procured locally from companies/stockists as per state/district rate contract.
- At Chainpaur the decrease in OPD is attributed to well functioning District hospital and availability of private practitioners nearby.

APHC

- Good building, recently built (nowdiha Bazar and Hyder Nagar), but acute shortage of doctors, ANMs, pharmacists, LTs and office staff.
- Because of lack of office staff, JSY payment for deliveries at APHCs are being handled at the block headquarters, causing inconvenience to beneficiaries.

MTC:

- Chainpur - Four children were admitted at the time of visit. There is a provision for Rs. 100/- per day for the mother as incentive.
- Hussainabad – 3 children were admitted at the time of the visit, 2 of which were category II children. Food was available only for the child and the mother had to travel back home for food and again come back to the admitted child.

Support Services:

- The diet is outsourced in DH however the same is not available in CHC/PHC.
- Signages are present.
- CHC Chainpur had good waiting area with comfortable seating arrangement. Emergency Referral Transport is not available.
- Though the CHC have ambulance it is generally used for other purposes (for transporting drugs and personnel etc.), patients who need referral are given Rs.250/300 for transport and they have to arrange their own vehicle.

Bio-medical waste management:

- Colored bins observed in most of the facilities.
- Health personnel have undergone training, yet the segregation and management of waste needs more focus.
- Pits with all kinds of waste in it were seen in some of the facilities.

IEC:

- Posters and wall paintings were seen in all the facilities visited.

- At one place the team also saw miking being done for sterilization camp. However overall plan which includes Sahiya and AWW as behavior change agents seems lacking

Supervision and monitoring

- During interactions with officials at facilities understanding of data as a tool for management planning and monitoring was not apparent.
- Data formats / HMIS are still viewed as something to be filled and sent to the HQ by functionaries at facilities.
- Monitoring of trends in service delivery or utilization is not being done most of the facilities and thus the epidemiological relevance of the work of the health facility does not come to notice of the service providers manning the facility.

Family Friendly hospitals

- Instructions for family friendly hospitals have been sent to the districts from the State.
- All the facilities were freshly painted, and had curtains, amenities for patients like water etc.

4) Outreach services

- Sub Centers: New buildings constructed (10% of all HSCs), but still many (56% of all HSCs) running in rented buildings
- 66 MMUs operational in the state with an operational expenditure of around Rs 2 lakhs per MMU (two observed as functional in Gumla)
- VHNDs organised as scheduled, with ANC, immunization, IFA distribution in Gumla
- Lack of focus on other services, other than RI in Palamu
 - Session planning good; fixed day approach known to community. Also being organised in unserved habitations
 - Good cross-sectoral linkage of frontline workers in Gumla

Other specific observations made by the teams are as follows:

HSC – Nodiha (Patan):

- The HSC is located in a quite new and spacious building.
- Covers 8 villages of 6530 population.
- This HSC used to undertake deliveries till April 2010 but due to the transfer of ANM, this was stopped. Though, HSC is well equipped with all facilities for undertaking normal deliveries.
- Daily OPD 10-20 patients
- Recently, new ANM has joined, who can be trained with experienced ANM.
- There is no tracking of the pregnant women by the ANM.
- Electricity connection can be applied for the building at HSC.
- Immunization coverage also hampered in the HSC in the absence of ANM though alternate arrangements were made.
- Record keeping was good and minutes of Sahiya's meetings were recorded on regular basis with main emphasis on RCH and FP. The other programmes were not discussed in the meetings.

Month	April 09	May 09	June 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10*
No. of deliveries	8	3	4	9	6	11	11	2	1	12	-	4	1

*No deliveries after April 2010 till Dec 18, 2010

HSC – Nawadih (Chainpur)

- Two ANMs are working at the HSC.
- Record keeping was quite poor.
- No tracking of the pregnant women and advance planning for field visits.
- OPD attendance was quite poor due to the attitude of the regular ANM.
- Lack of coordination between Sahiya's and ANM was observed.
- ANM could not demonstrate for taking blood smear. Moreover, there was no micro slide, lancet and cotton swab with spirit at the HSC to take blood smear for the patients.
- Out of three beneficiaries visited at their houses, payments were not paid to two mothers under JSY. The deliveries took place on 19th and 28th Nov. 2010 at Sadar Hospital.
- No IRS activities in the HSC took place during 2010.

HSC Chawkri and Nadiain:

- New building at Nadiain, not finished but the ANM moved in and used untied funds to renovate. Chawkri is in rented building but the owner had not received any rent payment since last 6 months, as the rent is not approved from the SDO office.
- No deliveries taking place in the Sub Centers, and the ANMs take the delivery cases to PHC.

There seemed to be lack of co-ordination between ANM and Sahiyya in some of the sub-centres visited. The work load distribution between the two ANMs was also not clear.

5) ASHA programme (Sahiya in Jharkhand)

- Around 92% Sahiys trained in 5 modules
- Timely payment of Sahiys in Gumla- but delayed for 2-3 months time in Palamu
- Lack of interest among Sahiys on non-incentivized activities like home visit, counseling, disease control programs
- Sahiya help desks are established in most DH/CHCs
- Supportive supervision structure for Sahiys initiated
- Coordination of Sahiys, Anganwadi Workers, ANMs is very good in Gumla, but not so visible in Palamu
- One Sahiya's Shelter is functional at Chainpur HSC, where Sahiya's coming from remote areas stay, in case they are required to stay for JSY work. This is an innovative idea which gives an opportunity to meet Sahiya's at one place and share their experiences.
- Sahiys seem to be empowered after receiving 5 modules of ASHA training. Average income of Sahiys around Rs. 2500 per month, mainly from JSY and transportation payment, but payment received in 2-3 months.

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

- ANC registration increased from 36% (2006) to 44% (2009)
- Only around half of them are converted to institutional deliveries (mainly due to lack of facilities at block and below)
- Acceptance and use of IUD is very low, even after the introduction of new IUD with 10-years life
- Name-based tracking started in Gumla, but not in Palamu
- Maternal death review needs strengthening and more detailed probing for clinical and social causes
- Especially maternal/ infant deaths related to malaria not getting tracked
- Initiatives taken in Jharkhand have resulted in impressive gains in immunization coverage. The SRS data (2008) shows that Infant Mortality Rate (IMR) in Jharkhand (at 48 per 1000 live births) is relatively low amongst the high Focus states. It is also lower than the national average of 55 per 1000 live births.
- Pregnant women and NBW tracking not started in Palamu. The due list, at places, was found incomplete. Immunization coverage seems to be slipping after the discontinuation of alternate vaccine carriers and vaccinators due to paucity of funds.
- Full immunization in Patan has been 78% and 62% during months of November 2009 and 2010. Percentage coverage of antigen ranged between 55% (ANC3) to 77% (DPT1 & OPV1).
- JSY payments in DH and some of the CHCs were on time. But payments for deliveries in APHCs and SCs at made at PHC and are delayed.
- The process of JSY payment varies at places. In one of the PHCs the beneficiary has to provide 3 photographs, the coupon and the discharge slip for payment. The modalities should be similar and all efforts should be made to make payments and provide birth certificates before the mother leaves the facility.

7) Nutrition

- MTCs seem to be underutilized in Palamu(3 cases in Hussainabad PHC, 2 of which were grade-II children). But in Gumla MTC at DH is optimally utilized.
- Tracking of severely malnourished children and planning of capacity at MTCs needs improvement
- Sahiyas' role in nutrition component needs to be strengthened
- Less focus on promoting infant and young child feeding practices
- Linkage of VHNDs with THR distribution in Gumla is effective
- Mother and child new NRHM ICDS cards are yet to be introduced
- No record of grade III/IV children could be obtained. There seems lack of coordination between ICDS and Health.

8) National Disease Control Programmes

a. NVBDCP:

- The basic items for diagnosis such as micro slides, lancet, stains, spirit swab were not available at HSCs.
- Over-dependence on RDKs (Monovalent diagnosis being done even in areas with higher proportion of Pv.

- The slide quality and its examination were found deficient.
- Treatment Protocols not adhered to.
- The quality of IRS was found to be totally unsatisfactory.
- There was no micro-plan for IRS available with the PHCs

b. RNTCP:

- Vacancy of contractual staff like Senior Treatment Supervisors, Senior TB Lab Supervisors and the duration for which the posts are vacant under RNTCP;
- Availability of lab technicians and lab consumables for conducting quality diagnostic sputum smear microscopy activities at the Designated Microscopy Centers needs to be ensured;
- Funds are getting released for programme from SHS in time. RNTCP account being sub account under main NRHM account. Financial Management guidelines of NRHM shared with programme officers.
- Whether RNTCP officers are called for review meetings.

c. NLEP:

- In Palamu, 193 cases of Leprosy were registered and under treatment (between April and Nov. 2010) in Patan block (Palamu district).

d. IDSP:

- No data on IDSP was shared with the team at the district level.
- One Epidemiologist is posted without other infra-structure.
- At Patan PHC, the IDSP report is manually prepared on weekly basis for 11 diseases only and sent to District.
- The prescribed format of IDSP is not being followed up.
- The computer and printers were found non-functional at the Patan PHC.

9) Institutional Mechanisms and Programme Management

- District Health Mission not meeting frequently
- District Health Societies meet frequently, but need more substantial discussions and decision making on public health and program issues, apart from targets and financial matters
- Decentralized procurement observed at facility level, procured locally from approved stockists, as per state/district rate contracts
- Supervisory visit plan/schedule not observed
- HMIS is manual below the block, and gets compiled as per the HMIS format at block level, which is entered in the web portal of NRHM. Feedback of HMIS reports down the reporting channel not observed.
- The hospital management societies and district societies still dependent on administrative clearances for funds and approval. Any item of expenditure above Rs. 1000 (at PHC level) and Rs. 5000 (at district level) needs administrative approval.
- Panchayats not in place, so coordination with PRI/local govt. not happening presently
- Program management staff, not having official authority, found it difficult to obtain data (for MIS) and to supervise field staff and activities.

10) Financial Management

- HR: No position created for Finance (Director & Accounts) and the position of SFM is vacant.
 - No DAM posted in Gumla
- The Statutory Audit of the State is awaited for the year 2009-10 (stipulated time : 31st July, 2010)
- Irregular Concurrent Audit System and no TOR available for Concurrent audit
- Ineffective utilization of RKS money in some cases
- Procurement procedures are not being followed in some cases under RKS funds
- The frequency of DHS meetings and RKS meetings can be increased (e.g. DHS-Gumla, 2 meetings in a year)
- Inadequate Internal Control mechanism observed in some cases
- Hospital Management Society funds getting utilized as per guidelines
- State utilization of untied funds under VHSC: 36%
- Delay in transfer of funds from DHS to Blocks (e.g. Gumla UF-VHSC- 29/9 to 2/11) and also in inter bank transfer.
- JSY payments are pending
- At DH-Gumla, payment pending from Dec'10 as there is no fund At DH-Daltonganj, delay from last 2 months due to non availability of cheque book.
- Audit Objections (2008-09): No approval of funds on the Note sheet and only verbal approval taken.

Some of the specific observations made by the team are as follows:

a. Manpower:

- (i) The State do not have the position of Director (Finance & Accounts) as the same has not been created . Hence, the said position is lying vacant.
- (ii) The position of State Finance Manager is also vacant. The State has initiated the process to fill up the vacant position.
- (iii) At presently the position of State Accounts Manager is being managed by the District Accounts Manager of Ranchi, deputed in State. The recruitment process for the State Accounts Manager has already been initiated by the State.
- (iv) Out of 24 Districts in the State, the position of District Accounts Manager in 19 districts are filled in and remaining 5 are vacant.
- (v) Out of 194 Blocks in the State, the positions of 170 Block Accounts Managers are filled in and the remaining 24 are vacant.
- (vi) The availability of manpower for handling accounts is not sufficient. As mentioned above the key positions such as Director (Finance & Accounts), SFM remained vacant in the State.

b. **Electronic Transfer of Funds:** The State is transferring funds to District Health Societies electronically. But the State is using different banks for different programmes for making electronic transfer of funds. It was noted that at SHS, the State is using Allahabad Bank for RCH Flexible Pool fund, State Bank of India for Mission Flexible Pool fund and RI /PPI the State is using Punjab National Bank. It is also noticed in-spite of electronic transfer there was a delay in clearance from one bank to another.

c. **Customized Version of Tally ERP-9 :** The State has procured Tally ERP-9 software at SHS and all the 24 DHS of the State. Training has been imparted but it is not properly implemented across the State. The SHS is maintaining books of accounts in Tally 9, but not in customised version of Tally. Presently the State do not have the data base regarding the implementation status of Tally across the State. The response from Tally

on trouble shooting measures is not very supportive. The State verbally reported that for each activity of customisation Tally is asking high professional charges.

- d. **Unspent Advances:** As per the Statement of Fund Position submitted for the month ended 30th November, 2010, the State is having huge Advances of Rs. 97.75 crores under Mission Flexible Pool and Rs. 30.78 Crores under RCH Flexible Pool.
- e. **Distribution of funds:** The funds are being distributed to DHS on the basis of utilisation and demand from the concerned DHS, not as per the approved DHAP of the District. It is also noticed that State is distributing the fund activity wise rather than distributing fund flexible pool wise. e.g. It has been noticed that in Gumla, JSY payment for the month of December, 2010 is pending because the fund earmarked for under JSY has been exhausted.
- f. **Auditing Procedures:**
 - (i) **Statutory Audit:** The Statutory Audit report for the year 2009-10 is pending for submission at GoI level. The report is under process for the consolidation and finalisation.
 - (ii) **Concurrent Audit :** The State has appointed concurrent auditor at SHS and for all the Districts except Deoghar. But no TOR has been issued to the Concurrent Auditor either by the State or any directive has been issued by the State to improve the internal control system. The Concurrent Audit at SHS level has recently started. As Concurrent audit has been recently implemented in the State hence the comment on quality of concurrent audit cannot be done as the summarised audit observations is not shared with the Ministry.
- g. **Delegation of Financial & Administrative Power:** At the time of creation of DHS in Districts, the State has issued directives on delegation of Financial & Administrative power.
- h. **Training :** From the Training Calendar maintained by the State, it is noticed no training to improve the capacity building of Finance personnel has been imparted by the State during the year 2010-11, except training on implementation of Tally ERP-9.
- i. **Updation of Financial Status under HMIS:** It has been observed that out of 24 Districts only 6 Districts had uploaded the FMR on HMIS for the second quarter of FY 2010-11.
- j. **Other Issues:** It has been noted that the frequency of DHS and RKS meetings are very less, generally twice in a year. It has been also noted that RKS money could be utilised more efficiently for health care services. The procurement procedures for high value articles were not being followed.

11) Decentralised local health action

- Village Health Committees formed and bank accounts created, but not functional in the absence of PRI. (Panchayat elections in state completed in December, and PRIs to be formed in the last quarter of 2010-11).
- VHCs involved in spray of DDT
- District PIP preparation, along with activities for preparing Block PIPs in place, in partnership with donor partners (UNICEF, USAID) and reputed NGOs (CARE, CINI).

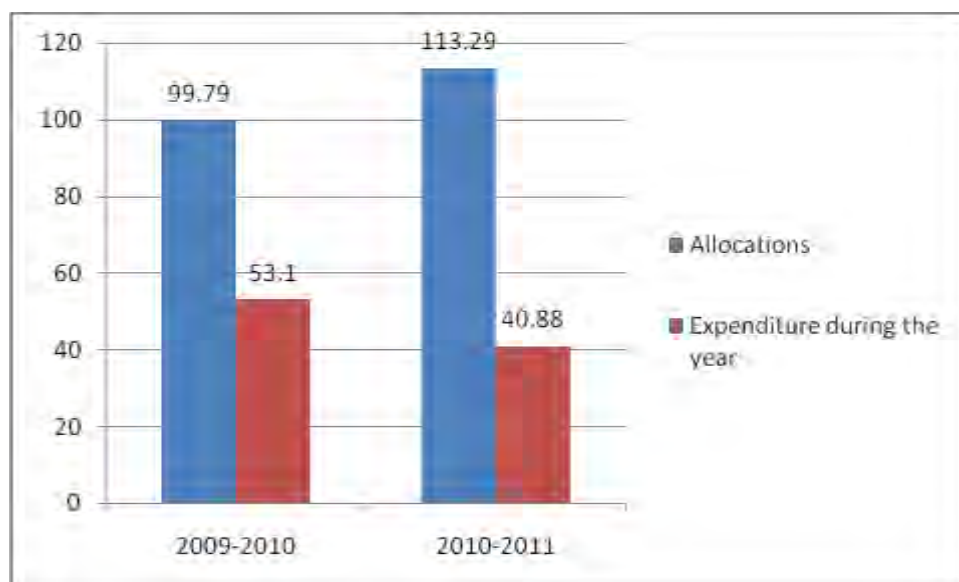
3(b) Status of progress of Rajasthan against specific objectives, expected outcomes, and expected outcomes at community level under NRHM

- NRHM is contributing to structural transformation
- Strong motivation, commitment and leadership at individual levels, vibrant and effective PMUs
- State initiative commendable to mobilise resources, address hard to reach, linking tribal dept, LWE IAP, WCD
- Very good initiative to introduce DHAPS, BHAPS, with participatory processes, linking with other sectors
- HR and Infrastructure gap filling initiated
- State innovations are promising – eg. Adolescent Week and Yuva Maitri Kendra, Family Friendly Week, IYCF training, Sahiyya Help Desks in DH/CHCs
- Encouraging progress in RCH, VHND / RI microplanning and tracking, SBA training
- Visible face of change in NRHM – Sahiyas

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

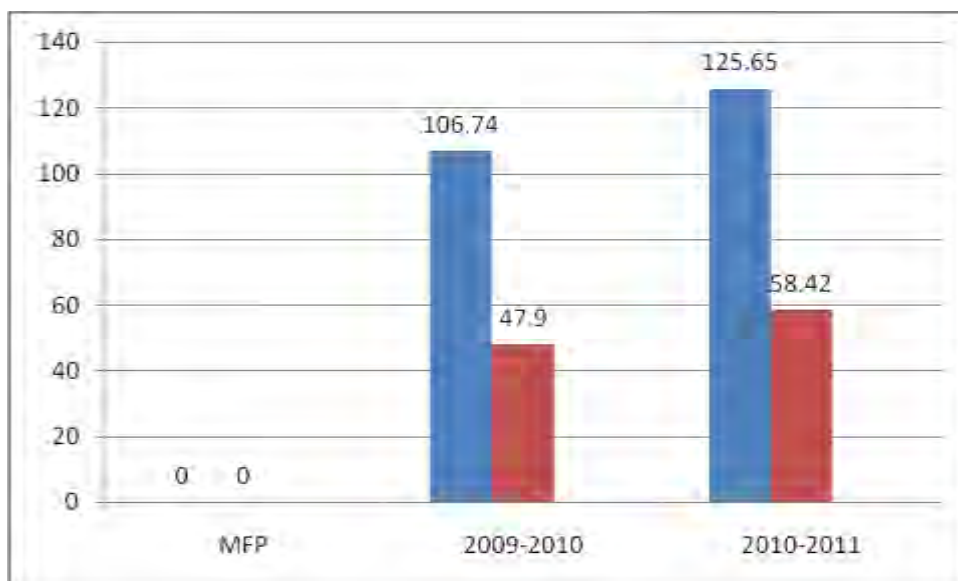
RCH- Technical Strategies & Activities

(Rs. In Crore)		
RCH	2009-2010	2010-2011
Allocations	99.79	113.29
Expenditure during the year	53.10 (as per FMR)	40.88 (FMR upto 2 nd Qtr)



Mission Flexible Pool

MFP	2009-2010	2010-2011
Allocations	106.74	125.65
Expenditure during the year	47.90 (as per FMR)	58.42 (FMR upto 2 nd Qtr)



Identified activities for low/Nil Utilization

Activities reported low utilization as per 2nd Qtr. FMR against approved PIP for the year 2010-11.

- **RCH Flexible Pool: Nil Utilization reported for...**
 - ARSH, Innovations/PPP/NGO, Procurement, FPS
 - Negligible Utilization Reported-----
 - Child Health(5.52%), Urban RCH(4.99%), Tribal
 - RCH(0.57%), Infrastructure & HR(3.21%), Inst. Strengthening (1.57%)
- **Mission Flexible Pool: Nil Utilization reported for...**
 - Hospital Strengthening , DHAP, Mainstreaming of AYUSH, IEC-BCC under NRHM, Training, SHSRC, New Strategies / Initiatives, Support Services, Research Studies, Analysis, Planning/Implementation/Monitoring,
 - Procurements (1.05%).

Details of low/nil-utilisation (till 2nd quarter of 2010-11), is shown in the following tables:

RCH

S.No	Activity	SPIP	Utilization	% age Utilisation of SPIP
A.2	Child Health	525.82	29.04	5.52%
A.3	Family Planning Services	255.40	0.00	0.00%
A.4	Adolescent Reproductive and Sexual Health/Arsh	20.34	0.00	0.00%
A.5	Urban RCH	80.10	4.00	4.99%
A.6	Tribal RCH	298.00	1.70	0.57%
A.8	Innovations/PPP/ NGO	118.00	0.00	0.00%
A.9	Infrastructure & Human Resources	1320.97	42.36	3.21%
A.10	Institutional Strengthening	429.00	6.74	1.57%
A.11	Training	1584.63	208.26	13.14%

A.12	BCC / IEC	683.81	49.32	7.21%
A.13	Procurement	2100.08	0.00	0.00%

Additionalities under NRHM

S.No	Activity	SPIP	Utilization	% age Utilisation of SPIP
B3	Hospital Strengthening	258.00	0.00	0.00%
B7	District Action Plans (Including Block, Village)	16.00	0.00	0.00%
B9	Mainstreaming of AYUSH	32.48	0.00	0.00%
B10	IEC-BCC NRHM	16.35	0.00	0.00%
B16	Training	15.14	0.00	0.00%
B18	Planning, Implementation and Monitoring	158.15	0.00	0.00%
B19	Procurements	325.00	3.40	1.05%
B22	New Initiatives/ Strategic Interventions (As per State health policy)	140.60	0.00	0.00%
B24	Research, Studies, Analysis	5.00	0.00	0.00%
B25	State level health resources center(SHSRC)	27.80	0.00	0.00%
B26	Support Services	654.26	0.00	0.00%
B.28	Other Expenditures (Power Backup, Convergence etc)	29.08	0.00	0.00%

Chapter 4: Recommendations

Based on the observations and findings of the CRM team had made the following recommendations to the state:

1) Infrastructure

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

2) Human Resource & Training

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

3) Healthcare services delivery – facility based – quantity & quality

- Accelerate Institutional deliveries- especially in hard to reach areas and scattered tribal populations
 - Encourage tola sahiyas,
 - Utilise new mini AWCs in these areas – 216 in Gumla
 - Link with Mata sahayta samoohs in ICDS
 - Use of culturally appropriate local transportation such as by charpoy/gidhuva/doli to the road point.
 - Provide appropriate vehicles as ambulances for kutcha roads.
 - Having a central point / toll free number for effectively attending to calls for transporting delivery cases.
 - Incentives/support for stay and food of pregnant woman and attendant prior to and for institutional delivery.
 - Strengthen/expedite provisions for stay and food of attendants as is planned in CHC Dumri, Sadar Hospital, Gumla.
- Staggering promotional activity and contact prior to VHNDs in hard to reach areas
- Improve security arrangements in hard to reach areas
- Standard treatment guidelines should be displayed in CHCs /PHCs.

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

4) Outreach services

- New women panchayat members should be mobilised for community based monitoring.
- Quality of ANC needs to be improved, and specifically ANC at AWCs during VHNDs
- Increase IEC related to VHNDs- especially through folk media, also involving ICDS mata samitis.
- Expand the services provided at VHNDs to include IYCF counselling, linked to distribution of THR
- RCH and tribal area camps and MMU schedule could use a fixed day approach
 - Improve microplanning and coordination between ANM, Sahiya, AWW at places in Palamu

5) ASHA programme

- Enhance incentives and connectivity (eg. mobiles) for Sahiyas (ASHAs), especially in hard to reach areas
- Strengthen the existing mentoring network for ASHAs
- Enhance incentive for trainers eg. BTT, DTT
- Strengthen linkages of Sahiyas with new PRI members
- Strengthen linkages of Sahiyas, AWWs, ANMs in Palamu
- Replicate Sahiya shelters as in Chainpur CHC
- Provide opportunities for education /training to those interested and recognition for good performance
- VOICE OF SAHIYYAS – (Five years from now) *“I want to be recognised as an ANM in my village”*

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

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

7) Nutrition

- Strengthen lactation management support in MTCs for mothers of infants less than six months
- Strengthen comprehensive preventive approach to undernutrition- in addition to Malnutrition Treatment Centres

- Expedite rolling out of new WHO child growth standards,
 - Release the new joint NRHM ICDS mother child card (prototype)
 - Procurement and replenishment of child weighing scales
- Utilise the Mata Sahayta Samoochs for NRHM and ICDS
- Create a common block training platform, for both ICDS NRHM
- Promote the concept of Malnutrition Free Panchayats
- Improve mobility of CDPOs, LS of ICDS in hard to reach areas and mobile connectivity of AWWs.
- Joint counselling IEC campaign for health and nutrition – using a life cycle approach, focusing on preventive family based care
- Strengthen the system of referral and follow up of cases to MTC through ICDS
- Strengthen Nutrition component in ASHA training modules
- Strengthen supply chain management of Kit A supplies, for addressing micronutrient malnutrition. These include IFA, Vitamin A supplements and zinc supplements with ORS for diarrhoea management

8) National Disease Control Programmes

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

9) Institutional Mechanisms and Programme Management

- In view of panchayat elections, revisit constitution of District Health Missions
- Extend existing NRHM Village Health and Sanitation Committee to include Nutrition and ICDS; this could be recognised as a sub committee of panchayat
- Build on the strong management support function in the state - PMUs and plan for institutionalisation in next plan
- Build on ongoing initiative for developing District Health Action Plans through participatory processes, with need based Block Health Action Plans
- Enhance management training opportunities for health programme managers, including visits to best practices
- Introduce a system of recognition and motivation for high performing district teams- including both regular and contractual staff
- Strengthen hands on training on the use of HMIS
- Improve the use of HMIS for decision making, and integrate hospital based indicators
- Inventory management needs strengthening – especially with regard to stock outs and reordering level
- Integrated data based management in IDSP needs to be used for early warning signals of outbreak
- Validation of data being generated needs to be ensured

10) Financial Management

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

11) Decentralised local health action

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

Chapter 5: State Specific Issues

In general, the state had suffered from government instability and governance issues that had held back various policy changes that are needed to address state specific issues, as the systems are still a legacy of undivided Bihar.

The CRM team felt the following issues that are unique to the state of Jharkhand; need to be addressed with urgency, calling for policy level interventions:

HR Policy

The state needs to urgently implement the proposal of cadre revision and associated reforms in service conditions, without which the staff across all levels feel de-motivated. As observed by the CRM team, all positions, especially among senior officials district, hospital, directorate level, are appointment and not promotion positions, causing serious instability among the officials. This may also involve restructuring of the directorate, in line with initiatives undertaken by Odhisa, Tamilnadu, etc.

Infrastructure and Civil Works

The department had created a Civil Wing under it, but many construction activities that started before it are outside its purview. The CRM team noted a lot of half finished buildings, causing serious infrastructure constraints adversely affecting service delivery. All civil works need to be brought under the purview of the department's civil wing.

Referral Transportation

Referral transportation in the state of Jharkhand is mostly based on government run ambulances or ambulances donated to NGO/Missionaries (similar to the West Bengal experiment). But the CRM team felt there is a lot of scope for improvement, especially in terms of referral protocols, fleet monitoring and management, linkage with appropriate hospitals/facilities, care-in-transit, etc. The state may look at the alternative options like Janani Express model of Madhya Pradesh, the Haryana model, or ERS models of Bihar/EMRI.

Vector-borne Diseases

The state has a few pockets that are Malaria and Kalazar endemic. A special strategic for elimination, especially for Kalazar, need to be taken up by the state, in consultation with national/international experts, and in partnership with local NGOs and PRIs. As it will involve close partnership with other departments also, the district administration of those districts need to be involved right from the strategy formulation stage for disease elimination.

PPP Policy

The state does not seem to have a PPP policy. Although many PPP initiatives had been undertaken by the state, mostly with Mission hospitals and NGOs, there seem to be a lack of mutual understanding among both government and private parties, mainly complaining of lack of transparency (on both sides). This calls for a transparent and need-based PPP policy framework for the state, especially when there are so many opportunities ranging from charitable trusts, NGOs and big corporate (for CSR).