REPORT ON 6TH COMMON REVIEW MISSION VISIT TO

JORHAT AND SONITPUR DISTRICTS:

ASSAM

04-09 NOVEMBER 2012

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LIST OF ABBREVIATIONS

AHS	Annual Health Survey
ANM	Auxiliary Nurse Midwife
ANC	Ante-Natal Care
AWTC	Anganwadi Training Centres
ANMTC	Auxiliary Nurse Midwife Training Centre
AWW	Anganwadi Worker
ASHA	Accredited Social Health Activist
ARSH	Adolescent Reproductive and Sexual Health
AES	Acute Encephalitis Syndrome
AYUSH	Ayurveda Yoga Unani Siddha Homeopathy
BPM	Block Programme Manager
BHAP	Block Health Action Plan
BPHC	Block Primary Health Center
BSE	Blood Slide Examined
CHC	Community Health Centre
CRM	Common Review Mission
CEmOC	Comprehensive Emergency Obstetric Care
C-section	Caesarean Section
DHS	District Health Society
DH	District Hospital
FMR	Financial Monitoring Report
FRU	First Referral Unit
FP	Family Planning
GNM	General Nurse Midwife
GoI	Government of India
HR	Human Resources
HSC	Health Sub Centre
HMIS	Health Management Information System
IPHS	Indian Public Health Standards
IMR	Infant Mortality Rate
IUCD	Intra-Uterine Contraceptive Device
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education Communication
IFA	Iron Folic Acid
ICDS	Integrated Child Development Scheme
IYCF	Infant and Young Child Feeding
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
JSY	Janani Suraksha Yojana
JSSK	Janani-Shishu Suraksha Karyakaram
JE	Japanese Encephalitis
LHV	Lady Health Visitor
LLIN	Long Lasting Insecticide Nets
LSAS	Life Saving Anesthetic Skills
MPW	Multi-Purpose Worker
MMR	Maternal Mortality Rate
MTP	Medical Termination of Pregnancy
MMU	Mobile Medical Unit
MDR	Maternal Death Review

MIS	Management Information System
MCTS	Mother and Child Tracking System
MP	Malaria Parasite
MPHC	Mini Primary Health Center
NBSU	Newborn Stabilization Unit
NLEP	National Leprosy Eradication Programme
NBCC	New born Care Corner
NPCB	National Programme on Control of Blindness
NLEP	National Leprosy Eradication Programme
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
NSSK	Navjat Shishu Suraksha Karykram
OPD	Out-Patient Department
OCP	Oral Contraceptive Pill
OPV	Oral Polio Vaccine
PIP	Programme Implementation Plan
PHC	Primary Health Centre
PMU	Programme Management Unit
PPH	Post Partum Haemorrhage
PRI	Panchayati Raj Institution
PPP	Public Private Partnership
RCH	Reproductive and Child Health programme
RHP	Rural Health Practitioners
RDK	Rapid Diagnostic Kit
RNTCP	Revised National Tuberculosis Control Programme
SRS	Sample Registration Survey
SOE	Statement of Expenditure
SOP	Standard Operating Procedure
SDH	Sub Division Hospital
SBA	Skilled Birth Attendant
SHS	State Health Society
SHRC	State Health Resource Centre
SIHFW	State Institute of Health and Family Welfare
TOR	Terms of Reference
TFR	Total Fertility Rate
TB	Tuberculosis
VHND	Village Health and Nutrition Day
VHSNC	Village Health and Sanitation and Nutrition Committee

CHAPTER I: TEAM COMPOSITION OF CRM: ASSAM

Under ***National Rural Health Mission (NRHM)***

(3rd -9th November 2011)

Table 1.1: Sixth CRM Team composition- Assam

Jorhat		Sonitpur	
Name	**Designation**	**Name**	**Designation**
Dr. S K Sikdar	DC i/c FP, MoHFW	Dr. D K Mangal	UNFPA
Dr. S. S. Das	Consultant (School Health Program), MoHFW	Dr. Abhishek Gupta	Consultant (NRHM), MoHFW
Mr. Rahul Pandey	Senior Consultant (Family Planning), MoHFW	Sh. Ashish Tiwari	Director, HUP Project, Plan India
Mr. Utpal Kapoor	FC (FMG), MoHFW	Dr. Swati Patki	SPM, Training Division, PHFI
Dr. Pragati Singh	Consultant (Public Health Planning), NHSRC		

CHAPTER II: INTRODUCTION

2.1 Demographic Profile:

Assam, the gateway to the north-eastern part of India is bordered in the North and East by the Kingdom of Bhutan and Arunachal Pradesh; along the south lie Nagaland, Manipur and Mizoram. Meghalaya lies to her South-West, Bengal and Bangladesh to her West. The economy is largely based on agriculture and oil and produces a significant part of the total tea production of the world.

The capital city is Dispur and Guwahati is the largest city. As per 2011 census, the population of Assam is 31.17 million and the population is scattered across 27 districts and 26312 villages. Assam is divided into three regions, each headed by a commissioner. Under each commissioner, there are several administrative units called Districts.

The State has the highest population density among the North Eastern states, of 396.8/km^2. The literacy rate is 73.13%; the male literacy rate is 78.81% and female literacy rate is 67.27%. The sex ratio is 954 per 1000 males.

Table 2.1: Demographic Profile-Assam

Total Population of the State	3,11,69,272	Census 2011
Male	1,59,54,927	Census 2011
Female	1,52,14,345	Census 2011
Sex Ratio	954	Census 2011
Population Density (per Sq Km)	397	Census 2011
Decadal Growth Rate	16.93	Census 2011
No of Districts	27	
No of Developmental Blocks	219	
No of Block PHC	149	

2.2 Health Indicators:

The health Indicators have shown a gradual improvement over the years, which is well evident from the declining trends of MMR, IMR and TFR. The table below presents the current status of health indicators and the socio demographic indicators of Assam.

Table 2.2: Health Indicators-Assam

Parameter	Present Status	
	SRS	**AHS (2010)**
Maternal Mortality Ratio (MMR)	390 (2007-09)	**381**
Infant Mortality Rate (IMR)	**55** (2011)	**60**
Total Fertility Rate (TFR)	**2.5** (2010)	**2.6**

Table 2.3: Socio demographic Indicators-Assam

Indicator	Source : Annual Health Survey 2010 *(Reference period of estimates 2007-09)*
Crude Birth Rate (CBR)	21.9
Crude Death Rate (CDR)	7.2
Natural Growth Rate	14.7
Neonatal Mortality Rate	39
Post Neo-natal Mortality Rate	20
Under Five Mortality Rate	78
Sex Ratio at Birth	925
Sex Ratio (0-4 Years)	956
Sex Ratio (All Ages)	953

The maternal mortality ratio of Assam is among the highest in the country. As per the maternal death review largely the maternal deaths has been due to Eclampsia followed by hemorrhage and anaemia. Sepsis, obstructed labour and abortions also contribute to few maternal deaths in the state.

The graph clearly shows the declining trend in the maternal mortality ratio. As per the recent AHS data there has been a total 99 point drop of MMR during NRHM period which is the highest drop in the country during NRHM period.

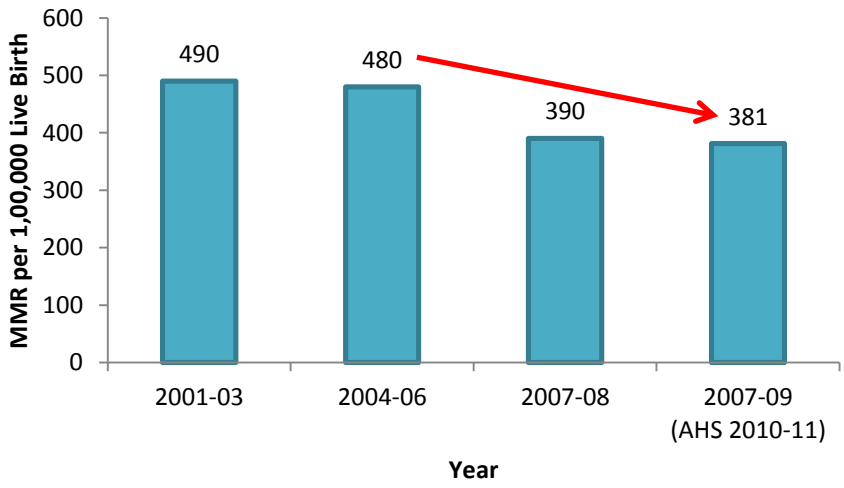


Fig 1: Trend of MMR in Assam

The Infant mortality in the state is largely due to the neonatal mortality rate which is 39 per 1000 live births as per the latest AHS figures. During the NRHM period there has been a 12 point drop in the figures of IMR.

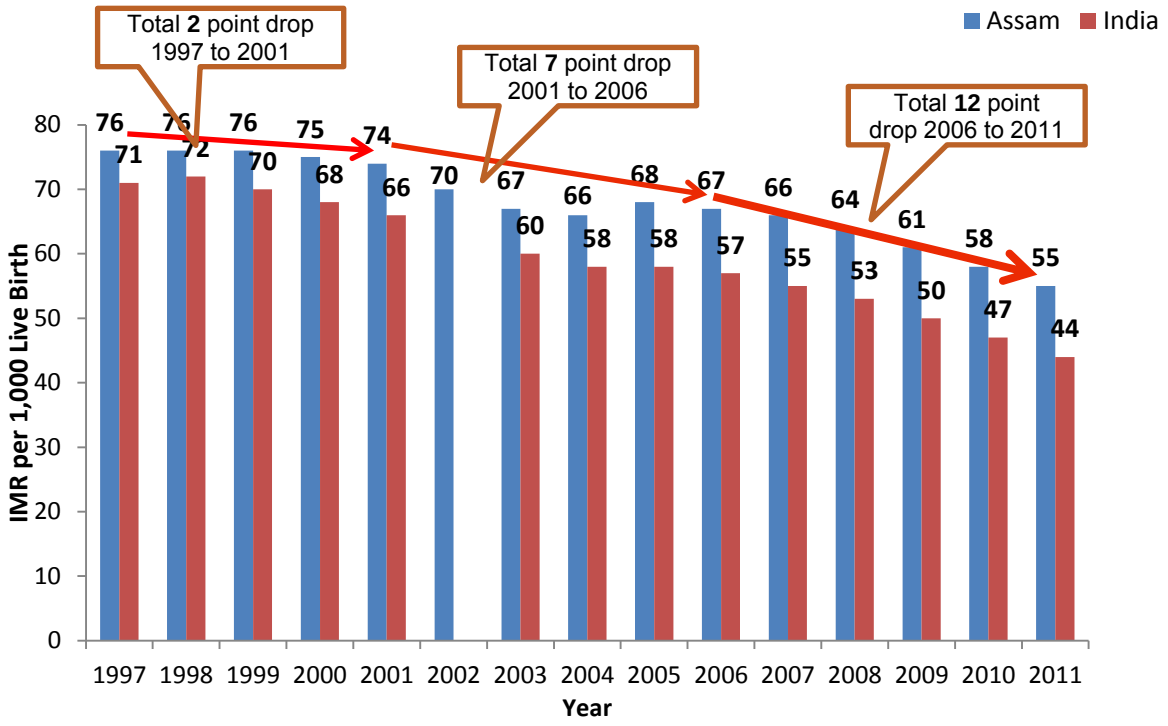


Fig 2: Trend of IMR in Assam

2.3 Public Health Infrastructure:

The state has 4604 HSC, 968 PHC including block PHCs, 108 CHC, 28 District hospitals and 13 Sub-divisional hospitals. Apart from the existing infrastructure the 626 new Subcenters, 65 PHC, 55 CHC has been approved in PIP 2012-13. **There are multiple nomenclatures of public health facilities that exist in the state- BPHC (Block PHC), MPHC (Mini PHC), SD (State Dispensaries) etc**.

Table 2.4: Public Health Infrastructure in Assam

Sl. No.	Type of Health Institutions	Number as in 2005	Present Status
1.	Health Sub-centers	4726	4604+626 (Approved in 2012-13)
2.	Primary Health Centers	647	968 + 68 (Under Construction) + 65 (Approved in 2012-13)
4.	Community Health Centers	93	108 (FRU=6) + 61 (Under Construction) + 55 (Approved in 2012-13)
5.	District and Sub divisional hospitals (SDH)	21/03	25+3/13

The state currently has five functional Medical Colleges and five more colleges are under construction. The details of teaching institutes have been given below.

Table 2.5: Health Institutions in the State

Health Institute	Number
Medical Colleges	5 (Functional – AMCH, GMCH, SMCH, JMCH, FAAMCH) + 1 (Under construction - Tezpur) + 4 (Foundation stone laid - Diphu, Dhubri, Kokrajhar, Lakhimpur) + 1 (Under consideration for PPP mode, Nagaon)
Regional Dental College	1 (Guwahati)
Ayurvedic College	1 (Guwahati)
Govt. Homeopathic College	3 (Guwahati, Jorhat & Nagaon)
Medical Institute (For DMRHC Course)	1 Medical Institute, Jorhat (RHP)
Regional College of Nursing	1 (With B Sc/ M Sc Course)
B Sc Nursing College	2 (AMCH & SMCH being started)
GNM School	20 + 3
ANM Training School	18
Institute of Paramedical Science	3 (attached to GMCH, AMCH & SMCH)
Institute of Pharmacy (Dip Pharma)	3 (attached to GMCH, AMCH & SMCH)
National Institute of Pharmaceuticals (M Pharma)	1 (Functioning temporarily at GMCH)

2.4 State Initiatives:

2.4.1 MAMONI SCHEME (Under Assam Vikash Yojana)

- All pregnant women are eligible for availing the scheme.
- During the First Registration, the Pregnant Women is given Mamoni, a book on antenatal, natal and postnatal care.
- During her 2nd ANC, the pregnant woman is given an account payee cheque of Rs. 500/- as a nutritional support.
- During here 3rd ANC she is given Rs. 500/-

Table 2.6: Progress under Mamoni Scheme

Year	For 2nd ANC	For 3rd ANC	Total
2009-10	1,68,346	91,185	2,59,531
2010-11	4,81,364	4,16,696	8,98,060
2011-12	3,48,163	3,01,874	6,50,037
2012-13 (Apr-Sep)	2,14,965	2,05,060	4,20,025
Total	**12,12,838**	**10,14,815**	**22,27,653**

2.4.2 MAJONI - SPECIAL ASSISTANCE TO GIRL CHILD (Under Assam Vikash Yojana)

- "Majoni" – Social assistance to all the girl child born in the family up to second order is given a fixed deposit of Rs. 5,000/- for 18 years – an initiative by Govt. of Assam
- The families conforming to the Govt. policy of 2 children is only be eligible for the scheme.
- Under "Majoni" scheme, total **2,20,926** Fixed Deposit has been issued.
    - 2009-10 = 43,541
    - 2010-11 = 77,917
    - 2011-12 = 73,617
    - 2012-13 (Apr-Sep) = 25,851

2.4.3 MOROM- FINANCIAL SUPPORT TO INDOOR PATIENTS OF GOVT. HOSPITALS (Under Assam Vikash Yojana)

- The Morom scheme will provide financial support to indoor patients of Government Health Institutions for supplementary nutrition and compensation for wage loss during hospitalisation and post hospital expenses.
- Indoor patients admitted to a Hospital will receive Rs. 75/- per day for Medical College, Rs. 50/- per day for District Hospital and Rs. 30/- per day for SDCH/ CHC/ PHC.

Table 2.7: Progress under Morom Scheme

Year	No of Patients Received Morom Fund	Amount paid under Morom Fund (Rs. In Lakhs)
2010-11	170,390	383.04
2011-12	225,040	451.40
2012-13 (Apr-Sept)	96,218	230.82

2.4.4 FREE OPERATIONS FOR CHILDREN HAVING CONGENITAL HEART DISEASE- An initiative from Govt. of Assam

- Free operations for children having congenital heart disease at Narayana Hrudayalaya, Bagalore.
- 1055 children with Congenital Heart Diseases have been screened at Guwahati Medical College Hospital by experts from Narayana Hrudayalaya, Bengaluru and send for operation

2.4.5 SUSRUSHA - FINANCIAL ASSISTANCE TO PEOPLE WHO HAVE UNDERGONE KIDNEY TRANSPLANTATION - An initiative from Govt. of Assam

- Under "Sushrusha" scheme, an amount of Rs. 1.00 Lakh is granted as Financial assistance to people who have undergone Kidney transplantation after 1st April 2010.
- The scheme launched on 23rd August 2010
- So far 156 patients have received the benefit till 31st October 2012.

2.4.6 OPERATION SMILE - FREE SURGERY FOR CHILDREN HAVING CLEFT PALATE AND LIP

- Free surgery for cleft palate and cleft lip.

- The programme is being implemented by an international NGO “Operation Smile”
- New OT at MMCH, Guwahati started on 9th May 2011 and up to 27th September 2012, 3805 operations conducted.
- Total 6857 nos of children having cleft lip has been operated under “Operation Smile” up to 27th September 2012 since inception.

2.4.7 SANJEEVANI VILLAGE HEALTH OUTREACH PROGRAMME (Including NCDs)

- Sanjeevani – Village Health Outreach Programme is once-a-month, fixed date outreach initiative that will result in converged health services at the Village level.
- Sanjeevani is being introduced throughout the state with 78 Mobile Health Units (MHU).
- Each MHU is being manned by Registration & Measurement Officer, lab technician, Pharmacist, ANM and Pilot.
- The services aims in early identification, Screening, referral, follow-up and free medicines for effective Chronic disease management. Based on the screening done in VHOP, the beneficiaries are referred to the nearest PHC for confirmation, prescription and commencement of treatment.
- Each MHU will have a pre-defined calendar and route plan for delivering the services covering 2 villages and a population of 3000 each day on an average and 48 villages in a monthly cycle of 24 days.
- Total 78 nos of Vans deployed for identified chronic disease in rural area of Assam.
- Sanjeevani - Village Health Outreach Programme covered 3744 villages of Assam & covered 91 BPHC, 127 Development Block and 1670 Sub Centre
- Total 62,04,126 (per month) Population covered by VHOP Van

Table 2.8: Progress under Sanjeevani Scheme

Sl	VHOP Service Detail	Performance from 1st March 2011 to 20th September. 2012
1	Total Visit	9,21,051
2	Total Registration	5,67,006
3	Total Screening of Chronic Diseases	1,19,455
4	Total Chronic Disease confirmed	34,341

2.5 District Brief and Health service delivery:

The CRM team covered two districts of Assam – Jorhat and Sonitpur.

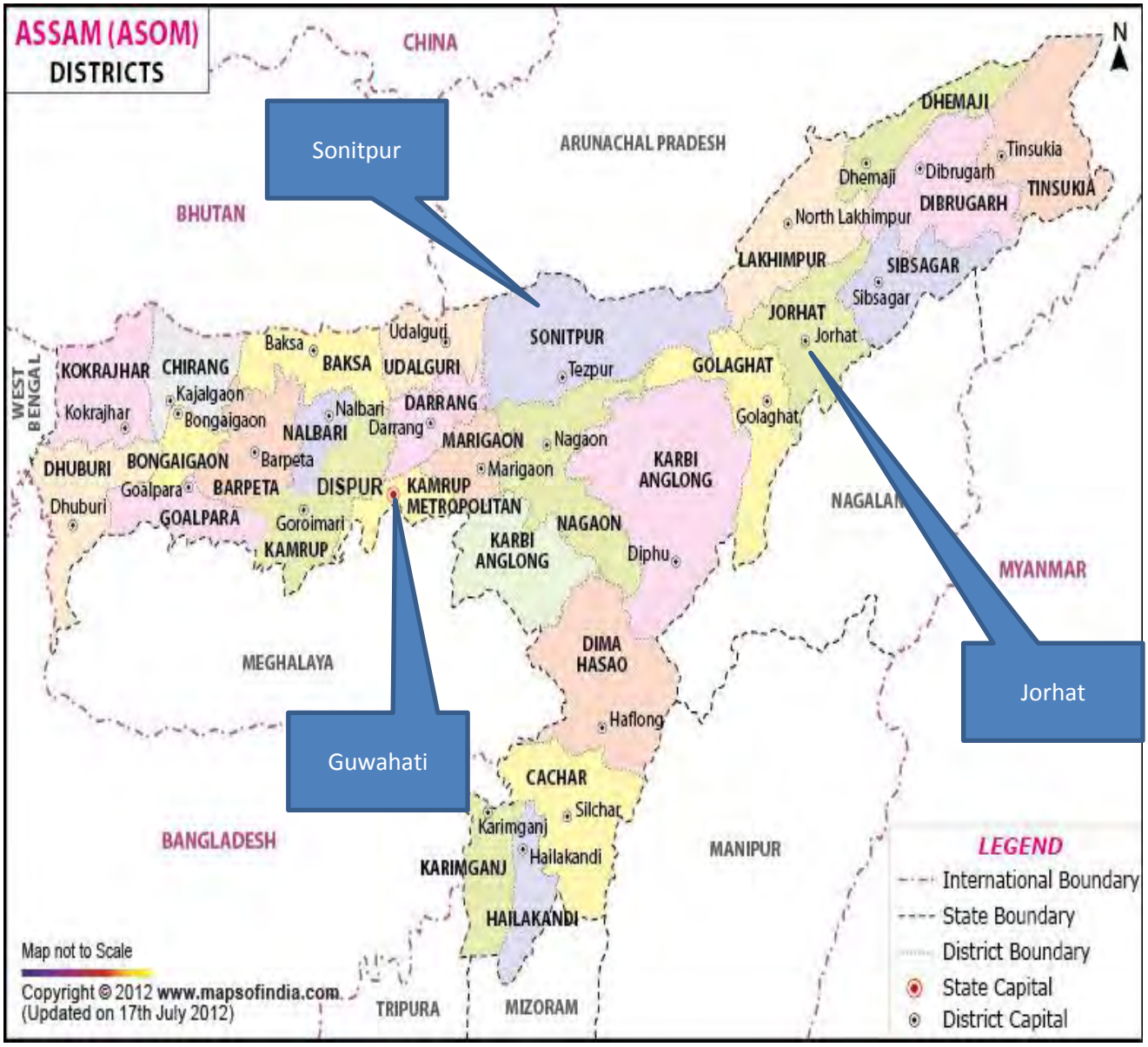


Table 2.9: Demographic Profile- Jorhat and Sonitpur

	Assam	Sonitpur	Jorhat
Total Population of the State	**3,11,69,272** (Source: Census 2011)	**19,25,975** (Source: Census 2011)	**10,91,295** (Source: Census 2011)
Male	**1,59,54,927** (Source: Census 2011)	**9,89,919** (Source: Census 2011)	557,944 (Source: Census 2011)
Female	**1,52,14,345** (Source: Census 2011)	**9,36,056** (Source: Census 2011)	533,351 (Source: Census 2011)
Sex Ratio	**954** (Source: Census 2011)	**946** (Source: Census 2011)	956 (Source: Census 2011)

	Assam	Sonitpur	Jorhat
Population Density (per Sq Km)	**397** (Source: Census 2011)	**365** (Source: Census 2011)	383 (Source: Census 2011)
Decadal Growth Rate	**16.93** (Source: Census 2011)	**15.67** (Source: Census 2011)	**9.21** (Source: Census 2011)
No of Developmental Blocks	**219**	**14**	**8**
No of Block PHC	**149**	**7**	**7**

Table 2.10: Socio demographic Indicators- Jorhat and Sonitpur

Source: Annual Health Survey 2010-11			
Indicators	**Assam**	**Jorhat**	**Sonitpur**
CBR	21.9	20.0	19.8
CDR	7.2	8.2	6.5
IMR	60*	57	68
Neo- natal Mortality Rate	39	43	46
Under Five Mortality Rate	78	71	80
MMR	381	430	367
Sex Ratio at Birth (SRB)	925	962	949
Sex Ratio (0-4 Years)	956	983	977
Sex Ratio (Total)	953	975	968
TFR	2.6	2.2	2.3

* As per SRS 2011 IMR is 55

2.5.1 Public Health Infrastructure:

Table 2.11: Health Institutions in the District – Jorhat and Sonitpur

Type of HI	Assam	Sonitpur	Jorhat
District Hospitals	25	1	0 (1 Medical College)
SDCHs	13	2	2
CHCs	108	3	4
PHCs	968	54	42
Sub Centres	4604	274	144

2.5.2 Health Service Delivery Indicators:

Maternal and Child health Indicators:

The table below compares the health service delivery indicators of Assam and the visited districts, Jorhat and Sonitpur. Jorhat has comparatively better indicators as compared to Sonitpur. The fact correlates well with the field observation discussed in subsequent chapters of this report.

Table 2.12 Health Indicators (AHS 2010) – Jorhat & Sonitpur

Indicators	Assam	Jorhat	Sonitpur
Mothers who received any Antenatal Check-Up (%)	91.1	94.1	86.5
Mothers who received 3 or more Antenatal (%)	61	71.9	56
Mothers who received at least one Tetanus Toxoid (TT) injection (%)	91	94.1	86.2
Mothers who consumed IFA for 100 days or more (%)	15.3	21.1	15.5
Mothers who had Full ANC (%)	11.9	18.2	11.8
Mothers who received ANC from Govt. source (%)	69.4	69.2	74.7
Mothers whose Blood Pressure (BP) taken (%)	87.8	94.1	76.1
Mothers whose Blood taken for Hb (%)	74.6	94	38.8
Institutional Delivery (%)	57.7	68.5	53.4
Delivery at Govt. Institution (%)	44	52.9	40
Delivery at Private Institution (%)	13.1	15.2	11.3
Delivery at Home (%)	41.8	29.6	46.4
Delivery at home Conducted by skilled health personnel (%)	35.1	41.6	12.5
Safe Delivery (%)	70.1	79.7	58.5
Less than 24 hrs. stay in institution after delivery (%)	34.3	34	25
Mothers who received Postnatal check-up within 48 hrs.of delivery (%)	57	66.9	55.6
Mothers who received Postnatal check-up within 1week of delivery (%)	50.4	68.6	60.5
Mothers who availed financial assistance for Government Institutional delivery under JSY(%)	90.2	89.7	90.4
Children aged 12-23 months who have received BCG(%)	93.3	94	93.3
Children aged 12-23 months who have received 3 doses of Polio Vaccine (%)	75.5	83.8	82.5
Children aged 12-23 months who have received 3 doses of DPT Vaccine (%)	72.2	73.9	71.8
Children aged 12-23 months who have received Measles Vaccine (%)	77.3	86.6	76.2
Children aged 12-23 months Fully Immunized (%)	59	68	57.5
Children who have received Polio doses at birth (%)	75.2	73.6	68.6
Children who did not received any Vaccination (%)	3.3	2	2.8

2.6 Lists of facilities visited by the team

Facility Type	Jorhat	Sonitpur
DH	Jorhat Medical College – 1	Kanaklata Civil Hospital - 1
CHC/ SDCH/ FRU	Garmur, Kamalabari, Teok and Titabor – 4	Biswanath Chairali – 1
BPHC/ MPHC	Dhekorgorah, Kakojan, Nakachari, Moriani and Baghshung, – 6	Haleswar – 1
State Dispensary	Rangachahi – 1	
SHC	Nimati, Gharbolia, Mokhuti, Phuloni, Komar Khatuwal, Rajabari, Dholi & Na-Ali-Dhekiajuli – 8	Borjarani, Shankar Maidan, Pub Jamugiri and Bakarigaon – 4
ANMTC	Jorhat, GNM & ANM TC – 1	Nursing School – 1
Other	DPMU and Boat Clinic – 2	DPMU, Boat Clinic, TE PPP - 3
Total units	**22**	**11**

CHAPTER III: FINDINGS

Executive Summary

The sixth CRM visit to Assam was taken up from 3rd Nov'2012-9th Nov'2012. A multidisciplinary team with the representatives from MoHFW, NHSRC, Developmental Partners and Civil Society covered 26 public health facilities, 2 teaching institutes, 2 boat clinics, 1 PPP facility and 2 DPMUs in Jorhat and Sonitpur district of Assam. The output of the visit was based on ten by ten TORs which covered all the key parameters of NRHM.

Caveat: due to last minute changes on account of extraneous factors, no poor performing district could be visited. Hence the team visited two better performing districts.

The visit started with a district briefing and a four day field visit to the above mentioned districts. Subsequently the district debriefing was done in the presence of district collectors in both the districts. In the last day of the visit state debriefing was done by the CRM team in the presence of Additional Chief Secretary, Govt. of Assam.

Assam, the gateway to the North East is one of the 18 high focus states under NRHM. **CRM team observed that the districts have good infrastructure and other inputs (such as HR, equipment etc) in place and now there is a need to leapfrog into the next phase of strengthening systems to ensure universal coverage and quality service delivery.**

Key positives:

- Facilities generally have good and adequate infrastructure, especially NBSUs at all BPHCs, CHCs and FRUs.
- Labour rooms and OTs at most facilities are in good condition and well equipped
- Adequate availability of Specialists in the districts
- ANMs, by-an-large knowledgeable and committed at SHCs
- Sub-centers have full complement of personnel (2 ANMs, FA, MPW & RHP at delivery points)
- Good referral transport (108 services)
- ASHAs a major strength of the system – highly motivated, knowledgeable and committed.

Key challenges:

- High out of pocket expenditure
- Low utilisation of facilities
- FRUs including medical college not conducting emergency caesareans
- Planning process including supportive supervision system weak
- Procurement and logistics management is very poor such as irrational procurement and "push system" of supply of medicines

The TOR wise key findings are summarized below:

TOR I: Facility Based Health Care:

Assam has adequate number of facilities with all the patient amenities. In terms of improved service delivery and quality of care there is a need to strengthen the in-facility monitoring so as to address the gaps in biomedical waste management, crowding of wards and drug availability. Non-provisioning of AMC for equipment is a major concern in both the districts visited.

The state has witnessed more than 300% rise in both OPD as well as IPD in the NRHM implementation years. The concern now is the rational distribution of the case load over the facilities, as it was observed during the visit that only few facilities take up the increased OPD & IPD numbers and many other facilities with very good HR are not contributing.

The state is having a huge supply demand mismatch of the drugs which is resulting in an increased out of pocket expenditure. Despite the launch of cashless schemes like JSSK the beneficiaries are still being forced to spend money handsomely on treatment.

TOR II: Outreach & Patient Transport Services:

The adequacy of Subcenters is satisfactory in Jorhat, barring exceptions like Ghadbolia HSC which is serving a population of 15500. In Sonitpur the HSC to rural population ratio is slightly on a higher side so the district requires additional HSCs. All the districts in Assam are following a two ANM norm and the work distribution is well defined between the two ANMs as per geographical distribution.

All the Subcenters are providing basic MCH services but needs expansion in terms of IUCD insertion and adolescent service provision. Each 'delivery point' HSC in Assam has been provided with a RHP, equipped to conduct normal delivery, but the state needs to develop SOP and Standard treatment guidelines for the RHPs.

All the districts of Assam has MMU in place, the concern is the positioning of these MMUs and cost implications incurred when these vehicles are taken to field without the availability of suitable providers. Apart from MMU the outreach services are also being provided by the 15 boat clinics in Assam. It was observed during the visit that these boat clinics are overstaffed.

ARSH program has not geared up in the state. The emergency transport is being provided by the 108 services which is largely covering the pregnancy related emergencies followed by acute abdomen and injury cases.

TOR III: HR - Adequacy, Skill and Performance

In terms of HR availability Assam is relatively better off as compared to other high focus states. The maximum gap is in the availability of specialists (Gynaecologist, Paediatrician and Anaesthetists). The HSCs have full complement of staff consisting of two ANMs, one MPW and one Female attendant.

Presently there is no system of performance appraisal of the staff. The state does not have a specialist cadre and is in the process of developing such a system.

TOR IV: Reproductive and Child Health Program

Maternal Health:

Assam presently has highest recorded MMR and on the positive side has witnessed almost a 20% decline in MMR during the NRHM implementation period. The delivery point and FRU infrastructure is well in place. Labour rooms were in general in good condition barring the emergency drug availability. The infection prevention practices as observed in both the districts require strengthening. There is a system of quality assurance in place but the monitoring schedule for the same is not defined and no action plans and action taken reports are being formulated. There is a huge gap in home deliveries between the AHS and reported HMIS figures depicting that the home deliveries largely go unreported. JSY physical and financial matching is still in a nascent stage in the state. JSSK has been launched a year back in Assam and the team observed few gaps in terms of diet provision at the facilities below CHC, drug availability and increased out of pocket expenditure.

Child health and Immunisation:

There has been significant decline in IMR during the NRHM period; however, it's still significantly high. State has new born care corners available at every level barring 1-2 HSCs in both the districts. NBSUs with equipment have invariably been developed in all CHCs/ BPHCs by the state; however, majority of these are not functional leading to crowding of higher level facilities (especially SNCUs). SNCUs are a major boon for the poor population; however, lack of dedicated staff makes it unsustainable. Weighing of new-borns is a major concern considering, proper weighing machines are not available at most of the facilities.

Various surveys suggest that there has been improvement in coverage of various vaccinations; however, BCG-Measles dropout is still significant. Cold chain management (condition of equipment) is generally good in both the districts. At most of the facilities, staff (ANM/ LHV) is not aware of proper reconstitution technique of the vaccine which could lead to AEFI. Coverage of tea garden/ internally displaced population is poor in the district visited.

Family Planning:

Overall sterilisation numbers have declined in the state and especially male sterilisation has declined considerably. State has issued guidelines for fixed day service delivery for FP services; however, there is no linkage with ensuring supply as well as making common public aware of availability of these services. State has trained majority of ANMs/ LHVs/ GNMs in IUCD insertion; however, their output remains very low due to lack of motivation on the part of these trained providers.

TOR VI: Community Process including ASHA, PRI, VHSC, CBM and NGO

ASHA s are well trained and empowered in Assam. In Jorhat the first round on Module 6&7 has been completed whereas in Sonitpur it is yet to be started. ASHA support structure is well in place, with few gaps like Jorhat is yet to select block facilitators. State has introduced many innovations (non financial incentives) for ASHA s to keep up their motivation like ASHA Radio Programme, ASHA Post

Card, ASHA Bi- Cycle, ASHA Insurance and Medical Reimbursement, ASHA Rest Room at District Hospital and ASHA Supervisor Diary. VHSNC are largely focusing on Maternal and child health (immunization). Adolescent component is missing in these sessions.

TOR VII: Promotive Health Care, Action of Social Determinants and Equity Concerns.

There are very few instances of convergence in the district. The block plans as observed in the visit are not inclusive of the intersectoral convergence. In terms of Nutrition the state currently has four NRCs and now in the process of expanding it to six more. Apart from this the state is in process of establishing fourteen Nutrition Counselling Centers at the level of block PHC and CHC. The School health program is rather weak and the state is yet to include pre school population in the existing program. Linkages with School health programme and the national disease control programmes as expected under holistic programme implementation is not reported.

TOR VIII: Programme Management

Availability of programme management personnel up to the BPHC level is not an issue in the state. Planning process needs strengthening, it's not participatory and primarily "format based" planning is carried out. It was very clear that there is lack of coordination between NRHM and regular staff starting from block to state level; same was also echoed by district collector during the debriefing. Huge data bank is available in the HMIS; however, this data is not being comprehensively analysed making it only a data entry portal.

TOR IX: Knowledge Management including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology.

SIHFW is present at the State level providing the major training assistance. The Institute had also established an MCH Cell in its building in collaboration with the UNICEF. SIHFW is involved in conducting and monitoring of trainings besides evaluation of trainings. At Sonitpur ANMTC is newly constructed and is being utilized. Jorhat district has ANM/GNM training centre as well as RHP training institute. The ANM/GNM training centre has taken no batch of ANM since 2007 due to legal case. The fresh GNM batch is taken every 3 years and not on yearly basis. This training centre is in need of training aids and audio visual equipment. Team encountered certain quality issues as far as HMIS and MCTS is concerned.

TOR I: FACILITY BASED HEALTH CARE

- Nearly all the facilities visited have good infrastructure in place. All the SCs are having at least residential quarters for one ANM facilitating the stay of ANM at the SC. **However in majority of the HSCs the ANMs are not maintaining headquarters**. Except at Medical College, Jorhat the facilities had enough space to support the current client load. **It was also observed that after the implementation of NRHM several new facilities have come-up in the state and existing facilities have been revamped with major/ minor renovations to make them patient friendly**:

Table 3.1: Public Health Infrastructure-Assam

Type of facility	Numbers
District Hospitals	25 + 3 (New)
SDHs	13
CHCs	108 + 61 (Under Construction) + 55 (Approved in 2012-13)
PHCs	968 + 68 (Under Construction) + 65 (Approved in 2012-13)
Sub Centers	4604 + 626 (Approved in 2012-13)

Source: State information

- Data provided in the RHS-2011, also substantiate the same point:

Table 3.2: Status of health facilities (RHS 2011)

Facility Type	Govt Building			Rented			Other		Under Construction		Total		
	2005	2011	Change (%)	2005	2011	Change (%)	2005	2011	2005	2011	2005	2011	Change (%)
SHC	2637	2723	3.26	2472	1513	-38.79	0	368		1679	5109	6283	22.98
PHC	610	888	45.57		50					118	610	1056	73.11
CHC	100	108	8.00							60	100	168	68.00

The above table clearly shows that there has been increase in number of facilities functioning in the government building which allows the health system to focus on delivery of quality services. The table also highlights that construction of facilities have been taken up after the advent of NRHM in 2005.

	DH	Population per DH	SDCH+CHC	Population per SDCH/CHC	PHC	Rural population per PHC	SC	Rural population per SC
Jorhat	1 (Medical	1091295	6	181883	42	20755	144	6054

	DH	Population per DH	SDCH+CHC	Population per SDCH/CHC	PHC	Rural population per PHC	SC	Rural population per SC
	College)							
Sonitpur	1	1925975	5	385195	54	32497	274	6405
Assam	25	1246771	121	257597	968	27666	4604	5817

The numbers of facilities are adequate in Jorhat as per population norms. However in Sonitpur there is need for more facilities (CHC as well as SC). As a whole Assam has adequate number of facilities as per the population norms.

- In spite of good infrastructure in place, it was observed that **plan for infrastructure development is not inclusive**, although, the state mentioned that there is a policy for infrastructure development which is based on facility need and load. It was noted that at some of the facilities (primarily at CHC level) needing major equipment, have not been included in Block Plan/ DHAP/ SPIP[1]. **It also highlights the issue that district planning generally excludes the facilities above BPHCs (i.e. CHCs, SDCH, FRUs etc) while making yearly plans.**
- Almost all the facilities visited were found to be generally clean and have patient amenities such as waiting area, sitting arrangements, drinking water etc. In some cases, toilets meant for patients were locked (Jorhat) and in Sonitpur toilets provision were absent in SDH and are inadequate at other facilities. **Good amenities have been developed for the patients; however, if not being allowed to be used defeats the whole purpose.**
- As mentioned earlier, facilities are found to be adequate in the districts and accessible through good road connectivity; however, **at some places distance between facilities are very less which lead to low utilisation of one of the facility**[2].
- Both the districts have one government blood bank in place along with 1-2 private blood banks.
- **Non execution of AMC for equipment is a major concern;** it was observed that many new and lifesaving equipments (such as at BSU and SCNU) do not have an AMC in place leading to occasional halt of these critical services.
- Crowding of wards due to unrestricted entry of attendants and male relatives in female wards leading to poor infection prevention practices and safety and privacy of the patients. It was observed in many of the facilities that too many male attendants/ relatives and bystanders were present in the wards, especially post natal wards. Although, it was mentioned by the state that there is "visiting hours" specified; however, at none of the places it is adhered to. **By not adhering to this norm, facilities are at a greater risk of increasing infections rates in new born and mothers**.
- Bio-medical waste management is an area of concern in both districts. At every facility, it was noted that Colour coded bins are available, deep burial pits are in place; however, lack of

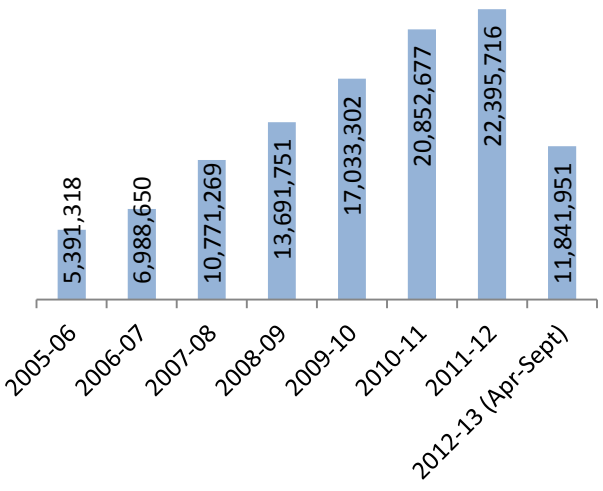
[1] Blood Storage unit in Teok FRU in Jorhat
[2] Baghshung and Dhekorgorah PHCs are vry close to medical college and hence virtually very low patient load.

motivation and commitment on the part of hospital staff lead to poor waste management systems:

- As a routine, waste not disinfected before disposal
- Deep burial pit available but not used uniformly.
- No centralized waste collection mechanism in place.
- Waste disposal protocols are not followed or adhered to.

Aggregation of Waste at Medical College, Jorhat

Facility utilization - As mentioned earlier, state has added good infrastructure and HR in the system and there has been **quantum jump in OPD and IPD numbers during the NRHM period**:



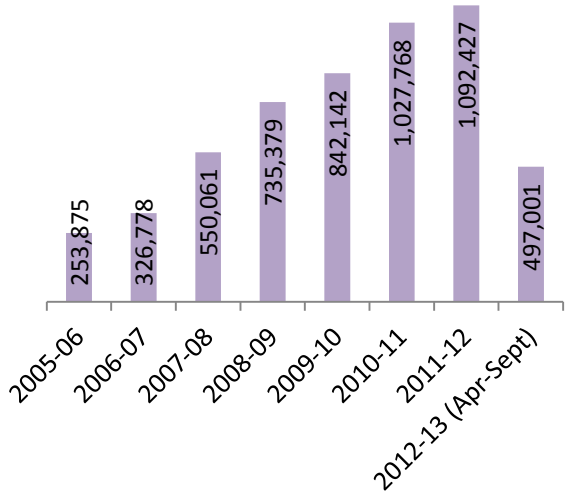


Fig 3: Number of OPD case load -Assam

Fig 4: Number of IPD case load-Assam

Table 3.3: Percentage increase in the OPD and IPD loads from 2005-06 to 2011-12, in Assam

	2005-06	2011-12	Change (%)
OPD	53.92	223.96	**315.36**
IPD	2.54	10.92	**329.92**

However, a closer analysis of the facility wise load (as observed during the field visit) reveals that only few facilities take up the increased OPD & IPD numbers and many other facilities with very good HR are not contributing:

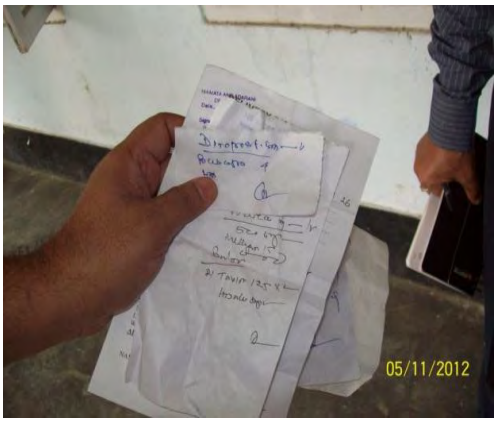
Table3.4: OPD and Delivery loads of various facilities of Jorhat

Facility - Jorhat	OPD/ day	Del/ month	Available HR
Dhekorgorah (MPHC)		1-2	1 MO, 2 SN, 2 ANM
Garmur (CHC)	300-400	150	1 Gynec, 1-Anaesth, 1-Radiologist, 5-MO, 10-GNM, 1-ANM
Rangachahi (SD)	30-40	25-30	1-MO, 2-GNM, 1-ANM
Kamalabari (CHC)	100	30	2-MO, 5-GNM, 2-ANM
Kakojan (BPHC)	40-50	5	4-MO, 5-GNM, 4-SN, 4-ANM
Teok (FRU)	60-70	150	1-Gynec, 1-Paed., 1-Anesthetist, 2-Other Spe. 18-GNM, 3-ANM
Nakachari (BPHC)	60-70	30	2-MO, 4-GNM, 5-ANM
Moriani (BPHC	50	35-40	3-MO, 2-GNM, 4 ANM
Titabor (CHC)	150-200	130-150	2-Gynec, 2-Anaesth., 1-Surgeon, 13-other Doctors, 8-GNM, 7-ANM, 2-LSS
Baghshung (BPHC)	50-60	3-4	1-Paed, 2-SMO, 1-ENT, 1-Ayurveda, 2-GNM, 4-ANM

- Jorhat:
  - Compared to number of provider/ infrastructure in place, output in terms of OPD, delivery etc is pretty low.
  - **As per district data, OPD numbers have declined in Jorhat**
- Sonitpur - OPD and IPD load is primarily concentrated at DH only.

- In spite of huge funding in terms of procurement of drugs/ diagnostic services for pregnant mothers and newborns, it was noted that o**ut of pocket expenditure is high at all the facilities. Ironically, in some of the cases patients were asked to buy those medicines which are available in the drug stores:**
  - Patients asked to buy medicines, even though RKS money is also being used for procuring drugs.
  - In one of the unique case, it was noted that at Medical College, Jorhat, beds rented by patients and are lying in the corridors of the facility.
  - Medicines prescribed from outside in spite of drugs available in the stores of the facility.
  - Although various charters, information boards are in place to inform patients/ community about their entitlements especially drugs; this is not completely known to the patients and due to which they tend to buy medicines from the open market

– One of the Subcenter (Borjarani) in Sonitpur district with RHP posted were collecting registration charges.



Medical prescription with drugs prescribed from outside (Jorhat)

Rented beds in the Corridor, Medical College, Jorhat

- **As highlighted time and again, drug management system is an issue in the state:**
  - None of the facilities had bin-card system in place; expiry register is not maintained at any of the facility, making it difficult to know which medicine is on the verge of expiry.
  - At most of the facilities it was observed that supply is not always based on the demand, there are many drugs/ consumables which are not required by the facilities are pushed from the top. IVth generation I/V antibiotics available in huge quantities grossly disproportionate to the requirement [3].
  - Some of the basic drugs/ consumables such as syringes, IFA, Catgut, Diclofenac inj. not available in the state and purchased by the patients from the market.
  - However, it was also noted that some of the SHCs (Komar khotwal) have recently expired IFAs (which indicate that IFA was not used at SHC) while same is not available at higher facility
  - **EDL not enforced in any of the facilities.**

Stocked in Ceftriaxone injections in Kakojan Block PHC

[3] At Kakojan PHC-Jorhat, Trioxone injection was found in abundance, while facility did not really demanded for it.

Recommendations:

As highlighted in this section the state now has basic infrastructure/ equipments in place; however, now there is a need to strengthen some of the systemic issues:

- Infrastructure development to be based on actual need of the facility and DPMU & BPMU should be made accountable for including infrastructure need of all type of facilities in the annual PIP.
- State is already taking up exercise in terms of mapping health centres which are very close to higher facilities; however, there is a need for serious review of these types of facilities and if needed re-deploy some of the staff to other facilities where there is higher demand.
- Facility monitoring by head of the facility along with block and district level officials should be promoted to ensure:
    - Amenities/ facilities available for patients are open and usable.
    - Bio-medical waste management system is adhered to reduce infections
- Drug management system need complete overhaul. State has already started some exercise to find out what are the drugs which are unnecessarily pushed in to the system; however, this should be prioritised and taken up immediately.
- State needs to make community aware of their entitlements and make them demand their rights in terms of drugs, consumables and diagnostics etc.

TOR II: OUTREACH & PATIENT TRANSPORT SERVICES-SUB-CENTERS, MOBILE MEDICAL UNIT/EMRI, ALS/BLS ETC

2.1 Sub centers:

Overall number of Sub centres is adequate. There are 143 sub centers in Jorhat district i.e 6096 rural population per Subcentre. In Soniput however the number of subcentres are inadequate, number of required SCs is 385 but 279 are existing.

Table 3.5: Subcentre details in Assam, Jorhat and Sonitpur

	Jorhat	Sonitpur	Assam
Total number of Subcentre	143	279	4604
Functioning in Government Building	128	181	2759
Functioning in Rental Building	15	98	1845
Subcenters with ANM quarter	121		
ANMs staying in ANM quarters	23		
Subcenters with ANM quarters under construction	3		
Subcenters in which ANMs residing at the distance of 5 or more than 5 km	32		
Subcenters serving more than 5000 population	30	75	1652
Designated Delivery points	4	-	195
Delivery points conducting more than 3 deliveries *(As per average of 2011-12)*	2	-	77

Source: State PIP 2012-13 and District Data

- It was seen that in both the districts and state as a whole most of the Subcentres are housed in Government buildings. Almost all the Subcenters have two ANMs. In Jorhat among all delivery points Fulbari SC and Salmora SC, ANM position is vacant. It was also observed that Ghadpolia SC is serving 15500 populations, so the ANM here was overloaded and therefore the number of immunization sessions conducted was lower than the required.
- The construction of SCs is done by the State Government through the Assam state housing board. The recent construction work undertaken is going at a steady pace except Lahowal SC, Jorhat which has not started yet. In 2010-11 all the construction work has been finished except Madhya Ahatguri (Majuli) SC, Jorhat which was surrendered.
- The job distribution among the two ANMs is as per geographical distribution. All the Subcenters visited had clearly defined work plan for each ANM. All the Subcenters visited had Male health worker usually designated for disease control activities, both communicable as well as non communicable.

Package of services:

- All the Sub centres are providing basic antenatal care services, immunization services. The Jorhat district has 15 delivery points which are equipped to provide delivery care services but last year's data shows that only 6 of these delivery points had conducted delivery and out of which only one is conducting more than the stipulated three deliveries per month. Package of

Services at Sub centre needs expansion in terms of IUCD provision. During interaction with ANMs, team found that nearly all of them are well trained in IUCD insertion but not practicing IUCD at Sub centres. VHNDs are being conducted from morning 8:30 AM to 2:30 PM every Wednesday. Adolescent Component has been found missing in VHND sessions and no data is being maintained for the same.

- The sub centers are supplied by injectables, usage of which is questionable (Nimati SC- had Mag Sulf. The RHP curriculum mentions the category of injectibles which can be administered by them however the list is generalized and does not provide the exact name of injectables which RHP can administer. All the subcenters visited had functional needle cutters and colour coded waste bins. The adherence to the protocols needs strengthening supportive supervision.

2.2 Outreach Services:

Immunization Sessions and VHSNC:

- The Jorhat district has 1104 anganwadis and the expected number of VHND is 13096. In 2011-12, 11665 VHND took place in the district and in 2012-13 (till sep) 5778 VHND took place. There has been a progressive rise in the number of VHND in the district. These sessions however are not covering adolescent component. All the centres were preparing the beneficiary list well in advance. It was observed in few Subcenters that the beneficiary list was not being updated and the previous immunization records also showed many drop out cases which were not traced in the coming sessions.
- The coverage of all the vaccines has increased in the district Jorhat. There were some data inconsistencies observed which might have concealed the real picture.
- Nearly all the SC visited in both the districts had immunization microplan well displayed in the facility. Ghadpolia SC is serving 15500 populations, so the ANM here is overloaded and therefore the number of sessions conducted is lower. In few of the Subcenters return vials were seen.
- **In Titabor FRU, Jorhat it was observed that the low birth weight babies were not being provided birth dose**.
- In Sonitpur, reported fully immunized children-86% (2011-12), according to CES report (2011-12) percentage of fully immunized children is 77%. The main constraints reported by the district are 'difficult to reach' populations. (Tea garden population, riverine islands and internally displaced population)

Medical Mobile Units:

- All 27 Districts of Assam have MMUs. In addition to that, the Sub-divisional level MMU was recently launched in 23 subdivisions of Assam to increase the services.
- Each MMU consists of a unit that is equipped with diagnostic facilities such as portable X-ray machines, Microscopes, ECG equipment, Ultrasound machines, autoclaves, stretchers, a mobile pharmacy and the like. These MMU units comprise of three vehicles with inbuilt OPD, laboratory facility and other essential diagnostic accessories. A generator for power supply is also fitted in each MMU. These specially designed units have two medical officers, two nurses, a lab technician, a radiographer and a pharmacist and driver. Both the districts have three

MMUs. In the MMU visited in Teetabaur CHC, Jorhat the post of radiographer was vacant, so the radiology vehicle was not being utilized, and the laboratory output was very poor, but as a mandate the fleet of all the three vehicles was being taken to the field. These kinds of arrangements have cost implications and the usage of the vehicles needs to be rationalized. It was observed that the MMU visit was made within the vicinity of a facility (2-3 km). The integration of school health program was missing.

Table 3.6: Utilization of MMU

Sl no	Year	No of Camps Held	No of Patient Treated
1	2007-08	183	40,304
2	2008-09	1,789	299,454
3	2009-10	4,226	671,911
4	2010-11	4,866	680,064
5	2011-12	5,194	668,441
6	2012-13 (Upto Aug'12)	3,449	443,084
Total		**19,707**	**2,803,258**

Source: State Data

Boat Clinics:

- There are **15 Boat Clinic Units** operational in the **13 Districts** of the State, viz.Barpeta, Dhemaji, Dhubri, Dibrugarh, Jorhat, Lakhimpur, Morigaon, Nalbari, Sonitpur, Tinsukia, Bongaigaon, Goalpara and Kamrup.
- The Boat Clinic renders the services to the island areas through outreach health camp. At the beginning of every month the District wise action plan were prepared and the boat clinic team comprises of two Medical officers, GNM, two ANM, Lab Tech, Pharmacist and other support staff visits the island according to action plan. In these districts, the boat clinics are reaching the poor and marginalized population with sustained health care since last two years. The boat clinics provide both preventive and curative care to the population residing in the islands. **It was observed that surplus staff has been appointed in these boat clinics and the utilisation is quite low. The costing too was on the higher side at the rate of 4 lakhs per boat as against Rs 2 Lakhs per boat in Kerala for similar facilities.**

Table 3.7: Boat Clinic Achievement, Assam

Sl.	Activity	2008-09	2009-10	2010-11	2011-12	2012-13 (Apr-Sept)
1	No of Camps organized	1,038	1,867	2,159	2,776	1,087
2	No of patients treated under General Health Checkup	91,839	1,41,413	1,77,300	2,25,141	92,498
3	Routine Immunization	8,994	20,389	22,468	24,817	8,791
4	Ante Natal Care (ANC)	3,201	6,064	9,020	14,679	5,298
5	Post Natal Care (PNC)	993	1,202	2,422	3,499	1,259
6	Vit A	1,463	7,170	8,088	11,037	4,226

Sl.	Activity	2008-09	2009-10	2010-11	2011-12	2012-13 (Apr-Sept)
7	Spl. Vaccination	1,343	1,330	2,656	6,201	166
8	IPPI	4,281	1,684	105	56	217
9	Family Planning	2,533	14,030	38,728	88,913	31,210

Source: State Data

Boat Clinic at Jorhat

Boat Clinic at Tezpur

2.3 Social marketing arrangements:

ASHA Contraceptive Delivery Scheme:

- In Jorhat very few ASHAs reported sales of contraceptives (condoms, OCPs and ECPs) and reason cited was the difficulty in selling contraceptives as most of the community people are known to them asking for money from these clients is difficult. Most of the ASHAs were empowered and well aware of their responsibilities and responded that even the male clients are approaching them for condoms.

2.4 ARSH:

- There is no district level nodal officer for adolescent Health.
- ***Menstural hygiene*** programme was introduced in both the district through ASHA is working very efficiently. The supply of the sanitary napkins is regular and users are very much aware and excited by the scheme. However there are concerns about the quality of napkins.
- ***Adolescent Friendly Health clinics*** established in Block PHCs three years back is now closed in Jorhat and the space used for other purposes. One of the PHC Kamla Bari, Jorhat visited a room was dedicated for AFHC is found now being occupied by the AYUSH doctor as the MO responsible for the AFHC proceeded for study leave two years back. In the Other Block PHC of Titabar the AFHC is demolished to address space constraints. Thus functional clinic was not reported in the district. Client attendance and coverage is as well not reported.
- ***WIFS:*** District preparedness for Weekly Iron Folic Acid Supplementation was not reported in the District of Jorhat. However OSD in the State intimated that the convergence meeting at State level included all districts. However as Jorhat District is not aware of the WIFS implementation, no plan of District WIFS advisory committee or Quality Assurance committee

is reported. No plan of training the teachers from Schools and Anganwadi centres was reported or described.

2.5 Emergency & Patient Transport services:

The EMRI vehicles are operational as emergency transport vehicles in Assam. The EMRI is run through a state level call centre. Apart from these the CHC Medical college also has facility vehicles. There is no designated call centre for the facility ambulances.

Table 3.8: Performance of 108 EMRI in Assam

Sl	Emergency services	Performance (From 6th Nov'08 till 30th Sep'12)
A	Total Calls	1,13,30,339
B	Total Life Saved	50,230
C	Category wise Patient Breakup	Total 11,12,443
1	Pregnancy Related Emergency	4,30,431 (39 %)
2	Acute Abdomen	1,80,804 (16 %)
3	Injury	1,17,898 (11 %)
4	Cardiac Problem	41,823 (4 %)
5	Respiratory Problem	36,915 (3 %)
6	Poisoning/ Drug Overdose	19,008 (2 %)
7	Others (Fever, Infection, Burn, Allergic Reaction, etc)	2,85,564 (26 %)

Source: State Data

2.6 AYUSH:

- Jorhat district has 14 Ayurvedic and 3 Homeopathic doctors in Mini PHC, State Dispensaries, CHC and FRU. The facilities are provided with limited AYUSH medicines. It was observed that as an ayurvedic medicine only Guglu has been supplied in the facility. Further it was seen that the stock maintenance of these drugs is done by the AYUSH doctor himself and is not registered in the stock register of facility store. As per HMIS 2012-13, 1.7% of the OPD is AYUSH OPD. No specific IEC programme conducted on mainstreaming and strengths of AYUSH systems. The technical monitoring of AYUSH doctors service delivery is practically not exist.

Recommendations:

- An evaluation for the effectivity of RHP may be taken up by the state so as to roll up the program further. State needs to formulate Standard treatment guidelines and SOP for RHPs.
- Strengthening of VHND in terms of provision of adolescent services

- An evaluation of boat clinics, in terms of staffing and cost effectiveness may be taken up by the state.
- Adequate staffing of MMUs and/or rational use of the same may prove to be cost effective in providing desired services to the community. An additional strategy of linking up with the school health programs may be explored.
- The State needs to pay special attention to adolescent health component.
- State Adolescent Health unit needs to be strengthened and work in tandem with district health societies.
- District nodal person for ARSH needs to be designated and strengthened.
- Establishment of ARSH clinics, regular mentoring with data mining and reporting is required.
- WIFS roll out – procurement, training, committees needs to be prioritised.

TOR III: HR - ADEQUACY, SKILL AND PERFORMANCE

- State has taken some steps to improve the HR situation:
  - Manpower appointed under NRHM are posted in the Institutions where there is no regular sanctioned post of manpower or in underserved areas
  - Compulsory one year Rural Posting for MBBS doctors to get admission in the PG courses.
  - The Specialist recruited under NRHM have been posted at FRUs and District Hospitals wherever required
  - Specialist cadre is under consideration
  - Initiated 3 yrs Diploma course of "Rural Health Practitioners". A total of 324 Rural Health Practitioners have been recruited under NRHM and posted in Sub-centers (SC-C) where delivery has started
  - **e-HRMIS:** Online Portal developed for HR database. On 29th day of every month, the database is published in the public domain of NRHM, Assam Website. Presently this e-HRMIS is only acting as a database portal and the gaps identified from it are not being addressed.
- It has been observed during the visit that the **availability of HR at every level, especially at SHC level was very encouraging**:
  - All the SHCs have full complement of personnel- at least 2 ANMs, FA, MPW and 15 (Jorhat) have RHPs
  - All the higher facilities are manned by adequate number of doctors and paramedics
  - Good number of HR has been added under NRHM

Table 3.9: HR status in Assam

Category (Key Staff)	Required as per IPHS	In Position			Gap as per IPHS	% Gap
		Regular	Under NRHM	Total		
Doctors (Allopathic) including Specialist	6402	2461	699	3160	**3242**	50.64
Gynaecologist	281	202	26	228	**53**	18.86
Paediatrician	252	89	23	112	**140**	55.56
Anaesthetics	231	86	6	92	**139**	60.17
Radiologist	38	14	1	15	**23**	60.53
AYUSH Doctors	1304	355	407	762	**542**	41.56
Staff Nurse	11728	2001	2705	4706	**7022**	59.87
MPW	4604	1822	391	2213	**2391**	51.93
RHP	4604		324	324	**4280**	92.96
ANM	10624	5146	4878	10024	**600**	5.65
LHV		452	0	452		
Lab Tech	3074	707	584	1291	**1783**	58.00
Pharmacist	2878	1110	273	1383	**1495**	51.95
Radiographer	590	91	50	141	**449**	76.10

  - Above table clearly reflects that more than 10000 medical and paramedical staff has been added in the system through NRHM which is around **42% of total available HR** in above categories; this is a significant contribution of NRHM.
  - Above table also shows that **on an average there are around 8-9 gynaecologists, 4-5 paediatricians and 3-4 anaesthetists in each district**; which, if rationally deployed would be able to cater the load in each of the district.
- Increase in HR has resulted in improved performance especially in terms of institutional deliveries and C-sections (Jorhat):
  - Inst. Del: 15737 in 2010-11 to 16656 in 2011-12
  - C-sections: 2707 in 2010-11 to 3756 in 2011-12
- In spite of good HR available in the districts, it was observed that, **round the clock emergency services are not provided at all the facilities (emergency C-sections) in both the districts**. It was noted that even at the medical college level, C-sections services are not provided during a particular period in the day[4]. **Anecdotal evidences suggest that majority of the FRUs (designated) only provide elective C-section services**. This clearly defies the purpose of making these facilities equipped for provision of round the clock emergency services.
- Although state has developed system for facility specific posting of specialists and doctors, the team noted **aberration of policy for deployment of specialists**. This is a one off case; however, state should take steps to ensure that a specialist such as Gynaecologist is not posted at PHC/ MPHC[5].
- State has a good data base of all the HR posted at different level of facilities; however, **there is no system for performance appraisal of service providers**. There are monthly reviews conducted at the district level; however, it seems to be ad-hoc arrangement since no systemic plan for review is in place. Some of the key specialist staff is not reviewed on the basis of their performance (number of deliveries, C-sections etc).
- **Lack of supportive supervision system** was visible at every level during the visit. Minor technical issues, in the labour room or OT which may be corrected at the facility level is generally ignored since neither facility in-charge nor other doctors try to monitor their own facility and support ANM/ SN so that they can provide quality services. Further, it was observed that even block and district level officials are not conducting supportive supervisory visits.
- State does not have proper cadre for specialists; however, state mentioned that the process is on to develop a new cadre for the specialists.

Recommendations:

- State needs to consolidate the number of HR added under NRHM and available through regular source and develop a system so that the maximum output and quality service delivery can be ensured:

[4] It was revealed that at Jorhat medical college there is no C-section conducted between 1-5PM for want of adequate gynaecologist (although 8 are posted in the medical college). Similar issues were observed in Sonitpur DH

[5] A gynaecologist is posted at MPHC Morioni (Jorhat)

  - State has facility based data of HR, their performance may now be monitored to see the output
  - Placement of HR should also consider geographic distribution.
- Supportive supervision is a strategy which has been stressed time and again; however, state should now focus on institutionalising this system. Programme managers and officials at every level should be entrusted clear technical / programmatic areas for supervision and monitoring.

TOR IV: REPRODUCTIVE AND CHILD HEALTH PROGRAM

RCH services are available and planned in all the facilities visited in both the districts, except NRC and Adolescent health services.

4.1 Maternal Health:

The MMR of the state is 390 (SRS: 2007-09). As per the AHS -2010 (reference period 2007-09), the MMR for the 23 districts of Assam varies between 342 in 4 districts to 430 in 5 districts.

Delivery Points:

Table 3.10: Status of Delivery Points in Assam

Cat	Total	L 1	L2	L 3	Delivery Points
MC	6			6	6
DH	24		2	21	23
SDCH	13		2	11	13
CHC	108	11	71	26	108
PHC	968	116	437	1	554
SC	4604	195	0	0	195
Total	**5723**	**322**	**512**	**65**	**899**

Source: State PIP

Jorhat district has 58 delivery points out of which 15 belong to tea estate area.

Table 3.11: Delivery points in Jorhat District

Facility	Designated Delivery Points	Functional Delivery Points	Remarks
SC	4	2	>3 deliveries/month
BPHC+MPHC+SD+Non FRU CHC	36	12	>10 deliveries/month
BPHC	6	3	
CHC (Non FRU)	3	3	
MPHC	18	4	
SD	9	2	
FRU (CHC+SDCH)	3	3	>20 deliveries/month
Medical College	1	1	>50 deliveries/month

Source: District Data

- Jorhat district has 3 FRUs which are conducting C-section. Teok FRU, as discussed above is not conducting emergency C-sections. The table below shows the % C-section deliveries in FRUs of Jorhat. It can be seen that the medical college is catering to the maximum load of complicated deliveries.
- It can be inferred from the table above that the early registration is Sonitpur is very less. The figure correlates well with the high home deliveries. The AHS 2011 figure reports almost 30% home deliveries in Jorhat district whereas the district is reporting 4-5% of home deliveries in HMIS. Some ASHAs interviewed said that they have not reported home deliveries since last 2-3 years. As per the district officials the number of home deliveries is larger in the tea estate area.

There is a huge gap in home deliveries between the AHS and reported HMIS figures depicting that the home deliveries largely go unreported.

Table 3.13: Maternal health indicators of Jorhat, Sonitpur and Assam

	ANC Registration	% ANC registered in first trimester	3 ANC	Institutional Deliveries	Home Deliveries	Skilled Birth Deliveries
Jorhat	84.8	66.2	71.9	68.5	29.6	41.6
Sonitpur	80.8	35.5	56	53.4	46.4	12.5
Assam	78.9	54.4	61	57.7	41.8	35.1

Source: AHS 2010

- The referral of complicated cases is largely by 108 ambulances. The riverine belt, Majuli also has a boat 108 ambulance for the cases to be referred to jorhat.

MTP services:

Table 3.14: MTP Services- Assam

Assam- Jorhat - Abortions - Apr'12 to Sep'12				
MTP Less than 12 weeks	MTP More than 12 weeks	Abortions (spontaneous/Induced)	Abortions in Pvt Facilities	Abortion Rate against expected pregnancies
1,603	45	1,067	-	11.3%

Source: HMIS 2012-13 Analysis

The rate of MTP was higher in Jorhat especially in Majuli. The providers assume that probable reason is that the tribals prefer MTP as a way of contraception. However, the major concern is that neither programme managers nor service providers are sure about the underlying reasons for high abortions in certain areas.

4.2 Quality of Care:

Labour Rooms:

- In general the labour rooms were in good condition, well equipped with newborn corners in both the districts. Emergency drugs like adrenaline, atropine, Mag Sulf was not present in most of the facilities in both the districts. At some places the medicines were present in the store but not being indented regularly by the labour room. In Medical College, Jorhat which is handling maximum complicated cases there was no emergency drug in the labour room and also it was not equipped to handle huge case load of 20-25 deliveries per day. It was observed that the hospital staff at medical college is not taking foot stamp of the child which is a legal mandate of hospital records. The Infection prevention practices needs strengthening and adherence to protocols. Most of facilities visited didn't have supply of Sodium Hypochlorite. Staff requires training for preparation and usage of hypochlorite solution. By and large nurses were trained in SBA in both the districts except at Medical College Jorhat. 48 hours stay is not being uniformly ensured in both the districts.

- In Sonitpur the protocols and guidelines are not practiced even strictly at District hospital and SDH (Use of Inj. Oxytocin for prevention of PPH is not practiced instead they are still using Inj./Tab Methergin). Inj. Oxytocin is used for enhancing deliveries. In all institutions team observed that infection prevention practices are poor (Boiling instruments instead of autoclaving seen in operation theatre of District Hospital where C-Section are conducted). C-Sections are only performed at District Hospital and that too in morning hours. In all the cases CephaloPelvic Disproportion is mentioned as indication for C-section. According to doctors at District hospital Emergency C- sections are not performed as vacant beds are not available. Due to heavy case load at District hospital, large no. of postpartum women were lying on the floor, corridors and even on the ramp to the first floor. Patients used their own mattresses/beddings in these places. Infection control is very poor.
- At Baghchug Block PHC, Jorhat although the delivery load was low but the staff nurses were regularly maintaining the partographs. All the other delivery points visited were not maintaining the partographs.

Quality Assurance Mechanism:

- The district has a designated committee for quality assurance of RCH services. There is a separate committee for Family planning services quality assurance. The state also has designated formats for monitoring of public health facilities. The usage of these formats was limited by the monitoring teams and no action plan was being made to address the gaps identified. Both district and state communicated that there is a definite monitoring schedule but the mandate for the same was not present at the district level.

4.3 JSY:

- The state has reported an increasing trend of JSY cases since 2005. The graph below shows that till now nearly 1.8 lakh beneficiaries have benefitted under the scheme.

Fig5: Trend of JSY beneficiaries in Assam

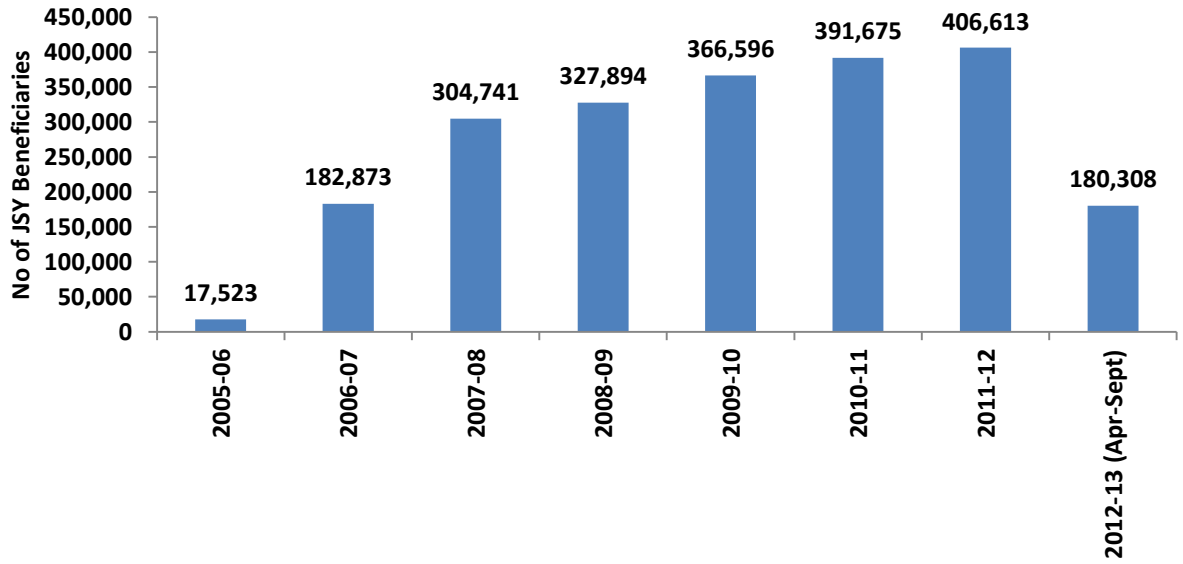


Table : JSY beneficiaries in Jorhat and Sonitpur

District	Expected JSY Beneficiaries in a year	Expected JSY beneficiaries from Apr-Oct'12	JSY Beneficiaries being paid incentive (HMIS-2012-13, till Oct.)	% of beneficiaries paid incentive out of the expected beneficiaries
Jorhat	14266	8322	6144	73.8
Sonitpur	24920	14537	9639	66.3

Source: State PIP 2012-13, HMIS 2012-13

- Both the district is ensuring cheque payment to all the beneficiaries. As per the discussion with the program managers in Jorhat district it was revealed that there are some delays which arise when the beneficiaries don't have bank account. This also results in physical and financial mismatch of JSY figures, sometimes. The district is planning to take up this issue and organize a camp where they are planning to call bank representatives and beneficiaries, so that the bank account may be opened under a single roof.
- 48 hour stay is still a challenge for the district. The state has started an initiative where by Mamta Kit is given to all the beneficiaries who stay for 48 hours or more in the facility. It was however observed in few facilities that Mamta kit was being issued to all the maternity cases irrespective of the 48 hours stay. The reason cited by the providers was that they have to issue Mamta Kit due to administrative and political interference.

4.4 JSSK:

- JSSK was inaugurated on January 2011 and the actual implementation was started from March 2011. The JSSK evaluation by the team was based on observation, interaction with providers, beneficiary interviews and interaction with the private pharmacy shops outside the facility. In all 15 beneficiaries were interviewed in different facilities of Jorhat district.
- *IEC Activities:* The JSSK display was in local language but insufficient, this correlates with the low awareness among beneficiaries as assessed during the interview. During the district briefing the program managers were suggested to explore the option of distributing pamphlet along with MCP cards as another IEC option.
  In Assam, 1369 nos of Information Boards were installed in all the delivery points viz DH, SDCH, CHC, MPHC and RHP SCs. Advertisement regarding Janani Shishu Suraksha Karyakram was published in 31 nos. of newspapers at the time of launch of the scheme. Advertisement about *"ADARANI-Drop back facility"* was published every Tuesdays of the month for June, July and August, 2012 covering 31 newspapers. Television advertisement on Janani Shishu Suraksha Karyakram was broadcasted on all empanelled channels everyday in the month of February, 2012 for creating awareness about the scheme.
- *Diet:* The diet was not being provided at the level below CHC. The reason cited by the providers was that they find it difficult for outsourcing the same, moreover the state has not provided any state specific guidelines to the districts for the same. In the facilities where the diet was being provided there was no fixed dietary plan. The kitchens visited in the facilities were clean. The state is also providing mother's Horlicks as a nutrition supplement to all the

maternity cases. In Assam, 197840 units of Nutritional Supplement have been supplied under JSSK till August, 2012.

- *Drugs:* In all the facilities team found out a drug supply and demand mismatch. The availability of emergency medicines varied from facility to facility. Few of the facility were purchasing the emergency medicines from local purchase as the regular supply for the same was not there. In all the facilities there was no supply of disposable syringes, catgut, diclofenac injection, calcium tablets. The beneficiaries were purchasing certain medicines from outside. The case was more evident in Majouli.
- *Home to Hospital and Inter facility (108):* Overall total of 75869 beneficiaries have availed these services as per the Reports up to September, 2012 in Assam.
- *Drop Back:* is provided by *Adorani* vehicle all over in Assam. In Assam 63527 patients have been dropped back at their homes after delivery through this service up to October, 2012. The team observed in one of the BPHCs (Jorhat) that out of 150 deliveries reported in one month 120 drop backs have been provided.
- *Out of Pocket Expenditure*: Nearly 90% of the beneficiaries reported OOP largely due to purchase of medicines. Few also incurred expenditure on transportation. The out of pocket expenditure ranges from Rs. 50-500. In Medical College in case of non availability of hospital beds, the beneficiaries were renting out camp cots at the rate of Rs 100 per day per bed from open market.
- The physical reporting of JSSK is not streamlined across the district and needs to be strengthened

4.5 Maternal Death Review:

The state has a designated MDR Committee. At the district level MDR done were as per the protocols, largely there were facility based MDR. It was also observed that the community level tracking of deaths was weak in both the districts and very few communities based MDR were there. The state is developing online software for analyzing the causes of maternal deaths. Most of the maternal deaths in 2011-12 and 2012-13 have been due to Eclampsia followed by haemorrhage, anaemia and sepsis. It was observed that the verbal autopsies being carried out in both the districts investigated only the medical causes of deaths but the social causes were being missed.

4.6 Child Health:

SNCU/NBSU:

- Establishment of SNCUs is a major step taken by the state to address neo-natal and in-turn infant mortality. 16 SNCUs are functional in the state.

Table 3.15: Status of SNCU-Assam

Institutional capacity	Assam
Target	27
In High Focus District	14
In Non High Focus District	13
Functional	16
Ready for operationalisation within 1 month	3

Institutional capacity	Assam
Expected to be functional by end of Dec' 12	3
Under Construction	3
Under process of preparation of plan estimate	1
Case Admitted (2011-12)	10,808
Case Referred (2011-12)	453
Case Died (2011-12)	1,173
Survival rate (%)	89%
Case Admitted (Apr' 12 - Aug' 12)	5,114
Case Referred (Apr' 12 - Aug' 12)	246
Case Died (Apr' 12 - Aug' 12)	638
Survival rate (%)	88%

Source: State Data

- The visit to SNCUs in both the districts revealed following points:
  - Jorhat SNCU is one of the 'state of the art' facilities available in the public health system. The Occupancy rate is also very high; at the time of the visit 75% of the beds were occupied. It was also informed that some times, one bed supports 2-3 newborns making the occupancy rate more than 100%.

SNCU, Jorhat Medical College

  - Dedicated but very less number of staff managing the SNCU leading to high stress level on the part of the staff and possible quality lapses as well as force attrition.
  - In the Jorhat district it was noted that Medical College does not take ownership of the SNCU, considering it the property of the District Health Society. This is not a positive sign for sustainability of the SNCU.
  - In spite of GoI's commitment and funding support for drugs for newborns, SNCU at Jorhat does not have enough medicine supplies. It was also informed that Rs. 5.00 lakhs available/ SNCU is not enough for Jorhat district.
  - SNCU's equipments do not have an AMC in place, leading to breakdown of some of the life saving equipments.
  - There is a separate inborn and out born unit. Mostly the inborn admissions are due to asphyxia while in out born it was due to sepsis. The SNCU is well maintained and following infection prevention protocols.
  - As per the last month's data of SNCU there was an almost equal distribution of male and female cases.

- In Sonitpur SNCU is available at District hospital and properly functional with paediatrician.
- As informed by the SNCU in-charge in Jorhat, there is 9% mortality of in-born admissions compared to 15% mortality of out-born admissions.

Table 3.16: Status of NBSU in Assam

Institutional capacity	Assam
Functional	130
To be functional in next Qtr.	152
Under Construction	108
No. of delivery at the Health Institution having functional NSU	19,716
No. of live birth	19,218
No. of still birth	481
No. of baby requiring resuscitation	1,096
No. of LBW babies	3,506
% of LBW babies	18.24%
Case Admitted (April' 12-Aug' 12)	962
Case Cured(April' 12-Aug' 12)	732
Case referred (April' 12-Aug' 12)	159
Case Died (April' 12-Aug' 12)	25
% of Death of Admitted Cases	3.41%

Source: State Data

- **NBSUs is taking strong roots in the state** with almost all the BPHCs, CHCs and FRUs visited had state of the art units with the full complement of hardware and equipments. However the units are likely to start functioning in the coming months though human resource for the same may be a problem. This is a clear issue of mismatch of infrastructure and HR in the district. This single intervention has the potential to impact the IMR in a significant way in the near future.
- New born corners were available at all the facilities including SHCs in the Jorhat district, while the team visiting the Sonitpur district did not find a NBC at a delivery point SHC. By and large ANMs/ SNs were aware of level of temperature in warmers; however, it was evident that these machines are not widely used. Further, it was not clear what are the criteria used for selecting a new born to be kept in the NBC.

Management of Childhood Illness:

In Jorhat district first round of Module 6&7 is completed and the ASHAs are making HBNC visits as per the protocols. The field level functionaries were well aware or the management of childhood illnesses, usage of ORS and mandate for post partum visits. Sonitpur is yet to roll out module 6&7.

- Number of infant deaths has increased in Jorhat district which is a matter of serious concern. However, the district collector mentioned that improved reporting is one of the key reasons

for high reporting of infant deaths. There is no mapping of areas which have started reporting higher deaths making it difficult to understand the underlying causes for the same.

- Proper weighing machines are not in place, making it difficult to measure right weight of the baby which in turn would have impact if it is a low birth weight baby. Major equipments have been purchased by the state; however, smaller but very critical equipment such as weighing machine has not been prioritized.
- NRCs are not in place in both the districts visited; however, state informed that setting up of the 4 NRCs is under pipeline.

Immunization:

- State has reported continuous improvement in full immunization over the years; however, still there is a long way to go. It was observed that many segments of the population such as Tea Estates, internally dispersed population etc. are not uniformly covered in the routine immunization hampering overall full immunization coverage:

Table 3.17: Immunization achievement by various sources

	NFHS-3	DLHS-3	AHS-2010	Change % pt. (NFHS-DLHS)	Change % pt. (DLHS-AHS)
BCG	62.40	83.80	93.30	21.40	9.50
Measles	37.40	64.40	77.30	27.00	12.90
Drop-out: BCG to Measles	25.00	19.40	16.00	-5.60	-3.40
Full Immunisation	**31.40**	**50.90**	**59.00**	**19.50**	**8.10**

  - Above table clearly suggest that there has been significant improveme in all the components of immunisation schedule. However, pace of increase has declined.
  - Drop out between BCG and measles has declined; however, it still remain significant (16% point)
- Cold chain management is overall good in both the districts with some exceptions. ILRs and DFs are generally in good condition and functioning well. However, in one of the facility in Sonitpur it was noted that non-functional equipment are not repaired.
- Most of the staff managing cold chain is aware of "how" and "where" to store vaccine/ diluent in ILR and DF which is appreciable.
- At most of the facilities, staff (ANM/ LHV) is not aware of proper reconstitution technique of the vaccine and which lead to AEFI. This is a clear issue of the lack of facility level supportive supervision.
- Temperature book available at all the facilities; however, not uniformly updated at every level.
- In a one off case, it was noted that birth doses of vaccinations are not administered to low birth weight babies; however, reasons for the same could not be explained by the facility staff. The same could not be explored at other facilities; however, there is possibility of same being repeated at other places[6]. This is a sample case.
- Beneficiary due list is not updated some of the SHCs resulting in drop outs for many vaccines[7].

[6] Titabor FRU, Jorhat
[7] SHC Rajabari, Jorhat

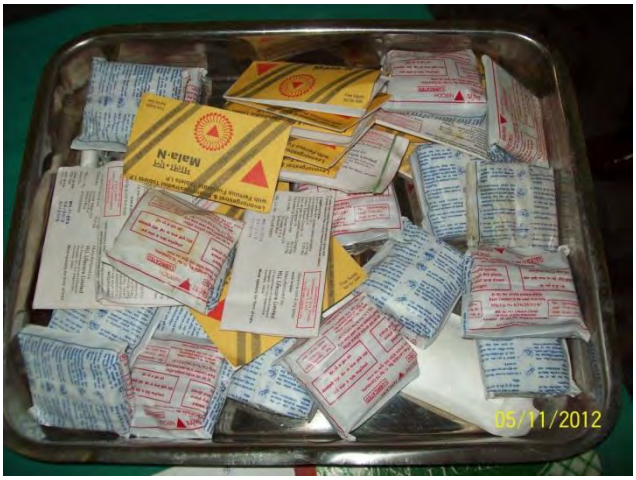
- It was a common finding that in none of the subcenters in Jorhat the facility date of opening of Vitamin A bottles has been recorded. Biannual round was recently conducted in Jorhat in the month of July.
- In Sonitpur cold chain equipment were available and working properly and temperature monitoring was done regularly but the non-functional equipment are kept un-repaired and was not replaced by the State Govt. after repeated requests from the facilities. Generator connection to the Walk-in Cooler is not provided at the District Hospital. Many equipment like ILR, Deep Freezers were lying at District hospital unrepaired and non-functional and requires replacement.

4.7 Family Planning:

- State has reported decline in sterilisation numbers and same was visible during the visit of the districts: number of sterilizations (both male and female) have declined in Jorhat from 4931 in 2010-11 to 2875 in 2011-12 (almost 50% decline). Male sterilisation has declined in Sonitpur district.
- Male sterilisation ahs declined significantly in the state from 14072 in 2009-10 to 6999 in 2011-12. This is ironical considering there are good motivated ASHAs in the districts which are bringing more than 8-9 clients for NSVs in a single camp. These ASHAs may used as counsellor/ communicator to motivate other ASHAs and clients in different areas:

- It has also been observed that data reported in HMIS (for sterilisation) and separately to FP division does not match leading to misleading analysis of the situation.
- Although state has informed on several occasion that fixed day service for sterilization have been initiated, the same could not be observed during the visit. Most of the places camp approach is being followed for sterilisation service delivery.
- ANMs, LHVs and GNMs are aware of right technique of IUCD insertions; however, output is very poor (max 1-2 IUCDs per month). In majority of the cases IUCD insertion is not carried out at SHC level and even if a client is motivated, he/she is taken to higher facilities (PHCs/ MPHCs) for IUCD insertion. All the SHCs are equipped to provide IUCD insertion services; however, lack of motivation on part of providers is leading to poor output.
- It was also observed that poor counselling of clients is also a primary reason for low uptake of IUCD services.

- All the SHCs have displayed boards highlighting days for various kind of services including FP services; however, clients / community is not aware of the same due to following reasons:
  - Most of the places the chart is in English language which is not the native language of the state.
  - The chart vaguely says “FP” services” and does not specify IUCD/ Condoms/ OCPs etc.
  - State has not made efforts to popularise the fixed services except putting up the charts at the facilities.
- In a rare incidence, expired IUCD was found at one of the facility in Jorhat and ANM was not aware of the same[8]. This could be seen only at one facility; however, this is a serious issue.
- ASHAs are aware and upbeat about the delivery of contraceptive scheme; however, free supply is not withdrawn from SHC and PHC. The nodal person managing the scheme in the district is not aware of the right guidelines about the scheme.
- State has not notified about the new scheme of spacing about ASHAs about which ASHAs were very upbeat. State mentioned that the notification would be issued very soon.



Recommendations:

Maternal Health

- State needs to address the supply demand gap of drugs which was observed almost in all the facilities. A TNMSC approach can be used for the same to address the gaps.
- Facility in charge/unit in charge should ensure the intra facility supply of essential medicines in the respective departments through developing a feedback system for the same
- Adherence to the infection prevention practices requires more on job training and repeated monitoring of the health care providers.

[8] Mohkhiti Missing, SHC, Jorhat

- Quality standards and protocols need to be administered through trainings, monitoring visits and monthly or quarterly assessment of tertiary care level like Medical College through coordinated efforts of Medical education department and DHS which may prove to be an effective approach in raising quality standards.
- Existing mechanism of quality checks through DQAG/State quality cell needs to be streamlined and strengthened through development of regular visit plans, assessment of gaps and submission of action taken reports.
- Data management for JSY and JSSK should be effectively undertaken at district level to minimize the discrepancies at state level.
- Rational use of JSSK funds to provide free beds and emergency drugs to beneficiaries at different level of facilities based on the gaps identified in offering the services.
- Diet provision at the facility below CHC level needs to be implemented.
- Higher rates of MTP among tribal community need to be investigated.
- As mentioned above largely facility based MDR is being done in the districts. Considering the high MMR in the state more community based MDR should be undertaken. Linkage with the civil registration department to trace more and more maternal deaths can be an option. Simultaneously the state should also focus on capturing the social causes for the same.
- State needs to emphasize on tracking of home deliveries.
- State has discarded the multi-skilling training for anaesthesia and CEmOC. Considering the dearth of the specialist cadre state needs to ensure emergency obstetric and new-born care with immediate attention. This issue has also been raised in previous CRM also.

Child Health:

Overall supportive supervision and monitoring of facilities is required to improve the situation of child health & immunization in the state:

- State should immediately look in to the operationalization of NBSUs which are already constructed.
- Ensure availability of medicines at SNCUs and also dedicated staff.
- To address high NMR the state requires immediate operationalization of existing NBSUs.
- Supervisory staff should also be trained in terms of various issues of cold chain so that right information/ technique may be percolated at the immunization sites.
- Districts which are reporting higher number of infant deaths should map the facilities/ area which have increased number of infant deaths to understand underlying reasons.
- Establishment of NRCs to be taken on priority basis.

Family Planning:

- State now has good number of providers trained in all the techniques of Family Planning (female & male sterilisation and IUCD insertion), there is a need for operationalizing fixed day services by:
  - Making client/ community aware of their entitlements at different level of facilities and also popularise these days.
  - Facility based supportive supervision of staff trained in IUCD insertion to motivate them to start IUCD insertion at the level of SHC

  - Consolidate the training of ANM/ LHV/ GNM in IUCD and saturate the delivery points on priority basis.
  - State to map the availability of trained providers in minilap, lap and NSV and place rationalise them in such a way that maximum number of facilities could be operationalized to provide fixed day sterilisation services.
- State to re-orient all the programme managers and nodal officers regarding all the schemes of FP especially two new schemes viz. “home delivery of contraceptives by ASHAs” and ensuring “spacing between births”.
- Male sterilisation to be focused by the state; good motivators (ASHAs) may be taken as counsellor/ motivator to other districts.

TOR V: DISEASE CONTROL PROGRAMMES COMMUNICABLE AND NON-COMMUNICABLE

5.1 IDSP

- DSU, IDSP, Jorhat has generated 82 no EWS in the last 3 years – 2010-12 year to year comparison indicates that the EWs have increased from 18 in 2010, 37 in 2011 and 27 in 2012 till September.
- Reporting status of all the forms is increased and Jorhat district is constantly reporting 100 percent in P and L forms. Number of reporting units in 2012 has been increased with addition of Tea Estate and Private Hospitals. However reports from many Private Hospitals which have started reporting data couldn't be included as the IDSP portal is 'freezed'.
- Facilities in Majuli have poor reporting due to poor connectivity. The facility staff finds it difficult to submit hard copies on weekly basis.
- Report sharing from Jorhat Medical College (JMC) is a concern area. As the medical college has a level three laboratory facility samples is being send to the facility. However the data collection becomes tedious in absence of dedicated point person in the medical college. The JMC reporting usually gets delayed for this at least 15 days.
- Epidemiologist visit regularly is done regarding data generation and also in regards to case investigations by cross checking the data send from facilities and the entries included in OPD register in the column for provisional diagnosis. However because of less manpower the checks are not optimum.
- The DSU trained 175 MOs in district hospital and periphery centers out of total 233 present, of 104 LT 43 were trained- Jorhat Medical College LTs are yet to be trained, of 401 ANM, MPW and Pharmacist 278 are trained.
- In Sonitpur, IDSP unit at District level is well Functioning. Weekly reporting from the facilities is couriered after the completion of week. But reporting from difficult & hard to reach areas is poor. So it can be coordinated with the Boat clinics & MMUs.
- Data at IDSP unit and the Data with individual programme functionaries is not matching

Recommendation

- Point person may be made responsible and/or channels may be created at the low reporting facilities or centre(s).
- Capacity building for S form needs to be strengthened making the regular supervisor responsible to build capacities.
- IDSP data uploading problem for the private facilities can be looked into as this affect the EWs.
- Turn around time for diseases may be included as monitoring tool
- District Jorhat may be intimated on the data triangulation and cross verification across sources.

5.2 National Vector Borne Disease Control Programme (NVBDCP):

- In Jorhat district Malaria and AES and JE are prominent problems of NVBDCP.
- Manpower status for NVBDCP in 2012 indicated that, 11 Surveillance worker, 3 Surveillance inspector, 1 malaria inspector post are lying vacant. However both the microscopist is lying vacant in the district of Jorhat.

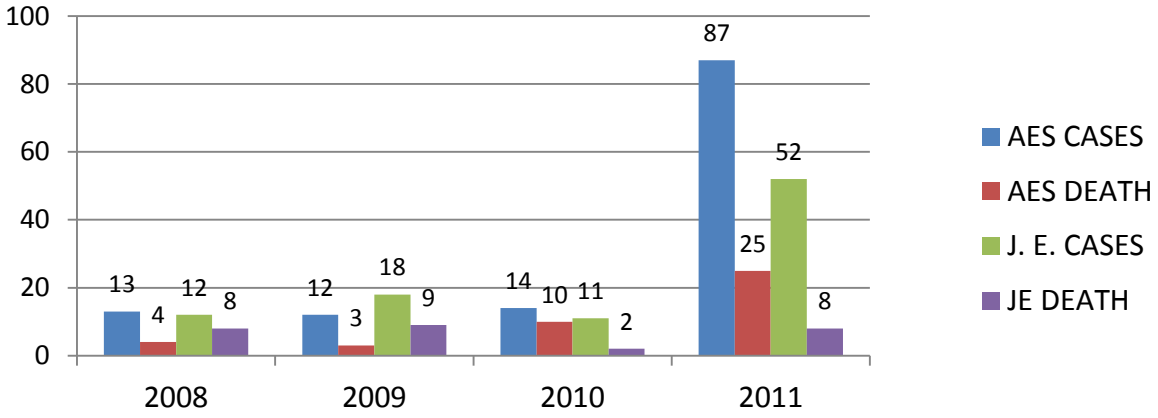
- Malaria endemic area in the district Jorhat is identified within the district and intensified intervention
- PHC based epidemiological report show lower number of cases total and PF PV in 2012 than 2009. The PF and PV data is however different than reported in IDSP in Jorhat in 2012. Nil deaths is reported in 2009-12.

Table 3.18: District Malaria data, Jorhat

Year	Population	TARGET OF BS	BSC/BSE	Total Malaria Cases	Pf. Cases	Pv Cases	Deaths
2009	1,206,430	NIL	114,263	353	289	64	7
2010	1,209,365	120,643	131,553	118	80	38	0
2011	1,213,399	180,962	137,807	112	90	22	0
2012	1,197,606	121,336	87,960	94	79	15	0

- BSC/BSE compared to target was 72.49% in 2012 and 76.15% in 2011. Surveillance system is working adequately. Each surveillance worker have two Subcentres dedicated. RD kit is issued to surveillance workers which are used for migrants from Shillong. If found positive in the kit treatment is given on the spot.
- ASHAs though equipped in the sample collection are more enthusiastic in facilitating the institutional deliveries rather than slide collection. Rs 10000 allocated to PHC for incentives of ASHAs often remain unutilized.

- **JE & AES c**ases and deaths are increased drastically in the district of Jorhat in 2011.



Indoor spray is conducted by team constituted at Sub Centre level with the person responsible for Malaria as supervisor. This is planned date wise and from district level back check team visit to verify whether sprays has been done or not.

- There are nine diagnostic centres under NVBDCP in the district in Block PHC (7), Zone, and district head quarter.

- In 2011, 10,500 LLN was distributed out of 10,500, in 2012-13, 8200 nets was requested during AES JE outbreak which has been distributed. LLN can be included to be distributed in Ashram Schools in endemic areas as done in Odisha.

Sonitpur:

- NVBDCP control and prevention strategies. The incidence and prevalence of vector borne disease are decreased attributing to detection, vaccination (J.E) and LLINs distribution. Mortality is also decreased. DATA
- RDKs are available with the ANMs and Blood slides are also sent to PHCs for microscopic examination.
- PMDT services have been rolled out from Feb, 2012.

5.3 Revised National Tuberculosis Control Programme (RNTCP):

- The coverage target was 85% and above this year Jorhat could achieve 83%. Kakojan block have been known for most TB cases, further the Tea Estates are also identified as localised TB centres in Jorhat district. It has been reported that the Tea estates laborers are often the common defaulters. Without constant monitoring and follow-up from the District unit the tea estates often fail to follow the guidelines of treatment. Patients thus are not also motivated to continue the complete treatment regime and often are the defaulters. To address the short coming monthly meetings with tea estates have been initiated under the chairmanship of the district collector where challenges and way out is being discussed. Confirmatory sero diagnostics is not done. Sputum and xray are used to identify cases.
- Linkages with private facilities are not optimal. The programme information in private nursing homes to be displayed is notified.
- All contractual staffs are placed in Jorhat. There is no shortage of lab consumables for conducting quality diagnostic sputum smear microscopy activities at the Designated Microscopy Centres. These supplies are contracted out and are supplied annually. Funds are getting released for programme from SHS in time. Last fund was received on August 2012. RNTCP account maintains independent account in the district.
- No financial Management guideline of NRHM is shared with programme officers.
- There is regular review of RNTCP officers.

Sonitpur:

- The Failure rate is high and MDR prevalence is increasing

5.4 National Program for Control of Blindness (NPCB):

- The Jorhat medical college eye OT has recently been made operational in the OPD complex, two eye surgeons has been deputed in the facility. The other center, Titabar eye OT is under construction and yet to be operational. There are total 12 eye surgeon in Jorhat of this 5 surgeons were trained (SICS/IOL/Phaco) and operating, but not optimally used due to non availability of Eye OT at FRU Titabor & Teok.
- Cataract programm in district Jorhat is supported through a MoU with Jorhat Lions eye hospital. The total operation in FY 2012-13 till September, 4.87% was conducted in

Governemnt facilities, 48.67% was conducted by NGOs and rest was reported from private nursing home.

- Linkages with School screening programme not mentioned and made operational. The programme focus was entirely on the cataract operation. Linkages with SSA eye screening programme is also weak, as SSA organize the camp on its own and does not ask for linkages with the programme for resources manpower.
- NPCB online MIS system has not started though training for the same was conducted in Guwahati. The portal did not function on the same day itself, the ID pass word did not work. Thus the reporting is based on manual report being sent to State. State supplied reporting formats however with the ophthalmic assistant at Teok PHC could not show his last month report in the format. This data is shared in monthly meeting. Deputy commissioner monitors the programme directly.
- There is one eye bank in the Jorhat district. Cornea transplantion reported 100% of collected. However follow up data not available.

Table 3.25: Eye Donation, Jorhat

Year	No. of cornea collected	No. of cornea transplant
2010-11	96	96
2011-12	78	78
2012-up to Sept./12	37	37

- Retinopathy of prematurity is not initiated as district is not aware of the need. District Nodal person is not aware of the procedure and don't have idea of number of premature babies born in the district.
- Rs 10 lakhs was received for the programme three months age and earlier in the financial yaer Rs 2 lakhs was received. Most of the fund was spend to clear the bill of Lions Eye Hospital payment.

Sonitpur:

- NBCP- screening for cataract and refractive errors is in place and corrections (Cataract surgeries and spectacle provision). Camps at school for screening ocular disabilities not regular/adequate. Functional eye OT is present in District Hospital. 2 more OTs are under progress in periphery level facilities which will Increase the overall coverage.

5.5 National Leprosy Elimination Program (NLEP):

- Coordination with NRHM is satisfactory but financial disbursement is dealt by the JD directly.
- Re-Constructive Surgery is not conducted in the district of Jorhat and cases are referred to Guwahati Medical college
- In Sonitpur NLEP- Treatment completion rate in last 2 years is 100% for PB and 98% for MB.

5.6 Non Communicable Disease:

- Jorhat is one of the 5 pilot districts of State of Assam for National Programme for Prevention and Control of Diabetes, Cancer and Stroke (NPCDCS) since the first year of initiation.

- Jorhat medical college have been made the nodal centre and fund of the District NCD is earmarked through the principal of the medical college instead through the District Health society. This has created operational problem like strengthening the peripheral health centres in rural areas.
- In March to Nov 2012 period 320,760 persons is screened of which 30,308 were found hypertensive, and 557 diabetic cases was reported. Surprisingly the same diabetic number is repeated over all months. It has been intimated that as near to expiry dated diabetic strips was supplied in Feb, 12 the tests was conducted only in the month of March, 2012 and the same data is being repeated in other months as presented by the District NCD cell. NCD data collation at District and State level does not include the age wise distribution of screened, even when the age data is available with MPWs.

Table 3.28: NCD Screening data, Jorhat

MONTH/ Year - 2012	TOTAL SCREENED	DIABETES	HYPERTENSION
MAR	20,969	557	2,017
APR	27,575	557	2,535
MAY	32,343	557	2,904
JUNE	37,080	557	3,187
JULY	41,160	557	3,533
AUG	46,163	557	3,843
SEPT	49,931	557	4,010
OCT	52,393	557	4,127
NOV(Till 02.11.2012)	53,106	557	4,152

- District NCD cell is expected to establish a CCU, Chemotherapy center and one NCD clinic at the tertiary facility district hospital according to guideline of NCD. Since Jorhat district does not have District Hospital the Jorhat Medical college has been entrusted with the responsibilities of establishing these three centers. With shortage of space according to guideline specification these centers are still to be established. However the required equipment and beds have already been supplied without any stock taking of space availability. As a result the instruments and equipment is lying idle in the hospital store unused.
- District level convergence (financial, communication, operational) with NRHM is raised as concern. There is no State direction regarding future pathways of implementation of the programme at district level.
- **Involvement of AYUSH doctors** in national health program specially NCDs is still to be made operational State and the five district health societies may lookinto the matter.

5.7 Disability screening and treatment

- Disability screening components is through the District Zila Parisad and not through the NRHM, district health society, Jorhat. The MPW identify the disable person and camp is organized. Types of disability identified are mainly of hearing impairment and orthopaedic.
- Linkages with the school health programme could not be ascertained as there direct linkages are still to be established. Through Sarba Siksha Abhiyan (SSA) school students are identified and the education department communicated for support to the Zila Parisad, beyond the SSA support to disable children. The Zila Parisad is mediating this convergence while district health directorate is still to develop a structured approach.
- In Sonitpur, there is a district rehabilitation centre for disability screening and treatment but it is not linked with the school health program.

TOR VI: COMMUNITY PROCESS INCLUDING ASHA, PRI, VHSC, CBM AND NGO

6.1 Involvement of Panchayati Raj Institutions representatives in the functioning of the VHNSC, RKS, and district health society

PRI members are the representatives of VHSNC, RKS in all the districts. In **Jorhat the PRI members have been made a signatory for fund release in the RKS**. In many facilities it was found that a large amount of cash has been kept in the facility and the planning for expenditure for the same was also not present. However the expenditure has been made in these funds. The district was communicated by the CRM team that there is no mandate that the PRI member should be made a signatory for cash disbursement and rather some government official should be a signatory.

6.2 ASHA

The state has 29172 ASHA and all of them have been given ASHA drug kit. The attrition of ASHAs is 4% in the state, mainly on being appointed as AWW, panchayat member or ASHA supervisors.
Jorhat district has a District community mobilizer. The district is planning to recruit Block facilitators also. At state level there is a separate cell monitoring ASHA program. All the ASHAs interviewed in both the districts were well educated (10^{th} class to graduate). The ASHAs interviewed were well aware about the vulnerable population in their area, HBNC protocols, family planning program, and disease control program.

ASHA Training

In Jorhat all the ASHAs have been trained for first round of module 6 and 7 and in Sonitpur training for module 6-7 will be starting from 16th Nov, 2012. The HBNC incentive has been rolled out in both the district. The ASHA training is an in house training and each ASHA was provided with the training modules and incentive. In Jorhat ASHAs in few facilities did not get module after the training. All the ASHAs interviewed had ASHA kits with them. The drug replacement is done by the BPHC to Sectoral PHC to ASHA during monthly meetings.

ASHA Incentive

The ASHAs reported to have received an average monthly incentive of 1000-1500. Certain actions has been taken by state to streamline payment of performance incentives to ASHA and reduce delay like it has been made mandatory that the ASHA will submit claim form by 3rd of every month and the concerned officer / BPHC accountant ensures all the claims get cleared on or before 10th of every month by Bank transfer also there is electronic transfer of ASHA incentive to reduce delay. In both the districts the fund transfer is done through a/c payee cheque and bank transfer. There were no major issues regarding payment of funds in both the districts, however there were instances where the ASHAs had come to collect the incentives several times in a month to collect the funds, though all of them have bank accounts the funds were not transferred. JSY Payment to pregnant women was not being done on the day of discharge many times, so the ASHA has to come specially to collect the payment, which can be avoided. The link workers and ASHAs payment are different.

The ASHAs have been given certain other non monetary incentives like bicycle, mobile sets, saris etc. 104 helpline is available for grievances complaints of ASHA. The state has initiated ASHA restrooms/ghars in certain district hospitals to ensure that ASHAs has a place to stay while they accompany a beneficiary for institutional delivery. In both the districts ASHA restrooms were not present and most of the ASHAs shared the concern that they face difficulty whenever they escort the beneficiary to higher facility.

State has certain specific Innovation under ASHA Programme:

- ASHA Radio Programme
- ASHA Post Card
- ASHA Bi- Cycle
- ASHA Insurance and Medical Reimbursement
- ASHA Rest Room at District Hospital
- ASHA Supervisor Diary

ASHA Support Structure

The state is following the norm of supervisory and supportive structure for ASHA, which is appreciable:

I. State Level : ASHA Resource Centre
II. District level: District Community Mobilizer & Assistant District Community Mobilizer
III. Block Level: NRHM Block Programme Manager
IV. Village Level: ASHA Supervisor
V. Status of ASHA Facilitator: 1 ASHA Supervisor for every 10 ASHAs are in place
VI. Status of Capacity Building of ASHA Community Mobilizer (no of training /workshop conducted in 2011-12): Bimonthly Review meeting and different workshop on Maternal Health, Child Health, Family Planning, Nutrition, etc.
VII. Monthly review meeting of ASHAs at PHC level and quarterly meeting at BPHC level.
VIII. In Jorhat district the selection of block level facilitators would be undertaken this year. Presently district community mobilizer is directly supervising the ASHA facilitators.

6.3 Village Health and Sanitation and Nutrition Committees (VHSNC)

VHSNCs are formed at the Village level with PRI involvement and ASHA as member secretary. The ASHA is conducting VHND, accompanying PW to the hospital for ANC and Delivery & proving sanitary napkins etc. VHSNC monthly meetings are conducted with recording of meeting minutes in both the districts visited. The members of VHSNC are PRI members, Mahila Samiti members, ANMS, ASHA, ASHA facilitator, AWW, School teacher.

VHSNC fund is largely being used for providing sanitation, cleanliness and drinking water. At Sonitpur all the ASHAs were instructed to buy weighing Machines and BP instruments for VHND to be held at Anganwadi centres.

Recommendations:

- ASHA ghar/resting rooms need to be constructed at Medical College, Jorhat.

TOR VII: PROMOTIVE HEALTH CARE, ACTION OF SOCIAL DETERMINANTS AND EQUITY CONCERNS.

7.1 Intersectoral Convergence:

There was very less convergence in the state, district and block PIPs. Jorhat district is planning to develop AW software and link it to MCTS so as to integrate ICDS and NRHM.

Block health action planning needs strengthening in terms of convergence of other department like ICDS, education department, water sanitation department etc. Linkage with civil registration department may also be explored to improve reporting of deaths.

There is no preferential financial and HR allocation for the high focus districts planned by the state.

7.2 Nutrition Rehabilitation Centers:

The state has four NRCs in Kokrajhar, Udalguri, Darrang and Chirang. All the NRCs are 10 bedded except the one in Darrang which is four bedded. During the year 2012-13 the state is planning to establish six NRCs (10 bedded) at Dhubri, Goalpara, Nalbari, Nagaon, Morigaon and Dibrugarh. Apart from this the state is in process of establishing fourteen Nutrition Counseling Centers at the level of block PHC and CHC. The selection of these centers was done on the basis of availability of rooms at the facility, the population of underprivileged groups and the selection was a joint effort of NRHM and social welfare department.

7.3 Gender and Equity:

The sex ratio of Jorhat district is 956 females per 1000 males and of Sonitpur district is 946 females per 1000 males while the state sex ratio is 954 females per 1000 males[9]. Sex ratio of Jorhat is better than the state average while that of Sonitpur is below state average. The BCC campaign against adverse sex ratio, Registration of Ultrasound machines/clinics, F-form reporting and analysis, Sensitization of the judiciary and the providers and effective detection and prosecution against offenders is very weak. The state has come up with good female centric innovative schemes such as Majoni, Mamoni and Mamta. These female centric schemes aim to improve the sex ratio in Assam, targeting the newborn girl by safeguarding education, health and nutritional rights through Majoni scheme, providing nutritional food to pregnant women through Mamoni scheme and improving post natal care, counseling on breastfeeding, full immunization during 48 hours stay in institutions and mamta kit to newborn baby through Mamta scheme.

7.4 School Health Program:

School Health Programme in the Jorhat district used a mixed implementation model with SHARP NGO run programme and District authority run programme. The NGO programme continued till December 2011 which was withdrawn after that. The district team (one) from the district administration constituted with the following members SDM&HO, one each of PHN, PHARMACIST, LDA, DRIVER, GRADE IV. In addition Staffs are also been attached with the team are one PHN in DHEKORGORA MPHC, UDALDA and a Vaccinator from joint director health services, Jorhat. Without any dedicated vehicle services of service of driver is used by the JD office.

[9] Census 2011

The universe of the schools is till class 8th - lower primary and middle schools according to State guideline till 2011-12. Total schools in these two category is 1890 schools (1845 rural and 45 urban schools) and the number of students to be covered is 109876 students (82902 LP, 26974 ME). State RoP approval maintains to widen the universe in 2012-13 to 6 -18 years of students in government and government aided schools. This though known as a concept in the district preparation for the same was however not reflected in the Jorhat District.

Table 3.30: School Health Programme			
Target schools LP and ME in Jorhat			1845
Students enrolled			109876
		2011 Till December	2012 Jan – Oct
Schools Covered		1702	44
Students covered		89387	2487
	Children identified with		
1.	ANEMIA	1296	261
2.	VITAMIN A DEFICIENCY	140	7
3	DEFECTIVE HEARING	26	
4.	SCABIES	318	70
5.	SQUINT	49	15
6.	DEFECTIVE VISION	51	78
7.	DENTAL CARRIES	178	85
8.	TONSILITIS	111	
9.	RING WORM	55	
10.	WORM INFESTATION	1060	295
11	Night blindness		26
	School Health talks	216	122
	Health camps	32	

The cumulative (District team and the NGO) coverage till December, 2011 was 1702 schools and 89387 students. In 2012 till November 44 Schools (2.33%); 2711 students (2.47%) was covered. Surprisingly the district presentation did mention only coverage of 172 schools which was later realized to be done under the National Tobacco Control programme and not the School Health Programme. This shows among other things ignorance at the district programme management unit lack of clarity of the already weak component.

The screening data reported indicated identification of large number of deficient students but very little on the infection data. The data is neither class/age specific nor gender specific. It is not known how many of the children screened were treated or required secondary or tertiary care facility support and how many of the referred accessed services. The standard format shared with States for quarterly reporting under School Health in FY 2012-13 is not found in the Jorhat district. State is also not reported the Physical and financial achievement data of the first two quarters of 2012-13.

District was notified that from 2012-13 LHV and inclusive education volunteers as proposed in State PIP, would be involved. Assam has been approved to include 149 dedicated team (150 Ayush doctor and 149 BDS) supported by MPWs, LHVs in 2012-13. Dedicated teams have been approved but yet to be recruited. Natural calamities and the recent ethnic unrest is cited as reason in delay of the recruitment process and is still to be prioritized. Discussion with the Officer on Special duty at the State level indicated that the recruitment is under process (advertisement and short listing done, interview was to begin in the last week of October but not reported in the time of CRM. Further Training of the LHV and MPWs are still to be started.

States where dedicated teams have been approved, they have to include preschool children below 6 years of age registered with Anganwari Centres under universal coverage of Children, till 18 years. This conditionality has been included in the Record of Proceedings (ROP), of financial year 2012 -13 approval. State of Assam thus needs to develop plan the outreach in the school vacation months to cover Anganwaris. The preparation at the district was also not reflected. Thus the programme is a non Starter.

Linkages with School health programme and the national disease control programmes as expected under holistic programme implementation is not reported.

As intimated to State already, Human, IEC and Financial across National Programmes like NVBDCP (National Vector Borne Disease Control Programme), RNTCP (Revised National TB control programme), NPCB (National Programme for Control of Blindness), NTCP (National tobacco Control programme), NIDDCP(National Iodine Deficiency Disorders Control Programme).We need to identify these allocations across different programmes which have linkages with and some programmes even have dedicated budget heads forSchool based implementation/outreach.

Emerging trends of non communicable disease and their predisposition at young age makes it important to build linkages with programmes like the National Mental Health Programme and the National Programme for Prevention and Control of Diabetes, Cancer and Stroke(NPCDCS). The later however still to initiate screening below age of 30 however IEC and preventive messages and measures like encouraging students to participate in regular exercising routine, diet diversification can be promoted. Programme implementation structures at District & Block level were found to be adequate. Nodal officer is responsible for 5 responsibilities – NCD, School Health, Biomedical Waste Management, Disaster Management and also the nodal officer of the ASHA programmes with out any support and ‘direction’.

District nodal officer raised concern of the working linkages with the district health society and the district programme management unit. According to him and supported by others from the health directorate highlighted that the linkage with NRHM district unit is still limited to the joint director office level and yet to be percolated to the nodal officer level. Operational dislinkages were reported in areas of communication, receipt of letters, directive from state and centre and getting timely financial resources and sharing of reports.

Recommendations:

- Intersectoral convergence should be well reflected in DHAP for various NRHM strategies. This can be achieved by organizing district planning workshops by DHS having the representations from various departments.
- Recruitment of dedicated school health teams, deployment, planning and training needs to be prioritised for School Health.
- Linkages of SHP with National disease control programme, disability for IEC, Manpower and resources may be initiated. State level meeting followed by district level meetings, updatation of convergence in regular monthly meetings could facilitate development of a comprehensive Health Programme which is symbiotic in nature as well.
- Follow up of children screened and referred to be established

TOR VIII: PROGRAMME MANAGEMENT

- In both the district, it was observed that programme management staff is in place at the district and block levels. As per state data there are around 1692 programme management personnel at state district and block levels:

Table 3.31: PMU staff position

PMUs	Staff in Position
SPMU	123
DPMU	396
BPMU	1173
Total	**1692**

- Although state has made arrangements for regular district visit by state nodal officers, there is no structured system of compiling reports and taking corrective actions. In this way these visits mostly limit to observation by the nodal officer without an actionable plan for improvement of services.
- District does not seem to have a plan in place for monitoring of the facilities and mostly ad-hoc visits are conducted. This reduces the district level action taking exercises which can actually address majority of the issues at district, block and facility levels.
- As highlighted in earlier sections facility level supervision by facility in-charge / doctors is not in place which s a major cause for various clinical/ managerial errors leading to poor quality service delivery. It has also been observed that in many of the cases facility in-charge / doctors are not aware of the right technique/ guidelines/ protocols which in-turn make them reluctant to carry out facility level supervision (such as in many facilities doctors are not aware of right technique of cold chain management system).
- HMIS data is only being entered but not analysed at any levels. It has also been observed that data reported by the state in HMIS does not always match with the data sent by to the GoI separately (this has been observed in terms of sterilisation data).
- There is no system of comparing physical and financial progress in the state; this limits the purpose of monitoring both physical and financial progress by the nodal officers of the respective programmes. This has been highlighted time and again in different reviews and visits; however, same has not been ensured by the state.
- MCTS data is being entered at different levels; however,
  - Not utilised by block / district officials for follow-up purposes.
  - UID-duplication was noted in some of the facilities. At some of places it was also observed that the UID noted in the registers were not in sequence and few of the numbers were missing in between.
- Coordination between NRHM and directorate seems to be a major issue. This has also been noted at the district level where there is a clear demarcation between regular and contractual staff. This is creating friction between staff and ultimately hampering service delivery.

- Planning process at district and block level is not participatory; mostly format based plans are prepared and real demand from the facilities not included:
  - Major expenses such as major repairs and equipments etc are booked on RKS/ untied fund, which ideally should be part of separate funding
  - At the block level, BPM is not involving CHCs & FRUs (which are above BPHC where the BP is placed) resulting that demand from these facilities are not included in the PIP.
  - There are various activities which are being proposed since past 4-5 years; however, there is no analysis of which of them have been implemented properly and which are not along with underlying reasons for the same.
- There is no accreditation of private facilities for provision of RCH services in the state; even in the information provided by the state, PPP has not been properly highlighted.
- State has been implementing PPP initiative with Tea Garden hospitals; however, there are several dissatisfaction regarding this initiative:
  - 7.5 lakhs per year paid annually however the commensurate return is not there because of non recruitment of doctors and non provision of delivery services
  - State informed that performance of these hospitals is being evaluated and numbers of MoUs have not been accepted in the current year; however, there is need for more rigorous evaluation of these hospitals and only those should be continued which are providing at least basic minimum services.
- RKS meetings are erratic and do not follow stipulated frequency. Except very few facilities, not more than 2-3 RKS meetings are conducted every year; this hampers the utilisation of RKS funds. It has also been noticed that major expenses have been booked on account of RKS and may result in non-availability of funds on emergency situations (such as construction of deep burial pits). These expenses can very easily be part of the regular PIP (DHAP).
- It seems Jorhat is the only district where elected representative are joint signatory in disbursement of RKS funds, this severely hampers the fund flow and utilisation of RKS money.

Recommendations:

- Planning process to move away from format based planning to participatory planning and also includes every level of facilities and their demand.
- State has designated nodal officers for each of the district; however, a system needs to be developed for compiling, analysing and taking action on the basis of findings of district visits.
- All the supervisory staff including JD. DHS, DPMU, BPMU, SDM&HO, facility in-charges etc should be oriented in all the protocols / guidelines/ schemes so that enable them to monitor the programme in right way.
- Use of HMIS data should be encouraged for planning and monitoring.
- PPP initiative other than Tea Garden hospitals should be explored in the districts with good number of private providers.
- RKS meetings and utilisation of funds to be streamlined and also disbursement/ utilisation of funds to follow GoI guidelines.

TOR IX: KNOWLEDGE MANAGEMENT INCLUDING TECHNICAL ASSISTANCE, SIHFWS, SHSRC, ANMTCS, DTCS AND USE OF INFORMATION TECHNOLOGY.

9.1 State Institute of Health and Family Welfare:

SIHFW is present at the State level providing the major training assistance. The SIHFW has a separate administrative unit and separate hostel for boys and girls with a capacity of 30 in each wing. SIHFW is involved in conducting and monitoring of trainings besides evaluation of trainings. The Institute had also established a MCH Cell in its building in collaboration with the UNICEF.

Table 3.32: Staff Position as on date under the control of Director of Health Services (FW), Assam

Sl. No	Name of The Post	Sanctioned	In position
1	Principal	1	1
2	PHNI	2	3
3	MLCD	1	Deputed elsewhere
4	Statistician	1	Deputed elsewhere
5	Social Science Instructor	1	-
6	Health Education Instructor	1	-
7	Health Education Ext. Officer	4	-
8	Head Assistant	1	Deputed elsewhere
9	UDA cum Accountant	2	2
10	LDA cum Accountant	1	1
11	LDA cum Typist	2	2
12	Artist cum draftsman	1	1
13	Computor	1	1
14	Projectionist	1	1
15	Steno-Typist	1	-
16	Driver	3	2
17	Grade IV	12	10 (2 Deputed elsewhere)
18	Sweeper	1	1

Source: State PIP 2012-13

Man Power on Contractual Basis from NRHM in position since 2007 under the administrative control of the Mission director, NRHM

Table 3.33: HR status SIHFW

Sl No	Name of The Post	Sanctioned	In position
1	Director	1	1
2	Epidemiologist	1	1
3	Consultant –Training	3	3

4	Consultant –Maternal Health	1	1
5	Management Expert	1	1
6	Demographer	1	1
7	Office Assistant	2	2
8	Block Accounts Manager	1	1
9	Regional Training Coordinator	5	5

Source: State PIP 2012-13

At Sonitpur ANMTC is newly constructed and is being utilized. Jorhat district has ANM/GNM training centre as well as RHP training institute. The ANM/GNM training centre has taken no batch of ANM since 2007 due to legal case. The fresh GNM batch is taken every 3 years and not on yearly basis. This training centre is in need of training aids and audio visual equipments.

Recommendations:

- Post training follow up needs to be integrated with monitoring visits to observe the adherence of facility staff with the protocols shared during training.
- GNM training center at Jorhat needs to be equipped with audiovisual and updated training aids for effective participatory training. Clear provision should be made to take up fresh batch of GNM students every year considering the demand and supply of the same.
- Program Managers should be advised to analyse and utilize the information collected in HMIS to make it a part of monitoring and planning process for this the HMIS data should be an integral part of information and planning in DHAP and subsequently state plan.

TOR X: FINANCIAL MANAGEMENT

DISTRICT FINDINGS – JORHAT

Areas of Concern	Action Recommended
• Delay in disbursement of Untied Funds, Annual Maintenance Grants and RKS Grants to CHC, BPHC, MPHC, at DHS and for SC and VHSC at BPHC level	There is an avoidable delay of 1-2 months in release of untied funds due to issue of Demand Drafts by DHS and BPHCs instead of e-transfers to final beneficiary unit. In 2011-12, releases made in January 2012. In 2012-13, the untied funds are not released so far.
• DHS is receiving funds on activity basis instead of flexipool basis or DHAP basis thus hampering funds allocation for all activities at DHS level (35 releases received in12-13)	SHS to consider adoption of flexipool approach for funds allocation within approved RoP for the DHAP and issue guidelines to all DHS for efficient funds allocation for all approved activities
• DHS is not preparing monthly FMR on the basis of approved budget vis a vis actual expenditure. Instead of approved budget, funds receipts are shown as budgets for each activity.	SHS to immediately communicate approved budget / RoP and supplementary RoP to all DHSs as soon as RoP is received from GoI. All DHS to carry out variance analysis of FMR and take necessary action in review meetings
• Adequate funds not made available for JSSK and EOPD to BPHC, MPHC, FRU by DHS and affecting implementation of these scheme	SHS/ DHS to make correct estimation of funds requirements and release sufficient funds for JSSK and EOPD and backlog to be avoided under these scheme
• Funds releases for RNTCP, NPCB and NCD are not made through DHS and FMR prepared without obtaining expenditure data from vertical programs	Funds releases to all vertical programs needs to be routed through SHS/ DHS and similarly a consolidated FMR needs to be prepared after collecting expenditure data from all vertical disease control programs
• Tally ERP software implemented upto BPHC level but not implemented at MPHC level. Accountants posted at MPHC/BPHC not imparted Tally ERP Training	Tally ERP software must be implemented upto MPHC, FRU, SD level and all Accountants should be fully trained in Tally ERP as well as Operational guidelines for Financial Management.
• Sub-centres and VHSC are not submitting monthly Statement of expenditure and Utilization Certificates thus impacting overall funds utilization level and showing high unspent balances	ANMs and ASHAs should be given one day orientation training in Untied Funds, annual maintenance and RKS funds utilization and BAMs to make monitoring visits for timely submission of pending SoEs and Utilization certificates by Sub-centres and VHSCs
• SoE & U/Cs submitted by PPP-TE are not being analysed at DHS level and releases made in 2012-13 despite high unspent balances without approval from SHS	Funds position and activities of PPP-TE need to be monitored closely for effective funds utilization and necessary action to be initiated against TE if diversion of funds is noticed
• Outstanding advances have registered	Age-wise analysis as per format available in Financial

sharp upturn (up by 31%) from 31-3-11 till 31-3-12 under RCH & MFP	management guidelines will help to reduce the pending advances and efforts to be made by DHS to settle pending advances

STATE FINDINGS:

- **Disbursement System:** Instead of flexipool system, a piecemeal approach has been adopted by SHS and several activity-wise funds releases processed at SHS consume lot of time and leads to unnecessary delays in funds release. The number of releases made need to be minimized. Due to delayed releases, activities viz. FP, CH, JSSK & Training have slowed down.
- **State Share:** To ensure quick release of 2nd tranche of funds from GoI, state need to ensure that no state share is kept outstanding and sanctioned state share of Rs. 144.00 crore is credited into bank account and audit report of 2011-12 is submitted at the earliest. Further, Utilization certificate for 2007-08 in respect of outstanding state share of Rs. 46.26 crore need to be submitted by the state to reduce shortfall.
- **Concurrent Audit:** As per revised guidelines, Audit Committees are required to be set up at state and district level to appoint and monitor auditing process. SHS has not submitted executive summary report of concurrent audits conducted during 2011-12.
- **State Finance Manager:** The post of SFM has been vacant and needs to be filled up on priority basis.
- SHS need to communicate GoI's approved RoPs to each DHS to enable DHS to prepare FMR correctly and SHS should carry out detailed analysis of the physical and financial performance reported by every District and initiate necessary action during review meetings
- State need to follow differential financing method to maximize the benefits of untied funds, AMG & RKS. State should release funds through direct credit into concerned bank accounts instead of issuing Demand Drafts.
- **RKS/ HMS:** Out of total 743 RKSs in the state, only 163 are registered under Society Act. State to expedite registration of RKS/ HMS urgently. The bank account of RKS to be jointly operated by MO Incharge & other MO nominated by MO Incharge.
- Internal Audit wing of the SHS need to be strengthened to ensure follow-up on audit comments.
- The compliance report to the Statutory Audit report review done by GoI is still pending which need to be expedited by State Health Society.
- **Procurement System** of the SHS needs complete makeover and Central Drug Store of SHS and District Drug stores need to be fully computerized so as to avoid stock outs and better inventory management.
- State need to prepare a manual of procurement and circulate the same to DHSs to streamline the process.
- As per the recommendations of 5th CRM and audit report of 2010-11, several lacune were noticed in the procurement system of the state which need to be replied to by the Procurement wing of SHS.

- Integration of NDCPs with SHS and DHS is yet to be achieved. SHS need to open Group Bank account having linked sub-accounts as advised by GoI. SHS to prepare a consolidated FMR incorporating physical and financial data obtained from vertical programs.
- Tally ERP software implemented upto BPHC level but not implemented at MPHC level. Accountants posted at MPHC/BPHC need Tally ERP and Financial Management Guidelines Training. SHS should prepare training calendars for 2012-13 & 2013-14
- Special attention to be paid for timely collection of Statement of expenditure and U/C from SC & VHSC

ANNEX-1

DISTRICT FINDINGS

JORHAT

Nimati Subcentre

- Date of Visit: 4th Nov'2012

Key Findings:

- Population served- 4550
- Number of Villages- 6
- Human Resource- 1 RHP, 2 ANM, 1 MPW and 1 Male Attendant
- Facility Timings- 8 AM-2PM
- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Normal Delivery, Post natal Care, Referral of high risk cases, Immunization, Management of childhood illness, Management of fever cases.
- Outreach sessions-
    - Immunization and MCH services: The work plan was divided area wise between the two ANMs, Monday and Tuesday were planned for house to house visits
    - NCD screening: was done by MPW 10 days a month, Screening is being done for all the persons above 30 years. The cases with high BP or blood sugar are being referred to the PHC (by referral slips) for subsequent examination by the Doctor. The target for screening is 1563 persons per year.
- Lab Tests- Hemoglobin Testing, Blood Sugar
- IEC material was well displayed in the facility.
- Labour room was separate and privacy was well ensured.
- Injectibles like Mag Sulf was present in the Labour room. As per the interaction with the staff it is not being given by the RHP or ANM.
- The weighing scale in the labour room was not calibrated and was not clean.
- The instruments were being sterilized in Boiler and the ANMs were well aware of the protocols
- BMW bins were present
- ASHA-ASHAs were well educated and well aware. Average monthly incentive for ASHA=Rs. 1500-2000, ASHA diary was well maintained, ASHA kits were present, The delivery register at SC matched with the ASHA register, ASHAs were trained ill first round of Module 6 and 7, ASHAs find it difficult to stay at PHC when they take the cases for delivery.

Dhekorgorah PHC

- Date of Visit: 4th Nov'2012

Key Findings:

- Population served- 41632
- Human Resource- 1 MO, 2 SN, 2 ANM
- Delivery-1-2/month

- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Normal Delivery, Post natal Care, Referral of high risk cases, Immunization, RTI/STI, IUCD insertion, Management of fever cases
- Lab Tests- Hemoglobin Testing, Blood Sugar, Blood grouping, Urine examination, Malaria testing, Sputum collection centre
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was absent, Supply demand mismatch was well evident. Sometimes extra drugs like metoclopromide and mannitol are sent by state, which remain unutilized.
- Disease Control- The facility has reported no cases of malaria positive since five years.
- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was not present.
- BMW waste disposable bins were present.
- The facility has staff nurse quarter and conducting night deliveries as well.
- The deliveries requiring blood transfusion or the complicated cases are being referred to medical college, which is at a distance of 2-3 km from the facility.
- The PHC did not had any arrangement for the stay of ASHA.
- There was no provision of diet for the beneficiaries under JSSK, the reason cited was that they find it difficult to arrange for food from outside.
- ASHA-ASHAs were well educated (10^{th}-12^{th} pass) and well aware. Average monthly incentive for ASHA=Rs. 2000-3000, ASHA diary was well maintained, ASHA kits were present, VHSC meeting minutes was well maintained and the key issues of discussion revolved around maternal and child health care, ASHAs were trained ill first round of Module 6 and 7. ASHA meeting is held every Saturday in the PHC. ASHA facilitators were trained for three days and the training was residential.

Gharbolia Subcentre

- Date of Visit: 4^{th} Nov'2012

Key Findings:

- Population served- 15500
- Number of Villages- 10 and Tea garden area
- Human Resource- 2 ANM, 1 MPW, 1 ASHA Supervisor and 1 Female Attendant
- Facility Timings- 8 AM-2PM
- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Post natal Care, Referral of high risk cases, Immunization, Management of childhood illness, Management of fever cases
- Outreach sessions- Immunization and MCH services: The work plan was divided area wise: 1ANM is assigned to tea garden area and other serves 10 villages. The ANM was overburdened and the work plan seems inadequate. The immunization sessions conducted are less than the required sessions in that area.
- Lab Tests- Hemoglobin Testing, Blood Sugar
- The IEC material was well displayed in the facility.

- The facility records were complete and MCTS ID was mentioned in a sequential manner in the registers.

Mokhuti Subcentre

- Date of Visit: 5th Nov'2012

Key Findings:

- Population served- 4026
- Human Resource- 2 ANM, 1 MPW and 1 female attendant
- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Post natal Care, Referral of high risk cases, Immunization, Management of Childhood Illness, Management of fever cases
- Outreach sessions-
    - Immunization and MCH services: The workplan was divided area wise between the two ANMs, Immunization day in facility is on every Wednesday.
- Lab Tests- Blood Sugar. Hemoglobin test was not being done although the facility had hemoglobinometer but the ANM was not using it. Presently ANM was writing advice in each of the cases requiring Hb testing and the same were being referred to the nearby PHC after which follow up is taken and the readings are then written on the SC register. In practical sense it was observed that in the ANC register Hb reading for few ANC cases were missing and these were also not being followed up.
- Few expired IUCDs were found in the facility.
- Untied fund balance= Rs. 7000, large amount was being spent on Xerox.
- Immunization- Records were complete, beneficiary list was present, a separate drop out list was also present, Date of opening of Vitamin A bottle was not mentioned.
- IEC material was well displayed, It was observed that in one of the drawings in the facility IUCD 380, figure was not drawn correctly and needs modification.
- ASHA-ASHAs were well educated (10th and 12th) and well aware. Average monthly incentive for ASHA=Rs. 800-1000, ASHA diary was well maintained, ASHA kits were present, ASHAs were trained ill first round of Module 6 and 7 but were not being given the modules after the training, ASHAs were distributing condoms but said that they did not had any formal training for the same.

Garmur SDCH

- Date of Visit: 5th Nov'2012

Key Findings:

- Population served- Whole Majuli (approx 2 lakh) and Lakhimpur border
- 100 bedded hospital, presently 50 beds were functional
- Human Resource- 1 Gynecologist, 1 Radiologist, 1 Anesthetist, 3 MO, 1 Dentist, 1 AYUSH, 1 Pharmacist, 2 LT, 10 GNM, 1 ANM
- OPD= 300-400 per day
- Delivery= 140-150/month
- C-section=10-15/month (elective C-section)

- 1 Blood Storage Unit: At the time of visit the blood storage unit had positive blood groups stored, the temperature graph was not working. The facility staff said that the power back up is through generator however if there is a power cut in the night then there is no designated staff in the facility to look for the power back up of BSU. The facility is receiving blood from Medical College Jorhat and the hospital also conducts transfusion camps in the facility itself.
- 1 Ambulance
- 2 EMRI vehicle
- NBSU infrastructure present but not operational yet.
- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Delivery-Normal and C-section, Post natal Care, Referral of high risk cases, Immunization , Management of fever cases, RTI/STI, IUCD insertion, Minor Surgeries
- Lab Tests- Hemoglobin Testing, Blood Sugar, Blood grouping, Urine examination, Malaria testing, Sputum testing, HIV testing
- Pharmacy- Stock registers were not updated, No expiry register was maintained, Bin card system was absent and Supply demand mismatch was well evident.
- Catgut, Drip set, Cannula, Disposable Needles, Emergency drugs- Adrenaline- was not present
- The patients were being prescribed drugs from outside, an incidence was seen were the generic salt of the drug was present still the drug was being prescribed from outside.
- EDL was not present
- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was there but not being used, limited usage in the laboratory as well.
- Labour room and OT was in general clean and well equipped.
- The cases are being referred to Jorhat Medical College by boat, there is no specific referral mechanism and the sometimes the patient has incur a high out of pocket expenditure due to this.
- Patients were being provided diet two times a day, no dietary plan was present.
- As per the beneficiary interview the awareness about the JSSK was nil.
- IEC display was satisfactory
- Return vial of polio was found.
- Maternal Deaths- Facility level verbal autopsy were being conducted as per the protocols. As per the providers the community level deaths are also being covered and filled by BPM or ANM. No community level autopsy was found in the facility.

Phuloni Subcentre

- Date of Visit: 5th Nov'2012

Key Findings:

- Population served- 6138
- Human Resource- 1 RHP, 2 ANM, 1 MPW and 1 female attendant

- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Normal Delivery, Post natal Care, Referral of high risk cases, Immunization, Management of childhood illness, , Management of fever cases, IUCD removal
- From Jan till now= 29 deliveries
- OPD load= 12-13 per day
- OPD timings: 8:30 AM -2:30 PM
- No fixed ANC day
- There was no light connection in the Subcenter
- RHP was well aware of the treatment protocols.
- Outreach sessions-
    - Immunization and MCH services: The workplan was divided area wise between the two ANMs, Immunization day in facility is on every Wednesday.
    - NCD screening is not done, glucose testing strips were out of stock.
- Lab Tests- Blood Sugar, Hemoglobin test. The facility had both Haemoglobinometer as well as Haemoglobin estimation strips. The strips are utilized when the case load is high.
- Injectibles like Amikacin and Tramadole were present in the facility
- Records were complete. The facility had a well maintained drug stock register with the expiry dates mentioned and the near expiry drugs were separated out regularly for the distribution.
- There was a separate labour room ensuring privacy.
- BMW bins were present.
- Immunization- Records were complete, beneficiary list was present, a separate drop out list was also present, Date of opening of Vitamin A bottle was not mentioned.
- ASHA-ASHAs were well educated (8^{th} and 10^{th}) and well aware. Average monthly incentive for ASHA=Rs. 800-1000, Every ASHA had cycle, ASHA diary was well maintained, ASHA kits were present, ASHAs were trained in first round of Module 6 and 7

Rangachahi State Dispensary:

- Date of Visit: 5^{th} Nov'2012

Key Findings:

- Human Resource- 1-MO, 2-GNM, 1-ANM
- OPD= 30-40 per day
- Delivery= 25-30/month
- Facilities Available- Antenatal Care, Delivery-Normal, Post natal Care, Referral of high risk cases, Immunization, Management of childhood illness, Management of fever cases.
- Lab Tests- Hemoglobin Testing, Blood Sugar, Blood grouping, Urine examination, Malaria testing, Sputum collection. Microscope was not present.
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was absent and Supply demand mismatch was well evident.
- EDL was not present

- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was not present.
- Labour room was in general clean
- No dietary provision for the patients.
- NBSU infrastructure was present but was not operational.
- Return vial of polio was seen.

Kamlabari CHC

- Date of Visit: 5th Nov'2012

Key Findings:

- Human Resource- 2-MO, 5-GNM, 2-ANM
- OPD= 100 per day
- Delivery= 30/month
- Facilities Available- Antenatal Care, Delivery-Normal, Post natal Care, Referral of high risk cases, Immunization, RTI/STI, IUCD insertion
- Lab Tests- Hemoglobin Testing, Blood Sugar, Blood grouping, Urine examination, Malaria testing, Sputum testing
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was absent and Supply demand mismatch was well evident.
- Catgut, Drip set, Cannula, Disposable Needles
- Emergency drugs was present
- EDL was present
- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was there but not being used, limited usage in the laboratory as well.
- Labour room was in general clean and well equipped
- Patients were being provided diet three times a day, no dietary plan was present.
- Patients are referred to Garmur SDCH and for referral they are utilizing rented or their own vehicle.
- Maternal Deaths- Facility level verbal autopsy were being conducted as per the protocols. As per the providers the community level deaths are also being covered and filled by BPM or ANM. No community level autopsy was found in the facility.

Kakojan Block PHC

- Date of Visit: 6th Nov'2012

Key Findings:

- Population Catered- 139000
- Human Resource- 4-MO, 5-GNM, 4-SN, 2 LT, 3 Pharmacist, 1 Ophthalmic Assistant, 4-ANM
- OPD= 40-50 per day
- Delivery= 5/month
- Beds=3
- Sub centers under PHC=19

- Facilities Available- Antenatal Care, Delivery-Normal, Post natal Care, Referral of high risk cases, Immunization, Management of childhood illness, Management of fever cases, RTI/STI, IUCD insertion
- NBSU infrastructure present but was not operational
- Lab Tests- Routine blood, No TLC, Blood Sugar, Blood grouping, Urine examination, Malaria testing, Sputum testing
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was absent and Supply demand mismatch was well evident.
- Ceftriaxone was stocked in
- Calcium, Diclofenac injection and disposable syringes were stocked out since three months.
- EDL was not present
- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was unavailable
- Labour room was in general clean and well equipped, Partograph preparation was there, and Emergency drugs were available.
- Newborn corner was present and as per protocols. The staff nurse however did not know about the temperature setting for the warmer.
- Patients were not being provided diet.
- ARSH clinic was present initially but now since 2-3 years it was closed

Komar Khatuwal Subcentre

- Date of Visit: 6th Nov'2012

Key Findings:

- Population served- 4640
- Human Resource- 2 ANM (1 on maternity leave), 1 MPW and 1 female attendant, 6 ASHA and 1 ASHA facilitator.
- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Post natal Care, Referral of high risk cases, Immunization
- Facility had expired stock of IFA, and the same was stock out in PHC.
- Expired Vitamin A was also present.
- Outreach sessions-
    - Immunization and MCH services: Immunization day in facility is on every Wednesday.
    - NCD screening is not done, glucose testing strips were out of stock.
- Lab Tests- Blood Sugar, Hemoglobin test
- Records were complete but the few of the MCTS ID were missing in the MCH register.

Rajabari Subcentre

- Date of Visit: 6th Nov'2012

Key Findings:

- Population served- 4525
- Human Resource- 2 ANM, 1 MPW and 1 female attendant, 6 ASHA and 1 ASHA facilitator.

- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Post natal Care, Referral of high risk cases, Immunization
- Outreach sessions-
    - Immunization and MCH services: Immunization day in facility is on every Wednesday.
    - NCD screening is not done, glucose testing strips were expired.
- Lab Tests- Blood Sugar, Hemoglobin test
- Records- There was a mismatch between the beneficiary list of immunization session and the Immunization register, the drop out cases were not being traced. Similar mismatch was also present in other vaccines also resulting in drop out of cases
- ASHA-ASHAs were well educated (10th and 12th) and well aware. Average monthly incentive for ASHA=Rs. 1000- 1500, ASHA diary was well maintained, ASHA kits were present, ASHAs were trained in first round of Module 6 and 7 in an in house training

Teok FRU

- Date of Visit: 6th Nov'2012

Key Findings:

- Human Resource- 1-Gynec, 1-Paed., 1-Anesthetist, 2-Other Spe. 18-GNM, 3-ANM
- OPD= 60-70 per day
- Delivery= 150-200/month
- C-section= 30-50/month (elective)
- 1 Ambulance (2 drivers)
- BSU is present but not functional and in need of repair since two years.
- Facilities Available- Antenatal Care, Delivery-Normal and C-section, Post natal Care, Referral of high risk cases, Immunization, RTI/STI, IUCD insertion
- Lab Tests- Hemoglobin Testing, Blood Sugar, Blood grouping, Urine examination, Malaria testing, Sputum testing
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was absent and Supply demand mismatch was well evident.
- Catgut, Drip set, Cannula, Disposable Needles, Calcium - was stock out
- EDL was not present
- Copies of last indent made were not present as the facility is not keeping the Xerox or OC of the same.
- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was there but not being used, limited usage in the laboratory as well.
- Labour room was in general clean and well equipped
- Patients were being provided diet two times a day, no dietary plan was present.

Nakachari PHC

- Date of Visit: 6th Nov'2012

Key Findings:

- Population Catered- 103754
- Human Resource- 2-MO, 4-GNM, 5-ANM
- OPD= 60-70 per day
- Delivery= 30/month
- Beds=6
- 1 Ambulance (2 drivers)
- Facilities Available- Antenatal Care, Delivery-Normal, Post natal Care, Referral of high risk cases, Immunization, RTI/STI, IUCD insertion
- NBSU infrastructure present but was not operational
- Lab Tests- Hemoglobin Testing, Blood Sugar, Blood grouping, Urine examination. Microscope was not working, Gloves and hypochlorite solution was not being used
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was present and Supply demand mismatch was well evident.
- Drugs like calcium, Diclofenac inj and disposable syringes were stocked out from state supply but the facility has stored health mela stock for its use in daily OPD.
- EDL was not present
- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was there but not being used
- Labour room was in general clean and well equipped

Moriani MPHC

- Date of Visit: 6th Nov'2012

Key Findings:

- Population Catered-
- Human Resource- 3-MO, 2-GNM, 4 ANM. A gynaecologist has been posted in the Mini PHC
- OPD= 50 per day
- Delivery= 35-40/month
- Beds=Officially no bed but 6 beds are maintained
- 1 Ambulance (2 drivers)
- Facilities Available- Antenatal Care, Delivery-Normal, Post natal Care, Referral of high risk cases, Immunization, RTI/STI, IUCD insertion
- NBSU infrastructure present but was not operational, 3 beds
- Lab Tests- Hemoglobin Testing, Blood Sugar, Blood grouping, Urine examination, Malaria, Sputum Collection. Shortage of supply of slides and the same are being reused after washing with water, Bleaching powder/ hypochlorite solution is present but not being used.
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was present and Supply demand mismatch was well evident.
- Drugs like calcium, Diclofenac injection, emergency drugs (adrenaline, atropine), Mag Sulf and disposable syringes were stocked out
- EDL was not present
- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was there but not being used

- Labour room was in general clean and well equipped
- The facility has reported 9 PF and 7 JE cases this year.
- The TB slides are sent to Bagrun PHC for testing

Jorhat Medical College (Visit to SNCU and Labour room)

- Date of Visit: 6th Nov'2012

Key Findings:

- The Medical College was earlier a district hospital and has been converted to a medical college. However the infrastructure has not been upgraded to the level of medical college.
- Human Resource- Labour Room:8 Gynaecologists, SNCU: 2 Paediatricians
- Delivery= 250/month
- Labour Room: was in general clean and equipped. No emergency tray or drugs were present in the labour room. The staff nurse has not underwent SBA training. C-section rate is almost 46%, with a substantial number of night deliveries. The facility is not conducting any deliveries between 3-7 PM, despite having 8 gynaecologists. Partographs are not prepared. The facility staff is not taking a foot stamps in the case sheets and were also not aware of the fact that it needs to be done.
- The wards were overcrowded and few of the beds were in hospital lobby. On enquiring it was found that the beds to these patients were being rented by a private vendor at the rate of Rs. 250 per bed.
- SNCU: The SNCU although situated in the medical college but comes under the control of DC. There were 6 beds for outborns and 8 beds for inborn. The SNCU was well equipped and clean. The treatment charts were as per the protocols. On an average the admission rate for SNCU is 50 per month and there was equal distribution of male and female cases. The most common cause for admission in the inborns was low birth weight and asphyxia and in outborns it was low birth weight and sepsis.

District Training Centre ANM/GNM

- Date of Visit: 6th Nov'2012

Key Findings:

- The training center is currently not taking ANM batch as there is a court case of the same.
- The GNM batch is taken every three years rather than every year. The reason cited was that the training institute does not have adequate logistics for the same.
- Faculty- GNM=1, ANM=5
- Total students=46 (all are residential)
- After 3 years the students are placed in Medical College for the practical training.
- The institute is in the requirement of training aids and other logistics
- For IUCD training the institute has Joey model and equipments.

Titabor CHC

- Date of Visit: 7th Nov'2012

Key Findings:

- Population Catered-
- Human Resource- 2-Gynec, 2-Anaesth., 1-Surgeon, 13-other Doctors, 8-GNM, 7-ANM, 2-L
- OPD= 150-200 per day
- Delivery= 130-150/month
- Beds=34
- 3 Ambulance (2 drivers)
- 1 BSU- Temperature chart was maintained, had all the positive blood groups, no provision for annual maintenance
- Facilities Available- Antenatal Care, Delivery-Normal, Post natal Care, Referral of high risk cases, Immunization, RTI/STI, IUCD insertion
- NBSU infrastructure present but was not operational
- Lab Tests- Routine test, Hemoglobin Testing, Blood Sugar, Blood grouping, Urine examination, Malaria, Sputum examination, Nischay kits are supplied during camps.
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was present and Supply demand mismatch was well evident.
- Drugs like Diclofenac injection, saline and disposable syringes were stocked out from state supply
- The extra supply received in distributed to the MiniPHC.
- EDL was not present
- Infection Prevention- BMW bins were present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was being used but not as per the protocols.
- Labour room was in general clean and well equipped
- 2 PF and 2 PV cases has been detected till now. PF rate has shown a rise, in 2010 it was 82% and rose to 95% in 2011.
- Two collection centers of TB come under the facility.

Dholi Subcentre

- Date of Visit: 7th Nov'2012

Key Findings:

- Population served- 2372
- Human Resource- 2 ANM, 1 MPW and 1 female attendant, 3ASHA.
- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Post natal Care, Referral of high risk cases, Immunization
- Outreach sessions-
    - Immunization and MCH services: Immunization day in facility is on every Wednesday.
    - NCD screening is not done, glucose testing strips were out of stock.
- Lab Tests- Blood Sugar, Hemoglobin test
- Records were complete. Record keeping was very good and each register was well updated.

Na-Ali-Dhekiajuli Subcentre

- Date of Visit: 7th Nov'2012

Key Findings:

- Population served- 4836
- Human Resource- 2 ANM, 1 MPW and 1 female attendant
- Training undertaken by staff- Routine Immunization, IMNCI, NSSK, SBA and Copper T
- Facilities Available- Antenatal Care, Post natal Care, Referral of high risk cases, Immunization, Management of childhood illness, Management of fever
- Outreach sessions-
    - Immunization and MCH services: Immunization day in facility is on every Wednesday.
    - NCD screening is not done, glucose testing strips were out of stock.
- Lab Tests- Blood Sugar, Hemoglobin test
- Records were complete
- Beneficiary list and drop out list was present.

Baghshung Block PHC

- Date of Visit: 7th Nov'2012

Key Findings:

- Population Catered-
- Human Resource- 1-Paed, 2-SMO, 1-ENT, 1-Ayurveda, 2-GNM, 4-ANM
- OPD= 50-60 per day
- Delivery= 3-4/month
- Beds=6
- 1 Ambulance (1 driver)
- Facilities Available- Antenatal Care, Delivery-Normal, Post natal Care, Referral of high risk cases, Immunization, Management of childhood illness, Management of fever cases, RTI/STI, IUCD insertion
- NBSU infrastructure present but was not operational
- Lab Tests- Routine blood, No TLC, Blood Sugar, Blood grouping, Urine examination, Malaria testing, Sputum collection
- Pharmacy- Stock registers were maintained, No expiry register was maintained, Bin card system was absent and Supply demand mismatch was well evident.
- Diclofenac injection, Calcium and Emergency drugs not present.
- EDL was present and displayed in the facility.
- No local purchase is done.
- Infection Prevention- BMW bins was present and being used, functional needle cutters present, hypochlorite/ bleaching powder supply was unavailable.
- As per the facility staff the sterilization was being done by the autoclave but the autoclave log book was not maintained since last four months
- Labour room was in general clean and well equipped, Partograph is maintained.
- Newborn corner was present and as per protocols. The staff nurse however did not know about the temperature setting for the warmer.

- Patients were not being provided diet.
- ARSH clinic was present initially but now since 2-3 years it was closed.
- The PHC has four sectors under it for TB testing, the slide quality testing is done monthly
- No malaria positive cases has been reported this year
- The laboratory reporting is worth mentioning, records were well maintained and the facility is keeping a separate record of severely anaemic females.

SONITPUR

District Hospital (Kanaklata Civil Hospital)

- Issues of overcrowding in maternity ward and quality of care issues.
- C section related issues: number vs. quality
- Proposed MCH center location – as per guidelines….
- Infection prevention practices and waste management is sub optimal.
- Cleanliness – though outsourced and having a big contingency of cleanliness staff – the cleanliness of the hospital is not appropriate.
- Roles and Responsibilities of HR
- ILR Replacement
- Immunization Clinic management is not proper.
- High maternal mortality in the institution.

DPMU

- Follow up on the monitoring and field visit reports of the SPMU by the DPMU.
- Participation and supportive supervision in VHSND needs to be strengthened.

SDH (Biswanath Chairali)

- None of them are functional as FRU and 24 X 7.
- Quality of Care
- Infection Prevention Issues
- Hospital Waste Management
- Roles, Responsibilities and Reporting Relationships of HR

MPHC (Haleswar)

- Payment of Mamoni and JSY is being made at the Sinabheel tea estate hospital, which is the private hospital (not accreditated) and not as per the guidelines.

RHP SC (Borjarani Subcenter)

- Quality of Care
- Infection Prevention Issues
- Training
- PP follow up.
- User charges at RHP sub center