6th Common Review Mission
WEST BENGAL

2nd – 9th November 2012

Ministry of Health and Family Welfare

Government of India

CONTENTS

LIST OF ABBREVIATIONS

SDH	Sub-Divisional Hospital
ANM	Auxiliary Nurse Midwife
BPHC	Block Primary Health Centre
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homeopathy
GP	Gram Panchayat
HQ	Head Quarters
CES	Coverage Evaluation Survey
GNM	General Nurse Midwife
CHC	Community Health Center
BMW	Biomedical Waste Management
CRM	Common Review Mission
DH	District Hospital
DHS	District Health Society
DLHS-3	District Level Household Survey-3
DMHO	District Medical and Health Officer
DOTS	Directly Observed Treatment, Short course
DPMU	District Programme Management Unit
PM/ WM	Pashchim Medinipur / West Medinipur
RKS	Rogi Kalyan Samiti
HMIS	Health Management Information System
HR	Human Resources
IEC	Information Education and Communication
IMEP	Infection Management and Environment Protection
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
MCTS	Mother and Child tracking System
MD	Mission Director
MIS	Management Information System

MMR	Maternal Mortality Ratio
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare, India
HA	Health Assistant
MPW	Multi-Purpose Worker (male)
NSV	Non Scalpel Vasectomy
NVBDCP	National Vector Borne Diseases Control Programme
PC&PNDT	Pre-Conception & Pre-natal Diagnostic Techniques
PHC	Primary Health Center
PMU	Programme Management Unit
RHS	Rural Health Statistics
RNTCP	Revised National Tuberculosis Control Programme
SC	Sub-Center
PHN	Public Health Nurse
SPMU	State Programme Management Unit
SRS	Sample Registration System
TFR	Total Fertility Rate
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee

EXECUTIVE SUMMARY

A Common Review Mission led by Dr. Dinesh Baswal, Deputy Commissioner (Maternal Health) Ministry of Health and Family Welfare, Government of India and development partners visited West Bengal during November 3-9, 2012 to review the implementation of NRHM. The Mission visited two districts, Murshidabad and Paschim Medinipur. Key findings of the CRM are summarized below:

Positives:

- ✓ **Infrastructure:** Good footfall in all the public health facilities. The daily average OPD load in PHCs is 100 and it is about 200 -250 per day in BPHCs and RHs. Diet was being provided to all the in-patients in public health facilities.
- ✓ **Service Delivery:** Fair Price Outlets for Medicines, Implants and Consumables are set up in 35 medical institutions of the state (including Medical Colleges, District Hospitals and Sub-Divisional Hospitals)
- ✓ **Outreach and service delivery:** MMUS are functional in LWE affected districts and MMUs were seen operational in Pashchim Medinipur. Alternate vaccine delivery to deliver vaccines to the site of VHND employed.
- ✓ **Community Health Workers:** There is a large number of Health Workers in the community. The ASHAs are also highly educated. In order to continue capacity building of ASHAs, the State has initiated two initiatives - Receive Only Terminal (ROT) and ASHA Talk Show.
- ✓ **Referral Transport:** Nischay Yans and vouchers for assured transport of mothers and neonates are being used.
- ✓ **Maternal Health:** Protocols for identification of high risk cases were displayed in sub-centres in PM and were being followed in sub-centres in the Murshidabad.JSY payment was being done to all the women timely.
- ✓ **Child Health:** In 2005, there were no SNCUs/ NBSUs / NBCCs in the State. As on 2011-12 the state has established 545 NBCCs , 125 NBSUs and 22 SNCUs and the state targets to raise these facilities to 640 NBCCs , 305 NBSUs and 49 SNCUs by the end of FY 2012-13. SNCUs were very well functional in both the districts. NBCC were present at all the facilities in Pashchim Medinipur
- ✓ Thalessemia Unit present in both the units
- ✓ **Human Resources:** Nurse Practitioners and Additional MOs are posted to address the shortage of doctors in the State
- ✓ NGO involvement has been seen. Eg: Ambulances, MMUs, ASHA training, help desks in various facilities.
- ✓ **Disease Control Programmes:** Testing for malaria, kala azar, sputum for AFB were being done in all the facilities. Micrfilaria rate of 0 has been reported from both the districts. Kala azar fortnight is being observed in the State since 2011. Two rounds of active search for KA cases over a fortnight have been conducted in all the 11 endemic districts in 2011. The intensive drive has resulted in capturing many more cases.
- ✓ Review meeting: Every second Saturday of the month, MoS (H7FW) reviews the programmes with all the CMOHs

West Medinipur:

- ✓ MTP services were being provided in 6 facilities including medical college.

- ✓ Staff position & Fund position – adequate, Fund flow – timely
- ✓ Special drives/ camps are being organised to improve delivery outcomes in PM
- ✓ Audit – timely, completed for FY (11-12), ATR submitted as per observation
- ✓ No UC pending at block and district

Murshidabad:

- ✓ Good utilization of public health facilities for institutional deliveries
- ✓ There has been 30%-35% in increase in number of JSY beneficiaries from 2009-10 to 2012-13 in Murshidabad district.
- ✓ Outreach activities in island in the Padma River due to soil erosion is appreciable.
- ✓ FMR – monthly submitted (district and sub-district)
- ✓ Payments of staff / Agencies by A/c Payee cheques
- ✓ BRS: Monthly Bank Reconciliation done.

Issues:

- ✘ **Infrastructure:** Huge shortfall of Health Infrastructure at state level as well as in both the districts. Only one CHC, two PHCs and 1267 SCs have been sanctioned for new constructions till 2011-12 in the state. Further, in 2012-13, only one more PHC is sanctioned. The state has failed to use the opportunity to develop health infrastructure under NRHM. Facilities are unhygienic especially higher facilities (bad toilets, rodents, cats, dogs and even goats in the hospital premises). Provision of staff quarter is inadequate for MOs and GNMs in all the facilities visited and need repair.
- ✘ **Service delivery:** No special efforts to reach marginalized, except through the VHNDs in Jurshidabad
- ✘ **Community Processes:** VHSNC has been formed at Panchayat level but it is not quite functional. RKS have been formed at all the facilities. However, they are not registered as a society under the Societies Registration Act as per the national guidelines. RKSs have huge unspent balances.
- ✘ **Accountability:** Citizen's charter, RKS composition, were not displayed anywhere in the facilities. There is no system for systematically recording and addressing grievances.
- ✘ **Affordability:** User charges are being levied at Sub-divisional Hospitals and District Hospitals. However, they were not prominently displayed. Prescription for drugs and diagnostics from the private sector was a common practice resulting into High Out of Pocket Expenditure on account of high expenditure on drugs and diagnostics.
- ✘ **RCH:** Increase in the Maternal Mortality Ratio in the State from 141/100000 live births as per SRS 2004-06 to 145 /100000 live births as per SRS 2007-09. Early marriages is an issue in the state leading to preterm deliveries and LBW. Infants.
- ✘ **Delivery points:** 3.8% of the public health facilities were functional as delivery points in the State. Out of 10356 SCs only 11 are conducting more than 3 deliveries per month. Among 272 PHCs which are 24x7, 54 are conducting more than 10 deliveries in the State. Among 102 FRUs (CHCs and other FRUs, includes DH), only 96 are conducting C-Sections and are functional FRUs. Murshidabad has only 4 % delivery points leading to overcrowding in the facilities. The stay for 3 days and 7 days for normal and C- Section is not possible.
- ✘ Diazepam inj was being given to 10-15 delivering women in DH Murshidabad.
- ✘ Blood Banks were functional in the visited facilities but needed strengthening.
- ✘ Capacity building initiatives are limited and need to be scaled up in the State especially for SBA, BEmOC, NSSK, F-IMNCI.

- Number of nishchay yans is insufficient to cater to the total load for assured transport. Availability at night was an issue.
- **Arsenic:** 4 districts namely, districts Murshidabad, Nadia, Malda and South 24 Parganas have high arsenic content in their ground water level. In Murshidabad,10 blocks have high arsenic in the water and was unsafe to use.
- **Anwesha Scheme:** 135 MoUs have been signed so far in the state to provide institutional deliveries under Ayushmati scheme but only 71 of these are functional delivery points. In Murshidabad out of 21 MoUs signed in the district only7 facilities were conducting deliveries more than 100 per month.
- **Family Planning:** In Murshidabad, in 2009-10, in some of the areas like Beldanga I, B'gola I, Jalangi there was very good acceptance of NSV. However there was serious deterioration in 2010-11 .
- **Thalessemia:** In Murshidabad, out of the 198 children tested, 141 found to be normal and 38 to be carriers and 7 found diseased. Ie., 3.5% of children were diseased out of 198 children tested
- **Disease Control Programmes:** Reporting for IDSP is not adequate and complete in both the districts. ABER is much below the receommended level throughout the State. Kala-azar is endemic in 11 districts of West Bengal. Malda, Murshidabad, Dakshin Dinajpur, Uttar Dinajpur and Darjeeling districts have a higher caseload. The annualised new smear positive case detection rate in both the districts is below the desirable level.
- The achievement for cataract surgeries is much below the targets set in both the districts as well as in the State

Recommendations:

Infrastructure:

- The state needs to establish more health facilities. The higher facilities need to be decongested. Delivery points should be increased.
- Key strategic areas and facilities than need focused and prioritized attention.
- Maintenance of facilities needs to be improved and RKS funds need to be utilized for the same.

Service delivery:

- Patient services need to be improved. Availability of mattress, curtains, screens, mackintosh etc. to be ensured as well as the facilities need to be made disabled friendly along with provision of stretcher, wheel chair, trolley as well as easy access (ramp).
- User fees needs to be abolished.
- Prescription for drugs and diagnostics from private sector needs to be stopped.
- Private practice by doctors needs to be checked.
- 24x7 lab services must be made available at least at the DH, SDH and RHs.
- The crude paper method for estimating hemoglobin needs to be replaced with Sahli's method.
- Blood Banks also need to be strengthened.
- National guidelines for management of BMW need to be followed in all facilities.

Human Resources

- Incentives to be provided to those working in LWE affected areas.

- Coordination of link workers, community health guides, ASHAs, ANMs and anganwadi workers.

Training & Capacity Development

- The nursing staff of the low performing District / Facilities should be trained on a priority basis in SBA and NSSK and IUD.
- All MOs of low performing facilities should be trained BMOC

Reproductive and Child Health

- All ANCs must be screened for RTI/ STI and HIV in the four blocks with high migration in Murshidabad district (Suti I, Suti II, Raghunath ganj II, Farakka)
- Protocols to be followed by health personnel at various levels especially at the sub centre level and VHND with regard to ANC
- Anivesha clinic should have linkages with the OPD
- The State needs to take specific actions to initiate systematic Infant Death Reviews.
- The district needs to ensure that all the NBSUs and NBCCs are made functional and refer only the critical cases to the SNCUs.

Community Processes:

- All the community processes in the State needs to be strengthened.
- Involvement of the PRIs need to be ensures. Accountability measures like displaying of citizen's charter and community monitoring needs to be initiated in the State.
- Simultaneously, a grievance redressal system needs to be set-up in the State

Monitoring and Supervision

- Monitoring and supervision of districts and facilities need to be strengthened.
- Visitors book to be maintained and checked at each facility.
- Evaluation of facilities to be done by staff (team) from other facilities (cross evaluation) so that there is self monitoring and learning through a checklist. Report to be submitted to the facility and the CMO.
- Visiting facilities by the CMO and senior officials as an open day wherein the patients, staff and others can bring up issues to be addressed on a quarterly basis.

Dissemination of information

- Services and facilities available in the facility to be displayed
- Duty roster of doctors alongwith timings to be displayed
- Proper signages to be displayed at the facilities and numbering of rooms.
- Citizen charter to be displayed
- SBA protocols to be displayed in all labour rooms
- Protocols to treat Asphyxia cases to be treated and followed
- Website of district health department providing information for dissemination and monitoring.

Drugs and Medical Equipment

- Strengthening of warehouse for storage of drugs at the district level.
- Regular supply of EDL should be ensured

- Regular monthly meetings with other concerned departments with special reference to PWD and PHE and sharing of water testing reports on a monthly basis.

The District Hospital at Murshidabad was visited once again after 2 days of initial visit. The CRM team had a meeting with the Medical Superintendent of the District Hospital, Murshidabad and specific suggestions for improving District Hospital/New General Hospital – Murshidabad were arrived at by the team after discussions with the Medical Superintendent, District Medical and Health Officer and State Officers. These are also placed in the report.

INTRODUCTION

A Common Review Mission led by Dr. Dinesh Baswal, Deputy Commissioner (Maternal Health) Ministry of Health and Family Welfare, Government of India and development partners visited West Bengal during November 3-9, 2012 to review the implementation of NRHM. The team was also joined by senior officers from the Department of Health & Family Welfare, Planning Commission, National Institute of Health & Family Welfare, National Health Systems Resource Centre, Independent Consultants and Public Health Foundation of India. Details of mission members are in Annex-1.

The main objective of 6thCRM was to undertake spot appraisal of the health system, reflect on success of strategies and policies, document the evidence in support/against the policy and identify course correction (if required). The team did an in-depth desk review of the documents and data available including the State PIP, Record of Proceedings of NPCC, HMIS data and variance analysis report before heading for the State.

Mr. Satish Chandra Tewary, Principal Secretary, DoHFW, Government of West Bengal, chaired the briefing meeting on 3rdNovember 2012, which was attended by officers and consultants of DoHFW. After the opening remarks by Dr. Dinesh Baswal, D.C. (Maternal Health), Government of India, on the objectives of 6th CRM, a detailed presentation was made by Ms. Sanghamitra Ghosh, Mission Director, West Bengal highlighting the progress, status of main programmes under NRHM and the new initiatives being taken by the State.

The Mission visited two districts, Murshidabad and Paschim Medinipur. The details of the facilities visited are in Annex 2. The Mission had a debriefing session on November 8th, 2012 chaired by Secretary DoHFW, Government of West Bengal. List of persons who were present in debriefing meeting is provided in Annex 3 The team would like to sincerely express appreciation and thank the officials of the Government of West Bengal, SHS, Directorate and staff of the facilities visited by the CRM for facilitating the review, providing all the documents asked for, appropriately and very openly responding to various issues raised by the CRM members and excellent hospitality provided.

Structure of the report

The Structure of this report is as follows:

- Chapter 2 provides a summary
- Chapter 3 gives background of the State based on the desk review.
- Chapter 4 is based on the field findings of the CRM. The chapter is structured into 10 thematic areas of the 6th CRM. For each theme, the State scenario or current status, followed by team's observations in the districts, observations and findings of 3rd CRM (as applicable) and progress thereafter and issues or areas of improvement has been provided.
- Chapter 5 provides the overall recommendations

6th CRM team to West Bengal and the districts visited

The 6th Common Review Mission was held between 2nd November and 9th November 2012. The mission at West Bengal was led by Dr. Dinesh Baswal, Deputy Commissioner, Maternal Health, Ministry of Health and family Welfare.

Team members of the 6th CRM:

- Dr. Dinesh Baswal, MOHFW
- Dr.Joydeep Das, NHSRC
- Ms Madhuri Narayanan, Vistaar
- Sh. Alok Verma, MOHFW
- Prof T Bir, NIHFW
- Sh. S. M. Meena, Planning Commission
- Ms Nirmala Mishra, PHFI
- Ms. Sandhya Nayak, MOHFW
- Mr. Sunil Nandraj
- Mr. Nikhil Herur,
- Dr Rachana Parikh

A national briefing workshop was held on 2nd November 2012 at NIHFW. A briefing workshop was held at the State on 3rd November 2012. Following the State briefing the team split into two teams and visited Murshidabad and Pashchim Medinipur (West Medinipur). These are highlighted in the following map.

Health facilities visited include District Hospitals in both the Districts, Nursing School in Medinipur district, Sub-divisional Hospitals, Rural Hospitals, Block PHcs, PHCs and SCs. During the visit,

interactions with the villagers and the PRI members were also held. Group discussions with ASHAs and ANMs were also held. The names of the facilities visited in both the districts are listed below:

Murshidabad District

- District Hospital – New General Hospital and Sadar Hospital
- Sagardighi RH
- Jangiapur SDH
- Lalbaugh SDH
- Gokarna BPHC
- Arjunpur PHC
- Anoopnagar PHC
- Panchgram PHC
- SC Harhari
- SC Sopara
- SC Gokarna
- SC Khasbaspur

Pashchim Medinipur

- Jhargram District Hospital
- Mednipore Medical College & Hospital
- Mednipore Nursing School
- Panchkuri PHC
- Daspur Rural Hospital
- Chandrakona Rural Hospital
- Dwaregeria Block PHC
- Lalgarh PHC
- Lalgarh SC
- Kanko SC
- Krishnapur SC
- Koshba SC

Background of Murshidabad and Paschim Medinipur

Murshidabad district is situated on the left bank of the river Ganges. According to the 2011 census Murshidabad district has a population of 71 lakh. It is the 9th most populous district in India. The district has a population density of 1,334 inhabitants per square kilometre (3,460 /sq mi). Murshidabad has a sex ratio of 957 females for 1000 every male, and a literacy rate of 67.53%. Beharampur town is the headquarters of the district. The majority of people of the district, around 64%, are Muslim by faith. 60% of the population lives below poverty line. 12% of the population belongs to SC and another 1.3% belongs to ST in the district. Among the industries in the district are India's largest power plant at Sagardeghi, a Central power plant at Farraka NTPC, a Hydropower project is also upcoming in the district. The District is the largest manufacturer of Bidi and employs more than 3.0 lakhs workers, mainly women and children. Silk is produced in the district and Murshidabad is famous for its high quality silk.

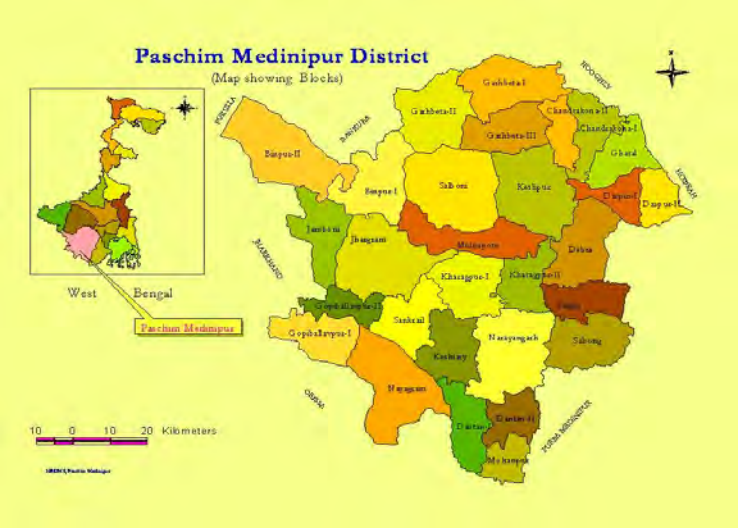
Borders - West Bengal's Malda district borders on the north, Jharkhand's Sahebganj district and Pakur district to the north-west, Birbhum to the west, Bardhaman to the south-west and Nadia district due south. The international border with Bangladesh's Rajshahi Division is on the east. Bhagirathi River divides the district into more or less equal halves. NH 34 passes through the districts leading to high rate of migrations.

In 2006 the Ministry of Panchayati Raj named Murshidabad one of the country's 250 most backward districts. It is one of the eleven districts in

West Bengal currently receiving funds from the Backward Regions Grant Fund Programme (BRGF). Insufficient maintenance of the environment around water sources, groundwater pollution, excessive arsenic and fluoride in drinking water pose a major threat to Murshidabad's health.

Paschim Medinipur or West Medinipur district is in the western part of West Bengal. It was formed in January 2002 after partition of Medinipur into Paschim and Purba Medinipur. The population of the district is 59.43 lakh as per census 2011. The population density is 636 per sq. km. The district comprises of 4 sub-divisions: Kharagpur, Medinipur Sadar, Ghatal and Jhargram. The SC population is 18% and ST is 15%. The Jhargam subdivision has 48% SC/ST population. There are 29 development blocks, 290 Gram Panchayats, 7498 inhabited villages. The sex ratio is 960 females per 1000 males. The literacy rate of the district is 79.04% (male 86.66% and female 71.11%). There are 44.32% BPL families as per RHS 2010.

The IIT, Kharagpur is situated in Medinipur district. The district is well connected with Kolkata by NH – 6 and also by railways. The district on the north is bordered by Bankura and Hooghly districts of the State, in the east is Howrah and Purba Medinipur, in the south is Odisha and on the west are Odisha and Jharkhand.



FINDINGS

TOR I: Facility based curative services-accessibility, affordability & quality.

The Health Department of West Bengal caters to the primary healthcare needs of its rural population through 375 Community Health Centre, 1984 Primary Health Centre and 7004 Subcentres. There is a huge shortfall in infrastructure as evident from Table 1. The situation in Pashchim Medinipur appears to be a little better than Murshidabad. Even then, only one CHC, two PHCs and 1267 SCs have been sanctioned for new constructions till 2011-12 in the state. Further, in 2012-13, only one more PHC is sanctioned. All 909 PHCs and all the CHCs are functional in government buildings. The state has not capitalized on the opportunity given by NRHM to build health infrastructure in the State.

Table 1 Shortfall of infrastructure in the State and the two districts visited

	West Bengal state			Pashchim Medinipur			Murshidabad		
	Req	In Position	Shortfall	Req	In Position	Shortfall	Req	In Position	Shortfall
CHC	723	348	375	44	29	15	47	27	20
PHC	2893	909	1984	174	84	90	190	69	121
SC	17360	10356	7004	1046	858	188	1139	832	307

Table 2 Status of Health Infrastructure in the visited districts

Pashchim Medinipur	Number visited	Murshidabad	Number visited
District Hospital, Jhargram	1	District Hospital	1
Medinipur Medical College & Hospital	1	Medical College	0
Homeopathy Medical College	2		
Central Govt./ Railways/ PSUs/ Other Depts (jail, Police, Urban Bodies, ESI etc)		Central Govt./ Railways/ PSUs/ Other Depts (jail, Police, Urban Bodies, ESI etc)	1
TB Sanatorium, Digri	1		
Sub Divisional Hospital (Kharagpur SDH and Ghatal SDH)	2	Sub-divisional hospitals (Jangipur SDH, Kandi SDH, Lalbagh SDH and Domkal SDH)	4
Rural Hospital (at par with CHCs)	23	Rural Hospital (at par with CHCs)	9
Block PHCs (at par with CHCs)	6	Block PHCs (at par with CHCs)	18
PHCs	82	PHCs	70
Sub Centres	858	Sub Centres	254+578

Pashchim Medinipur	Number visited	Murshidabad	Number visited
Homeopathic Clinic (co-located with CHC/PHC)	40	Homeopathic Clinic (co-located with CHC/PHC)	21
Ayurvedic Clinic (co-located with CHC/PHC)	12	Ayurvedic Clinic (co-located with CHC/PHC)	12

Presently, all the CHCs and PHCs are functional in government buildings. However, only 48.3% of all the SCs in the State are functional in governmental buildings. The sub-centres are classified as GP HQ sub-centres and Non GP HQ sub-centres based on whether they are situated in villages that are GP head quarters. None of the GPHQ SCs are without water supply and electric supply. However, a large number of Non GP HQ SCs have a poorer infrastructure. In Murshidabad, 324 of 578 Non GPHQ SCs are without the facility of drinking water and 358 of 578 Non GPHQ SC are without electric supply. Similarly in Pashchim Medinipur, 366 of such 568 do not have drinking water supply and 510 of 568 SCs in villages which are not GP headquarters do not have electric supply.

The footfalls in all the public health facilities are very good. The OPDs are overcrowded. The daily average OPD load in PHCs is 100 and it is about 200 -250 per day in BPHCs and RHs. However, the increase in OPD/ IPD as well as institutional deliveries in the last one year has been modest, around one to two percent (Table 3 & Chart 1). The provision of amenities for patients was not up to mark. Seating arrangements and basic facilities like toilets and drinking water was not provided in the OPD.

District Rural Hospital in PM district

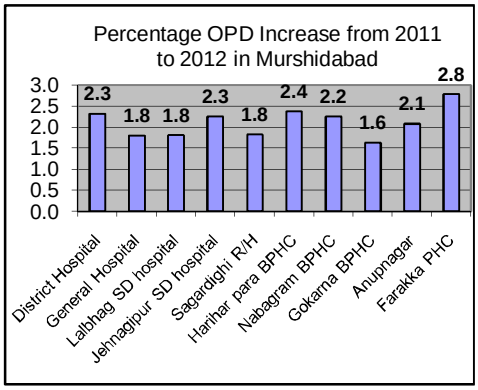
Pediatric Ward in Murshidabad District Hspital

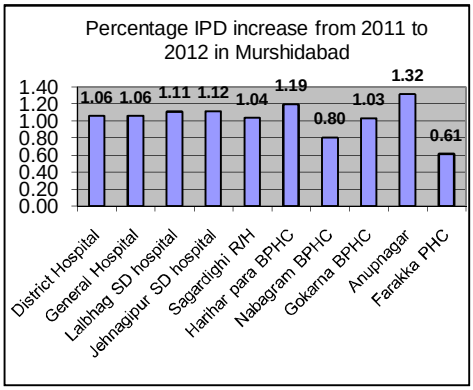
Table 3 OPD & IPD load in the visited facilities in PM district

Facilities in Pashchim Medinipur	Beds	2011 (Jan to Dec)			2010 (Jan to Dec)		
		Patient Load			Patient Load		
		OPD	IPD	Total	OPD	IPD	Total
Dwarigeria BPHC	30	58081	4798	62879	48876	5647	54523
Daspur RH	30	37933	1530	39463	43557	1215	44772
Chandrakona RH	60	81088	8268	89356	79329	8779	88108
Jhargram DH	265	285379	23424	308803	220075	19850	239925

Facilities in Pashchim Medinipur	Beds	2011 (Jan to Dec)			2010 (Jan to Dec)		
		Patient Load			Patient Load		
		OPD	IPD	Total	OPD	IPD	Total
MMCH	550	379830	74029	453859	374626	64510	439136
Panchkhuri PHC	10	20166	1010	21176	21889	865	22754
Lalgarh PHC	10	21117	1320	22437	34234	1743	35977

Chart 1: Percentage OPD & IPD increase in the facilities visited in Murshidabad district





Maintenance of health facilities:

User charges are being levied at Sub-divisional Hospitals and District Hospitals. Contrary to popular perception, due to huge patient load, significant resources are generated. 60% of the resources generated are deposited in the accounts of the Rogi Kalyan Samitis. The remaining 40% are submitted to the District Health Society. It was observed that the RKSs had huge unspent balances in most of the facilities visited in Murshidabad district. Additionally 'Citizen centric funds' to lift up the face of the public health facilities was also being provided by the State Government to undertake works/ projects that can be completed within a fortnight.

Different divisions were scattered through the campus in small buildings in most of the facilities in Murshidabad.

Overall, a low commitment of the department in maintenance of the facilities was perceived in both the districts. The protocols for inpatient admission and maintenance of wards were also not in place. In many of the facilities, segregation of male and female wards was not being done. The records were highly incomplete. Toilets were exceptionally dirty, without lights and practically unusable. Torn mattresses, presence of rodents, cats, dogs and even goats in the hospital premises were commonplace in both the districts.

The District Hospital – Murshidabad was exceptionally ill maintained. Open drains were observed to be running within the District Hospital. One such open drain was running just outside the door of operation theatre. Simultaneous construction activity was being undertaken in the DH which added to the chaos and patient discomfort. The BPHC at Anoopnagar in Murshidabad is situated among huge long standing water logging in the area. In the PM district, the indoor wards constructed in Panchkhuri PHC,

Lalgarh PHC and Daspur BPHC (all in PM district) with GTZ funding has no ceiling and the roof is lined with asbestos sheets. The floor of Panchkhuri PHC and Lalgarh PHC are cemented and there are no tiles. In Daspur BPHC, the floor has been tiled with RKS fund.

Bikes parked in corridors of DH Murshidabad

Toilet complex of male ward – DH Murshidabad

Goats in the female ward of Sagardighi RH - Murshidabad

Vicinity of BPHC Anoopnagar in Murshidabad

Overcrowding was a common feature in all the higher facilities. Two patients per bed was a common norm in both the districts. In Jhargram DH of PM, the patients were lying in the floor in the female ward as there is shortage of beds. Often pregnant women were seen seated in the corridors waiting for their turn for labour. The facilities were not disabled friendly. Lack of discipline was seen across the facilities like parking of bikes in the facilities, reporting of doctors, no observance of visiting hours. Informal payments in DH Murshidabad by support staff - Rs. 1000 for a male child born and Rs. 300 for birth of female child. The license of USG in Lalbag SDH of PM was not displayed.

Provision of staff quarter is inadequate for MOs and GNMs in all the facilities visited and need repair. One of the appreciable features however was that diet was being provided to all in-patients free of cost. The quality of food was good. Non-vegetarian food was also seen to be served in the facilities. The diet in the hospitals is contacted out to private parties and Self Help Group. Similarly the laundry service is being contracted out with RKS funding. Also in some facilities where there is shortage of sweepers, they have been recruited under RKS.

Residential quarters for staff at BPHC Anoopnagar in Murshidabad

Staff quarters renovated by using RKS funds in SDH Jangipur in Murshidabad

Blood Banks:

The BSU in Chandrakona RH was visited and found functional. The blood is collected from Ghatal SDH (mother blood bank) and is brought from the mother blood bank in vaccine carrier. The vibration free blood bag carrier is not available. The BSU during the time of visit had 1 unit of O+ve and 1 unit of B+ve blood. They regularly indent the blood for PPH, anemia and thalessemia cases. The blood bank in the Jhargram DH is functional round the clock and has stored units. There are four Blood Banks in Murshidabad district. All are with the government hospital.The Blood Banks visited at DH and at Jangipur SDH had applied for renewal of their licenses which have not yet been granted. Both the blood banks were not maintained well. In the Blood Bank at DH, there was only three units of blood was available. Blood collection kits are not supplied in adequate amounts and there is a shortage throughout the district as there is some enthusiasm in the district for donating blood.

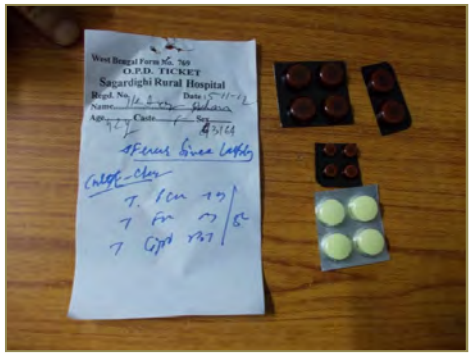
Defunct temperature recorder on a BSU in Sagardighi RH - Murshidabad

Stock availability at BB in DH Murshidabad

High OOP - Weakness of the public sector is the strength of the private sector and helplessness of the people:

Generally the availability of drugs in Murshidabad district was inadequate at most of the facilities. Although the situation in PM was better, there still was an inadequate supply of drugs. List of availability of medicines not displayed in any of the facilities visited in Murshidabad. A line of 7-15 chemists was always seen grouped together outside every public health facility visited in Murshidabad. Complete dosages were generally not being dispensed and often drugs (including antibiotics) were given for one or two days only. The drug stock registers were not updated and bin cards and expiry drug registers were not maintained generally. Expired drugs were found in the drug stores at RH Sardighi in Murshidabad district.

Drug tray in Male Surgical Emergency ward in DH Murshidabad



Medicines given for 2 days against a prescription of 5 days in Sagardighi RH murshidabad

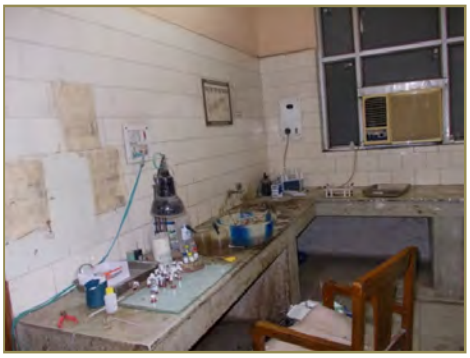
Drug storage at a secondary care hospital in Murshidabad

Line of chemists outside DH Murshidabad

A shortage of diagnostic equipment was seen in both districts. None of the sanctioned posts of lab technicians in Murshidabad district are vacant. None of the facilities including the District Hospital had a lab that was functional at night in both the districts. The lab Panchkhuri PHC in PM did not have any diagnostic facilities even as a LT was placed in the lab. The labs in both the districts at the PHC and BPHC level restricted their services to testing for hemoglobin, blood sugar and urine tests in addition to

malaria parasite and acid fast bacillus in sputum for tuberculosis. Hemoglobin was estimated by paper chromatography which is not a very reliable test. Large numbers of in-patients were asked to seek diagnostic services from a private laboratory. A significant presence of privately run laboratories was noticed around the public health facilities, particularly the CHCs, SDHs and DHs.

In both the districts, most of the patients seeking care in the public sector had either purchased medicines from commercial chemists or undertook diagnostic tests in private labs. Prescription by doctors for purchase of medicines and diagnostics from private sector was commonplace. Often the patients had to get tested in private laboratories as the results of the in-house labs were considered to be unreliable. User charges were levied on the diagnostics in public health facilities. SC/ ST and BPL patients are exempted from these user charges. However, the OOP would be considerably high for most of the patients considering that chamber (private) practice by doctors was also very common and allowed by the state Government for doctors working in secondary care facilities.

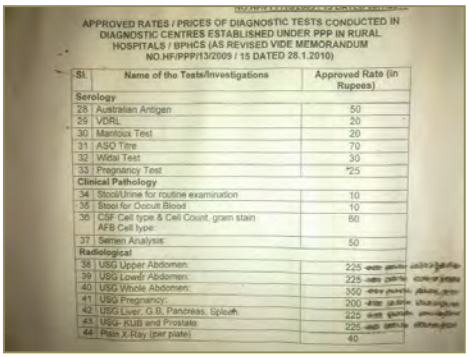


Laboratory in the District Hospital Murshidabad

Lalbagh S.D. Hospital, Murshidabad
RATE CHART FOR INVESTIGATION

S.No.	NAME	OPD Rate	N.Rate
	BLOOD TEST		
	O.P.D. & PAYING.		
1.	TC/DC	6.00	
2.	TC/DC/ESR/HB%	8.00	
3.	SUGAR F	10.00	
4.	" (PP)	10.00	
5.	UREA	10.00	
6.	HB%	8.00	
7.	B.T.C.T.	10.00	
8.	STOOL R/E	8.00	
9.	URINE R/E	8.00	
10.	" BS/BP	16.00	
11.	E.C.G.	28.00	
12.	X-RAY FOR ONE PLATE	30.00	
13.	PHYSIOTHERAPY	25.00	
14.	PLASTER	30.00	
15.	U.S.G. SCREENING		120.00
16.	EXTRATION EVERY ADDITIONAL TOOTH	6.00	
17.			
18.			
19.			
20.			

User charges for investigation placed inside a clerk's office



APPROVED RATES / PRICES OF DIAGNOSTIC TESTS CONDUCTED IN DIAGNOSTIC CENTRES ESTABLISHED UNDER PPP IN RURAL HOSPITALS / BPHCS (AS REVISED VIDE MEMORANDUM NO.HF/PPP/13/2009 / 15 DATED 28.1.2010)

Sl.	Name of the Tests/Investigations	Approved Rate (in Rupees)
Serology		
28	Australian Antigen	50
29	VDRL	20
30	Mantoux Test	20
31	ASO Titre	70
32	Widal Test	30
33	Pregnancy Test	25
Clinical Pathology		
34	Stool/Urine for routine examination	10
35	Stool for Occult Blood	10
36	CSF Cell type & Cell Count, gram stain AFB Cell type:	60
37	Semen Analysis:	50
Radiological		
38	USG Upper Abdomen:	225
39	USG Lower Abdomen:	225
40	USG Whole Abdomen:	350
41	USG Pregnancy:	200
42	USG Liver, G.B. Pancreas, Spleen	225
43	USG- KUB and Prostate	225
44	Plain X-Ray (per plate)	40

Rate chart of the PPP at Chandrakona RH in PM district.

A unique PPP for labs was observed in Chandrakona Rural Hospital in PM district. In this RH, the in-house lab undertook testing of Hb, MP and AFB only in the lab. For the rest of the tests including the complete blood count, urine examinaton, Widal test, Liver function Test, Lipid profile, etc were being done in the lab set up as a PPP in the premises of the hospital. Rates for the tests was fixed and displayed. Services for mothers and neonates and for 20% BPL population were free.

Waste Management:

General waste and biomedical waste management system were weak in most of the health facilities in both the districts. Plastic tubs were seen next to majority of the patients and were used as dustbins and were very filthy in all the visited facilities in Murshidabad district. The state has tied up with 3 firms for Common Bio-medical Waste Treatment Facility (CBWTF). The wastes generated in the hospitals are to be segregated and stored before being collected by the private firm. Colored bins were found at many facilities but waste was not being segregated as per the national guidelines in both the districts. In the health facilities visited, there is no proper place for storage of waste before being collected by private party for treatment and disposal. The Bio-Medical Waste (Management & Handling) Rules, 1998 were not being followed in the State.

Plastic tubs kept below each bed in all the facilities visited in Murshidabad

Waste segregation not being done

TOR II. **Sub-centers,** Outreach**,** Mobile Medical Unit**s & Patient transport services**

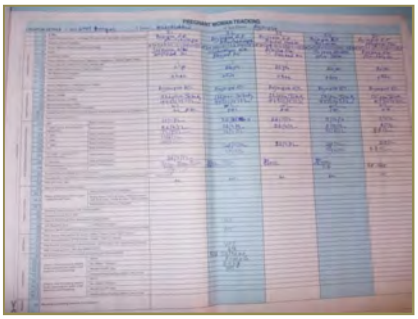
Sub-centres:

There is huge shortfall of sub-centres in the State and in both the districts (table 1). Both these districts are relatively huge with a larger rural population and greater number of people living below poverty line. Providing outreach therefore becomes all the more important in the district.

As highlighted earlier, a large number of sub-centres do not have electricity or water supply currently, all of which are non GP HQ sub-centres. Second ANMs are posted in 80% of the SCs in Murshidabad and 85% of Sub-centres in PM. However, there are huge vacancies of the male workers at sub-centres in both the districts. In Murshidabad, only 19% of the male workers are posted of the sanctioned 832 are vacant in the district. In PM, the situation is a little better with 44% of sanctioned male workers are posted. In Murshidabad, there were additionally huge vacancies (37% posted of the sanctioned 76 posts) in the in male Health Supervisors. Supportive supervision is being undertaken by the PHNs and GP supervisors. However, no documentation of the same is maintained. A visitor's book recording remarks of the various supervisors and visitors was observed but not maintained at the sub-centres.

Preparation for the VHND at a sub-centre in Murshidabad

ANMs and GP supervisor at BPHC Anoopnagar in Murshidabad



Mother and Child Tracking register used at sub-centre level in Murshidabad district

OPD services, antenatal services, family planning services (OCP, CC and IUCD insertion in some of the SCs where the ANMs are trained) are being provided at the SCs. Hb test and pregnancy detection tests were being conducted at all the SCs. But urine test (albumin and sugar) was not being done in all the SCs (though dip stick is available) especially in PM district. The SCs have been provided protocol for screening of high risk pregnancies. Mother and Child Protection cards were available and being used in the field. However, all the elements of the MCP cards were not being filled. Similarly, integrated MCH registers were also not available at all the SCs. MCTS tracking registers were seen at many of the sub-centres and were being used. Major drop out from 3rd to 4th ANC was observed in Murshidabad. In PM, none of the SCs were conducting deliveries. In Murshidabad on the other hand SCs were conducting deliveries. However, delivery points at SC level were concentrated in some blocks like Kardi, Beldanga-M, and in Raghunathganj II. List of SCs in Murshidabad where deliveries can be started is annexed with proper training of ANMs and linkage of referral transport.

In both the districts, immunisation was being provided at the SCs which was the main activity at the SC. The designated day is Wednesday. The vaccines are collected by the ANM from the cold chain point on the day of immunization. Alternate vaccine delivery provision is also being used for transporting vaccines to the vaccination site. A good turnout of pregnant women and children for immunization was observed during the field visits. Shortage of vaccines was not reported. Cold chain maintenance was being done by Block PHN and was found satisfactory.

The tickler charts was provided to all the SCs but was not being used in most of the SCs, particularly in Murshidabad. Due lists for tracking child immunization were however being prepared by SC ANMs in Murshidabad. Major dropouts from DPT 1 to DPT 3 in PM were observed in PM. The outreach sessions are not held regularly and this might be resulting in immunization drop out. Follow-up and tracking of mothers and infants for complete ANC and immunization need to be strengthened in both the districts.

Tickler chart in a sub-centre at Murshidabad


MCH card observed at a Sub-centre

Outreach activities like Immunization sessions and Village Health and Nutrition days were being held and micro-plans were prepared for the same. ASHAs, Link Workers, Anganwadi Workers assisted in community mobilization for the same. The services, mainly provided during VHND include antenatal services, immunization, and Family Planning services (CC and OCP). BCC for maternal and child nutrition is done through discussions with the participants.

Discussions with ANMs revealed that Disease Control Activities primarily a domain of the Male workers like container surveys, fever surveys, slide collection in rural areas, follow-up for treatment were being, etc were being undertaken by the ANMs in absence of male workers.

In both the districts, sub-centres were found to be collocated with the PHCs and BPHCs. While this is a good strategy to provide outreach services and preventive care to the population staying close to the PHC/ BPHC, it was noticed in some facilities, particularly, PHC Gokarna of Murshidabad, where the task of testing blood and urine was transferred to the sub-centre ANM by the Lab technician of the PHC.

Outreach:

Mobile Medical Unit:

The Government of West Bengal attempts to reach out to the unreached through Mobile Medical Camps in 23 blocks that are affected with LWE, 13 closed tea-garden areas in Jalpaiguri and through boat clinics in 9 blocks in the North and 24 blocks in South Parganas. Mobile Governance has also been initiated for OPD monitoring and presently 325 facilities are reporting through short message services regularly. In PM, uncovered areas in 11 LWE affected Blocks in 65 GPs with no functional hospital has been mapped. Most of these blocks are in Jhargram sub division. 11 MMUs are outsourced to 6 NGOs selected by the State are providing clinical and pathological and even radiological services in these blocks. There are no MMUs sanctioned in Murshidabad district.

These MMUs cover a SC area every week (except Sunday). The MMUs visit the village every week and conduct camps at fixed places on the fixed days. The services offered are medical checkup, ANC check –up, lab tests (R/E blood, urine, and stool, Widal test, MP and VDRL), X-Ray (60 MA portable) and free drugs. The services also include immunization and FP (distribution of OCP and Condom). The average cost that works out per camp is Rs. 6000/- to Rs. 10,000/-. All the arrangements are made by the NGOs which include hiring of vehicle, arranging Doctors, GNM, Pharmacists, Lab. Tech, Radiographer. Every day after the camp is over, the report is sent by the NGO from the field to the central server where it gets compiled. The information is ported in the database as well as for public viewing through the website link on www.wbhealth.gov.in.

Linkage with the nearest facility for family planning however needs to be done.

Soil Erosion Blocks:

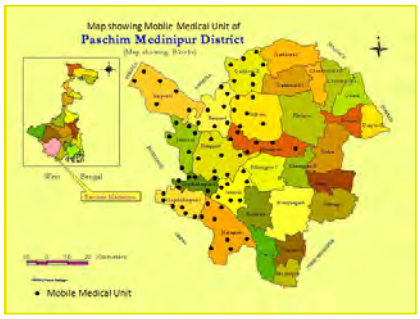
Ten out of 26 blocks namely Suti I, Suti II, Raghunath ganj I, Raghunath ganj II, Farakka, Samserganj, Bhagwan gola I, Bhagwan gola II, Jalangi and Domka and two municipalities Dhulian and Jangipur situated next to the Padma river which have caused soil erosion in the district to form and Island in the Padma river. In the Island formed 2 SCs have been established for the population there. Through the block Bhagwan gola II and Roshipur BPHC one outreach clinic per month take place though boats to this island.

Emergency and Transport services

A scheme for assures referral transport for pregnant women and infants was first launched in West Bengal in 2010. The service was called 'Nishchay Yans'. It also provided paid service to all other patients. Only NGOs and commercial small vehicles (private vehicles were not allowed to sign MoU and operate) who had signed MoU with Block Health Officials were allowed to run the service. The rates were fixed on Km basis. The charges for night (8PM – 8 AM) referral were fixed at higher rate than the day (8AM – 8 PM) referral. The drivers therefore preferred night referrals than day referrals because of higher rates and used to delay in reaching the patient for pick up. Moreover, there was scarcity of commercial vehicles in the rural areas. The scheme was then stopped in 2011.

In this year i.e. in 2012, under JSSK the scheme has been revamped. In the District level a call centre has been set up with "102" toll free number. A MoU has been signed at the Block level with the NGOs operating the ambulances. The mobile numbers of the ambulances is made available at Block Health Office, CHCs, PHCs and also given to the ASHAs. These ambulances are dedicatedly used for pick up, drop back and inter- facility referral transport of pregnant women and sick new borns. The rates have been fixed from the villages to the health facility (slab wise) and are paid accordingly.

The mothers are given 3 referral slips for themselves and 3 for their child during the 3rd ANC. With this referral slip, they can call "102" or dial the specific mobile number of the ambulance allotted to the block and the ambulance is sent to pick up the mother. A flip side is that mothers who might not have gone for 3rd ANC are deprived of the referral slip. In PM, only 66.4% of all the pregnant women received 3 antenatal check-ups in 2010-11. In 2011-12, 72.4% of all the registered pregnant women received 3 ANCs. In Murshidabad district, the situation is not much different. In 2010-11, 69.4% of the registered pregnant women had received 3 antenatal check-ups. In 2011-12, it rose to 80.6%. Thus, a significant number of women are denied assured transport as they have not come to the public health facility for 3rd Antenatal check-up. The state could instead provide the vouchers to all pregnant women irrespective of their 3rd ANC by delivering the vouchers at the homes of the pregnant women instead of distributing the vouchers at the 3rd ANC in clinics. Facility of ASHAs could also be used for the same.



On an average, 3 ambulances per block have been assigned which covers 2 lakh population having around 3400 PW. This accounts for 9.5 deliveries per day; considering the road connectivity and distance, at times availability of the ambulance is not feasible. None of these ambulances have oxygen cylinder, emergency drugs and para-medics to provide first aid to the patients during referral in the vehicle.

Majority of the women interviewed in the hospitals in Murshidabad were aware of the Nischay Yans. However, a majority had used private/ rented vehicles, buses and autos including 'bhanos' too for reaching the hospital. The facility of Nischay yans was not available at night in some places. Security and accessibility is also an issue limiting the service.

Ambulances have no emergency drugs or equipment

NGO rum ambulances in the state

Nishchay yan vouchers

Bhano' – the cycle rickshaw used for transporting a variety of goods in Murshidabad district including patients

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TOR III Human Resource for Health

Murshidabad:

Table 4 Government personnel available in the public health system:

	Sanctioned	In position	Vacant	% in position
Medical Officer	484	375	109	77
Technical Staff	159	60	99	38
Pharmacist	143	65	78	45
Nursing Personnel	797	766	31	96
Clerical Staff	221	112	109	51
HS (F)	76	28	48	37
HS (M)	178	166	12	93
HA – F	832	809	23	97
HA- M	861	164	697	19
GDA	1285	743	542	58
Sweeper	462	247	215	53
Driver	74	39	35	53

Currently, the district has managed to fill in 77% MOs and 96% of nursing personnel in the public health system. More than 50% vacancy was observed in the district for all the non-technical jobs especially the clerical, GDA, Sweeper and Driver positions.

Table 5: Personnel recruited through NRHM:

Category of Staff	Sanctioned	Vacant	% of Position
Medical Officer (26+7)	42	21	50
Specialist MO	21	21	0
Dist.Prog.Co.	1	0	100
Dist. Accounts Manager	1	0	100
Dist. Statistical Manager	1	1	0
Computer Assistant (RCH-II)	1	0	100
Accounts Assistant (RCH + NVBDCP)	2	1	50
Asst. Eng.	1	0	100
SAE	3	2	33
IDSP	3	0	100
Consultant- NVBDCP	1	0	100

GNM- Annwesha	26	21	19
Lady Counsellor-Annwesha	26	0	100
BAM	26	0	100
AP	6	0	100
DEO	67	5	93
Lab. Tec.-RNTCP	20	0	100
Lab. Tec.-RCH	2	0	100
RNTCP- STS	13	0	100
STL	13	0	100
RNTCP- TBHV	7	4	43
TBHIV (CO)	1	0	100
Driver-NLEP + RNTCP	2	0	100
2nd ANM	832	166	80
ASHA	5421	963	82

The District Statistical Manager position as part of district program management unit is vacant since last 2 years. It was observed that, the posts of GNMs for Annwesha are largely vacant in the district. Even though 80% of the 2nd ANMs and ASHAs were in position, considering the actual numbers, 166 ANMs and 963 ASHAs are still to be recruited.

Pashchim Medinipur

Table 6: Status of Regular Human Resources in the Pashchim Medinipur:

Category	Sanctioned	In Position	Vacant
Medical Officer	280	160	120
GNM	862	724	138
Pharmacists	150	120	30
ANM (1st)	858	814	44
Health Asst (M)	858	377	481
PHN	61	51	10
Lab. Tech.	78	42	36
Radiographer	34	23	11
ECG Technician	18	10	8
Group D	918	521	397
Sweeper	384	223	161

Table 7: Position of Specialists in the visited facilities of the PM District:

Hospital	O&G	Anesthetists	Pediatrician	Blood Bank / Storage	Remarks
Jhrgram DH	5	2 (trained during housemanship)	3	Blood bank	L3
Kharagpur SDH	2	3	2	Blood bank	L3
Ghatal SDH	3	2	1	Blood bank	L3
Chandrakona RH	1	1 (LSAS)	2	Blood storage	L3
Debra RH	1	1 (LSAS)	0	No	L3

There are two more O&G specialists, one each posted in Sabong and Salboni RH, 1 Pediatrician in Daspur RH in the district. Operationalization of four additional CEmONC centres covering the north

western and southern part of the district has been planned. However, due to shortage of human resources these centres have not been operationalised till date.

Table 8: Contractual Manpower under NRHM in PM district:

Designation	Sanctioned	In position	Place of Posting
District Programme Coordinator	1	1	DPMU
District Accounts Manager	1	1	DPMU
District Statistical Manager	1	1	DPMU
Assistant Engineer	1	1	DPMU
Sub Assistant Engineer	2	2	DPMU
Account Assistant	1	1	DPMU
Computer Assistant	1	1	DPMU
Computer Assistant (under SRI)	1	1	District Family Welfare Bureau
Programme Associate (for ARSH programme)	1	1	District Family Welfare Bureau
Block Accounts Manager	29	30	BPMU
Data Entry Operator	58	58	BPMU
Accounts Personnel	4	4	DH & SDHs
DEO	8	8	DH & SDHs & ACMOHs
Lady Counselor (for Adolescent Health Clinic)	30	30	BPC, RH & DH
GNM (for Adolescent Health Clinic)	29	12	BPC, RH & DH
DEO (for Adolescent Health Clinic)	1	1	MMCH
Lady Medical Officer (for Adolescent Health Clinic)	1	1	MMCH
2nd ANM	858	734	Sub Centres
Medical Officers (GDMO)		50	BPHC,RH & PHC
Medical Officers (Specialist)		1	RH
MPW	35	34 (under GFATM)	Sub Centres
MTS	1	1	Belpahari RH

The appointment of MOs and ANMs on a contract basis under NRHM has enabled the districts to operationalize some of the peripheral hospitals which were not functioning earlier. However, significant shortage of MOs & GNMs and vacancies against the regular sanctioned posts coupled with huge workload affects the quality of services in the public hospitals in the district.

Presently, the state is in the process of recruiting over 600 Medical Officers and 160 Specialists on adhoc (contract) basis under the State service. These MOs will be posted in PHCs, BPHCs and RHs and the Specialists in the planned CEmONC centers. Their services will be regularized under WBPSC eventually. This will help the state to tide over the manpower shortage and operationalize the hospitals in Public sector.

AYUSH:

In Murshidabad district, Ayurvedic hospitals/ dispensaries were collocated at 15 BPHCs and 7 PHCs. Homeopathic hospitals/ dispensaries were functional at 12 BPHCs and 19 PHCs in the district. Thus, 70% of all the 18 BPHCs were providing AYUSH services. However, during the visit the functionality of AYUSH clinics was not as good. E.g. in BPHC Gokarna there was one AYUSH doctor with only 4-6 patients per day. The clinic was not functioning as AYUSH centre. The doctor complained about lack of helper and pharmacists. Similarly in PM district. Homeopathy clinics are collocated with 40 facilities and Ayurvedic clinics are collocated with 12 CHCs/ PHCs.

Rational Deployment in the public health facilities:

The state has no written policy for the rational deployment of manpower. But the Doctors having specialization though are posted in the PHC are given the opportunity to work in SDH or DH through attachment.

In Murshidabad, as per the information shared by the district, there are 832 SCs and 809 ANMs (F) are in place. There are 35 SCs wherein the 2nd ANMs are residing in the health facility and district must focus upon them to initiate delivery services (attached in Annexure 1). The CEmOC facilities under the Ayushmati Scheme are concentrated in Domkal, Lalbagh and Behrampore and wherein we find that for 12 blocks on the eastern part of the district only 1 CEmOC is available as seen in the following map. Details of the scheme is mentioned under Ayushmati scheme.

Almost all the ANMs we met and interacted in the district mentioned that they were trained in SBA but none of them at SC level had conducted deliveries and the SCs only had an examination table.

In Jangipur SDH, staff nurses reported the duration of training to be 12 days. None of the staff nurses are trained for NSSK. Majority of the doctors are involved in private practice after 2:00 p.m. In the SDH Jangipur, 33 of 38 doctors were practicing after 2:00 p.m. Specialists are on call after 2:00 p.m. Private practice for the doctors at SDH and DH is allowed by the state.

During our interaction with the people at these public health facilities they complained about the doctors' absence to the health facilities. The doctors referred most of the drugs and diagnostic care which were available outside of the gate of the public health facility.

Retention policy:

The state has no policy to retain the manpower. But the attrition is less as the Govt. Doctors do not resign from the service. Only on getting PG seats they go on study leave. The Doctors working in the rural areas are entitled to Rs. 200 per month as rural allowance. There is no allowance for other para-medical staff working in rural areas.

The state must support the staff working in difficult area & also LWE affected areas with an allowance for Doctors or para-medical workers. The Paschim Medinipur district has a LWE affected subdivision.

Career Development of the Staff:

For career progression, there is no special policy. The MBBS doctors working in health services have seats reserved for PG courses but have to enter through the entrance test. There is no additional preference in terms of marking system for PG seats in case they have worked in difficult and LWE affected area.

The Doctors, ANMs and PMU staff recruited under the NRHM are bound by the NRHM guidelines. There is no human resource policy at District or Block level for ensuring future growth / career progression of the Doctors, ANM and DPMU / BPMU.

The state has the Public Health Nursing cadre. A GNM nurse with Diploma in Public Health Nursing (from All India Institute of Hygiene & Public Health, Kolkata and Community Health Education and Nursing, Singoor) or a BSc Nurse can get into the post of Public Health Nurse through WBPSC. They are posted in the Block as PHN (GNM with Diploma) or BPHN (BSc).

They look after the Public Health work in the block and all the RCH activities. Subsequently the BPHN gets promoted as Sister Tutor Nursing. The PHN can become the Ward Sister. They are promoted as Deputy Nursing Superintendent and subsequently as Nursing Superintendent. They get promotion as Deputy Assistant District Nursing Superintendent Additional DHS (Nursing) DHS (Nursing). The District Public Health Nursing and Health Officer at the District level is selection post.

Trainings all the HR available:

Table 9: Type of Training imparted in Murshidabad District

	MOs	Specialists	ANMs	SNs
Staff Available	**375**	**60**	**844**	**766**
IUCD	0	0	650	30
NSSK	8	2	0	0
SBA	11	0	29	951
IMNCI	28	0	635	35
F-IMNCI	0	0	0	0
Immunization	85	11	818	141
BEmOC	12	0	0	0
CEmOC	4	0	0	0
LSAS	0	0	0	0
MTP/MVA	12	7	0	0
NSV	159	0	0	0
Minilap	71	7	0	0
CCSP	0	0	0	0
Laproscopy	5	0	0	5
Kala Azar	47	0	210	37
Malaria	177	19	832	375
Filaria	139	0	832	271
Dengue	127	17	832	141
Diarrhoea	37	0	159	132
IDSP	172	13	0	129
HIV/AIDS	240	4	832	241
NLEP	140	0	834	0
RNTCP	124	0	371	0

Almost all the ANMs are trained in communicable diseases, immunization and IUCD programs. Emphasis must be laid on SBA and Counseling techniques for FP services.

The ANMs were not very clear of the no. of days they had attended for SBA training. Few of them mentioned it was 12 days and another few mentioned 15 days training in Gokarna BPHC and all the other facilities we got similar answers. ANMs at the BPHC and above only performed. Only 3% of the MOs are trained in BEmOC services 1% MOs for CEmOC services and 3.4% ANMs trained in SBA. It is evident that this is not sufficient in the district. Hence the district needs to scale up the BEmOC and SBA training in the district.

The BEmOC trained doctor must specially focus in:

- To conduct delivery using ventuse
- To Monitor and support the SBA trained ANMs

At Jangipur SDH, forceps deliveries were being done but no ventuse. The doctors accepted that ventuse could be started in the hospital instead of forceps. However, they can be oriented in this in a training site where it is performed.

About 35% MOs have been trained in communicable diseases.

Shortage of support staff:

There is an acute shortage of ward boys/ayas (group D staff) in the facilities visited. A total of 397 posts are lying vacant in the district. The duty roaster in the facilities visited shows overlapping of duties. There is also shortage of sweepers in the health facilities. A total of 161 posts are lying vacant.

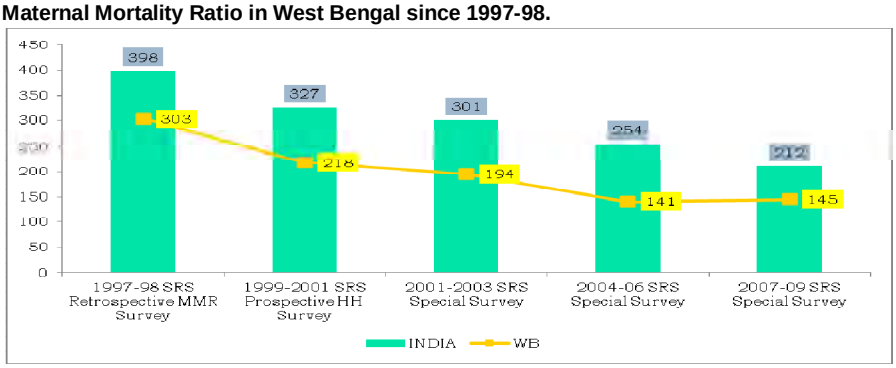
In some of the facilities visited (DH, SDH and BPHC visited), guards have been recruited under the RKS as per the guidelines.

TOR IV Reproductive and Child Health Programme

Maternal Deaths and Maternal Death Review:

MMR had been declining since (1997-98) till (2004-06) in the state. However, there has been an increase in the Maternal Mortality Ratio in the State from 141/100000 live births as per SRS 2004-06 to 145 /100000 live births as per SRS 2007-09.

Maternal Mortality Ratio in West Bengal since 1997-98.



Since there has been an increase from in MMR from SRS 2004-06 to SRS 2007-09 data, State will need to identify the gaps and will have to make some institutional changes to achieve the MDG in the year 2015.

The state needs to take lot initiatives to reduce MMR.

The key strategies to be taken are:

1. Increase the delivery points, at the moment only 4% are catering to the entire population.
2. Providing BEmOC and CEmOC services.
3. To improve the quality of ANC check up at the VHND and at Sub centre.
4. Screening of high risk cases and planning for the institutional delivery.
5. Capacity Building to be scaled up, especially on SBA, NSSK, BEmOC, FIMNCI.

It is estimated that only 64% of all the maternal deaths have been reported by the state as evident from the table below.

Table 10: Estimated reporting of maternal deaths by the State

	Population	Birth Rate	Live Births	MMR	Estimated Maternal Deaths	Reported Deaths	% of reporting
West Bengal	91,347,736	17.9	1,447,890	145	2099	1343	64.0
Murshidabad	7,102,430	25	137,313	210	288	253	87.7

State must focus on capturing and reporting all the maternal deaths in the state. Districts with a higher MMR also need to be identified and monitored on a monthly basis. It is recommended that the State focuses on increasing service delivery in these districts especially CEmONC services either by

strengthening the public health facilities through Government support and by increasing number of specialists posted or through PPP arrangement. The number of Delivery points in these districts should be increased and Maternal Death Review should be closely monitored and suitable action to be initiated.

The monthly MDR reports not been submitted, except for the first quarter of 2011-12 (Apr, May & June 2011). Committees for both Facility Based MDR (FBMDR) & Community Based MDR (CBMDR) have been formed. The training for community based MDR is going on in the districts.

In Paschim Medinipur district 45 maternal deaths were reported in 2011-12. Although the MDR committees have been formed at District level and facility level and the MOs in these facilities have been trained, none maternal deaths have been reviewed by the District MDR committee so far. Instead, 38 of these deaths were reviewed by the CMHO. The major causes identified were anemia, PIH and hemorrhage. Among the facilities visited, Maternal deaths were recorded at Chandrakona RH, Dwarigeria BPHC and at Jhargram DH. All the cases have been reviewed by the Hospital MDR committees. A common deduction across the reports was that the quality of ANC done in the field was poor. Screening of high risk cases and early referrals are not in place.

In Murshidabad district the MDR committee has been formed at District level and facility level and the situation is similar to PM. FBMDR is being done in the district Murshidabad and CBMDR is still to start in the district. MMR in Murshidabad district is 210 per 100000 livebirths, i.e 288 Maternal Deaths of which 253 deaths (88%) are was reported. Only 50% of maternal deaths were audited in Murshidabad. Of those audited major reasons identified Haemorhage, Hypertensive disorders and Sepsis.

Infant Death Review:

No specific steps have been taken by the State for institutionalizing Infant Death Reviews. No Infant Death Review Committees have been constituted in the State. However, infant deaths were being recorded in both the districts. The two major causes of deaths were prematurity / LBW and birth asphyxia. Infant death reviews can help in interpretation of the causes of neonatal and infant death and formulating strategies/ action to lower the mortality. The State needs to take specific actions to initiate systematic Infant Death Reviews.

Infant deaths in Murshidabad:

Cause of death	Duration	Number
Number of cases of Infant deaths within 24 hrs of birth		48
Number of cases of Infant deaths 24 hours to 4 weeks of birth with the probable cause being Sepsis	1. Up to 1 Weeks of Birth	50
	2. Between 1 week & 4 weeks of birth	24
	3. Total	74
Number of cases of Infant deaths 24 hours to 4 weeks of birth with the	1. Up to 1 Weeks of Birth	457
	2. Between 1 week & 4 weeks of birth	6

probable cause being Asphyxia	3. Total	463
Number of cases of Infant deaths 24 hours to 4 weeks of birth with the probable cause being LBW	1. Up to 1 Weeks of Birth	290
	2. Between 1 week & 4 weeks of birth	13
	3. Total	303
Number of cases of Infant or Child deaths between 1 month to 5 years of age with the probable cause being Pneumonia	1. Between 1 month and 11 months	71
	2. Between 1 year & 5 years	2
	3. Total	73
Number of cases of Infant or Child deaths between 1 month to 5 years of age with the probable cause being Diarrhoea	1. Between 1 month and 11 months	6
	2. Between 1 year & 5 years	
	3. Total	6
Number of cases of Infant or Child deaths between 1 month to 5 years of age with the probable cause being Fever related	1. Between 1 month and 11 months	18
	2. Between 1 year & 5 years	5
	3. Total	23
Number of cases of Infant or Child deaths between 1 month to 5 years of age with the probable cause being Measles	1. Between 1 month and 11 months	1
	2. Between 1 year & 5 years	1
	3. Total	2

It was observed most of the deaths occurred due to Asphyxia and LBW in the neonates. Hence the MOs must be trained in NSSK at the earliest to handle the sick neonates. The district needs to ensure that all the NBSUs and NBCCs are made functional and refer only the critical cases to the SNCUs.

Hence the district needs to identify the blocks where the critical cases are mainly been referred from. One of the major reasons could be due to early marriages. Hence BCC should be emphasized in delaying early marriages, if married to use contraceptives to delay pregnancy.

Delivery points:

3.8% of the public health facilities were functional as delivery points in the State. Out of 11675 SCs only 11 are conducting more than 3 deliveries per month. Among 272 PHCs which are 24x7, 54 are conducting more than 10 deliveries in the State. Among 102 FRUs (CHCs and other FRUs, includes DH), only 96 are conducting C-Sections and are functional FRUs. Therefore there are in total 444 delivery points in the State in the public sector which need to be strengthened and 68 among accredited private

health facilities. One delivery point caters to more than 4 lakh population. In Murshidabad, only 4% of the facilities are functional as delivery points in the public health facilities.

The state in addition to the existing delivery points in the public health system has introduced ayushmati scheme to scale up the delivery points in the state. This scheme caters to both normal and C-Section deliveries. 135 MoUs have been signed so far in the state to provide institutional deliveries. But as per data in Murshidabad it was observed that out of 21 MoUs signed in the district only7 facilities were conducting deliveries more than 100 per month.

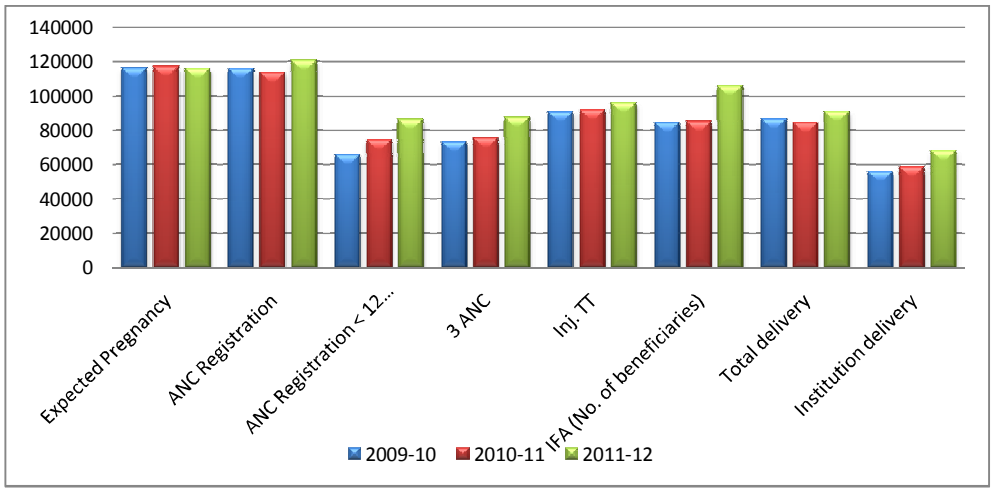
Considering the CBR of 25 births per 1000 population, total expected deliveries and requirement of the facilities to cater the delivery load for Murshidabad and Paschim Medinipur are mentioned below. As per international norms, a BEmOC facility is to cater a population of 1.25 lakhs and CEmOC facility is to cater to a population of 5.00 lakhs. The entire delivery load in both the districts is on the L2 & L3 level of facilities. The districts need to strengthen their sub centres for conducting deliveries. It can also be observed that 50% of the facilities are still to be upgraded for L2 and L3 level facilities.

Table 13: Availability of delivery points in the two districts visited

	Ideal scenario	Murshidabad		Paschim Medinipur	
		Required	Available	Required	Available
District Population	20,00,000	7102430		5943300	
Expected Deliveries	54000	195000		162000	
L1	50	175	3	150	0
L2	20	70	29	60	26
L3	4	14	6	12	10

RCH indicators of the State:

The ANC registration is almost 100%, but within 12 weeks is around 70%. The 3 ANC check up has increased from 63% (2009-10) to 75% (2011-12). The hospital delivery has increased from 64% (2009-10) to 75% (2011-12).



RCH Indicators of the visited districts:

Murshidabad District

Table 11: RCH indicators of the district in the last three years

Indicators (%) HMIS	ANC Registration	ANC registered within 1st trimester	3ANC	Inst. Delivery	Fully Immunized	sterilization	IUD
2010-11	100	52.2	70.9	69.5	80.6	79	70
2011-12	100	57.6	73.4	73.85	80.3	83.5	84.34
2012-13 up to Sept'12	100	60.2	75.6	74	85.26	18.73	46.1

Over the last three years, ANC registered within the 1st trimester has improved from 57.6% to 60% and also 3 ANC has also improved from 73% to 76% and institutional delivery has remained the same about 74% and where as immunization has scaled up from 80% to 85%. Family planning services usage has drastically dropped in the district from 84% usage to 19% and similarly the IUD insertion has also dropped by 50% in comparison to year 2011-12.

Considering the HMIS data from April 2011 to Dec 2011, it can be deduced that if all the medical officers conducted deliveries, on an average a doctor will have to perform only 1 to 2 deliveries per day as seen in the table below.

Table 12: Average Number of deliveries to be performed by each doctor per day

Name of the Facility	Deliveries/ year	MOs	Avg. Deliveries per Doctor	Avg. Deliveries per Doctor/ month	Deliveries/ day/ doctor
Hariharpara B.P.H.C.	1545	3	515	57	2
Gokarna B.P.H.C.	464	3	155	17	1
Arjunpur P.H.C.	361	2	181	20	1
Beniagram P.H.C. (working as Farakka BPHC)	697	3	232	26	1
Baharan P.H.C.	275	2	138	15	1
Panchgram P.H.C.	694	2	347	39	1

Corrrider of the labor ward in the DH Murshidabad with pregnant women waiting their turn

It was very disheartening to see the District Hospital of Murshidabad had 76 pregnant women waiting to deliver and similarly it was observed in the SDHs and RH about 10 -15 pregnant women were in queue to deliver and were waiting for their turn without adequate waiting space, beds, toilets and hygiene.

Paschim Medinipur District:

The ANC registration within 12 weeks is 70 - 80 % as seen during the visit. The 3 ANC coverage is approximately 60-70%. Drop out has been seen in few of the areas visited in Jhargram sub division. The PW are getting IFA and TT. Quality of ANC in the field was found to be poor. During the ANC, physical examination (abdominal) of all PW was not done primarily due to overcrowding. The blood is tested with Hb colour scale (card) during the ANC. The urine test is not done in all the SCs (though urine test kit was available) and the results are also not recorded in the MCH card. Other tests like ABO grouping, VDRL are not done for any pregnant woman. Most of the PHCs do not do Hb and urine test and send the PW coming for ANC to SC to get the tests done. The mothers were not given booklet on safe motherhood.

The district has set up 6 CEmONC centre and 55 BEmONC centre. The district has 6 CEmONC Centre (Medinipur Medical College, Jhargram DH, Kharagpur Sub-divisional Hospital, Ghatal Sub-divisional Hospital, Debra RH, Chandrakona RH). Out of 6 CEmONC centre, 4 have Blood Bank, 1 Blood Storage Unit and 1 does not have either blood bank or storage facility (Debra RH). All these facilities have O&G and Anesthetists. The district has a population of 59 lakh against which there are 6 CEmONC centre i.e. 1 CEmONC centre per 10 lakh population. The Jhargram DH has no Anesthetists. Two of the Medical Officers who have done 1 year Housemanship in Anesthesia are giving anesthesia for all operative cases. This has been allowed by the State Govt.

The district has 55 BEmONC centers of which 25 are doing more than 10 deliveries per month. 28 out of 82 PHCs are BEmONC centre. On an average these existing BEmONC centre are catering to a population of 1 lakh which is normal. More PHCs need to be planned based on OPD load, population and in uncovered areas to be operationalized as BEmONC facilities.

Table 13: Hospital delivery comparison in the facility visited:

Name of the facility with Type	Deliveries conducted during the year 2011-12 (April -11 to March -12)			Deliveries conducted during the year 2010-11 (April -10 to March -11)		
	Normal	CS	Total	Normal	CS	Total
Dwarigeria BPHC	933	0	933	837	0	837
Daspur RH	193	0	193	110	0	110
Chandrakona RH	1999	60	2059	1918	120	2038
Jhargram DH	3958	1395	5353	3006	944	3950
MMCH	8604	5045	13649	7085	3963	11048
Panchkhuri PHC	256	0	256	186	0	186
Lalgarh PHC	349	0	349	273	0	273

In the district 22 Medical Officers have been trained in BEmONC and are posted in BEmONC centre. The GNMs available in the CemONC and BEmONC centre visited had received training in SBA. The GNMs are well versed with ANC, delivery and are using partograph. A total of 359 GNMs have been trained in SBA. SBA training is only for 15 days duration and does not have a supportive supervision component for post training follow-up and performance improvement.

Recommendation: Increase the length of SBA training program to include refresher on core skills and adequate hands-on practice of deliveries. Introduce supportive supervision and post training follow-up.

None of the SCs are conducting deliveries in the district. The SCs are providing ANC service, immunization, family planning (OCP, CC and IUCD insertion in some of the SCs where the ANMs are trained). The blood is tested for Hb, urine for sugar and albumin (urine is not tested in some of the SCs though the kit is available). The SCs on exhaustion of the kit procure the same from the market using the untied fund.

Quality of services:

An example of the District Hospital in Murshidabad -

The district hospital had 5 labour tables, on which four deliveries were being conducted at the time of visit. None of the women were provided with gowns. In the corridor, there were four PW sitting on the floor with a new gown and a adhesive plaster pasted on their forehead which carried their name, EDD and date of admission waiting their turn for labor. The labor room was did not provide any privacy. There was no mattress or mackintosh on any of the labor tables. There were no spot lights. Partographs were also not maintained as the staff nurses were overworked. The adjacent antenatal ward had 12 beds and one toilet with 72 PW. The toilet was dirty and unusable and a huge pool of water was seen collected outside the toilet in the ward. It was shocking to see that 15% to 20% of the parturiting women, as informed by the gynecologist were given inj. diazepam. The indication was to allay anxieties in the women in such chaotic labor rooms.

Issues regarding duration of SBA training also needs to be highlighted as all the SNs on duty reported different duration of training. Only two of the SNs could tell the infection protocol.

The OT for LSCS was on the 1st floor and the PW were walking to the OT through the stairs.

There are huge unspent balances in the RKS accounts of the DH. These funds could have addressed many of the issues related to infrastructure for assuring a safer delivery. The practice of administration of diazepam to allay anxieties in the women admitted in the antenatal ward for labor needs to be stopped. Instead, the maternity wing needs to be strengthened to handle the larger caseload and provide a comfortable stay to the women.

High numbers of episiotomy were observed to be routinely performed in some facilities like Jangipur SDH and Panchgram PHC. In Jangipur SDH, in the last one month, 275/ 770 deliveries received episiotomy. In Panchgram PHC, even then an unusually higher number of perineal tears were recorded during labor.

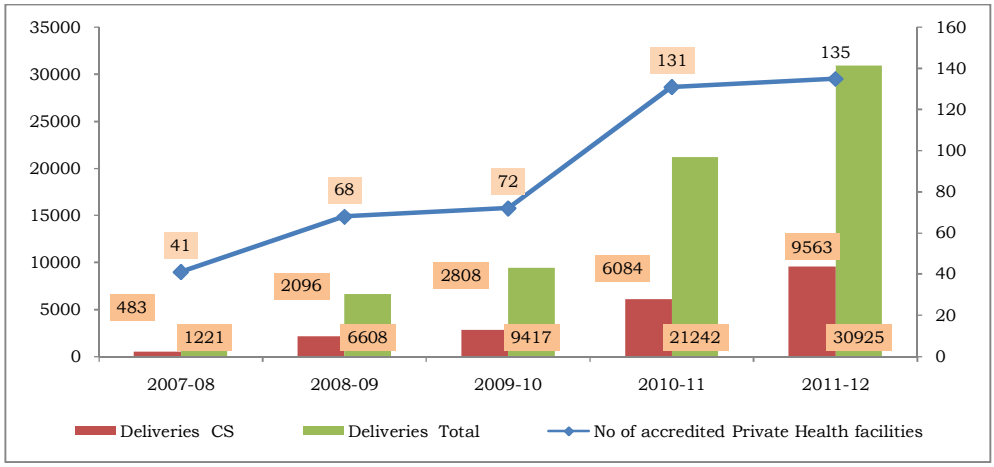
The SNs were over loaded with work hence could not maintain partographs in the DH. However, partographs were being maintained at Anoopnagar PHC, Gokarna BPHC and Jangipur SDH. Most

facilities did not display the labour room protocols like posters of PPH, hand washing. Poor maintenance of referral IN/OUT register in almost all the places visited apart from Jangipur SDH was seen.

Ayushmati Scheme:

The scheme is a pubic private partnership with accredited health facilities with the objective of reducing the incidence of maternal mortality and morbidity. The Ayushmati Scheme leverages the presence of the private sector by engaging it in providing essential and emergency obstetric care to pregnant women belonging to families from below poverty line, Schedule Castes and Schedule Tribes. The costs are reimbursed by the government. The surgical interventions are provided only at Sub District Hospitals and District Hospitals which are already operating with more than 100% bed occupancy. The costs are reimbursed by the government. The scheme intends to generate demand and improve access to services.

Subsequent to empanelment, a service agreement is signed with the hospital. The hospital will be reimbursed on a fixed rate basis (Rs.1515) by the government for each delivery conducted and the payment is made for a batch of 100 deliveries.



As seen above, at the state level, there is a rising trend of institutional deliveries at health facilities. 68% rise in normal deliveries and 64% rise in C-section in comparison from 2010-11 to 2011-12 has been observed. The C-Section rate among the in the year 2011-12 was about 31% of the total deliveries. This is marginally higher than C-Section rate 29% in year 2010-11.

As per the data received from Murshidabad district, Presently, the district has accredited 18 private health facilities under aysushmati scheme. Of the 18 facilities, 5 facilities did not conduct any delivery in the last year 6 facilities had were providing about 50 CS deliveries or even less and the remaining 7 facilities were conducting deliveries more than 100. Hence the district and state officials must closely monitor the performance of these facilities and suitably consider them in empanelling them in further future.

RTI/STI and ICTCs:

In Murshidabad district, RTI/STI services are reported to be provided in 33 facilities. However, it was observed that the RTI/STI services were not being given at the PHCs and higher facilities as the state has not yet procured the RTI/STI drugs.

RTI/STI	PHC	BPHC	RH	SDH	DH
No. of facility providing RTI/STI SCM services	0	18	9	5	1

Murshidabad district has a huge migrating population often from nearby States. Four blocks namely, Suti I, Suti II, Raghunath ganj II, Farakka have high migration from nearby districts. The district must focus up on these migration blocks to ensure all ANC are subjected for RPR & HIV testing. Camps can be held when these migrants come to their homes. This should be held in the facility which is in the centre of the block where people can access the services. Those cases identified can be linked to the nearest health facility for follow-up and treatment.

ICTCs:

All cases referred for ICTC testing were being tested different level of facilities. In Arjunpur PHC, ICTC centre was present, both counselor and LT were also available. The LT reported 4 HIV + cases in last 6 months. Similarly at Jangiapur SDH, ICTC technician was available but the counselor was not available. On checking the record from Jan 2011-Feb 2012, there were 34 HIV + cases, 2 ANC cases were reported recently. The linkage for ART is with Vardhaun Medical College for ART which was 200 km away. At Sagardigh 30 cases referred to Navagram to test for HIV. All these cases needs to be monitored closely for treatment and follow-up.

Safe Abortion Services:

The Report from the State on CAC six monthly reporting formats has not been sent by the state. 234 MTP trained providers are available. No information regarding their posting is however available. The SDHs, RHs and BPHCs are the Govt. approved MTP centres. In Murshidabad, 12 MOs and 7 Specialists have been trained in MTP services. However no MTPs were being conducted in the district. All the reported MTP cases were largely D&C for spontaneous or threatened abortion.

In Paschim Medinipur, one MTP centre is approved in the Govt. Sector in each of the 29 blocks of the district. The SDHs, RHs and BPHCs are the Govt. approved MTP centres. Similarly, in the private sector, 56 Nursing Homes/Pvt. Hospitals have been approved by the Govt. MTPs were reported to be conducted in the district. In 2010-11, the MTP conducted were 1008 - below 12 weeks and 315 - above 12 weeks. In the district, ToT of 6 Doctors on MVA has been completed. The District has planned to train 20 MOs and 20 GNMs on MVA. A total of 66 nos. of MVA kits have been provided.

SNCU/ NBSU/ NBCC:

In 2005, there were no SNCUs/ NBSUs / NBCCs in the State. As on 2011-12 the state has established 545 NBCCs , 125 NBSUs and 22 SNCUs and the state targets to raise these facilities to 640 NBCCs , 305 NBSUs and 49 SNCUs by the end of 2012-13 FY.

State level	Achievements	Target for 2012-13
NBCC	545	**640**

NBSU	125	**305**
SNCU	**22**	**49**

Similarly in Murshidabad district 2005, there were no SNCUs/ NBSUs / NBCCs in the State. As on 2011-12 the state has established 28 NBCCs out of the 31 Sanctioned, 19 NBSUs out of the 20 Sanctioned and all the 3 SNCUs which are Sanctioned and also 3 NRCs which are Sanctioned

Mushidabad	**Sanctioned**	**Achievements**
NBCC	31	**28**
NBSU	20	**19**
SNCU	3	**3**
NRC	**3**	**3**

The district has been able to establish almost all the facilities sanctioned for the district. It was also observed that the NBCC & NSBU at BPHC and SDH level were overloaded with infants and the infants needed to be given additional infrastructure of NBCC and NBSU for the state and districts.

Table 14: Functionality of the NBCCs, NBSUs and SNCUs in Murshidabad

Name of the Facility	Deliveries/ year	Available NBCC	NBSU	SNCU
Berhampur District Hospital	15098	Not functional	Over crowded	Functional
Jangipur SDH	6340			
Lalbagh SDH	4273		Not functional	
Sagardighi Rural Hospital	1093			
Hariharpara B.P.H.C.	1545			
Gokarna B.P.H.C.	464		Not Functional	
Arjunpur P.H.C.	361			
Beniagram P.H.C. (working as Farakka BPHC)	697			
Baharan P.H.C.	275			
Panchgram P.H.C.	694			

The SNCU at the DH was the only facility where the pediatrician had been maintaining the SNCU well and managing the very critical cases of infants. Example: an infant with weight of 750gms was admitted and the infant had improved its weight to 1150 gms. Majority of the cases admitted in the SNCU in the DH are preterm or asphyxia cases. The reporting format of the SNCU did not have pre term as a cause for admission and death of an infant. This needs to be added in the reporting format.

The Pediatric Unit of the district hospital is divided into units for 0-7 days (5) and 7-28 days (10) and the general consisting of 40 beds. They had very good referral card made for the peripheral facilities. However there are no protocols for referrals were made. This resulted in overcrowding of the DH. On interaction with the pediatrician he agreed that some of the cases referred are unnecessary referrals and could have been treated in the peripheral itself.

Two other NBSUs have been sanctioned at Lalbagh SDH and BPHC Gokarna. The NBSUs and NBCCs at the lower facilities were however found to be non functional throughout the district. The NBSUs and NBCCs at lower facilities need to be operationalised to decongest the DH.

Another example: At Lalbagh SDH in Murshidabad 2 birth asphyxia cases were there. The baby was seen at 1:00 pm and no protocol was observed.

In Paschim Medinipur 2 SNCUs have been completed out of 3 sanctioned. The SNCU in Medinipur Medical College & Hospital is functioning since August 2012. The SNCU in Medinipur MC&H is 16 bedded, has radiant warmer, photo therapy and 1 Ventilator. There is no separate inborn and out born unit. Most of the cases admitted are LBW, pre-mature, sepsis, asphyxia. The mortality rate is 10-15%. Of the other 2 SNCUs, SNCU in Ghatal SDH is ready be operationalized and in Jhargram DH, the work is in progress.

NBSU – A total of 8 NBSUs are functional in the district. It is functional in Chandrakona RH since June 2012. The NBSU has 1 radiant warmer and Phototherapy. The hospital has 2 Pediatricians. Since June 2012 to November 2012, a total of 95 new borns have been admitted and that too for 15- 20 minutes. The record shows that most of the infants admitted are asphyxiated babies. On improvement they are shifted to the ward and if there is no improvement they are referred to Medical College which is 40 km from the Chandrakona RH.

The NBCC in Panchkhuri PHC has a radiant warmer (bulb out of order, heating takes place), ambu bag, foot suction machine with infant feeding tube and Oxygen cylinder – it's in use for resuscitation of new born. Both MOs have been trained in NSSK and 3 out of 5 GNMs have been trained in SBA (Trained for 12 days). In all the PHCs/RH visited, the NBCC was functional with radiant warmer, ambu bag (size 0 & 1), mucus sucker and oxygen cylinder. Oxygen was filled up in the cylinders. In all the Health Institutions visited, the MOs have been trained in NSSK.

NRCs in Paschim Medinipur:

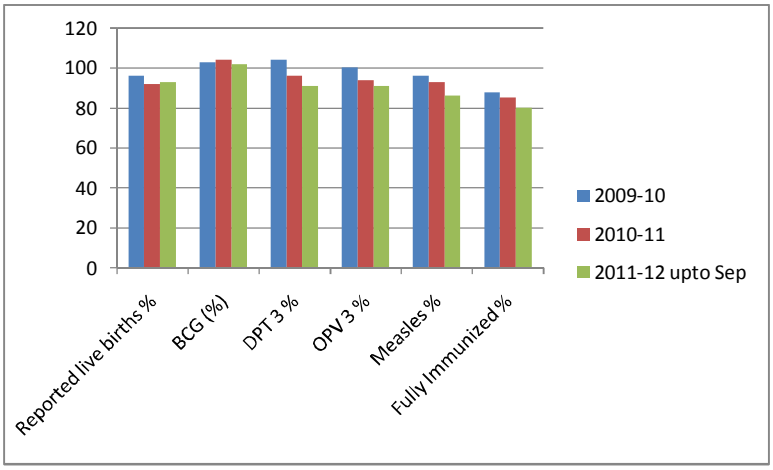
Two NRCs out of 11 sanctioned are functional. These are in Birpur and Kharaikamathani. they have been recently operationalised from 1st Nov'12. No malnourished child has been admitted so far. Following manpower has been recruited for the NRC – Nutritionist (1), Sahayika (4), Cook- 1 and

Programme Assistant (1). Training of AWW/ANM has been completed for screening of malnourished children

Immuniztion in Murshidabad:

It is very important all the infants and children are immunized but from the chart below it is seen that the immunization rates have been dropping from year to year. The district will have to ensure 100% immunization across the district. The PHN is managing the immunization program. PHN is to monitor the ANMs in the SC. It was suggested that cold chain handlers can manage under the supervision of PHN.

	2010-11(Apl-March)	2011-12 (upto March'12)	2012(upto Sept)
Full Immunization	85.1 %	84.28 % (139811)	47.37 % (70971)



Under 5 deaths are still very commonly observed in Murshidabad:

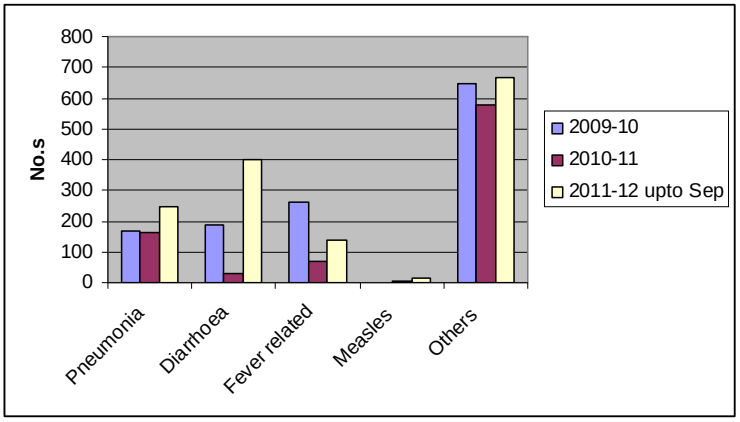


Table 15: Diarrhea cases & deaths in Paschim Medinipur

Year	Reported Cases	Death
2008	138809	6
2009	134872	0
2010	143763	3
2011	125467	0

Most common reasons are due to Pneumonia and Diarrhoea. The no. of overall deaths have increase from 2010-11 to 2011-12. Over the years the diarrhea cases have decreased. The diarrheal deaths have also decreased. In 2011, there was no diarrheal death and this year also there is no death reported because of diarrhea. ORS was available in the facilities visited and also with the ASHAs. The ASHAs are aware of the sign and symptoms of dehydration and use of ORS. However, no Zinc tablet was available in any of the facilities visited. Nor there was separate ORT corner in the health facilities visited.

The ARI cases as reported by the districts have decreased. There has been no reported death because of ARI. Tab. Sulphamethoxazole and Trimethoprim combination was available in all the facilities visited and with the ASHAs. The pediatric dose was available.

The hospital delivered cases are home visited by ASHA on 3rd/7th/14th and 28th day if the birth weight is more than 2.5 Kg and 2 extra days i.e. 10th and 42 days if birth weight is less than 2.5 kg. The ASHAs are given incentive of Rs. 175 and the scheme is in place for more than 1 year before the ASHA were given training on 6th and 7th Module. The ASHAs have not received any separate training on PNC or HBNC. The ANMs also visit the post natal mother during the field visit. During the post partum visit, the ASHAs check the mothers and the infant for any problem / sickness and refer them accordingly to the nearest delivery point.

Family Planning:

Murshidabad district:

Table 16: Family Planning: Achievements as a percentages of the ELA

	2009-10	2010-11	2011-12 upto Sep
Laproscopic TL	64	18	17
Minilap TL	118	147	16
IUCD	104	70	40
Male sterilization	21	0	1
Female Sterilization	113	84	27
Condom Users	49	98	79
OCP users	100	94	46

The sterilization services need to scale up. It is observed that family planning services have in comparison to the previous year in 2009-10, especially the sterilization among men including NSV. Fixed day was organized for family planning services. It was also observed contrary to belief that majority of the cases had undergone laproscopic sterlization after 2 issues.

One of the major issues was reporting. Report for Sept 2012 of Gokarna BPHC was analysed. It was found that the data was not reported properly.168 laproscopic sterlization were reported against the recorded 163 laparoscopic sterilization in the last month.

Laparoscopic sterilization is being done in camp mode in OTs of the public health facilities. In Anoopnagar PHCs, the OT however of the PHC was in a very bad condition. The approach to the OT was through a connecting bridge. In the OT, there was no proper OT table and Lap TL was being done with women lying on office tables shown in the pics below. The toilet was converted into an ante cum store room. Protocols for sterilization were also not being followed.

The table on which TL are performed in Anoopnagar PHC

Approach road to OT at Anoopnagar PHC

At Sagardighi RH IUDs and NSVs and tubectomy were being done by both lap and minilap. Tuesdays are FP days and lap TL is being done in a camp mode. NSV is very low. Post partum sterilization was also being done.

In 2009-10, in some of the areas like Beldanga I, B'gola I, Jalangi there was very good acceptance of NSV. However there was serious deterioration in 2010-11 . State and District needs to identify the reason for the drop and take remedial action. Eg. B'gola I- from 441 NSVs (2009-10) to 42 NSVs (2011-12).

Reasons might be:

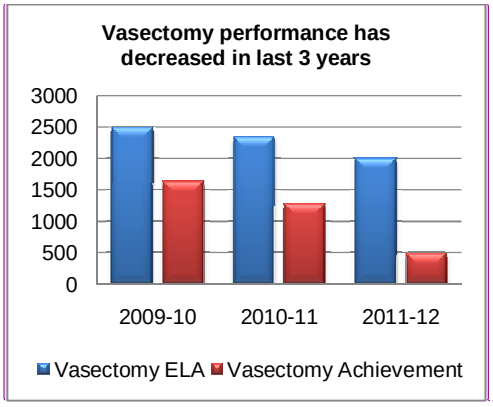
- Are the providers not available?
- Are the incentives not provided on time?

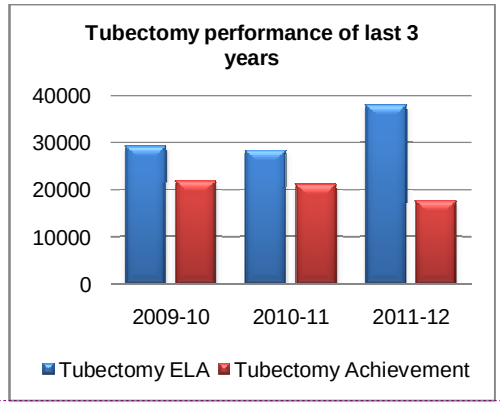
During population stabilization day, the State and the district can celebrate for a month and all the FP services may be provided in the selected district which are not performing up to the expectation. No conclusion can be drawn for laproscopic sterilization data, the data of all the family planning measures needs to be monitored very closely for improvement.

Pashchim Medinipur:

Table 17: Family Planning services at the visited facilities in PM district

Name of the facility with Type	2011-12			2010-11		
	Family Planning			Family Planning		
	NSV	Female sterilization	IUCD	NSV	Female sterilization	IUCD
Dwarigeria BPHC	3	465	150	3	374	67
Daspur RH	2	214	31	7	324	84
Chandrakona RH	33	1128	136	159	1178	159
Jhargram DH	13	421	29	43	662	36
MMCH	1	934	27	0	968	18
Panchkhuri PHC	3	102	1	0	102	1
Lalgarh PHC	0	0	4	0	0	2





Family Planning services in Paschim Medinipur

Comment [RP1]: Whom does the data belong to? as in which district/ state

The IUCD performance of the district is 107 % against ELA for 2010-11 and 101% against the ELA of 2011-12. The male sterilization has dropped from 65.4% (2009-10) to 54.7% (2010-11) and further to 24.7% (2011-12) against the ELA. Similarly the female sterilization has dropped from 74.8% (2009-10) to 46.7% (2011-12) against ELA.

In the Medical College, DH (1), SDH (2), 29 (RH & BPHC), Urban FW centre (1) & Kharagpur State Medical unit – fixed day FP services (Mini lap) are held 2 to 3 days a week depending on case load available. There are 121 MOs trained in Mini lap. These facilities have trained manpower or where trained manpower is not available; they are mobilized from other hospitals. In 2011-12, NSV done was 1631 against ELA of 2493.NSV services are also available in same facilities and there are 97 MOs trained in NSV. The motivation level for NSV is less in the community.

Quality Assurance Committee: In Murshidabad and Paschim Medinipur, there are District Quality Assurance Committees headed by the DM along with members of District Health Service like the Dy. CMHO, DPHNO.

The DQAC was formed for accreditation of trained Surgeons and MOs of hospitals for performing sterilization operation and compensation following failure or death during sterilization operation. The members were trained in 2008-09 by GTZ. The DQAC has not met for last 1 year. Hence, the DQAC is non functional. The DQAC has not been trained for quality checking of the hospitals quarterly and grading them. There is no visit to the hospitals for quality assurance and grading.

Janani Suraksha Yojana (JSY):

The total incentive under JSY for rural mothers is Rs. 700 (NRHM) + Rs. 300 (State Govt.) totaling Rs. 1000 and for urban mothers is Rs. 600 (NRHM) + Rs. 300 (State Govt.) totaling Rs. 900. The rural mothers on completion of 3 ANC are given Rs. 500 out of Rs.1000 and rest Rs. 500 is given on hospital delivery. The urban mothers on completion of 3 ANC are given Rs. 500 out of Rs.900 and rest Rs. 400 is given on hospital delivery.

The JSY payment is made to the mothers on spot in cash for institutional delivery. The payment is regular. The PW who deliver in Govt. hospital and are BPL/SC/ST are eligible for JSY payment. There is no backlog in JSY payment. The JSY incentive is added on with Rs. 300 for institutional delivery being contributed by the State Govt. The JSY beneficiary list was not displayed in the facilities visited.

Wall painting on JSY is present in most of the facilities visited. No other IEC/BCC materials were seen on JSY in market place or other areas in the districts. The mothers who deliver in home and had undergone 3 ANC, belong to BPL/SC/ST category are eligible for Rs. 500 under JSY. The money is paid by the SC ANM.

Total beneficiaries in last 6 months were 98% from rural and 2% from urban population. On discussion with the beneficiaries almost all of them mentioned they had received a cheque of Rs. 1000 for having gone through the delivery at the health facility.

JSY institutional deliveries payments in last 4 years in Murshidabad

Total no. of Blocks	2009-10	2010-11	2011-12	2012-13 (upto Oct)
26+7 (municipality)	24737	32101	40459	23811

There has been 30%-35% in increasing trend from 2009-10 to 2012-13 in Murshidabad district.

Janani Sishu Suraksha Karyakram (JSSK):

State launched the program from 15th Aug 2011. Free drugs and diagnostic is an issue. Informal payments reported at Bankura district. 292 state owned ambulances an operational 102 is toll free number, matriyan available. Vehicles are not fitted with GPS. Grievance system not institutionalized. IEC is poor in the facilities.

JSSK in Murshidabad:

There is a lot of out of pocket expenditure for normal and C- Section. Free diet was being provided. No diagnostic and drugs were available. There is already delegation of power for purchase of drugs (for antibiotics and others) however there was shortage of drugs in all the facilities visited. Similarly diagnostics were being done from outside laboratories. The district has only 4 % delivery points leading to overcrowding in the facilities. The stay for 3 days and 7 days for normal and C- Section is not possible, so the district should increase the delivery points. Referral transport needs to be ensured for all PW and infants. The data shared is incomplete and analysis could not be done. Data should be provided as per GoI prescribed format, so that analysis could be done. All CEmOC centers should have lab services with a lab technician available round the clock.

JSSK in Paschim Medinipur:

The JSSK has been implemented in the district. The information about free entitlement is displayed in the hospital. All the PW and sick newborn are provided free diagnostics (ANC, TT, IFA, Hb estimation). Urine test for albumin and sugar, ABO grouping, Rh typing, VDRL tests are rarely done forthe PW as these tests are not done in most of the visited facilities. All the SC have facilities for Hb Test (card test) and urine test for albumin and sugar (dip stick) – but urine test is not done and recorded.

The delivery is free for normal and c-section. The drugs and consumables required for normal and c-section are provided free from the hospital. In case of any item being out-of- stock the hospital provides that item from RKS fund.

For referral service the mothers during 3rd ANC are given referral vouchers 3 nos. each for themselves and their child. She signs and fills up the distance from her village to nearest delivery point. With this voucher they can call “102” and the empanelled ambulance / vehicles picks her up from home. The voucher is enchased by the driver after being verified at BPHC.

> *(A mother in Paschim Medinipur district who had 1 ANC, had home delivery, brought her 4 days old child to Jhargram DH for treatment spending Rs. 400 on her own. A termed 2nd gravid mother with no previous living child had 3 ANC and referral slip with her, came to Lalgarh PHC on the night of 05.11.12. at 11 PM following starting of labour pain. She did not call “102”thinking that the ambulance will not come in night as it is LWE affected district. She spent Rs. 700/- on her own to reach the hospital at night).*

The diet is provided free at DH, SDHs, RHs, BPHCs and PHCs. The diet supply is outsourced through third party in DH, SDHs, RHs and through Self Help Groups in BPHCs and PHCs. In the diet – breakfast and non-vegetarian meals are provided twice.

Adolescent Reproductive and Sexual Health Services:

Govt of West Bengal has universalized ARSH Clinics named Anwesha across all blocks in 18 districts and Adolescent Health Clinics at District Hospitals or Medical Colleges.

- In last few years; in West Bengal adolescent health programme has been rolled out up to all 341 blocks in 18 districts – 341 Anwesha Clinics at 341 blocks (BPHC/RH level) in rural areas and through setting up of Adolescent Health Clinics at 18 district hospitals in urban areas.
- School Health Programme has been implemented in Primary & Upper Primary Schools. For School Based Anaemia Control Programme it has been scaled up to 7486 girl schools to cover 4397206 students of class VI to XII.
- SABLA is implemented in 6 districts – Jalpaiguri, Cooch Behar, Malda, Nadia, Purulia & Kolkata.

As per data shared by the district on ARSH for April – September 2012, high prevalence of under-age marriages even in the 10-14 year age group is a serious cause for concern in both the districts. As per Anwesha clinic data in PM, 10 males and 115 females in the 10-14 year age group were married. 29 male MOs, 24 female MOs, 39 ANM/LHVs and 28 counselors have been trained on ARSH.

The Anwesha clinics are held three days a week from 9 AM to 4 PM. Many clinical services and counseling provided at the clinics are provided by a team of ANM and counselor. They refer the case to MO if required. Outreach programs are held in schools and in communities for three days in a week. All registers are maintained but the review showed that the quality of data is not good. Counseling is not targeted and needs improvement. As per the records reviewed at the clinic, 8-12 adolescents visit the clinic every day but during our visits to Anwesha we did not meet any adolescent. It is suggested that attention and efforts should be focused on strategies to delay age of marriage of unmarried girls, delay age of first pregnancy of married adolescents, ensuring good ANC and referral for pregnant girls, ensuring IFA supplementation for all adolescents. Data collected at the clinics and outreach events needs to be reviewed to improve the quality of data.
Job aids to be provided for RTI/STI cases and there should be linkages with OPD who are suspected of RTI/STI. The linkage between the Anwesha clinics and clinical services should be improved. Refresher training on counseling should be provided to ensure targeted and effective counseling to adolescents.

At sagardighi Rural hospital the the Anwesha clinc was functional and had been giving counseling services even to male. The lady counselor a facility had referred some to the ICTC center also. Although the menstrual hygine program was supposed to be implemented in the state and this district, none of the ASHAs reported distributing sanitary napkins in Murshidabad.

Thalassemia:

West Bengal is one of the states affected by thalassemia. In one study it was found out that the carrier rate is around 2.78%. The beta thalassemia principally affects the West Bengal population. Thalassemia units were found both in Paschim Medinipur and Murshidabad.

In the district of West Midnapur one Thalassemia detection centre has been established and it has been running by a NGO called 'Thalassemia Society' in the Medical Collage Building itself.

In Murshidabad district, 2 thalassemia units were established one in Behrampore DH and the other in Jangipur SDH.

Human Resource of the DH:

Sl. No	Designation	Allotted Post	Present Post	Vacancy Position
1	Medical Officer	1	0	1
2	Counsellor	2	2	0
3	M.T. (Lab)	2	2	0
4	DEO	1	1	0
5	Scavenger	2	2	0
Total		**8**	**7**	**1**

- It started functioning with One Medical Officer, Two Counsellors, Two MT (Lab)s, One Data Entry Operator and Two Nursing staffs. The lone MO resigned wef 31st July 2012. Since then no other MO have been posted to look after the unit. No outreach, Ante natal, blood transfusion and Desferal therapy has been done after July.

Report: 8th May 2012 to 31st October 2012

Particulars			Carrier					Diseased						
Respondent catagoury	Total	Normal	Beta Thal-carrier	HB E carrier	Hb S Carrier	Others Carrier	Total Carrier	Beta Thal	Hb E beta Thal	Hb S Beta Thal	Hb E homozygous	Hb S homozygous	Others	inconclusive
Antenatal	13	12	0	0	0	1	1	0	0	0	0	0	0	0
Pre marital	295	255	10	21	0	0	31	0	3	0	1	0	0	5
Post marital	411	304	42	48	0	0	90	1	2	0	1	0	0	13
Children	198	141	18	19	0	1	38	1	2	0	4	0	0	12
Others	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	**918**	**713**	**70**	**88**	**0**	**2**	160	**2**	**7**	**0**	**6**	**0**	**0**	**30**
Family of Disease/ suspected Disease/	128	22	58	40	0	0	98	0	3	0	0	0	0	5

carrier														
Suspected patient	2	0	1	0	0	0	1	0	0	0	1	0	0	0
Total	**1048**	**735**	**129**	**128**	**0**	**2**	**259**	**2**	**10**	**0**	**7**	**0**	**0**	**35**

Test were done for pre marital, post marital, children and family of diseased or suspected diseased or Carrier.
39% were tested for thalassemia during their post marital, following 28% tested for pre- marital and 18% tested for children and 12% tested for family of diseased or suspected to be carriers. Of the total tested it is observed that 22% after marriage and 76% family of diseased or suspected to be carriers.

Out of the 198 children tested, 141 found to be normal and 38 to be carriers and 7 found diseased. Ie., 3.5% of children were diseased out of 198 children tested. similarly it was observed that 1.3% diseased in pre marital and 0.97% diseased in post marital.

Counseling Report:

DATE	**PRE TEST**				**POST TEST**				**FOLLOWUP**
8th May to 31st October	**FAMILY**	**PRE MARITAL**	**POST MARITAL**	**ANTE NATAL**	**FAMILY**	**PRE MARITAL**	**POST MARITAL**	**ANTE NATAL**	
	376	**320**	**450**	**13**	**279**	**274**	**358**	**13**	**498**

Counseling done:
39% were counseled in their post marital, i.e ., almost all the patients screened has also been counseled. Only and 1.% had under gone through pre test and post test counseling. Around 15- 20% had dropped out pre and post marital for post test counseling .

Recommendation for thalassemia

- Pre Natal diagnostics to be established and ante natal test to scale up.
- Counseling:
    1. To the couples who have given birth to an affected child and to those identified at risk.
    2. Community career screening
    3. Network of centers and regional groups

- All PW should be screened for thalassemia.
- Simultaneously sensitize the public to thalassemia problem through various IEC/ BCC strategies.
- One of the method is introducing formal education in their school curriculum

TOR V. Disease Control Programs

Reporting for IDSP is not adequate and complete in both the districts. About 60% of S&P form has been completed within the time frame in PM. Gaps of S&P form are mainly irregular and not timely sending to the District IDSP Cell. Whatever data available has been used for the district plan of West Medinipur and relevant feedbacks (positive or negatives) are given to the Block level officials. Information generated on account of IDSP is useful for disease outbreak and surveillance.

Both the districts have seen a change in incidence on National Vector Borne Disease Control Program (NVBDCP). In Pashchim Medinipur, API has been coming down from year to year. Use of RDK, ACT in treatment of P.f malaria and extensive distribution and uses of LLIN in endemic blocks contributes in reduction. Malaria is endemic in this district. PM is an earstwhile GFATM supported district. The High Risk blocks are Binpur-I, Binpur-II, Jambani, Nayagram. Cumulatively, a population of 5.77 lakhs resides in these four high risk blocks. Murshidabad is one of the two districts where there has been a recent upsurge of malaria over the last three years. The high risk blocks in the district are Kandi, Khargram, Berhampore, Hariharpara, Suti-I,Raghunathganj-II, Sagardighi, Nabagram,Bhagawangola- I & II, Lalgola, Raninagar –I. Population living in these 12 high risk blocks is 31 lakhs.

Kala-azar is endemic in 11 districts of West Bengal. Malda, Murshidabad, Dakshin Dinajpur, Uttar Dinajpur and Darjeeling districts have a higher caseload. 60% of all the cases in the state are among the tribal population. In Murshidabad, 16.39% of all cases are among the tribal population. Seventeen blocks have been identified in five districts where prevalence of cases is more than 1 per 10000 population. Three of these are in Murshidabad – Farrakka, Samsherganj and Suti-II. Overall, Kala-Azar is endemic in 17 blocks of Murshidbad district namely, Farakka, Samserganj, Suti I, Suti II, RaghunathganjI, Raghunathganj II,Sagardighi, Lalgola, BhagwangolaII, Msd-Jiaganj, Nabagram, Jalanji, RaninagarI, Raninagar II, Kandi, Berhampore, Hariharpara. Japanese Encephalitis and Kala-Azar are not a problem in PM. Kala azar fortnight is being observed in the State since 2011. Two rounds of active search for KA cases over a fortnight have been conducted in all the 11 endemic districts in 2011. The intensive drive has resulted in capturing many more cases. Diagnosis of Kala Azar by dipsticks (rK39) is being done upto PHC Level.

Sporadically Chikungunya cases are found in one or two blocks out of 19 blocks in the PM district. Micrfilaria rate of 0 has been reported from both the districts. In 2012, a total of 602 confirmed cases have been reported from the district. Most of the cases have been reported from the blocks bordering Howrah and Hooghly. Only 1 death has been reported from the district.

Public health strategy under each program is being implemented as per government guidelines. The implementation of the programs is responsive to a great extent. Public health outcomes are also very good in the district. All types of public health programs for illness management are done as per guidelines. In both the districts all the posts for AMO and Malaria Inspector are vacant. A major problem is that ABER has been consistently low in the State. It was 6.34 in 2009 and 6.52 in the year 2010 and 6.06 in the year 2011 which is less than expected level of 10 in the State for last 5 years. Auditing of malarial deaths is being done in the States. It has been found that most of the deaths are due to delayed arrival in hospital/ or delay in detection & started treatment as reported by the State. The district Murshidabad is not following the protocol of random testing of positive slides.

The annualised new smear positive case detection rate in both the districts is below the desirable level. However, the cure rate is above 85% in both the districts. Pashchim Medinipur has achieved a cure rate of new smear positive cases of 93%, but the case detection of new smear positive is 70% only. A

reason for the lower level of new smear positive case detection could be due to under diagnosis of sputum negative pulmonary cases. DOTS plus has been launched in the district on 1st July 2012. Already 25 samples have been sent for culture and DST, out of these only 2 found MDR positive. The MDR treatment will be started from 19th November 2012 at NSS Kalyani (Netaji Subhash Bose Sanatorium).

The achievement for cataract surgeries is much below the targets set in both the districts as well as in the State. In 2011-12, 11327 teachers have been trained in the State. Of 12.96 lakh children screened for refractive errors, 80592 children were found to have refractive errors. Of these 38, 761 children were given glasses to corret the refractive error. The percentage utilization of cornea varies across the units of eye banks in West Bengal. Some of the eye banks are able to collect large numbers of cornea but their utilization rates are very low. A case in point is RIO Medical College – Kolkata where of the 1018 cornea collected in 2011-12, only 130 were utilized (i.e. utilization rate of 13%). In the PM district, there are two designated centres one at District Hospital, Jhargram and one at Kharagpur. IOL supply is regular and the performance of Govt. doctors is satisfactory. Screening has been done regularly as per micro-plan by PMA. In Murshidabad district, the centre at Government General Hospital was visited. The ward was clean and supply of IOL from government was confirmed to be regular and sufficient. During the time of the visit there was only one patient.

National Leprosy Elimination Program (NLEP), the prevalence of leprosy has increased due to active case detection. Last year 2011 it was in 11 blocks and this year 2012 it has been under taken for 18 blocks. Only 9 blocks were completed. It has been found that 15-35 age group is vulnerable to MB category. There are hardly any health facilities for detecting leprosy in the urban slum areas, but in these localities the prevalence of leprosy is quite high.

None of the visited districts are endemic for iodine deficiency. In case of National Iodine Deficiency Program, there is no supply of kits for testing salt. Only activity is performed through IEC and physical verification of salt in the district as a whole. Both the National Programme for Control of Cancer, Diabetes and stroke & National Programme for Health Care for the Elderly were launched in the State in the District of Darjeeling in 2010 – 11. Following this in 2011 – 12, two more districts viz. Jalpaiguri & Dakshin Dinajpur were included in the programme.

TOR VI. Community Processes, Community Based Monitoring and NGO involvement

ASHAs and community workers:

Based on Census, 2001, total no. of ASHAs approved for the state is 61008. The rural population as per census 2011 is 622.14 lakhs. So far, a total of 46992 ASHAs, i.e., 77.02 % of the approved have already been selected across West Bengal till date. ASHAs are selected by an ASHA selection committee includes Pradhan, ANM, and Supervisor. She has to have studied up to Class X and should be from the same village. 96% of all these selected ASHAs have been trained upto 5th module. Training in the 6th and 7th module has also been initiated. So far, 33% of all the selected ASHAs have been trained in 6th module and 21% have been trained in 7th module.

Supervision structure of ASHA is defined in the State. No ASHA resource centre is created. ASHA facilitators at block and GP level have been selected but could not be appointed due to court cases. Thus at the sub-centre level, the ANM in charge of the sub-centre monitors and supervises the performance of the ASHAs in her area. Generally there are 4-10 ASHAs per sub-centre depending on the population. There is a GP supervisor who monitors all the ASHAs in the Gram Panchayat. Generally, there are 20-25 ASHAs in a Gram Panchayat area. The GP supervisor along with the in-charge Health Assistant (Female) and Health Assistant (Male) of the GP HQ SC supervise all the SCs in the concerned GP. These health workers are also a member of the Health sub-committee (upsamiti) of the Gram Panchayat. The Block Public Health Nurse at the block level, supervises the functioning of all the sub-centres and ASHAs in the block. A district ASHA monitoring cell is formed comprising of Dy. CMOH III, District Public Health Nursing Officer (DPHNO), District Maternal and Child Health Officer (DMCHO), and District Programme Coordinator (DPC) under the CMOH. Similarly, at the state level, a State ASHA Cell under the MD, NRHM has been constituted.

The main focus is on monitoring ASHA performance to ensure that the payment of ASHA's payments is made accurately. The approach to supporting ASHAs is informal and ad-hoc and there is need to make the support mechanism more systematic to improve supportive supervision, feedback and problem-solving for keeping ASHAs updated and motivated. The existing monthly meetings should be utilized as platforms for training follow-up, ongoing capacity building and providing support to ASHAs. Further, there is no system for grievance redressal other than raising the complaint directly with the MO or CMO. Common demands of the ASHAs include fixed pay, bicycle and DISHA (ASHA shelters).

In order to continue capacity building of ASHAs, the State has initiated two initiatives - **Receive Only Terminal (ROT)** and **ASHA Talk Show**. ROT is a one way satellite communication where the live sessions are conducted at the State level and the same viewed live at the Block level at the BMOH office. Viewers can ring up the studio and talk to the resource persons directly to clarify their doubts. The ASHA Talk show is a radio talk show which is aired every Wednesday and is available in all channels of All India Radio (AIR) and FM Rainbow channel. New topics related to health is discussed and disseminated to ASHAs who can directly talk to the resource persons for their clarification. In both the districts however, none of the ASHAs we met spontaneously mentioned using the radio talk show.

An asset is that the general educational status of ASHAs was quite high. Most of the ASHAs encountered in Murshidabad district were educated beyond school and a good number were graduated themselves. Knowledge levels regarding ANC/ PNC/ Diarrhea were good among the ASHAs interacted. ASHAs visit the community 2-4 times in a week. Maternal and child health activities were the main activities. 32123 ASHAs have been given drug kits. However, Drug kits were given only once and then never replenished since 2010. ASHAs are however not given pregnancy kits or water testing kits. They

informed that gradually they had seen a perceptible change and there was less fear of the hospitals and institutional deliveries among the women.

A common pool of fund is created at the State level under Mission Flexipool to ensure payment to ASHAs from a single source. All ASHAs have bank accounts. E-payment has also been introduced throughout the State. However, in both the districts visited there was a delay in payment of incentives to ASHAs. In Murshidabad, ASHAs were paid only once in the last 6 months. This payment was not performance based and a lumpsum of Rs. 2000 or 1500 was paid based on pending payment. In PM, there was an almost two or months lag time for ASHA payments after the receipt of consolidated activity completion format at the end of each month from ASHAs. District does not receive any advance funds for making payments to ASHAs. ASHA Ghars "DISHA" guidelines have been issued by the state and work is just being initiated in some health facilities in PM.

The process of verification of the incentives amount payable to ASHA is quite elaborate and involves multiple levels of checks. It can be summarized as follows:

ASHA submits the request to ANM → ANM cross checks and approves incentives →ANM submits them to the GP supervisor → GP supervisor further cross-checks the claim of incentives with performance → Verified claims are then submitted to the Block Public Health Nurse →BPHN verifies the claims and submits the claims to the Block Medical Officer of Health → BMOH resolves any issues that may arise →The claims are then sent to the Block Accounts Manager for release of funds. Some ASHAs have been earning an amount as high as 4000 per month. It was informed that spurious recording of performance was quite prevalent. It is suggested that ASHA payment system should be reviewed to ensure timely payments.

In addition to ASHAS, a battery of Community workers was seen in the field. These were Lnk workers and Community Health Guides funded by the State budget. In each PHC, thus, there were 5-6 additional link workers. Each of the link workers are paid Rs. 216 as monthly honorarium. These are not trained in any specific health related activity and undertake community mobilization activities only. There were around 2500 CHG in Murshidabad. A strategy to constructively involve these should be thought out by the state. Many of the male link workers/ Community Health Guides can be trained and developed into Male multipurpose workers.

Community Processes:

It appears that community agitation is quite strong but community action isn't in the State. While the State of West Bengal may well boast of stronger PRI, the people's representatives have not succeeded in channelizing the people's voice and demand. It appears that the health department has not made sufficient attempts to involve the very people it is bound to serve. The potentials of the platforms of VHNNC and RKS are completely unutilized even after seven years of NRHM.

VHSNC has been formed at Panchayat level but it is not quite functional. The funds of the VHSNCs are transferred to the Ministry of Rural Development for the use by PRIs at GPs. However, upon interactions with the PRIs at the Gram Panchayat as well as the Block Panchayat in Murshidabad, it was learnt that the PRIs were completely unaware of the NRHM funds given for VHSNCs. In PM district, accounting for annual amount of Rs 10,000 for VHSNC is not clear. In one of the VHSNCs, it was found that the bank withdrawals are not supported by clear resolutions in the minutes of VHSNC meetings. ASHA is also a member of the VHSNC. VHSNC needs to be strengthened with more accurate and timely documentation of resolutions for fund withdrawals. While all the sub-centres were receiving untied funds, none f the sub-centres in Murshidabad district were getting Annual Maintenance Grants.

RKS have been formed at all the facilities. However, they are not registered as a society under the Societies Registration Act as per the national guidelines. RKs have an account under the Block Health and Family Welfare Samity. The user fees collected at the DHs and SDHs are also deposited in the account of the RKSs. Minutes are maintained and the cash books are also well maintained. In some of the facilities the funds were used to renovate and whitewash the quarters of the staff (Jangipur SDH in Murshidabad). However, the meetings are not held regularly every month. In most of the facilities visited, the RKS met once in 2-3 months. Among the visited facilities in Murshidabad, RKS meetings were held very irregularly in Gokarna PHC. Agenda is mostly focused on infrastructure and funds. It is suggested that RKS should be restructured and its meetings be made regular. Further, more time should be devoted for program performance review and devising remedial measures.

The user charges generate a significant amount of funds in a year. 60% is used for the facilities and 40% was given to the District Health society. In all the facilities visited, especially the higher facilities, it should be brought out that the state of the health facilities was appalling even as there were huge unspent balances in the RKSs. A systematic study of the factors for the same needs to be undertaken by the State.

In Murshidabad, the team encountered people complaining about the health services and availability of facilities, including doctors doing chamber practice, nonavailability of medicines, lab services compelling them to take diagnostic tests outside as well as condition of health facilities being in poor state and unhygienic in many health facilities. Interaction with the community members at Arjunpur PHC is particularly worth mentioning. The community members had gathered outside the facility and stood patiently waiting in the rain for the team to finish the inspection. As the team emerged from the facility to depart, the people gathered themselves around the members and shared that doctors are not on duty and they have to purchase drugs from outside. Staff nurses were not present at the time of visit at 8:30 p.m. Drugs are not being given to the patient. On an average there is an OOP of 1000-1200 for drugs. The MOs charged 40 rupees as consulting charges. Saline is available and the patients were not treated in PHCs. The community was highly agitated.

It is worth mentioning that the health department takes very little initiatives to appear transparent and provide services in a democratic manner. No citizen's charter was seen displayed at any of the facilities visited. In some of the facilities, list of services provided was however displayed. The user charges were not displayed in any of the facilities in the areas of patient movement. A display of the list of 'User Charges' was seen in DH Murshidabad, but it was not placed in area of patient movement and was discovered by the CRM team by chance. Similarly, list of RKS members was also not displayed.

There is no system for systematically recording and addressing grievances. No toll free number was identified in the State. The grievance box was seen in Sagardighi RH in Murshidabad. However, it could not be opened at the time of the visit. According to one respondent in PM, it was initiated but is not functional now. Based on the information, community monitoring processes have however not been initiated anywhere in the two districts.

TOR VII: Promotive Health Care, Action on Social Determinants and Equity concerns.

Convergence between ICDS, education department, water and sanitation and rural development is very important for addressing social determinants of health. Monthly meetings are held meetings are held at the block level under the leadership of BDO for the same.

No special efforts to reach marginalized, except through the outreach VHNDs, could be identified. It is suggested that use of participatory tolls should be introduced to identify left-out communities and expand outreach and coverage.

Nutrition Rehabilitation Centres are not yet operational in the district. It is suggested that NRCs should be established and expanded after review.

In PM district, the sex ratio in the district is 960 females per 1000 males. The number of Ultrasound machines is 75. There are 12 Portable machines and 63 fixed machines. IEC materials have been developed. Workshops and seminars are held for all MOs and nurses. District official say that sex is not an issue since it is good at 960 and tribals value their girls a lot. Information on PCPNDT committees or registration could not be collected. No display of poster, declaring that revealing the sex of the unborn child is an offence, was noticed.

It is suggested that gender and equity trainings be provided to all health staff and workers. The monitoring of implementation of PCPNDT Act should be increased.

BCC plans exist for different programs and a common BCC strategy is proposed in PIP but the same could not be reviewed. IEC materials were seen displayed at the health facilities in PM. In Murshidabad, however, the IEC materials were not displayed enthusiastically and were also very old. No specific job aids are provided to aid in counseling except those available in the MCTS card and posters. ASHAs are articulate but did not report use of any job aid for counseling and communication with mothers. The focus on BCC and counseling skills of ASHAs and ANMs should be improved. ASHAs and ANMs should be provided with job aids.

Arsenic Water Sources:

Insufficient maintenance of the environment around water sources, groundwater pollution, excessive arsenic and fluoride in drinking water pose a major threat to Murshidabad's health. As per the WHO recommends that 10µ/l of arsenic content is permissible but the state has raised it to 50 µ/l as safe. Similarly, PH value permissible limit is between 6.5-8.5 and Iron content permissible limit to 0.3-1.0 mg/l. Total hardness permissible limit between 300-600 mg/l.

State has identified that 5.3 million population are already affected from the arsenic content in the water. 4 districts Murshidabad, Nadia, Malda and South 24 Parganas have been identified of being high amount of arsenic content in the water of these districts. On persuasion with the district officials reports were collected regarding the water pollution for the district. Team leader found that there was a rusty water which was shown to the state officials also. A meeting was then called with PHE department and the water testing report was called.

The reports clearly described that almost all the tube wells in block Raninagar I, and GPs Tenkaripur, Hursi and Islampur Chak and block Raninagar II, and GP Malibari- I contained high arsenic in the water and was unsafe to use. It was also observed from the report for block Raninagar II, and GP Raninagar I that the 2 Tube wells had bacterial contamination also.

Currently in Murshidabad has been collecting water samples from various tube wells and sending these samples to the lab for testing for arsenic content, PH content, Iron and bacterial contamination.

Recommendations of water treatment:

- The state and district must supply field kits that can measure concentrations of 50 µ/l to gather instantaneous results and facilities for prompt action to find alternative water source if needed.
- The district needs to analyze the reports and inform the concerned authorities to prevent the further consumption of water from these tube wells.
- Another option can be sinking of deep tubewells below 200 meters and dug wells or ring wells (20-30 meters)
- To identify blocks or areas where most of the cases are coming as gastrointestinal, including diarrrhoea and abdominal pain which should be investigated and water sources from these areas needs to be tested on a priority.
- Field workers should be equipped with the knowledge on the health problems due to arsenic content trained in IEC/BCC to sensitize the public for identifying the arsenic affected sources.
- There needs to be better coordination between PHE & Health department and the reports should be regularly shared with the health department.

TOR VIII Programme Management including monitoring, logistics and issues of integration and institutional capacity.

Organisational Structure

At the state level:

The Staff strength of SPMU:

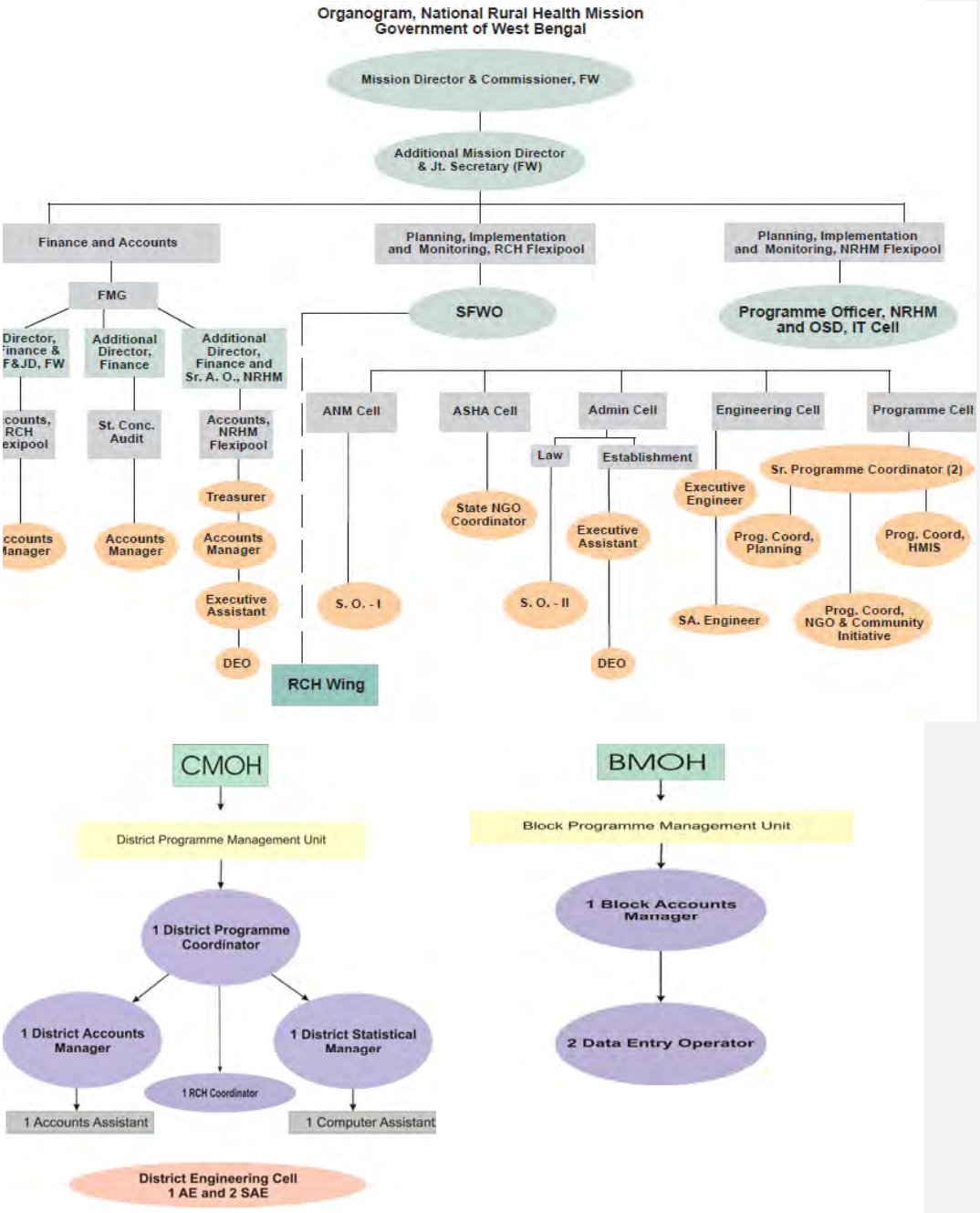
Sl. No.	Particulars	Sanctioned strength	Nature of post
1.	Mission Director & Commissioner, H & FW	1	Regular Staff
2.	Addl. Mission Director & Jt. Secretary, H & FW	1	Regular Staff
3.	Programme Officer, Ex-officio & Dy. Secretary	1	Regular Staff
4.	Sr. Account Officer		Regular Staff
5.	State NGO Co-ordinator	1	Contractual Staff
6.	Consultant (Bio Medical Engineers)	1	Contractual Staff
7.	Engineer-in-Charge	1	Contractual Staff
8.	Sr. Programme Co-ordinator	2	Contractual Staff
9.	Programme Co-ordinator	2	Contractual Staff
10.	Programme Co-ordinator	1	Contractual Staff
11.	Sub-Assistant Engineer	1	Contractual Staff
12.	Accounts Manager	3	Contractual Staff
13.	Executive Assistant	5	Contractual Staff
14.	Data Entry Operator	31	Contractual Staff
15.	Group-'D'	6	Contractual Staff
Total of State PMU: (A)		**58**	

The State Programme Management Unit is headed by the State Mission Director and Commissioner of Health and Family Welfare. The Jt. Secretary Health and Family Welfare is functioning as the Additional Mission Director; an organogram of SPMU is given below.

At the District level, **District Health & FW Samiti** consisting of the Sabhadhipati of Zilla Parishad, District Magistrate, ADM Health, OC Health, DPO – ICDS, CMOH, Zonal Leprosy Officer, Dy CMOH – 1, Dy CMOH – 2, Dy CMOH – 3, DMCHO, DPHNO, DTO, Addl MO, AO, RHTO and DPMU are involved in the formation of project implementation plan.

At the Block level, the Sabhapati, BDO, CDPO, BMOH, BPHN, PHN and BPMU take part. The teams remain fixed each year. Engineering set-up (consisting 1 Assistant Engineer and 2 Sub-Assistant Engineers – all of them from civil side, no one from Electrical side) has also been introduced from September 2010.

The CMOH holds a combined meeting of DPMU and regular staff together once every month. The MD NRHM holds a meeting with DPMU once every month. There is no integrated monitoring team.


Organogram, National Rural Health Mission
Government of West Bengal
Mission Director & Commissioner, FW
Additional Mission Director & Jt. Secretary (FW)
Finance and Accounts
Planning, Implementation and Monitoring, RCH Flexipool
Planning, Implementation and Monitoring, NRHM Flexipool
FMG
SFWO
Programme Officer, NRHM and OSD, IT Cell
Director, Finance & F&JD, FW
Additional Director, Finance
Additional Director, Finance and Sr. A. O., NRHM
ANM Cell
ASHA Cell
Admin Cell
Engineering Cell
Programme Cell
Accounts, RCH Flexipool
St. Conc. Audit
Accounts, NRHM Flexipool
Law
Establishment
Sr. Programme Coordinator (2)
Treasurer
State NGO Coordinator
Executive Engineer
Accounts Manager
Accounts Manager
Executive Assistant
Executive Assistant
Prog. Coord, Planning
Prog. Coord, HMIS
S. O. - I
S. O. - II
SA. Engineer
Prog. Coord, NGO & Community Initiative
DEO
DEO
RCH Wing
CMOH
BMOH
District Programme Management Unit
Block Programme Management Unit
1 District Programme Coordinator
1 Block Accounts Manager
1 District Accounts Manager
1 District Statistical Manager
2 Data Entry Operator
1 RCH Coordinator
1 Accounts Assistant
1 Computer Assistant
District Engineering Cell
1 AE and 2 SAE

Organogram of the DPMU *Organogram of the BPMU*

Each Programme or entity visits Districts sporadically; there is no regular frequency of monitoring visits. District Accounts Manager and Accounts Assistant are an integral part of DPMU. The District Health & FW Samiti is the highest body in the district that takes decisions about implementation of the health programmes including NRHM and also monitors the progress from time to time. CMOH of the district is the member-secretary of this Samiti and the district level programme officers are members. Accounts Officer of the Office of the CMOH is usually the treasurer of the Samiti.

HR status:

There are vacancies in the DPMU and BPMUs of Murshidabad district. Post of District Statistical Manager, part of the DPMU is vacant since 2 years and the others such as the District Program Coordinator, District Accounts Manager and Accounts Assistant are in place. Every BPMU has a Block Accounts Manager. In contradiction to Murshidabad we observed in Paschim Medinipur that there is no vacancy in the DPMU and BPMUs. DPMU has a District Accounts Manager and Accounts Assistant. Every BPMU has a Block Accounts Manager. The attrition rate in DPMU and BPMUs is negligible.

The attrition rate in DPMU and BPMUs is high in Murshidabad and on the other hand there are also few members of DPMU and BPMUs who have been working in the DPMU & BPMU for a long time. The reasons for high attrition rate are: There is no human resource policy at District or Block level for ensuring future growth / career progression of the DPMU / BPMU and members of DPMU and BPMU feel that the remunerations are not sufficient in view of the increase in cost of essential items. Only reason why the district program coordinator and accounts personnel are still working here in the district is because (i) increase in remuneration over a period of time and (ii) all of them are hopeful that they will get absorbed in the State Government jobs. However, Even though an engineering wing is set-up with 2 Asst. engineers in the DPMU the district has not managed to fill these positions.

The DHS must support and ensure the capacity building of the accounts personnel in view of the increasing disbursements and monitoring their utilization. The district must appraise the performance of the DPMU and BPMU using a structured questionnaire. On outcomes of the evaluation the CMOH must increase their salary in certain percentage.

Capacity Building:

The capacity building efforts are not sufficient in both the districts. Only one round of training have been given to the Murshidabad DPMU. There is no training calendar for DPMU / BPMU personnel at District or Block level. Programmes impart training as per their needs. DPMUs are clear and aware of whom to contact in SPMU or directorate for query solving or in case of doubts or clarification regarding any guideline.

An induction training must be given to both the DPMU and SPMU staff as and when the employee joins the PMU and also regular training to be given after a specified period.

However, the coordination between SPMU, DPMU and BPMU is good since these entities are involved in the formulation, implementation and monitoring of plan at their respective levels and work closely with each other. The PMU at various levels must monitor the line listing of severe anaemic pregnant women, low birth weight infants, also to monitor the implementation of JSSK, JSY & Ayushmati Scheme. The PMU to also ensure MDR, safe abortion, sterilization and immunization and other health programs. The PMU must also look into data for water testing for arsenic content and thalassemia affected blocks in West Bengal. The PMU needs to analyse all these data and to inform the BMOH

according to good and poor performing blocks and to focus on the poor performing blocks and areas. Similarly DPMU should collect the data and analyse and submit the data to CMOH.

Support and Supervision:

The SPMU reviews HMIS data and feedback is given to the DPMU. The DPMU staffs views the HMIS data. On or around 20th of every month, the Murshidabad DPMU organizes a review meeting with the Data Entry Operators of BPMUs where feedback is given to them about the quality of data. The HMIS data is used for improving programme implementation.

It was observed that poor dissemination of feedback from DPMU to BPMU using the HMIS or other reports by various Programmes for reviewing the status of implementation of respective Programmes. Monthly review meetings are held at the district level also with the BAMs of the blocks. The Dy CMOH - 3 and DIO hold a separate meeting with the BPHNs & PHNs every month, where details of RCH Programme are discussed.

Decision Making:

Review meetings: The state has a positive approach to review their programs every month. 2nd Saturdays the Health Minister chairs the meeting to review the districts along with the district CMOHs. Similarly the state also conducts the review meeting division wise. All the other health program officers and PWD officials to meet once in a quarter to review the performance at the state level.

Day	Frequency	Subject	Convenor	Participants
State level Meetings				
Monday of every week	Weekly	Monitoring Meeting with senior officials in the Department (Swasthya Bhawan)	Principal Secretary, H&FW	DME, DHS, Secy(FW), SFWO, Jt. Secys, Technical Officers etc
1st Monday of every month**	Monthly	Vector Borne Diseases (Pub. Health Programme excluding NCD, NPCB & Mental Health)	Secretary (PHP)	Principal Secretary, DHS, Director (RIO), ED, Dy. CMOH-II, Programme Officers, District Officials as may be necessary
2nd Monday of every month**	Monthly	Vector Borne Diseases (Pub. Health Programme excluding NCD, NPCB & Mental Health)	Secretary (PHP)	Principal Secretary, DHS, Director (RIO), Dy. CMOH-II, District Officials as may be necessary
3rd Monday of every month**	Monthly	Mental Health & District Mental Health Programme	Special Secretary (Mental Health)	Principal Secretary, DHS, Director (IOP), District Officials, Superintendents of Mental

Day	Frequency	Subject	Convenor	Participants
				Hospitals as may be necessary
2nd Saturday of every month**	Monthly	Review Meeting with all CMOHs	Special Secretary (MA)	Principal Secretary, DME, DHS, SFWO, SS(TDE)/JS(TDE), ED (State Samiti) and Programme Officers
3rd Saturday of every month**	Monthly	RCH & NRHM Additionality, procurement, stock etc.	Joint Secretary (Family Welfare)	Principal Secretary, DME, DHS, Secy(FW), SFWO, District Officials as may be necessary
4th Saturday of every month**	Monthly	Review Meeting on TB	Secretary (PHP)	Principal Secretary, DHS, DTOs and other officials
1st day of every month**	Monthly	Meeting with Principals of MC&Hs	Joint Secretary (ME)	Principal Secretary, DME, DHS, Secy(FW), SFWO, SS(MA) and others as may be necessary
	One day for each Division	Division wise RCH Review Meeting	SFWO	Dy. CMOH-III and other district level officials
	One day for each Division	Meeting with PWD and other executing agencies	Chief Engineer PWD	Dy. CMOH-III and other district level officials
District Level Meetings				
10th of every month**	Monthly	Public Health Meeting		
20th of every month**	Monthly	NRHM/RCH Review Meeting	SFWO	Dy. CMOH-III, Dist. PMU and other officials as may be necessary
Block level Meeting				
1st Saturday of every month**	Monthly	Block level Review Meeting	BMOH	Block level officials
Gram Panchayat level Meeting				
4th Saturday	Monthly	GP level Health Meeting	GP Pradhan	ANM, Health Supervisor, AWW,

Day	Frequency	Subject	Convenor	Participants
of every month**				Sanchalak-Swasthya Upasamiti, ASHA etc.

At the District level, the Accounts Officer and the District Accounts Manager are responsible for releasing salary of contractual employees. No mechanism for performance monitoring is done at the DPMU or at the BPMU.

It would be more appropriate if the BMOH monitors of performance of the BPMU staff. The monitoring of performance of DPMU staff is done by CMOH in his capacity as Member Secretary of District Health & Family Welfare Samiti. The DPMU and BPMU have understood the requirements of the plan and have been providing supportive supervision. However, the DPMU and BPMUs need to be strengthened in view of the increasing work-load. DPMU has no financial powers. However it can put in proposals in regard to existing programmes or innovative schemes in the District Health Action Plan in consultation with respective programme officers &/or the CMOH.

Drugs and Equipments:

There are some drugs and equipments whose procurement is done by West Bengal Medical Services Corporation. The details of procurement done by this Corporation are available on the website www.wbhealth.gov.in. For majority of drugs and equipments, Central Medical Stores (CMS) has provided rates and empanelled vendors. Procurement of drugs and equipments on this list does not require any tendering by the District. For the procurement of other drugs and equipments, tendering process based on Twin bid method – Technical bid followed by financial bid – is followed. The details of tender are provided on www.wbhealth.gov.in and www.murshidabad.nic.in. After procurement of drugs directly from the manufacturer, Goods Receipt Note is prepared in Store Management Information System (SMIS) software followed by mandatory sampling of received goods. Unless sampling details are recorded in the SMIS, Goods Issue Note cannot be prepared. The sampled drugs are then sent to CMS Kolkata under proper seal through speed post / courier for drug test. Consumption of drugs is commenced even before the availability of test report. This is based on the fact that with every lot of drugs procured from manufactures is accompanied by a report from manufacturer's laboratory. However, an adverse test report results in stoppage of further consumption of the drug. Procurement manuals are followed in the procurement. Annual requirement of drugs and equipments is prepared on the basis of consumption of previous and current year's demand. Since the entire system of procurement and distribution of drugs and equipments is based on web-based software application, the status of District Reserve Store can be viewed and monitored by everyone – from State HQ to peripheral users i.e. BPHC. The District can purchase equipments worth less than Rs 50000/- in a single order. The District can procure non-antibiotic items worth Rs 100000/- and antibiotics worth Rs 200000/- in a single order. There is no system of pass book.

Procurement:

The Dy CMOH – 1 is in-charge of procurement. The supply of next year is based on the consumption of previous year and current year's demand. There is a mechanism of buffer time and buffer stock. Buffer stock for which buffer time is 21-35 days. The supply of drugs and equipments in case of floods is based on the level of flooding, estimated on the basis of rainfall pattern. For other disasters, there is no disaster management strategy. The District does not have a common warehouse for health

systems and disease control programmes. There are separate warehouses for Family Welfare, NVBDCP, RNTCP, etc.

During any LWE violence, the District Hospital organize special camps for treating police personnel injured in landmine blasts. During disasters, Dy CMOH – 1 and Dy CMOH – 2 are closely involved in the relief operations.

Utilization of Drugs and Supplies:

Drug supplies are based on the consumption pattern of previous years and that ensures their responsiveness to utilization pattern. Up to 2011-2012, the CMS used to provide many vendors for a single item and the supply of drugs was uninterrupted. However, since 2012-2013 the procurement policy has changed and now the CMS prescribes only one vendor for an item. This results in a lot of supply orders from the various Districts with a single vendor as a result of which there is interruption in supply of drugs if the District does not get drugs within 35 days (the buffer time is 35 days).

During our visit to the facilities we observed that drugs were not available as per their Essential Drugs List (EDL), No EDL in the facility, in Sagardigh 16 drugs were available.

Institutional mechanism on Infrastructure:

A construction wing has been introduced in DPMU since September 2010. This consists of 1 Assistant Engineer (Civil) and 2 Sub-Assistant Engineers (Civil). At SPMU level, there is a Chief Engineer (Civil). This wing undertakes site-visits for monitoring the quality of construction and status of implementation of construction activities. This facilitates completion of construction and hand over of infrastructure. DPMU arranges transport for the construction wing in coordination with Regional State Transport Officer out of mobility funds available with DPMU.

Representatives of the PWD and PHE are members in the District/ Block H & FW Samiti where issues regarding construction and hand over can be issued in presence of all stake holders. In state level review meetings with DPMUs and with CMOHs, progress is reviewed.

All district have established RKS help desk at every facility in the district. Especially it was evident at the DH, SDH and BPHC in both the districts visited. The District has operationalised 25 NGO led ambulances and 67 private hired ambulances based on PPP model in Murshidabad and 99 ambulances in Paschim Medinipur.

It was also observed in Paschim Medinipur that some diagnostic centres are operationalized through the PPP model . In Chandrakona Rural Hospital of Chandrakona – II Block, a diagnostic centre is being run by Unimed Diagnostic Pvt Ltd on PPP model. An NGO called *Manbhum Anandashram Nityanand Trust* (MANT) is running MMUs in 11 inaccessible Blocks of the Paschim Medinipur District.

The State HQ provided standard contracts for signing with the successful bidders. The State HQ has floated tenders for operationalising Thalassemia diagnostic centres and MMUs.

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

State Institute:

Different training programmes for Medical Officers and TOT-s of different programmes are organized by the SIHFW. It does not have adequate number of faculties of its own, but manages by involving state trainers/ state officials/ experts in different disciplines as and when necessary.

Capacity Building:

Training programmes are rolled out in a cascade model from state to district to sub-district levels. In some of the training programmes, one facilitator from a level one step higher remains present to ensure quality.

Usually the training outcomes are evaluated by use of pre- and post-exposure questionnaire. In SIHFW, feedback is taken from the trainees in a structured format.

There is no separate person in the districts to push forward the training programmes. The respective programme officers usually organize such programmes in addition to many other tasks. This is one of the reasons of slow progress in some aspects. Getting financial approval faces constraints in some cases.

- Training should be decentralized.
- Dy. CMOH should be entrusted the task of scaling up the capacity building and funds should be provided as per their need.
- At the state level DD MCH should supervise the capacity building of RCH training.
- The training sites needs to be accreditated by QAC .
- Training should be monitored for quality.

Development Partners and their technical assistance:

The World Health Organisation (WHO) is supporting the District in Acute Flaccid Paralysis programme for polio eradication. WHO also supports technical monitoring of the RNTCP through its Consultants. Two such personnel are associated at the state level with the TB Branch. UNICEF has provided training support during the take-off of the Fluorosis Control Programme in the state.

ICMR Virology Unit, Beliaghata, Kolkata and NIV-Pune provide the state with laboratory back-up for selective diseases e.g. dengue, chikungunya, JE, Chandipura Virus etc. CRME (ICMR), Madurai carries out vector surveillance for JE in northern districts of the state. They have also expressed their agreeability to impart Entomological training to state personnel.

SHSRC and others:

Yes, the state has a Strategic Planning and Reform Steering Committee constituted. The committee will be chaired by Principal Secretary and convened by Director, SPSRC and Special Secretary. Most senior officers of Directorate and Secretariat are its member. He is assisted by a Joint

Director to coordinate the functions of the officers and to deal with all administrative matters including procurement of Technical Assistance. At present, twelve technical officers, out of which seven are full time. Apart from them the functional areas of SPSRC are clubbed under eight thematic areas and 5 consultants for PPP, Healthcare financing, community participation, Public Health Planning, Quality Assurance programs.

At the State level, Regional Resource Centre, CINI is working as the State Training Centre. At present, CINI is providing all technical support to the State in respect to training, material development and maintaining database. CINI is responsible for conducting TOT of coordinators and co-facilitators of MNGOs at district level provide training follow up support to MNGOs at field level at the time of training of ASHAs, development of IEC materials for training and development of HMIS of ASHA programme. The Community Medicine Department, Pediatrics Department and Obstetrics Department of Medinipur Medical College and Hospital (MMCH) have been providing support to Paschim Medinipur District in training through help in preparation of training manual and undertaking Training of Trainers.
A mother NGO called *Ganna Unnyan Samity, Kolkata* is active in Murshidabad to provide ASHA training and handholding of ASHAs. An NGO called *Prabuddha Bharati Shishu Teertha* is also active in the Paschim Medinipur District for ASHA training.

Using the data in planning process: At state

HMIS data are used for state planning and mid-term corrective actions as well. These data help the state programme officers and authorities to prioritize areas for monitoring and resource inputs. Programmes like RCH, NVBDCP etc. are benefited out of this. HMIS data analyzed by GIS are used for making decisions on strengthening of maternal care facilities.

There is a defined mechanism to give feedback to the district level users. Each programme has its system of district review at the state level. The review meeting of the DPMUs is a good opportunity for feedback on MCTS but it is not effectively used in Murshidabad district.

Using the data in planning process: At district

The HMIS and MCTS data is only being used in the preparation of district plan. The HMIS or the MCTS is not been effectively used for improvement in the RCH services in the district of Murshidabad. This data is used only in fund allocation and monitoring the status of implementation of various Programmes. The low performing units are only identified and no strategies are devised to improve the situation.

For example, the pace of sterilization had dropped significantly across the district and no special efforts had been made to improve the situation. It was observed from HMIS data that the ANC registration was not satisfactory. When some units reported high number of low birth weights, pre term from some pockets of the district, the district has not yet analysed and addressed these issued. Where as in Paschim Medinipur, The low performing units are identified and strategies are devised to remedy the situation. For example, in Gopivallavpur – I block, the pace of sterilization was not found satisfactory. So, special drive was initiated which helped in sterilization picking up pace in the Block. It was observed from HMIS data that the ANC registration was not satisfactory. So, ASHAs were given “Nischay Kits” so that the ANC could be provided to pregnant women who were unwilling to come to the health facility. This improved the ANC registration. Some PHCs were reporting high number of maternal deaths; the indent for Magsulph injection by these PHCs was monitored to determine whether lack of this injection is the

cause of maternal deaths. When some units reported high number of low birth weight new-borns, poster competition was held for PHN and BPHN to sensitise them on how to remedy the situation. Immunisation figures if units in the third quarter are analysed and low performing units are asked to take up special drives.

A meeting of Data Entry Operators (DEOs) of BPMUs is held around 20th of every month where feedback is given to them on quantity of their data. This has not helped the District in achieving accuracy of data. The District has already started facility-based reporting on HMIS but still to scale up. The reports can be downloaded by users at sub-district level.

MCTS:

MCTS is being implemented in the District as per Government of India guidelines. MCTS data is only been entered but not helped in identifying the low performing units and devising remedial measures. There is no other tracking system being implemented in the District. At the District level, Dy CMOH – 3 is the nodal officer and at the Block level, BMOH is the nodal officer for MCTS. Line listing of severely anemic pregnant women and low birth weight new-borns is not done in Murshidabad district.

At State level:

Pregnant women and mothers:

	ELA Pregnant Women	ELA for 6months	Total Mothers Registered	% Achievement
Mothers Registered on MCTS Server	**1698242**	**849121**	**5,89,257**	**69%**

Infants & Children:

	ELA (Infants)	ELA for 6 months	Total Children Registered	% Achievement
Count of Children Registered on MCTS Server	**1598398**	**799199**	**3,90,835**	**49%**

Expected deliveries in the state is 849121 PW where as only 589257 PW have been registered under MCTS. There is a gap of 31%. Total Live births registered under MCTS is 390835 against the 799199 expected live births registered to be registered. The district must try to ensure that they cover 100% under MCTS.

In Murshidabad:

Pregnant Women & Mothers:

Total Mothers Registered	Mothers with Anemia Severe<7	Mothers with Anemia Moderate<11	Mothers With Complica-tions	Mothers who delivered Child weighing<2.0 kg	Mothers Death	Mothers Registered Today 01/11/2012	Mother Records Updated Today 01/11/2012	Mothers Registered Last 30 days	Mothers Updated in Last 30 days	Mothers Marked for Deletion
69,135	61	14,117	438	58	3	60	37	8,039	2,764	6

Infants and Children:

Total Children Registered	Children without Self Phone No.	Children without ANM Name	Children without ASHA Name	Children Death	Children Marked for Deletion	Children Registered Today 01/11/2012	Records Updated Today 01/11/2012	Children Registered Last 30 days	Children Updated in Last 30 days
44,217	6,188	0	0	64	12	148	41	7,887	2,537

Gap in MCTS registration in Murshidabad district:

	HMIS Total Registered	MCTS Total Registered	% of achivement
ANC Registration 12	**77625**	**69135**	**89**
Total no. of Live Birth	**71765**	**44217**	**62**

1st trimester ANC registration in HMIS in Murshidabad district is 77625 PW where as only 69135 PW have been registered under MCTS. There is a gap of 11%. Total Live births registered under MCTS is 44217 against the 71765 live births registered under HMIS. The district must try to ensure that they cover 100% under MCTS.

Public health and Epidemiologist experts:

The post of Epidemiologist (IDSP) is filled in the district. However the Dy CMOH - 2 and the Subdivisional Asstt CMOHs have been trained on outbreak investigation in a 3-day programme arranged out of state budget.

Non- Technical Staff Trainings:

Clerical staffs (Permanent) have got training in Financial Management. The District Programme Coordinator of DPMU has got training to design trainings. This training was held in Administrative Training Institute, Kolkata. Other contractual staff has been imparted training in HR Management, Financial management, programme wise training, store management & web based training HMIS, MCTS.

BAMs of the BPMUs have been given training on using Tally software along with a brief exposure on financial management. Block and facility level Data Entry Operators have been trained in IDSP.

TOR X Financial Management-especially fund flows, accounting and absorption

Good Practices

- ✓ Books of accounts were properly maintained in Tally ERP-9 software as well as manually at State/ District /CHC/ PHC level.
- ✓ Smooth Electronic transfer of funds up to BPHC level.
- ✓ Bank Reconciliation Statement was prepared at all levels.
- ✓ Timely reporting was observed from Block level to District health society.
- ✓ Uniform accounting practice is being followed by District Health Society.
- ✓ JSY registers is maintained properly and all the JSY records and photographs of beneficiaries maintained properly at CHC/ PHC level.
- ✓ Supportive Supervision Team visits the facility on quarterly basis to check finance/ accounts and for overall quality development of the health facility.
- ✓ Corpus Funds are generated out of user charge of the facility situated within the State, District and above the tier of Rural Hospital.

Key observations

- ❖ **Financial Human Resource:**

  There is a shortage of two District Accounts Managers (Malda and Birbhum districts) out of 19 sanctioned posts. Out of 341 sanctioned post of BAM position, 14 posts of Block Accounts Manager are vacant in 9 districts. The State Accounts Manager position at state level is yet to be created.

- ❖ **Electronic Fund Transfer**

  Funds are transferred from State Health & Family Welfare Samity to District Samities and District Samities to Block Samities by RTGS e-transfer system via United Bank of India. But, below the block level due to lack of core banking system at most of the places, funds are transferred from block level to PHC and Sub centre level by A/c payee cheques as these PHC/Sub centres bank account with Banjiya Gramin Vikash Bank, which takes 15 days to transfer the fund. Funds are disbursed on the basis of DHAP. It is informed that in District Head Quarter of Murshidabad, the account officer of the office of the CMOH is the Treasurer of the District Samiti. Hence payments are made from his office to staffs /Agencies by A/c Payee cheques while the DPMU maintains the accounts pertaining to these payments. There is no significant delay in disbursement of fund at sub district level.

- ❖ **Delegation of Financial and Administrative Power**

  The order of delegation and administrative power down the level has already been issued by the State Samiti as per the guidelines of the GOI

❖ **Tally ERP9 Software**

Tally ERP9 software has been installed at all level (State Health Samiti, 19 District Health Samities and 341 Block Health Samities). But not seen the tally generated consolidated final accounts in prescribed format across the level. Accounts were maintained in Tally ERP9 and manually also for the FY 2011-12. all the transactions were entered in Tally ERP 9 for the F.Y 2012-13 as on Oct. 12, however opening balance of 1st April 2012 was not entered in Tally software due to the finalizing the shifting of activities from MFP TO RCH. In Murshidabad district, out of 26 blocks 5 blocks are facing some technical issues related to up gradation of licenses. It is found that Tally ERP 9 at sub Divisional Hospital Level has not been introduced.

❖ **Programme wise unspent Balance of Advance as on 30.09.2012**

Sl. No.	Scheme	Unspent Balance as on 30.09.2012 (Rs.)
A	RCH Flexible Pool	1,70,70,27,282
B	Additionalties under NRHM (Part B of PIP)	3,71,78,69,122
C	Immunization (Part C of PIP)	17,02,52,640
E	IDSP	48,52,014
F	NVBDCP	10,75,89,411
G	NLEP	1,38,23,668
H	NPCB	3,94,81,950
I	RNTCP	11,55,31,308
	Total:	5,87,64,27,394

Substantial amount of advances (Rs. 587.64 Cr) are unspent balance and bank balance is Rs.551.03 Cr for programmes as on 30th Sept, 2012. Details of Program wise advances are maintained but no age wise advances details are available. There are no salary advances and staff advances given.

Total outstanding advances of agencies were lying for Rs. 30.82 Cr. under RCH Flexi Pool and Rs. 398.89 Cr. under Mission Flexipool as on 31 Oct 2012. Advances are given to the agencies again without settlement of the previous year balances and also old advances balances are not settled. Major outstanding agencies advances are as follows:

Name of the Agencies	Op. Balance as on 01/04/2012	Advances paid during April 12 to Oct 12	Total Outstanding Balance as on 31st Oct 2012

WB Medical Services Corporation	13,00,54,357	15,00,91,210	28,01,45,567
Executive Engineer-I PWD Suburban Division	10,80,233	2,10,25,000	2,21,05,233
Executive Engineer PWD Kolkatt Division	1,00,90,333	0	1,00,90,333
West Bengal State Rural Development Agency	46,58,85,368	3,62,40,000	42,58,21,669
WBIIDC	17,39,39,497	0	17,39,39,497

❖ **Maintenance of books of accounts & records**

Books of accounts are being maintained both, manually and by using customized Tally ERP9 software. Books of A/c are maintained at different level as Cash Book, Ledger, Stock register, Advance register.Monthly FMR is submitted from block to district on 3rd working day of subsequent month, from district to State on 10th working day of subsequent month and from State to GoI 20th of subsequent month on quarterly basis without physical data. It is observed that at Sagardigih Rural Hospital MURSHIDABAD Program wise Cash book, advance register was not maintained properly and also no age wise details of the advances maintained. This has also been observed by Concurrent Auditor. There is no monitoring at Sub Centre level accounts. Cheques issue register was being maintained however cancelled cheques are not entered. At Arjunpur PHC earned Rs.1,71,000/- on account of after selling old articles/ equipments of PHC as per the guidelines of H& FW Dept. of WB. and this money was utilized for other than JSY patients. Used mainly for ambulance services, mosquito repellents, repairs and renovation of the PHC.

❖ **State Share Contribution**

As per State Govt. records there is no shortfall in State Share during the period from 2007-08 to 2011-12, but as per records of the GOI there is shortfall in State Share of Rs.111.67 crore during the corresponding period and Rs. 224.80 crore for the F Y 2012-13. During Financial Year 2012-13 state has contributed of Rs. 63.75 crore and Rs.272.72 crore is outstanding as state share.

❖ **Budget V/s Expenditure**

The total approved budget of the State for the financial year 2012-13 under NRHM is Rs.1096.99 crore (Inclusive of committed Liabilities Rs. 5.99 crore) against which the expenditure incurred by the State up to Sep 2012 is Rs.292.35 crore equivalent to 26.79 % of approved PIP. The State has only 29.54% expenditure under RCH Flexible pool against the approved SPIP of Rs.515.89 crore and only 24.18% expenditure reported under Mission Flexible Pool against the approved SPIP of Rs. 421.07crore.

❖ **RKS**

RKS has been constituted at all level from state to block as RKS is not a registered body as per the Societies Act. There were Separate bank account and cash book maintained for the same. Audit of the RKS funds are not doing separately.

In BPHC Anupnagar (Duliyan Municipality) the RKS meetings are not held on regular basis due to various constraints such as the MLA or any other participant was pre occupied with other roles.

Last meeting was held on 23/7/12 and the next meeting proposed is after 18th Nov. In Arjunpur PHC, they meet regularly once in a month, last meeting was held on 13/10/2012. Members attended in this meeting: MLA, Panchayat pradhan, MO, Pharmacisit, LTs, SNs, NGO representative. In both the facilities minutes of RKS meeting maintained properly.

- **Corpus Fund:**

It is generated out of user charge of the facility situated within the State, District and above the tier of Rural Hospital. All the facilities are taking user charges from the general patients to retain 60% of the total collection which is used to improve the PHFC i.e. medicine purchase, security guard, vehicle service, cleanliness, repairs etc and remaining 40% transferred to the RKS Corpus Fund. The RKS Corpus Fund are distributed to the facilities of the all Districts as per their requirement. This fund is further utilised once in year though out the State to renew the patient amenities available in the facilities and to restore cleanliness under the programme "CITIZEN CENTRIC FORTNIGHT ACTIVITY"

During the Financial Year 2011-12, the Samiti earned Rs. 10.92 crore through user money and unspent balance under RKS Corpus Fund as on 31/03/2012 is Rs.21.16 crore. It is observed that an amount of Rs.19.50 Lacs had been released from Murshidabad District Corpus Fund to all facilities for organizing "CITIZEN CENTRIC FORTNIGHT ACTIVITY" for the F.Y 2012-13. The amount of Rs. 50000/- had been paid to each of 26 Blocks and one RH and Rs.1,00,000/- each for six facilities of DHFW.

It was observed that during visit in Panchgram PHC received fund of Rs.14000/- from Corpus Fund and this fund was utilized to refurbish the toilets. The Sub Divisional Hospital Lal Bagh received Rs. 1 Lakh and has used this money for chairs in the waiting area, drinking water facility and others. Sagardighi Rural Hospital received of Rs. 50000/- from District Corpus Fund for observing Citizen Centric Fortnight Prog. The fund has been utilized for the de-bushing and maintenance of the overhead water tank.

- **District Illness Assets funds**:

District illness assets funds for BPL covering all kinds of illness up to Rs. 2000/-. The total amount for the facility received is Rs. 75000/- from the State budget and the health facility has used only a sum of Rs. 6000/- so far.

- **SST- Supportive Supervision Team:**

There are 2 members from the state; one is from medical and the other is from non medical background. They will visit the facility on quarterly basis to check for overall quality development of the health facility. The process involves in looking in to the health facility from the time of entry of a patient in to a health facility until the patient leaves the facility. They look into the administration, Accounts, clinical treatments etc.

- **Fixed Asset Register:**

Fixed assets register were not maintained under NRHM at State and District level.

- **ASHA Incentives:**

The Asha incentives are not paid due to departmental enquiry from District Magistrate regarding irregularities and violation of NRHM guidelines in Murshidabad District. Funds will not be sent by district till the enquiry was sorted out. There are delays in the payment in most of the facilities. As verified at Sagardighi Rural Hospital on 5th Nov 2012 in the cash/bank book it is revealed that ASHAs were paid on 19th Oct 2012 for the month of June 2012 through e-transfer. From July on wards payments to ASHAs were pending because:

-Scarcity of funds
-After receiving the activity report from the ASHAs- by the ANMs, it takes nearly one month for verification. Only after the verification is made payments were given to the ASHAs, it is observed one and half month of delay.

In BPHC- Anupnagar (Duliyan Municipality) facility the payment of ASHA for the month of July 2011 was paid in Dec 2011. i.e 5 months delay. There is a 13 month delay i. e. from Aug 2011. Adhoc payment of Rs. 900/ASHA is paid as per defaulting 13 months and balance of Rs. 700 will be adjusted later after the DM's enquiry is sorted.

- **JSY**

JSY registers are maintained properly in all the facilities but not in a prescribed format. Separate cash book for JSY funds was not maintained at Arjunpur PHC, BPHC- Anupnagar (Duliyan Municipality) however subsidairy cash book was maintained at Sub Divisional Hospital Lal Bagh. JSY funds are received in cash at Arjunpur PHC through the block (Farakka block primary health center) and at Panchgram PHC through Nabagram Block H& FW Samiti due to non core bank accounts. All the JSY payments to the beneficiary are paid in cash which is not permissible as per GoI guidelines. There are some delay in payments due to incomplete documentation. JSY beneficiary gets Rs. 500/- after 3rd ANC at Sub Centre and balance of Rs. 500/- after delivery at the time of discharge or after submission of required documents whichever is earlier. Documents are required such as
- Discharge Certificate
- Gram Panchayat Certificate
- JSY Card
It is noted that Rs. 612400/- was paid to JSY beneficiaries for the month Oct. 2012 in Sub Divisional Hospital, Lal Bagh. It is also observed that in the same facility, the payment to beneficiary is paid to mother after the delivery a sum of Rs. 1000/- as per the State has issued an order under revised guidelines for implementation of JSY on 21.08.2012 file no: H/CFW/235 (52/HFW/NRHM-201/08) that JSY payments of Rs. 1000/- to be paid to the mother after delivery at the health facility. No payment will be made after completion of 3 ANC. This order is w.e.f. 1st Oct 2012.

- **JSSK:**

Similar practice observed across the district, of reimbursing money towards JSSK medicines to the pharmacy stores.

- **Diversion of Funds**

There was no diversion of fund in FY 2011-12 as reported by Concurrent Audit. There are some diversion with in the sub program but there are no diversion between the programmes.

❖ **Untied Funds / AMG**

The State has incurred low expenditure in Untied Funds of Rs. 14.17 Cr against the budget of Rs. 52.18 Cr i.e. 27.15% for the F Y 2011-12 whereas 35.73% utilised as on Oct. 2012. However 56.49% utilized under Annual Maintenance Grant against SPIP of Rs.11.63 Cr in 2011-12 and 35.90% utilized as on Oct. 2012.

❖ **Training**

Meeting with State and district level accounts personnel is organized regularly on monthly basis to monitor and evaluate the financial position as well as financial system. Besides this, four workshops with state, district and block level accounts personnel during the F.Y. 2011-12 and two workshops during F.Y. 2012-13 (up to Aug 2012) have also been organized. Generally two trainings are organized by State per year, however Training calendar has been not maintained by State.

❖ **Financial Integration under NRHM**

Integration of Financial Management Processes with disease control programme is in process

❖ **Procurement:**

Procurement procedure is being followed as per the State Procurement Policy. All the procurement for the districts and blocks are done through District Reserve Store (DRS) by State Health & Family Welfare Samity. They have a customized software i.e. 'Store Management Information System'(SMIS). Agencies / Suppliers are selected from State by tendering. If the prescribed medicines not available in the hospital, doctor prescribes the medicine and the patients goes outside to a registered pharmacy. On submitting the prescription to these registered pharmacy shops the patient will receive the drug without any payment and the pharmacist collects all these prescription and submits it back to the Health Facility for the reimbursement.

❖ **Civil Constructions:**

Construction, repairs, renovation of all Sub-divisional and District hospitals are conducted by PWD. Constructions, repairs, renovation for facilities from RH to Sub Centre are done by Panchyat Raj Institions.

❖ **Bank Reconciliations:**

Bank Reconciliations was prepared on monthly basis at all level. As examined the BRS for the month of Oct.'12 following observations

- There are time barred cheques for the year 2010-11 still pending in BRS at state and district level also.
- Some fund has been receipt from Samiti by Program but the release order has not reached of the program whereas not entered in the Cash book.
- There are some long pending cheques for the 2010-11 and 2011-12 in transit with the bank.

❖ **Interest earned against NRHM funds:**

Earned Interest is also utilized for approved activities in the PIP as and when required. It is observed that District H & F Welfare Samiti has earned interest of Rs.79,76,403/- and out of this Rs. 9,54,917/- expenses have been incurred for organising meeting / contingencies in Financial Year 2011-12.

- **Unspent Balance under RCH-I:**

There is no unspent balance under RCH-I and EAG Scheme.

- **Income tax:**

The TDS, Prof. Tax, Vat are deducted regularly and deposited timely. Quarterly return of e-TDS is also regularly filed. At Kandi Block Health & Family Welfare Samiti, Gokarna BPHC, registration renewal and TDS Return was not available and also Profession Tax Return not submitted in F.Y. 2011-12.

- **Auditing Procedure** :

Statutory Audit:

Chartered Accountant Firm is appointed from State Level for the purpose of Statutory audit of State Health Samiti, all district health samities and 40% of block health samities. The firm prepare district-wise separate audit report and submits to the Secretary, District Health Samities. They also prepare consolidated audit report of the State and submit it to the State Health Samiti.Statutory Audit for the F. Y 2011-12 in the Murshidabad District Balance Sheet as on 31/03/2012 are completed but the Audit reports are not submitted by the Statutory Auditor at district level. In Pachimi Medinipur District, the Statutory Audit for the year 2011-2012 has been completed and submitted to state within stipulated time period.

Statutory Audit for the F.Y. 2011-12 is expected to receive by GoI by third week of November 2012.

Concurrent Audit:

The Concurrent auditor is appointed by the State Samiti for every district and block. District concurrent audit is done monthly basis and Block audit quarterly basis. It was observed that in Murshidabad district, the concurrent audit had been completed as on March 2012 and informed that the Concurrent Audit for last 2 quarter (April-Sept 12) not started. Concurrent Audit at Sub Divisional Hospital Lal Bagh was completed as on Sep 2012. The report of this concurrent audit is yet to receive. However the report for June 2012 had been received.

CAG Audit: The State has submitted the compliance report of NRHM Performance Audit (2005-08). Action Taken Reply of further CAG audit is under preparation.

Key recommendation:

- ✓ Vacant positions of accounts personnel should be filled up on priority basis.
- ✓ One accounts personnel should be posted at PHC level where the case load of deliveries is high.
- ✓ Due to day by day increasing workload and diversification of activities, trainings and refresher course to accounts personnel are needed. There should be a proper orientation and training

programme for Sarpanch and ANM to make them clear about the guidelines prepared for utilization of untied funds.

- ✓ Long pending cheques / Stale cheques should be reverted and taken into account for. Transit cheques should be reconciled with the banker.
- ✓ State Health Society should ensured timely appointment of Statutory Auditor and Concurrent for timely submission of auditor report to Ministry of Health.
- ✓ RKS should be registered under Society's Registration Act and audit should be done as per guidelines of the Ministry.
- ✓ Hard copy of financial report generated from Tally ERP-9 should be kept at all level duly signed.
- ✓ State should properly monitor the fund flow system and ensure the timely payment of JSY, ASHA and Family Planning cases. Uniform JSY beneficiary register format may be introduced at all level. Cash Payment of JSY, JSSK and FP is to be strictly avoided.
- ✓ District Accounts Manager/Accountant may also plan to visit at least two blocks in a month for supervising the working of the Accountant and submit his report to the CMHO and a copy to the concerned BMO.
- ✓ The expenditure should be booked in the appropriate head of FMR and duly reported on quarterly basis.Physical and financial progress of work should be monitored and also report in FMR.
- ✓ The State needs to analyse the Reports of Concurrent Audit of all the Districts and ensure its compliance.
- ✓ Advance register should be maintained along with ageing.
- ✓ All the cheques should be serially entered in the register including the cancelled cheques.
- ✓ Statement of Expenditure should be sent on the basis of Trial balance.
- ✓ Time line for submit the Financial Report:
- ✓ State should strictly follow the time line for submission of Financial report as under:-

S.NO	Report	Date on which to be sent
1	FMR	Quarterly(within a month of end of the quarter
2	Statement of Funds position	Monthly
3	Utilization Certificate	Annual (By 31st July along with the audited statements)
4	Statement of interest earned by DHS & SHS	Annual
5	Statement of confirming State share contribution	Quarterly (Within a month from end of the quarter)As soon as contribution is credited in bank

6	Statement of Advances (united funds/RKS/VHSNCs/Sub centre)	Quarterly
7	Audited Statement of Accounts and Audit report of SHS	Annual by 31st July of the following year

- ✓ Income Tax provision for deduction of TDS must be followed by the State for statutory requirements.

RECOMMENDATIONS:

Infrastructure:

- The state needs to establish more health facilities. The existing facilities could be classified into low and better performing and the low performing facilities should to be monitored on a monthly basis. The higher facilities need to be decongested. Delivery points should be increased.
- Key strategic areas and facilities than need focused and prioritized attention. Suggested indicators to be used to identify could be OPD, IPD, Deliveries, Drug availability, Human resources, Finance, Record maintenance, etc.
- Maintenance of facilities needs to be improved and RKS funds need to be utilized for the same.

Service delivery:

- Patient services need to be improved. Availability of mattress, curtains, screens, mackintosh etc. to be ensured as well as the facilities need to be made disabled friendly along with provision of stretcher, wheel chair, trolley as well as easy access (ramp).
- User fees needs to be abolished.
- Prescription for drugs and diagnostics from private sector needs to be stopped.
- Private practice by doctors needs to be checked.
- Lab services need to be strengthened at all the level. 24x7 lab services must be made available at least at the DH, SDH and RHs.
- The crude paper method for estimating hemoglobin needs to be replaced with Sahli's method in the peripheral facilities like Sub-centres and PHCs. Wherever there is a significant workload a semi-auto redressal analyzer should be installed for blood tests.
- Blood Banks also need to be strengthened.
- The BMW management needs to be strengthened and the national guidelines need to be followed in all facilities.

Human Resources

- The State needs to make efforts to fill up the vacancies through regular or contractual appointments.
- Incentives to be provided to those working in LWE affected areas. Provide non financial incentives to staff at all levels.
- Rotation policy for difficult to normal areas
- Coordination of link workers, community health guides, ASHAs, ANMs and anganwadi workers

Training & Capacity Development

- The nursing staff of the low performing District / Facilities should be trained on a priority basis in SBA and NSSK and IUD.
- All MOs of low performing facilities should be trained BMOC
- Staff to visit other better performing facilities
- To have a mentoring group that would provide support and assistance to CMO and the team.

Reproductive and Child Health

- Indentified high risk cases must only be referred to higher facilities.
- Capacity building to be emphasized to the appropriate staff for BEmOC, NSSK, F-IMNCI and SBA.
- All ANCs must be screened for RTI/ STI and HIV in the four blocks with high migration in Murshidabad district (Suti I, Suti II, Raghunath ganj II, Farakka)
- Quality of ANC needs to be improved.
- Protocols to be followed by health personnel at various levels especially at the sub centre level and VHND with regard to ANC
- Anivesha clinic and the OPD should have linkages with the OPD so that the RTI & STI cases are referred and also after counseling they may be referred to ICTC centres for testing. Those found positive should be linked to the ART centre and to be followed up regularly.
- The State needs to take specific actions to initiate systematic Infant Death Reviews.
- The district needs to ensure that all the NBSUs and NBCCs are made functional and refer only the critical cases to the SNCUs.
- On a pilot basis the cold chain handlers after orientation could be allowed to handle the cold chain and the PHN should supervise through a checklist the services rendered by the ANM. She will also evaluate through the checklist the quality of VHNDs. PHNs should be oriented about the process.

Community Processes:

- All the community processes in the State needs to be strengthened.
- Involvement of the PRIs need to be ensures. Accountability measures like displaying of citizen's charter and community monitoring needs to be initiated in the State.
- Simultaneously, a grievance redressal system needs to be set-up in the State

Monitoring and Supervision

- Monitoring and supervision of districts and facilities need to be strengthened.
- Supportive supervision for ANMs need to be strengthened
- Visitors book to be maintained and checked at each facility.
- Weekly reports (key identified areas in just 1 page) from facilities to be sent on email to MO and they should come with explanation with regard to the gaps in the monthly meetings.
- Evaluation of facilities to be done by staff (team) from other facilities (cross evaluation) so that there is self monitoring and learning through a checklist. Report to be submitted to the facility and the CMO.
- Visiting facilities by the CMO and senior officials as an open day wherein the patients, staff and others can bring up issues to be addressed on a quarterly basis.
- Perinatal condition as a data indicator in the reporting format to be removed and can be made more specific.

Dissemination of information

- Services and facilities available in the facility to be displayed
- Duty roster of doctors along with timings to be displayed
- Proper signages to be displayed at the facilities and numbering of rooms.
- Citizen charter to be displayed
- SBA protocols to be displayed in all labour rooms

- Protocols to treat Asphyxia cases to be treated and followed
- Website of district health department providing information for dissemination and monitoring.

Drugs and Medical Equipment

- Strengthening of warehouse for storage of drugs at the district level.
- Procurement and supply chain management. Could use the RNTCP model
- Regular supply of EDL should be ensured
- Coordination
- Regular monthly meetings with other concerned departments with special reference to PWD and PHE and sharing of water testing reports on a monthly basis.
- Finance
- Weekly monitoring of finance income and expenditure at district and facility level across all the heads. In the monthly meeting MOs or concerned staff should come with FMR and physical and financial report.

Specific recommendations for improving the DH Murshidabad.

The District Hospital at Murshidabad was visited once again after 2 days of initial visit. The hospital was obviously spruced up by the Medical Superintendent. The CRM team had a meeting with the Medical Superintendent of the District Hospital, Murshidabad. The following suggestions for improving District Hospital/New General Hospital – Murshidabad were arrived at by the team after discussions with the Medical Superintendent, District Medical and Health Officer and State Officers.

- All the open drains in the hospital building and the premises should be covered.
- Thorough cleaning of the hospital premises, toilets, bathrooms, white-washing, waste segregation and disposal as per guidelines along with necessary electrical works need to be done.
- Painting of cots, removal of construction material, provision of new mattresses, privacy, curtain screens, sitting areas for relatives, drinking water facility, shed for the patient waiting area, security staff appointment to be provided.
- Waste bins at strategic places to be given.
- Bed pans, covered spittoons and hand washing facilities to be provided.
- Signage to be displayed and numbering of the rooms to be done.
- Assessment of actual requirement of eye beds needs to be done.
- Decongestion of both male and female wards on the ground floor and utilisation of the first floor wards properly.
- Paying beds and eye beds if vacant should be used for general patients in case of overcrowding.
- Doctors' rosters for the week should be prominently displayed
- A nursing station to be set-up close to the patients being examined by the doctor so that immediate treatment of emergency cases can be given in casualty
- Display of services provided in the hospitals prominently.
- Grievance redressal committee to be formed and their contact details to be displayed prominently which should consist of local prominent person, one senior district health official and SDM.
- Round the clock availability of medicines as per the State EDL as per caseload to be ensured.
- Medicines to be stored as per guidelines.

- Display of availability of medicines and their quantity at the pharmacy.
- Monitoring group to be formed consisting of the District Collector, Zilla Parishad chief and representative of the health dept. this monitoring group will monitor all the work and report the progress to the Principal Secretary (Health)/Mission Director.
- All SBA protocols should be displayed in the labour rooms
- Blood bank should follow protocols and needs to be strengthened.
- Labeling of pregnant women on forehead and administration of diazepam to delivering women without adequate indication need to be stopped immediately. Instead, I card tags or wrist bands can be used.
- Pregnant women needing CS are using stairs to go to the OT. For such cases, a proper ramp system should be made and be taken through a trolley to the OT.
- Mackintosh to be made available to all pregnant women, emergency and surgical cases.
- Trolleys, wheelchair and stretcher should e bade available for them at the entrance
- Protocols to be set-up for dealing with the mentally deranged patients and unknown patients.
- Stray animals and rodents to be kept away.
- Parking of vehicles should not be done in the hospital building and a separate parking facility to be provided
- All discarded articles to be condemned through the condemnation board regularly.

Annexure - Innovations:

1. **Pubic Private Partnership –**

- Diagnostic Facilities in Rural Hospitals and BPHCs –
  Diagnostic Centres (Pathological Labs) established by Private Sector Partners in the Rural Hospitals / BPHCs is one of the oldest schemes under PPP approved by the Department and running since 2004. This scheme at present is decentralised where the District Health and Family Welfare Samiti decides for the RH/BPHC, floats the tender and selects the private partner for establishment of the Pathology/USG Laboratory. At present 47 (forty seven) such Diagnostic Units are functioning in the RHs and 31 (thirty one) such Centres are running in BPHCs in the districts of the state.

- CT Scan Units under PPP at District Hospitals –
  The Scheme was initiated during 2008.
  PPP CT Scan Units are being established in 9 (nine) District Hospitals at Purulia, Purba Medinipur, Birbhum, North 24 Parganas, Howrah, Hooghly, Nadia, Uttar Dinajpur and Coochbehar. At the District Hospital of South 24 Parganas, Darjeeling, Dakshin Dinajpur and Jalpaiguri installation of PPP CT Scan Units are under process.

- CT Scan Units under PPP at Medical Colleges and Hospitals –
  The Scheme was initiated in August 2001.
  At present the following 10 (ten) Medical College and Hospitals have their CT Scan units functioning under PPP: Calcutta Medical College and Hospital; NRS Medical and Hospital; RG Kar Medical College and Hospital; SSKM Hospital; National Medical College and Hospital; Bankura Sammilani Medical College and Hospital; Midnapore Medical College and Hospital; Murshidabad Medical College and Hospital; Malda Medical College and Hospital and JNM Hospital, Kalyani.

- MRI Units under PPP at Medical Colleges and Hospitals –
  The Scheme was initiated during 2008-09.
  At present 6 (six) PPP MRI units are installed and are functioning at the Medical Colleges & Hospitals in the state—these are at Calcutta Medical College and Hospital (by M/s EKO Diagnostic Pvt. Ltd.), at NRS Medical College and Hospital (by Spandan Diagnostics), at RG Kar Medical College and Hospital (by Midnapore Diagnostics Pvt. Ltd.), at North Bengal Medical College and Hospital (by AMRI Ltd.), at Burdwan Medical College and Hospital (by Falguni Nirman Pvt. Ltd.) and in Bankura Sammilani Medical College and Hospital (by AMRI Ltd.).

- O&M Scheme for High End Diagnostics & Dialysis Services: The Department has undertaken an endeavor to install High-End Diagnostic Equipments [CT Scan, MRI Scan and Digital X-Ray (DR/CR)] and Dialysis Services in Medical Colleges & Hospitals and District/Sub-Divisional Hospitals under Operation and Management mode through selected O&M Contractor under PPP. Here the Department would procure the machineries and the concerned facility would be responsible for site preparation (with civil and electrical works and power augmentation, if required). The selected private partner would run and manage the unit. 46 medical institutions of the state (including Medical Colleges, District Hospitals, Sub-Divisional Hospitals and State General Hospitals) have been earmarked for the scheme.

- Fair Price Outlet (for Medicines, Implants and Consumables) through PPP: In order to streamline the supply of medicines, consumables and implants with special emphasis on quality and cost, to the people the Department has also taken a recent initiative to involve suitable and competent private sector organisations for establishment of round the clock operation of Fair Price Outlet (*Najyamuller Aushadher Dokan*) within the premises of some earmarked government hospitals under PPP. 35 medical institutions of the state (including Medical Colleges, District Hospitals and Sub-Divisional Hospitals) have been earmarked for this PPP scheme.

2. **Mobile Medical Units (MMU) –**
   For providing health care services in the riverine blocks of Sundarban areas, the DoH&FW launched Mobile Health Clinic Services in 1999 in partnership with 5 NGOs for providing basic health services in the region. Service delivery contracts were executed with those NGOs covering 351 villages in the Sundarbans. Health services provided by the NGOs include: General Clinic, Ante Natal, Post Natal Clinics, Special Camps, Awareness Generation, Diagnostic Labs and Family Planning Services. Mobile boat dispensaries are used in this remote region containing adequate stock of medicines and provisions for basic diagnostic tests like X-Ray, Routine Blood Test etc.

3. **Mobile Health Camps –**
   OPD and Emergency First Aid (including RCH, Curative services and Diagnostic facilities) services are being provided in very remote and difficult 23 LWE (insurgency infested) blocks of 'Jangal Mahal' (scattered in the three districts of Paschim Medinipur, Bankura and Purulia) and Tea Gardens of Jalpaiguri district. Since late December 2011 / January 2012, the Mobile Health Camps are now held by selected NGOs for 6 days a week – at a pre-fixed site in each Gram Panchayat area where there is no PHC or BPHC. Each GP has a Mobile Health Camp at a fixed day of every week. The camps are so designed as to provide services to all population under that geographical area, including beneficiaries covered under Anganwadi Centres.
   A web-based reporting and monitoring system has been introduced, where the NGO reports the performance of the camp on a daily basis from a pre-registered mobile from the camp site, after closing of each camp. This data is automatically entered in a website specially designed for the purpose. The GPS tracking system tracks the position of the mobile and shows the exact position of the camp site on Google Map. Micro-plan of the camps, validation of the plans by Block and District level officers and posting comments about performance of the camps – are all possible on the website itself.

4. **Community Delivery Centre –**
   Community Delivery Centres (CDC) and Ayushmati Centres were initiated in the remote areas of South 24 Parganas, North 24 Parganas and Jalpaiguri districts mostly for attending cases where normal deliveries could be done. These are run by NGOs where JSY services and free transport/ambulatory services to the pregnant mothers could also be made available. At present there are 7 CDCs and 15 Ayushmati Centres running in South 24 Parganas, 9 CDCs and 8 Ayushmati Centres running in North 24 Parganas. In Jalpaiguri Dumling Tea Estate at Mal Block and Raidak Tea Estate at Kumargram Block has 2 CDCs run by NGOs.

5. **SNCU and SNSU –**

SNCU or sick newborn care unit or special care newborn unit is a newborn care unit in the vicinity of the labor room that provides care to all the sick in- and out-delivered newborns excepting for those requiring assisted ventilation or major surgery. Apart from managing the admitted sick newborns, it will also provide the follow up services to the high-risk newborns and would also impart training for the HR on the newborn care. Equipped with Radiant Warmers, Phototherapy units, oxygen concentrator etc each SNCU are of 10-12 special beds (with a provision to accommodate 20 beds due to increased demand, if any). At present there are 23 SNCUs running in the state spread over the districts (mostly in SDH/DH and a few MC&H)

Along with the SNCUs, operationalisation of the SNSUs (Sick Newborn Stabilisation Units) is another key intervention in the state. This is an arrangement for the prompt, safe and effective resuscitation of babies and for the care of the sick NBs. It's situated closer to the community. Most sick NBs can be stabilized at this level (block/FRU level). At present there are 125 SNSUs operational in the state.

SNCU at MALDA DH

6. **Disease Surveillance –** Value Addition is done by the IDSP data in the form of issuing alerts in different occasions e.g. increased incidence of acute diarrhea, measles, malaria, dengue, chikungunya etc. For the purpose a GIS based monitoring is introduced for prevention and control mechanism (area focused). Feedback is also provided by this to NVBDCP on dengue, chikungunya and JE cases that help in targeted action and priority setting.

7. **Administrative Reforms –**
   - Development of Separate Public Health cum Administrative Service Cadre
   - Introduction of Biometric Attendance for Officers at Swasthya Bhawan for automatic monitoring of regular attendance
   - Introduction of Software for District Reserve Store (DRS) for purchase & inventory management of medicines & equipments at district levels –

     A dedicated web enabled software 'Store Management Information system' has been introduced in all procuring units to generate procurement order against bound allotments (this ensures regular and timely supply of medicines & equipments in the periphery). The system also generates receipt in the form of Goods Receipt Notes (GRN) and facilitates

processing of payment. A Vendors' Portal has been created to on line access regarding order status, provided GRN status and bill status by the vendors. This has enhanced transparency and accountability. In the previous years, the total budget allocation under drug head was around Rs 80.00 crores per year. During the year 2012-13, there has been a quantum enhancement in the drug budget. It has increased to Rs 284 crores.

- Formation of WBMSC for coordinated construction activities, planned procurement & supply of equipments including logistic support

- Performance based incentives to primary health facilities

- Tagging of some state hospitals (with nearby MC&Hs) as satellite centres for MCH e.g. Sambhu Nath Pandit Hospital, Kolkata as the satellite hospital SSKM Hospital.

8. RSBY –

Rashtritya Swasthya Bima Yojana (RSBY) is a health insurance scheme for the BPL population to provide protection against financial liabilities arising out of health shocks that involve hospitalization. The BPL family (unit of five) envisaged to be enrolled into the scheme would be insured up to a total sum of Rs. 30,000/- per annum (on a floater basis). The scheme was launched in West Bengal during 2008-09, but till very recently only private nursing homes / hospitals were the service providers to the beneficiaries. From 2nd January 2012, Howrah District Hospital has been brought under the scheme fold as the first government hospital in the state to be the provider. Taking Howrah DH as a pilot case, a decision has been taken to extend the service to other government health facilities (Medical College and Hospitals and other DH/SDHs) as well. Apart from Howrah DH, the Scheme is now operational at Purulia DH (Deben Mahato Hospital), Bankura MC&H, North 24 Parganas DH (Barasat), Dakshin Dinajpur DH (Balurghat), Jalpaiguri DH and Coochbehar DH. The rest of the District Hospitals are at various stages of preparatory initiatives for initiation.

9. Facility based Monitoring & Supervision –

a) SMS based OPD tracking (introduced from August 2011) in MC&Hs of the state – for timely and proper functioning of daily OPD services. Daily report regarding opening of the OPD mentioning the starting time of the same is being impressed upon.

b) SMS based tracking of deaths of infants and mothers – for better planning and implementation of services for Mother & Child Care

c) GIS based tracking of Mobile Health Camps and MMUs – for ensuring better service delivery in remote and difficult areas.

d) Supportive Supervision Teams (each team comprising of officials from Administrative cadre and from WBPH&AS cadres) from State Headquarter for Secondary Tier Hospitals (SDH/DH) on a monthly basis – for identification of gaps in service delivery, troubleshooting and coordination.

e) ROT – satellite based communication (Receive Only Terminals) with two way video and one way audio system to monitor (including capacity development for) major and impending issues from the state connected to 341 blocks in the state. The hub (studio-end) is placed at Roop Kala Kendra the social communication wing of the State Government.

10. Nurse Practitioner in Midwifery Course:

The Nurse Practitioner Course in Midwifery has started in West Bengal in the year 2002 as a pilot project by the Indian Nursing Council. Till date two batches (First batch – four students, March' 2004 and Second batch – eleven students, January' 2011) was passed out.

Since creation of post took long time, the Nurse Practitioner of first batch except one were absorbed through competitive examination / promotion in other posts like DPHNO, senior lecturer, senior sister tutor. The remaining candidates have joined the said post in September' 2010 (on ad-hoc basis). The second batch of this course has got appointment on August 2012.

The main objective of creating this Nurse Practitioner in Midwifery post is to strengthen skilled Midwifery care to mother and new born in remote rural areas. The Nurse Practitioners in Midwifery are responsible for providing autonomous care to women prior to pregnancy, during pregnancy, at child birth, after child birth and care to new born in the remote rural area.

As they have joined very recently in this post, the evaluation of the course will take time. But it is expected that they will provide comprehensive to the mother and new born in the remote rural area which may reduce the maternal and child mortality and morbidity rate in future.

11. Addl MOs who have undergone 3 years training:

Total number of C.H.S.O.s who got Training in 6 Health Institute for 3years 8 Months including Theoretical & Job Orientation Training were 323.

Out of these 323, 306 undertook training at National Medical College & Hospital which may be considered as Condensed MBBS course, in 3 batches.

1st batch of 93 completed the course on 1st July 2004.
2nd batch of 95 completed the course on 1st July 2005.
3rd batch of 118 completed the course on 1st July 2006.

After completion of the said course, they have been registered by W.B.M.C. and designated as Additional Medical Officer (A.M.O)

These Additional Medical Officers were posted in the PSCs, BPHCs & Rural Hospitals and bear the same responsibility as other MBBS Medical Officers.

Their performances as Medical Officers are quite satisfactory. In some BPHCs they have acted as Acting BMOHs in time of emergencies. They do all the duties of a Medical Officers with MBBS degree including handling of Police Cases as well.

Annexure 1.

Details of 2nd ANM staying at Sub-center Quarter in the District of Murshidabad.

Namea of the Block	Name of the Sub-center	Name of the 2nd ANM
Kandi	Srikantapur	Akali Hembrom(Soren)
Raninagar-II	Suprigola	Merina Khatun
Hariharpara	Tortipur	Minara Khatun
	Sahajadpur	Alpona Ghosh
Bhagwangola-I	Kuthirampur	Bandana Chowdhury
	Madapur	Modinamanawara Khatun
	Habaspur	Chandana Khatun
Bhratpur-II	Kherera	Firdoshi Begum
	Raigram	Tanusree Ghosh
Beldanga-I	Maniknagar	Sefali Halder
	Gangapur	Ferdousi Begum
	Maheshpur	Jinat Aman
	Bhabta(N)	Ahasunessha bIbi
	Begunbari	Nilufa Yesmin
	Andiron	Shila Mondal
Msd.-Jiaganj	Kapasdanga	Rijia Khatun(Bibi)
	Hasnabad	Hazra Bibi
	Nutangram	Sharifa Khatun(bibi)
	Amaniganj	Nandita Halder
	Ayeshbagh	Reba Mazumder
	Boarderpara	Bani Aarkar
Jalangi	Kritanyapara	Benuara Khatun
Domkal	Raipur	Tushi Halder
	Maddha garibpur	Sanju Manawara Begum
	Ramna Etbarnagar	Smt.Rubiya Khatun
Suti-II	Azadnagar	Nilima Roy
	Mahesail-II	Soma Sarkar
Raninagar-I	Tenkarip;ur	Mita Roy
	Balumati	Reboti Rishi
	Paharpur	Joytsna Das
	Lochanpaur	Samina Parvin
	Gopinathpur	Mita Biswas
Burwan	Jugsora	Mamata Saha
	Biprasekhar	Kalpana Saha (Chandra)
	Jikharhati	Niyati Das

19/11/12

Chief Medical Officer of Health
Murshidabad