

**National Rural Health Mission
Common Review Mission
Tripura
15-21st November, 2007**

1. Introduction

The Common Review Mission (CRM) under the NRHM visited the State of Tripura during 15-21st November 2007. The aim of the CRM was to assess the performance of NRHM in the state in line with the Framework for Implementation, focussing on Health Systems rather than on disease or programme specific assessments and was thus over and above the technical review missions that various Programme Divisions (NDCPs, RCH, etc) undertake from time to time. The emphasis of the CRM was to assess the status of the existing health systems and how efficacious they were in securing a fully functional public healthcare delivery system at each level.

2. Review Methodology

The CRM team included four officials/experts from the Ministry and were accompanied by key officials of the State Government. The CRM members split into two teams so that the status of the health care delivery system could be assessed in two districts. The two districts chosen were Dhalai and West Tripura districts. As none of these districts had a functional District Hospital (DH), the team visiting West District also visited south district where there is a functional DH.

The State Government made a detailed presentation on 15th November, 2007 on the health profile of the State, the status of the health infrastructure, the new initiatives taken by them as also the specific interventions targeted for the vulnerable and inaccessible population. The achievement and progress made by the State after the approval of the PIP was also detailed alongwith the constraints. Some of these are listed below:

- The State has since communicated to the Gol the 10% increase in health outlay and 15% contribution of state finances to NRHM.
- Joint Accounts opened for almost all the RKSs (97 / 99);
- Recruitment of Ashas, Training (1st module) in North & Dhalai Districts
- Ashas equipped with colourful coats/aprons and Kit bags – lends a unique sense of pride and belongingness
- **The State had issued an OM formalising the incentive structure for payments to ASHAs on all heads.**
- The State was evolving strategies to address the shortage of nurses, doctors and paramedicals
- **Most of the positions of MPW (male) were filled up.**
- The position of Utilisation Certificates on account of the WEBEL project and Construction activities was poor. The State informed that the pace of construction of health infrastructure was slow due to a lack of agencies in the market and the PWD was facing a capacity constraint (supply-side). The State was requesting that they be allowed to use the rates followed by national level construction agencies like NBCC.
- The State mentioned that the NPCC did not approve their annual de-worming campaign, and that it was necessary since it had implications on the number of diarrhoea cases.
- The State desired that there was a significant delay in the issue of Certificates to Doctors after they had completed the Anaesthesia Training Course from Silchar Medical College and this affected them since the Doctors could not practise without the certificates.
- The State had introduced Telemedicine and Tele-ophthalmology with the State Hospital where difficult cases could be discussed with experts.
- The School Health Programmes were quite popular and successful

After the State presentation, the CRM split into two teams to cover the selected Districts. The Dhalai team comprised of Mr. Pravin Srivastava, Director (Statistics) and Ms. Archana Varma, Deputy Secretary (NRHM), MoHFW. The West Tripura team comprised of Dr. Charan Singh, Joint Director-

NVBDCP, MoHFW and Mr. Gautam Chakraborty, Expert, Health Care Financing. The teams were accompanied by Mission Director (NRHM), Govt. of Tripura, Director FW, State Programme Officer – NVBDCP, Chief Medical Officers (CMO) of the respective districts, state IEC officials and other officers at Sub Division, Block and PHC level.

The second team primarily focussed the review on West Tripura district. South Tripura was covered only to review the DH, as neither Dhalai, nor the West District had a DH. The CMOs in the District gave a presentation on the District Profile and the status of the health infrastructure and the programmes before the team proceeded to visit the various facilities in the Districts.

The CRM covered the following health institutions in Dhalai, West and South districts:

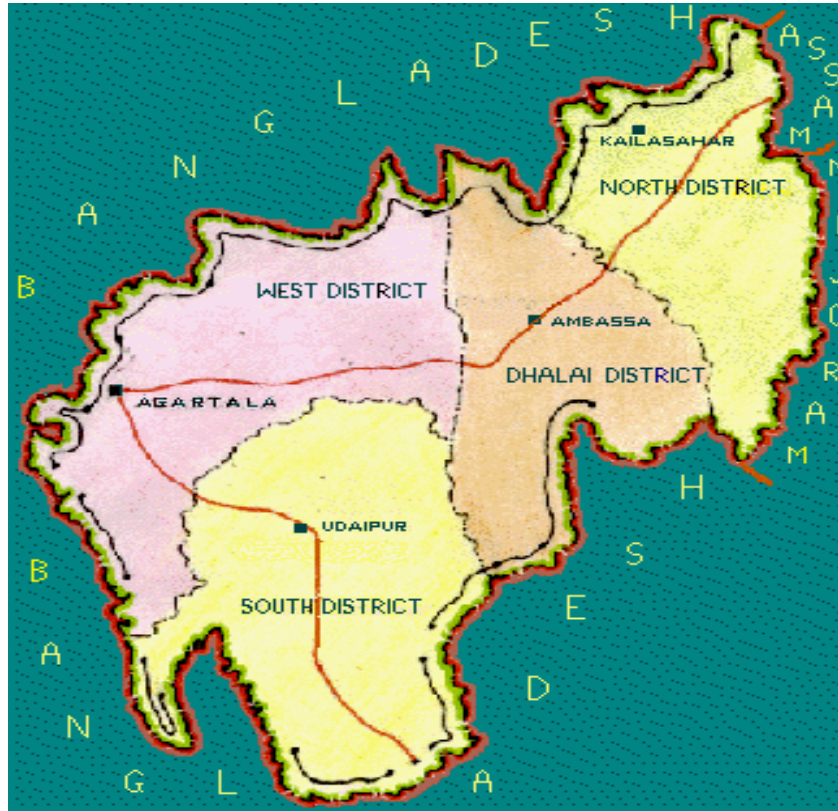
Institution/Place	Nos	Location
District Hospital (DH)	01	Tripura Sundari District Hospital, Udaipur (South Tripura)
Sub Division Hospital (SDH)	04	Gandachara and Kamalpur (Dhalai), Sonamura and Bishalgarh (West Tripura)
Community Health Centre (CHC)	01	Mohanpur (West Tripura)
Primary Health Centre (PHC)	09	Ganganagar, Kulai, Salema (Dhalai), Narsinghgarh, Bamutia, Anandapur, Bishramgarh, Kathalia (West Tripura); and Kakraban (South Tripura)
Health Sub Centre (SC)	10	Harinchara, Durbajoy, East Nalichara, Kolachari (Dhalai), Airport, Laxmilunga, Tulabagan, Bishalgarh, Bhabanipur (West Tripura); and Purba Mirza (South Tripura)
Training Institute	01	District Health Training Institute, Dhalai
Villages	02	Baligaon (Dhalai), Purba Mirza (South Tripura)

The CRM team reviewed the records and registers in these institutions and also collected the facility profile. in both the districts, before visiting the health facilities. The team also interacted with the health staff in the health facilities visited and conducted in-depth interviews with the staff, which included Medical Officers, Nurses, Lab Technicians, MPW (Female and Male), LHV.

The team also interacted with the community and community members including Panchayat Chairman at District, Block, Sub-division, and Gram Panchayat level. The team also met President of Standing Committee of Health at Block level. One FGD was conducted with ASHAs who had recently completed training on the first module but were not fully functional yet (West District). Two FGDs were conducted with villagers in two different villages. Patients admitted in the wards and their attendants were interviewed informally at DH, SDH and PHC. The team also witnessed Village Health Days (VHD) in two different villages, which involved integrated IEC and various events/competitions for the women and children.

3. State Profile

The State of Tripura has an area of 10,491.69 sq km having 856 kms of international border with Bangladesh, 109 kms long border with Mizoram and 53 kms border with Assam. Around two-thirds of the state is hilly with six major hills running in the North-South direction. The hilly terrain makes a large area of the State difficult to access and this has implications on the accessibility of the people to formal health care.



3.1 Demographic Profile

The population of the State of Tripura is 31,99,203 (2001 census) having an urban population of around 5.50 lakhs (17%). The decadal population growth is 15.74 %. The sex ratio is 950 females per 1000 males. The male literacy rate is 81.47% & that for female is 65.41%, average being 73.66%. The density of population in the State is 304 per sq. km.(2001 census). Tribal population is 9.93 lakhs (31%) and the population of the Scheduled caste community is 4.5 lakhs (16%). There is a high percentage (66%) of population Below Poverty Line (BPL).

Population Characteristics of Tripura compared with India (2001 Census)

Sl	Indicator		TRIPURA	INDIA
1.	POPULATION	Persons	31,99,203	102,70,15,247
		Male	16,42,225	53,12,77,078
		Female	15,56,978	49,57,38,169
2.	DECADAL GROWTH RATE	1981-1991	34.30	23.86
		1991-2001	15.74	21.34
3.	POPULATION DENSITY (Per Sq.K.M.)	1991	263	267
		2001	305	324
4.	SEX RATIO (No. of female / 1000 male)	1991	945	927
		2001	950	933
5.	LITERACY	Persons	73.66%	65.38%
		Male	81.47%	75.85%
		Female	65.41%	54.16%

There are four districts in the State, out of which the last addition was Dhalai District in 1995, which is included in **Rashtriya Sama Vikash Yojana (RSVY)** for development of infrastructure and other related developments. There are 15 sub divisions with 40 Rural Development Blocks. Total numbers of Tehsils are 183 with 874 Revenue Moujas. All total there are 1062 numbers of villages, out of which

522 are within the ADC area and 540 are gram Panchayats outside ADC area. In the State there are 4 numbers of Zilla Parishads with 23 numbers of Panchayat Samities. There is one Autonomous District Council whose area extends in all four districts. Out of the 40 Blocks, 19 Blocks are under ADC (West –6, South – 4, North – 4, Dhalai – 5). Out of the 19 Blocks, 16 Blocks have 100% Tribal population. The no. of Tribal Population in the Blocks other than these 19 have a marginal Tribal population.

Details of A.D.C. Area

Sl.No	INDICATOR	WEST	NORTH	SOUTH	DHALAI	TOTAL
1.	No. of Rural Development Blocks	16	08	11	05	40
2.	No. Gaon Panchayats	248	103	155	34	540
3.	ADC Blocks	06	04	04	05	19
4.	ADC Villages	180	79	167	96	522

The District wise demographic profile is given below:

Sl. No	Indicators	West District	North District	South District	Dhalai District	Tripura
1	Area (Sq. Km.)	3047.78	2108.05	3023.57	2312.29	10491.69
2	Population	15,32,982	5,90,913	7,67,440	3,07,863	31,99,203
3	Rural Population	11,22,915	5,28,244	7,13,293	2,89,001	26,53,453
4	Urban Population	4,10,067	62,669	54,147	18,867	5,45,750
5	ST Population	3,87,081	1,50,500	2,89,519	1,66,326	9,93,426
6	SC Population	2,95,698	82,902	1,27,307	49,817	5,55,724
7	BPL (family)	2,27,596	72,180	1,06,453	45,641	4,51,870
8	Density(Sq. Km)	505	281	243	139	304
9	Sex Ratio	951	951	945	935	950
10	Literacy	77.3%	73.0%	69.9%	60.9%	73.66%

3.2 STATE HEALTH PARAMETERS

The health parameters (vital rates) in the State of Tripura vs. the national estimates are tabulated below:

Parameter	National	Tripura	Source
1. Infant Mortality Rate(IMR)	57	36	SRS-2006
2. Maternal Mortality Rate (MMR)	301 (2001-03)		SRS
3. Crude Birth Rate (CBR)	23.5	16.6	SRS-2006
4. Crude Death Rate (CDR)	7.5	6.3	SRS-2006
5. Natural Growth Rate (AGR)	16.0	10.3	SRS-2006
6. Total Fertility Rate (TFR)	2.9 (SRS-2005)	2.2 (NHFS-3)	
7. Couple Protection Rate (CPR)	46.6	22.2	MoHFW: FW Statistics - 2006

It may be observed that while the IMR at the All India Level declined from 58 (SRS – 2005) to 57 (SRS-2006), for the State of Tripura it increased from 31 to 36 during the same period and it is a matter of concern which the State needs to keep in mind while realigning their health strategies. The TFR as measured through the NFHS also showed an increase from 1.9 to 2.2 in the State.

The key health indicators as captured through the District Level Household Surveys (DLHS) are tabulated below:

Key Indicators	India		Tripura	
	DLHS – I (1998-99)	DLHS - II (2002-04)	DLHS – I (1998-99)	DLHS - II (2002-04)*
Any Antenatal Checkup	19.2	19.5	19.7	20.8
CPR (Any Modern Method)	36.9	27.5	34.5	22.2
Full ANC	45.8	42.0	33.4	17.9
Full Immunisation	65.3	73.4	69.2	82.2
Mean age at marriage for Girls	44.2	50.1	51.0	66.4
Percent girls marrying below age 18 years	31.8	16.0	34.8	11.9
Percent of births of order 3+	42.5	45.7	40.4	42.7
Safe Delivery	25.3	21.1	12.0	25.1
Three or more Antenatal check-up	34.0	40.5	46.1	62.4
Total Institutional Delivery	40.2	47.6	48.3	65.1
Unmet Need (Total)	54.2	47.6	46.3	26.7

From the table it can be seen that while most of the key indicators have shown an improvement from DLHS-I to DLHS-II, the percentage of Full ANC fell.

3.3 STATE HEALTH INFRASTRUCTURE

Out of the six state hospitals, there is one State Hospital (IGM Hospital) situated in Agartala, which only caters service exclusively to mothers and children. There are two District hospitals, one each at South and North Tripura district and one is under construction at Kulai (Dhalai District). There are 11 sub divisional hospitals, out of which 3 are in ADC area. As a part of the primary health care delivery network, there are 539 sub-centres under 73 PHCs in the state and 9 Community Health Centres. There are two Blood storage centre and six Blood Banks in the State.

Health Infrastructure at a glance

Sl. No	Health Institutions	West District	North District	South District	Dhalai District	Tripura
1	State Hospital	6	0	0	0	6
2	District Hospital	0	1	1	0	2
3	Sub. Div. Hospital	3	2	3	3	11
4	C.H.C.	5	1	3	0	09
5	P.H.C.	22	18	23	10	73
6	Sub – Centre	243	96	143	57	539
7	Ware House	1	1	1	0	3
8	Blood Banks	2	2	1	1	6
9	Blood Storage Centre	1	0	1	0	2

4. Observations of the Common Review Mission

A. State Level Observations:

4.1 General Observations

The team observed that the State had basic health delivery structure in place with a motivated team of medical personnel. With NRHM acting like a catalyst the State had come up with innovative strategies in addressing the needs of the underserved and hard to reach areas. A remarkable and unique feature was the role of the Government Doctors' Association in assisting the Government in maintaining low levels of absenteeism. The association plays a strong positive role in ensuring rotational rural posting of the doctors (on a yearly basis) and also acts as peer pressure to deliver 24x7 services, even if adequate staff is not available. Another motivator for the health personnel was the fact that the salaries and TA/DA claims were paid on time.

At the overall level, there was a lack of trained and skilled staff, in number of doctor/paramedic/nurses, and this is an acute problem in the state. Recently two medical colleges (one under PPP) and a nursing college (under PPP) have come up in the state, and the first batch is expected to be out in 3-4 years time. There is no paramedical training institute in the state and they are devising ways to relax the criteria for experience in polytechnics. The state was also having difficulty in getting skilled medical/paramedical persons from other States in view of the peculiar location of the State and even the advertised posts (on contractual basis) continue to remain vacant as most do not want to work in the State. Also, there are only two ANM training centres in the state located in North and South district, producing around 50 ANMs every one-and-half years. There is need for two more ANM training centres in Dhalai and West district.

4.1.1 State Mission

The State Mission, headed by a Mission Director, who also holds additional post of Registrar of Societies, is functional. Though various steps to improve the functioning of the health systems have been initiated, greater synergies with the DHS and DFW need to be created so that there is more effective utilisation of the existing resources including manpower. The Mission has already achieved integration of all IEC cells under each of the programs (RCH, TB, Malaria, etc.) and the integrated IEC cell is working under the SPMSU. The Mission has also initiated the integration of Planning, Training and Statistics, which is expected to be completed within this financial year (2007-08). A refurbished building for the Mission is coming up within the Directorate of Family Welfare. However as it is located on the top floor which is quite hot, the office premises could be climatically controlled so that a conducive working environ is created.

4.1.2 Institutional Arrangements

At the district level, coordination problems were noticed across health programmes because of different physical location of offices of RNTCP, Malaria, and the CMO offices. As an illustration, it was observed that while Malaria (NMEP) is short of sanctioned staff, RNTCP has all staff positions filled and this created an imbalance especially in malaria endemic areas.

The DPMU though in position was not able to function optimally. The financial management system is weak and needs to be strengthened more so since the District Accounts Manager is also burdened with other routine administrative work of the CMO office. There is designated workstation and dedicated office infrastructure for the DPMU staff, which is expected to improve after new CMO offices are constructed/renovated. The regular government staff, especially the ministerial staff, feels alienated from the NRHM activities as there is a presumption that these activities are to be done by the contractual staff recruited under NRHM. On the other hand, the contractual NRHM staffs do not get the required cooperation and inputs from the regular, especially in terms of data/reports. There is a need to clearly define the roles of these contractual positions and their interplay with the regular staff so that both work in tandem. There was also a felt need to have regular sensitisation sessions on NRHM for both the regular and contractual positions.

In addition, to address the problem of integration between the regular health and family welfare activities and NRHM activities, a few senior state officials had proposed merger of the Directorate of Health and the Directorate of Family Welfare. It was also suggested that the Director Family Welfare may be given additional charge of Executive Director-NRHM and the ED will be function under the MD-NRHM. It was also suggested that instead of creating radically new systems under NRHM, there should be a smooth transition, making use of the existing structures and systems as far as possible.

The state officials also suggested that the funds flow for all the vertical programs might be convergent on the DHS (District Health Society), but the programs could continue with separate accounts. It was observed that Tripura State had evolved a method of funds flow such that expenditure to be incurred by the State Health Society was first transferred to the DHS/DFW for expenditure, who then had to follow the State Govt rules with associated delays and rigidities. As this was a self-defeating exercise, the State needs to rectify this anomaly so that the full flexibility required and expected from a society mechanism is realised.

At present the fund transfers from the state to district to the facilities is through the state cooperative bank and the transfers and reconciliations are facilitated through telephonic conversations, which is a unique way of ensuring fast flow of funds to the District and Sub-District levels. In order to obtain additional funding under NRHM the state needs to overcome the expenditure bottlenecks in civil works, procurement of Mobile Medical Units, generators, installation of hospital waste management system in the facilities.

B. Key Observations: Districts/Facilities

B1. Functional facilities: *Establishing fully functional Sub Centres, PHCs/CHCs/Sub Division/District Hospitals*

Apart from the two District Hospitals in North and South districts, a 150 bedded District Hospital is presently under construction in Dhalai, which is being funded from NEC funds (This was not mentioned in the State PIP and the details need to be provided). It was, however, observed that there was slow progress in construction activities due to work overload of the construction agency (PWD). Many SDH were also observed as working like CHC (with 30 beds), which needs to be upgraded to FRUs with additional manpower and infrastructure. Many Sub Health Centres are also being built under funds from various schemes available with the District Magistrate, but the viability and location remains an issue unless provision for fixed day visit by doctors is ensured in these Sub Centres. Most of the PHCs visited were also not offering basic diagnostic facilities apart from diagnosis under various programmes (sputum examination and malarial slide testing). Almost all the PHCs visited were also conducting deliveries and providing in-patient care, especially because of the availability of doctors in the facilities round-the-clock. In Dhalai the team observed an average farthest distance of health facility from the villages to be around 15-20 km, which is substantial given the hilly terrain. This calls for more facilities, which is constrained by the availability of manpower and the ability to undertake civil construction and procurement in a timely manner.

○ Equipment and Procurement

It was observed that there is adequate availability and off take of drugs in facilities but there is a need for sensitization of doctors on prescribing generic drugs. The state drug list also needs to be revised with the provision for life saving drugs, paediatric suspension/dispersibles. Equipment/drug procurement is also being done by RKS and Sub Centre committees using the untied funds. The State needs to sensitise the RKSs that their prime activity (procurement or otherwise) should be directed towards patient welfare, with a focus on serving the under-privileged and poor.

Private diagnostic centres were active in the neighbourhood of the block and sub-division level hospitals and it seemed that except for Malaria and TB, most basic diagnostics are done by the private centres.

○ Quality of Services

It was observed that lack of skill and equipments poses a limitation to quality care at Sub Centres. The CRM teams observed lack of baby weighing machine, Hb-meter, BP machine at Sub Centres, which restrict the quality of ante natal and child care.

Also, neo-natal care quality at PHCs and SDHs requires special attention, especially in view of the SRS reporting an increase in the IMR in Tripura State. Neo-natal corner can be made operational at Kamalpur, which has a high requirement for such a facility. Patient overload at a few facilities also affect quality of care. It was observed that average length of stay (ALOS) for delivery cases in Kamalpur SDH was around 1.5 days, whereas the accepted norm is 3 days for normal delivery and 8-10 days for caesarean cases.

Another area where improvement is required is hospital waste management. Although deep-burial pits are being dug and commissioned in some facilities, no system of scientific waste segregation (at the point of waste generation), treatment (apart from sterilisation and needle destroyers in some facilities), transportation and disposal were observed. All staff also need training in waste segregation and treatment including training in handling hazardous waste.

In the facilities visited, piped water from PHE and Rural Water Supply and solar lights from RSVY funds were generally found available and functional. However advocacy and RKS involvement on facility cleanliness is needed.

○ Utilisation of Services

Most of the facilities showed an increasing trend (Monthly averages) in OPD load, but Kamalpur showed a 12% decline. But the IPD however was a mixed baggage with a few facilities showing decline (Gandachara by -11%, Kulai by -64%) whereas some (Kamalpur 17%, Salema 56%) showing an increase. Institutional Deliveries showed a significant increase in absolute numbers, but not in the percentage share in total deliveries, which showed only a marginal growth % from 2005-06 to 2006-07. The State needs to monitor the percentage increase of institutional delivery (institution wise) vis-à-vis home deliveries.

○ Untied Funds

It was noticed that the untied funds (for the RKS and Sub Centre) have been mainly utilized on minor repair needs, office expenses, emergency procurement of equipment and drugs, upkeep and sanitation, water filters, water tank cleaning, deep pit for AD syringe disposal (Harinchara SC), sprucing facility premises (Salema PHC). The registers of these funds are well maintained and up-to-date.

There is also an apprehension among the hospital in-charges that these funds have increased the load of record keeping and so additional support was required. The state has already completed the recruitment process of appointing Accountants-cum-Data Assistants under NRHM for each facility having RKS and it is expected that this will go a long way in improving the record keeping practices and flow of information. The State could greatly benefit by sharing the Best Practices for fund utilisation of untied funds.

B2. Human Resources (HR): *Increasing and improving human resources in rural areas*

It was observed that the health staffs are committed and enthusiastic. The state can look at sustaining it through incentives, even for paramedics and support staff. The deployment policy is by and large rational although there were instances of a few erratic transfers (Salema, Durbajoy).

It was observed that ANMs are not locals in Dhalai which affects community bonding, accommodation, and language for communication. It is suggested that the future recruitments should be based on local criteria (for contractual appointment of ANMs).

The state also faces an acute shortage of specialists. So, Multi-skill training is needed as an interim measure, which is currently underway for Anaesthesia, but there is demand for paediatric care also. Also, doctors agreeing to serve in hard areas for a 3 year period may be sponsored for PG courses with condition to serve for two more years after completion of course.

It was observed that the ANMs and Staff Nurses generally lacked the required skills although they had the knowledge. This calls for refresher training on a rotational basis at the district/state level and

also outside the state, as there are not many training institutions in the state. Also the role of MPW (Male) in performing RCH functions could also be looked at and they could be suitably incentivised by the State, which might be very useful for remote areas. There is also an acute shortage of Lab technicians and other paramedics in the districts.

Training for MOs in PHCs/ CHCs/SDHs under NRHM has started. Sensitization and capacities of secretarial staff in the districts need to be built for their integration into the NRHM system. Various modes of trainings can also be looked into like distance learning for management courses (IIM Kolkata). CME for doctors and nurses may also be explored as an option in view of difficulty of doctors to leave the field, which can be backed by incentives as necessary.

It is also necessary to have a separate SHRC as a Nodal Technical Assistance agency, to fill the gap in availability of technical assistance needed in various clinical, technical and programme management domains.

B3. Accountability: *Accountable health delivery*

It was observed that PRIs were actively involved in management of facilities through RKS and Sub Centre Committees. One Panchayat had invested Rs. 62 lakhs in Kathalia PHC for renovation and construction. On the other hand, involvement of PRIs at PHC level is hampered (as in Bamutia PHC) as Block Panchayat Chairman has to head these RKS, which are spread across in the block. As a result PRIs are not always available for signing and approving vouchers/expenditures for RKS of PHCs which are located far from the Block HQ.

PRIs also have involvement in JSY as the beneficiaries are being certified for BPL/SC/ST by panchayats. The expenditure on JSY beneficiaries is discussed in the RKS meetings, in the presence of PRI and other members.

Evidence based planning and monitoring is still not being fully implemented as Household surveys for ascertaining local health indicators and disease burden not being undertaken. The targets for TB, Malaria are still based on national estimates and not on the evidence of local disease burden.

B4. Empowerment: *Empowerment for effective decentralisation and flexibility for local action*

The Sub Centre Committees have been formed in all the Sub Centres but Village Health & Sanitation Committees are yet to be formed. This is hampering transfer of untied funds to the villages which has additional benefits for the underserved areas. The Rogi Kalyan Samitis are functioning well with active participation of GPs, ADCs. The fund utilization appears satisfactory. The PRIs have been gainfully engaged and appear to be making positive contribution and the relation between health staff and PRIs appear to be harmonious.

○ ASHA

The selection of ASHA is through an open and transparent process with full involvement of the PRIs. In Dhalai ASHAs have been trained in the first module and ASHA kits have been distributed to them. The training has started in West district. The training also included training them on RDK (Rapid Diagnostic Kits, for Malaria).

The bright red coats and blue kit bags given to the ASHAs have given them a unique sense of pride and identity. The ASHAs are presently working as drug dispensers/JSY motivators. There is a demand for regular/sustained remuneration for the ASHAs, and the government has framed a system for remuneration to ASHAs linking their expected performance under various programmes (like as DOTS worker) with the payments.

To sustain the motivational level of the ASHAs, it is essential that the mentors/ linkage with the health system are established at the earliest. Also, linkage with ANM/AWW needs to be strengthened. As the ASHAs are co-located with the AWWs in the Anganwadi Centres, it may affect the financial viability of the ASHAs with the upcoming increase in the number of

Anganwadis. The State may explore additional avenues incentives for ASHAs for sustainability/viability.

B5. Maternal and Child Health (MCH): *Reducing maternal and child deaths and population stabilisation*

- JSY and Institutional Deliveries
 - Health Workers, Community and PRIs aware of JSY and the norms for beneficiaries
 - Substantial increase observed in number of JSY beneficiaries
 - PRIs certifying SC/ST/BPL status for JSY beneficiaries based on 1997 data and a provisional list prepared last year
 - JSY expenditure is discussed in RKS meetings where PRIs are present,
 - Home deliveries still preferred in tribal pockets with difficult access to health facilities.
 - No significant change was observed in rate of institutional deliveries before and after introduction of JSY. It is still hovering around 50 – 70% in different districts.

- Maternal Health and ANC
 - No Maternal Deaths were reported from the institutions visited in last one year
 - ANC services in the periphery limited to IFA distribution and TT immunisation. Not all MPW (females) are skilled in abdominal check-up and taking BP.
 - Health Workers are most often referring cases to institutions. None of the MPW (Females) contacted in the Sub Centres reported conducting deliveries themselves.
 - TBAs are active in the interior and tribal pockets, including in Muslim villages. They are being trained under tribal area programmes funded by district administration.

- Immunisation and Child Health
 - Immunisation coverage is reportedly over 70%.
 - Community aware of need of immunisation, but not fully aware of the immunisation schedule
 - No vaccine preventable diseases were reported
 - Most common ailment among children was diarrhoea
 - Hepatitis-B was common in some PHC areas
 - No polio cases were reported, although one AFP case was reported last year in West district
 - IMNCI as a strategy is still not practiced by health workers and at community level
 - Special Immunisation Days observed in some inaccessible pockets.
 - Special de-worming campaign implemented by state half-yearly, covering most of the rural areas including school children (80% penetration of identified sites by Oct '07). Special Immunisation drives can be combined with these.

- Family Welfare Services
 - IUD is not popular in the state among the community. **It was also observed that IUD insertions were done only by MOs at RH/SDH level**
 - NSVs are reported in the region (above 10 cases per year in West District), however, there are few acceptors
 - Conventional Contraceptives (OCP, CC) are available in sufficient numbers at all levels of health facilities

B6. Preventive & Promotive health: *Action for preventive and promotive healthcare*

- NVBDCP
 - The area is malaria prone. Increase in number of cases and malarial deaths observed.
 - Community more open to impregnated bed-nets as compared to DDT
 - Slide examination being done at PHC level
 - Lab Technicians under Malaria better skilled than other technicians
 - Drug resistance among population (around 60%) found in Dhalai
 - IEC posters found in and around institutions
 - RDKs being used by peripheral level health workers
- RNTCP
 - Staff position under RNTCP filled up at district level
 - Sputum positive conversion rate more than 80% and cure rate more than 85%
 - Sputum examinations being done at PHC level, X-ray available at SDH and above. No facility for sputum culture.
 - IEC posters observed in DOTS centres
- IDD
 - No frank case of IDD was reported in the state
 - Universalised Iodised salt used by people and also for animals
 - IEC undertaken during Village Health Days. Special camps for promoting iodised salt at different levels, including community and retailers.
- NPCB
 - PHC-Kulai – Eye OT idle due to delay in electrification (>1 yr)
 - Eye check-up of school children under school health programme, along with distribution of glasses (Needs to be picked up in Dhalai)
 - Eye camps and cataract camps being organised as per schedule
 - Infection after eye surgeries not reported
 - Tele-ophthalmology observed in a Block (Kathalia), run by state funds
- NACP
 - No HIV+ case reported
 - VCTC and Sentinel Surveillance being carried out at DH level
 - Integrated IEC being undertaken

B7. Disease Surveillance

It was observed that IDSP centres are operating at all levels and registers are being maintained. The Supervisors and MPW/ANMs have also received training under IDSP and they are maintaining the registers and sending reports in the prescribed formats. The PHCs have received computers but software is not installed yet. Facilities are waiting for data-entry operators to be placed by the state, the selection for which has been completed.

It was also observed that no hospital is recording diagnosis in the in-patient registers in the wards except a few (PHC Bamutia), which inhibits assessment of disease burden or preparation of epidemiological profile of the area.

B8. Hamlet to Hospital Linkage: *Forging linkage between hamlet and hospitals for curative services*

The state has separate funds for Referral transport facility for critical maternal and child cases, and the funds are placed with the RKS of the respective facilities. It was observed from the RKS registers that 60-80% of these funds had been utilised by the hospitals. But there was an expressed need for RKS managed referral transportation/ambulatory care, preferably through involvement of local groups like SHGs, Cooperatives, etc. The community was appreciative of referral support but wanted an ambulance service from villages. The ambulances functioning in the hospitals were found to lack first aid and resuscitation facilities and while transporting patients, no

medical assistant was accompanying the patient. This was necessary in view of the long distances they had to travel.

B9. Health Information System (HIS)

Integrated MIES Format for flow of physical performance data were found at the lowest level (ANM). Multiple reporting is still in vogue, under different programmes. Reporting under NRHM is being undertaken by the contractual staff and often differs from the record-based reports or programme performance reports. There is a need to publish/disseminate District and facility profiles/reports that are prepared to the subordinate facilities and also be available for scrutiny by the general public. Facility surveys reports were not found in the facilities and it is suggested that copies of these reports should be retained at facility level also.

Community monitoring is not in place yet, but PRIs are involved in sanctioning expenditure of untied funds across all facilities. It was felt by the CRM that SPMU and DPMU need to create local level monitoring indicators for facility-specific IPD and OPD rates, performance growth rates, financial performance etc. Such analysis should be shared with the other stakeholders as an effective monitoring tool.

B10. Planning & Monitoring: *Planning and monitoring with community ownership*

Village plans are prepared based on household health data and with involvement of PRIs. Facility surveys were conducted but without involvement of community/PRI. The Planning & Monitoring Committees at various levels have yet to be established.

B11. Equity: *Work towards women's empowerment and securing entitlements of SC/ST/OBC/Minorities*

Disaggregated data of access to health facilities by population groups need to be established. The state has conceived a special initiative for reaching out to interior areas through Helicopter service for one-day health camp in tribal pockets with no access by road. Mobile medical units are yet to be procured. An increasing trend was observed in number of JSY beneficiaries but no visible increase in institutional deliveries observed before and after introduction of JSY. ***The State needs to analyse the reasons for the evident inclination for home deliveries and how to motivate the pregnant mothers to access the services in institutions and devise strategies accordingly. In fact the IEC activities need to be monitored for both reach and impact.***

B12. Convergence: *Convergence of programme for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing safe drinking water, etc. with community support*

Though Societies are merged at the state and district level, accounting and reporting are still maintained separately. Construction of health facilities (SC/PHC) are being undertaken from funds under different schemes with the District Magistrate showing greater involvement of the administration at district and block level. There is representation of all departments in District H&FW Society. MOs participate in meetings of other departments chaired by DM/SDM. PRIs participate in DDT spray by certifying coverage of households and providing volunteers. HIV/AIDS activities are still being conducted separately under SACS. Village sanitation committee not yet merged to form health & sanitation committee and nor have accounts been created to enable transfer of untied funds.

B13. Chronic Diseases: *Addressing burden of chronic diseases*

Integrated IEC is being conducted, especially through Village Health Days, which is generating huge response. Two such events were witnessed by the CRM team. There was enthusiasm among women and children on various competitions for which prizes were distributed in the form of impregnated bed-nets, soaps, etc. The State had embarked on an innovative scheme for an annual de-worming campaign for the entire population so that the cases of diarrhoea are minimal.

B14. Social Security: Social security to poor to cover for ill health linked impoverishment and bankruptcy

Although the State had taken special care that no needy person is denied access or actual delivery of health care, there was no formal community health financing/demand side financing initiative being undertaken at the community level. Hospitals, with current bed capacity are also not equipped to guarantee hospitalisation of all needed. One of the reasons is the need for more availability of “bedded PHCs” at accessible locations so that the SDHs are not overtly overburdened as was noticed in the Dhalai District (see District Report). This needs to be given a serious concern and options for guaranteeing health care to the poor needs to be explored.

5. Response of State Government

After the presentation (**Annexure III**) made by the CRM to the State Government on the observations and findings of the CRM, the following feedback was given by the State:

- a) That while the CRM observed that the patients had to pay to avail of the ambulance services or referral transport, the state government clarified that the Ambulances were being provided free of cost when available. In some places SHGs have been involved for the operation of these ambulances.
- b) The State had not received approval of the RCH component of the PIP, which is affecting their implementation schedule.
- c) Village Health Day are very popular and is an important component of an integrated IEC effort by the state.
- d) Helicopter Health Camps are being organised for the underprivileged and inaccessible areas.
- e) Under the Mental Health Programme, approval of three proposals is pending with MoHFW.
- f) NVBDCP (Malaria)
 - Second line treatment is followed in Dhalai after it was observed that the strain was resistant to Chloroquine
 - A proposal for honorarium for DDT spraying in 93 DC Blocks is pending with MoHFW.
- g) The State will re-examine the records for the rise in the IMR and also establish systems for monitoring the OPD/IPD facility-wise.
- h) The present requirement of 5 years rural service for PG course may be broken up as 3 years rural service prior to PG and 2 years compulsory rural service after PG.
- i) Nursing remains a major challenge. While the State Nursing Council has lowered its norms – the availability of good faculty is an issue within the State and perhaps some incentives may need to be worked out. In addition, the quality of training outside Tripura is suspect as the State observed that some these institutions had no Hospital attached to the school which has implications on the quality of nurses passing out.
- j) In view of the shortage of medical, paramedical and technical personnel, often a single person received multiple training and there was a need for a training reserve.
- k) Incentives to medical workforce (like 13 months salary, Chhattisgarh PHC/GP award schemes) could be explored for retaining the motivational levels.
- l) The state government acknowledged housing for the medical and paramedical staff as major challenge and assured taking appropriate steps.
- m) Shortage of Lab Technicians was a serious constraint and in fact very few are AICTE recognised. Alternatives need to be explored.
- n) BPMU is to be equipped with Data/Accounts manager at Sub division level upwards for facilitating maintenance of records and transmission of information
- o) Mainstreaming RMPs along with mainstreaming of AYUSH is also needed.
- p) Post of Director Accounts in SHS to be created under State Health Mission Directorate

District Report: DHALAI

**CRM Team: Mr. Pravin Srivastava, Director, MoHFW
Ms. Archana Varma, Deputy Secretary, MoHFW
Director FW, CMO (Dhalai), Jt Dir RCH, DPMU**

Facilities visited

District Hospital	---	PHC being upgraded to a 150 bedded District Hospital - under construction from State funds
Sub-Divisional Hospitals	02	Gandachara Kamalpur
Community Health Centres	---	---
Primary Health Centres	03	Ganganagar – New Norm PHC Kulai Salema
Health Sub Centres	04	Harinchara (PHC-Kulai) Durbajoy East Nalichara (PHC-Kulai) Kolachari (Kamalpur SDH)
Training Institute	01	District Health Training Institute
Village (Lady Pradhan)	01	Baligaon

A. Dhalai District profile

1. Dhalai District is a mountainous district carved out of the North Tripura district during 1995. The district is comprised of 4 Sub-divisions, Ambassa being the administrative head quarter. The district has a population of 3,07,868 (Census 2001) which is predominantly rural (94%) and has a mixed population of tribal and non-tribals. The District has a geographic coverage of 2,312.29 sq. kms and a population density of **139/sq. km**. According to the Census-2001, the distribution of Population is as follows:

	No of Households	Population	Population Ratios	Sex Ratio	% SC	%ST
Rural	57,788	2,89,001	93.9%	966	16.0%	56.8%
Urban	4,297	18,867	6.1%	951	18.2%	11.4%
Total	62,085	3,07,868	100.0%	965	16.2%	54.0%

2. Dhalai District is a backward district and is also one of the 250 enlisted poorly developed districts in the country. Poor socio – economic condition, ignorance, taboos and poor communication has impeded the pace of development in the district and thus requires special interventions.
3. Dhalai District does not have a District Hospital or a CHC. The Sub-Divisional Hospitals are functioning as CHCs and the PHC Kulai is being upgraded to a **150-bedded District Hospital** from the State funds. Though this aspect was not mentioned in the State PIP, the construction work has commenced and is likely to be completed within 18 months. The Team visited the construction site and saw the site

plan. It was observed that the medical staff (CMO etc) need to be involved with the plan and stages of construction.

4. The Health facilities and Human Resources in the District are as follows:

SI No	Health Facility	Nos	Staffing pattern							Remarks
			Spl't	MOs	SN	LT	AYUSH	MPW(F)	MPW(M)	
1.	District Hospital	0	Positions to be created and filled up before construction is complete							
2.	SDH/CHC	3	3 (12)	16 (12)	27 (27)	7 (2)				
3.	PHC	12	- (6)	20 (19)	20 (58)	5 (9)	4 (18)			6 are 24x7
4.	Sub-Centre	67						42 (50)	51 (41)	

Note: The figures in parentheses denote vacant positions as reported by the District.

5. The incumbency position of contractual Human Resources as reported by the District are as follows:

SI No	Designation	Sanctioned	In Position	Vacancy
1.	District Programme Manager	1	1	
2.	Accounts Manager	1	1	
3.	Data Assistant	1		1
4.	HOMEOPATH MEDICAL OFFICER	15	3	12
5.	AYURVED MEDICAL OFFICER	15	3	12
6.	Accounts Manager (IDSP)	1	1	
7.	Data entry operator (IDSP)	1	1	
8.	COMPUTER ASSISTANT(Immunization)	1	1	
9.	Lab. Tech	-	2	
10.	MPW	-	6	
11.	Store keeper	1	1	
12.	Driver	1	1	

6. The RVSy (now BRGF) of the Ministry of Rural Development has invested in the health sector and the health facilities visited had solar powered lights on the SDH/PHC campus and in key rooms.

B. Assessment of the case load being handled

7. The DPMU prepares a report of the In-patient and Out-patient load in the facilities. A sample report is given below:

Health Institution		In-Patient		Out-Patients		Average Monthly Growth%	
		2006-07	2007-08*	2006-07	2007-08*	In-Patient	Out-Patient
SDH	GANDACHERRA	4,544	2,354	2,503	9,407	-11%	544%
	B.S.M, KAMALPUR	10,025	6,838	30,888	15,887	17%	-12%

Health Institution	In-Patient		Out-Patients		Average Monthly Growth%		
	2006-07	2007-08*	2006-07	2007-08*	In-Patient	Out-Patient	
	CHAI LENGTA		2,573		4,867		
PHC	CHAWMANU	3,680	2,344	6,651	5,133	9%	32%
	AMBASSA	-	-	12,785	10,122		36%
	KULAI	8,219	1,726	16,458	15,692	-64%	63%
	SALEMA	34	31	14,895	12,869	56%	48%
	NAKASHIPARA	2,826		9,392			
	MARACHERRA	1,257		14,241			
	MANU	6,614	3,198	7,871	5,550	-17%	21%

Note *: Figures for 2007-08 relate to April – October, 2007
Blank cells imply that the reports are not available

C. Preparedness of health facilities for inpatient care and utilisation of beds for such care

8. The hilly and difficult terrain in the District makes it a challenge for the people in the remote areas to access health care facilities and services. The CMO is energetic and enthusiastic and keeps the motivational levels of his team of officers very high and this reflects on the good services being provided at the health facilities in the District. The District has 3 Sub-District Hospitals, where the PHCs refer patients. In view of the varying services being provided at the PHCs and SDHs, the Doctors exercise their discretion in referring patients to the other facilities and at times to the State HQ (Agartala). In fact the Salema PHC (which provides only day time services) refers patients to Kulai PHC, which is near the District HQ and is being upgraded to a District Hospital.
9. The Team noticed that PHCs located in remote areas (like Salema PHC) do not have staff quarters and accommodation for the MOs and Staff Nurses needs to be addressed as it was affecting the functionality of the health centre and increasing its utilisation. It was also observed that the patients at this PHC were referred to other facilities and even normal deliveries were referred to further off “bedded – PHCs”. The fallout was that it was affecting the people’s perception of the public health system – and perhaps reinforcing their decision to go for home deliveries. Another consequence was that these referrals were loading/congesting the 24x7 PHCs and SDHs.
10. The patient load at the facilities visited were as follows:

Health Centre	Location	Medical Officers	Beds	Average Patient Load	Remarks
SDH	Gandachara	4 MOs 1 O&G	50	20 daily	Had telemedicine facilities
	Kamalpur	8 MO 1 Dental	75	100 daily	Had recently started surgeries
PHC	Ganganagar (New Norm PHC)	2 MOs 1 Ayush	5-6	32 mthly (2006-07)	No Inpatients , however, providing 24x7 services for emergencies. Desire

Health Centre	Location	Medical Officers	Beds	Average Patient Load	Remarks
					for beds
	Kulai	5 MOs 1 Dental	30	60-100 daily	
	Salema (Day care only)	1 MO 1 Ayush (H)	5-6	50 daily 60 daily (Ayush)	No laboratory testing. Desire for beds

D. Quality of services provided for institutional deliveries

11. Of the facilities visited, the SDHs and PHC Kolai were equipped for deliveries, however, only SDH Kamalpur was in a position to do Caesarian Sections.
12. The facility-wise Institutional Deliveries are tabulated below:

Institutional deliveries in Dhalai District

Health Centre	Location	2005-06	2006-07	2007-08
SDH	Gandachara	232	250	230
	Kamalpur	626	760	460
	Chailengta	120	135	67
PHC	Manikpur	0	0	0
	Chawmanu	62	93	80
	Manu	361	395	251
	82-Mile	60	123	54
	Maracherra	21	13	10
	Nakashipara	52	28	24
	Salema	1	0	0
	Kulai	534	562	353
	Ambassa	0	0	0
	Ganganagar	0	0	0
	J.B. Para	0	0	0
	Total		2069	2359

13. The PHCs visited had ambulances that were used for transporting patients to the next functional PHC, SDH or State Hospital at Agartala.
14. The PHCs where deliveries were not taking place had Staff Nurses who had not done deliveries since long. Thus even if these PHCs are made 24x7 or bedded PHCs, the evident lack of upto date hands-on skills would be a major impediment. There is a need to rotate the MOs and Staff Nurses with the SDH/Bedded PHCs for a short duration so that their skills get refreshed before making the PHCs bedded. In fact an experienced team of MO and SNs can be posted to the PHCs that are to be bedded or made 24x7 so that people's confidence can be restored in the public health system.

E. Systems in place for immunisation and visible changes at the field level

15. The District had made efforts for improving the immunisation coverage through ANM/ASHA interventions. The CMO had introduced a "Tickler Box" at each of the health centres visited which ensured that the children to be immunised are effectively

categorised month-wise. This made it easy for the ANM to identify the cases to be targeted for the month and also gave information on the “full immunisation” and “dropout” numbers.

16. For the dropout cases, it is suggested that the reason for dropouts should also be recorded in the card.

F. Diagnostic facilities at health facilities and their effectiveness

17. The diagnostic facilities were available only at SDH Kamalpur and PHC Kulai. It was informed that SDH Chailengta also had diagnostic facilities. The details for the facilities visited are as below:

Health Centre	Location	Diagnostic facilities
SDH	Gandachara	Sputum AFB, Blood MP, Blood Grouping, TC, DC, ESR
	Kamalpur	Blood Grouping, Hb, Pregnancy, MP Slide, Sputum AFB, Urine (R), Stool, TCDC, ESR, Widal, VCTC, Blood routine
PHC	Kulai	Blood Grouping, Stool, Sputum AFB, MP Slide

18. In spite of very few diagnostic testing facilities in the governmental system, there were hardly any private players for specialised diagnostics.
19. X-ray facility was available at SDH Gandachara and SDH Kamalpur; the latter also had ultrasound facilities. For the admitted patients X-rays were free of charge, Rs 10 was charged for out-patients and Rs 40 for outside/private patients. At SDH Kamalpur, the ultrasound charges were Rs 200 for general users and Rs 100 for BPL patients. There was no shortage of X-ray plates.
20. The other PHCs were not providing any diagnostic testing facilities.

G. Manpower position in health facilities

21. The position of key manpower resources in the health facilities visited is given below:

Key manpower position

Institution										Remarks
	MO	Ayush	SN	LT	Pharmacist	MPW (M)	MPW (F)	ANM	GD A	
SDH Kamalpur	12	3	17	6	5	3	8	3	35	1 Dental Surgeon
SDH Gandachara	4		8	1	1	1	1	1		1 Obs & Gyn
PHC Nakashipara	2		3	1	1	4	5	3	12	
PHC Salema	4		3		3	2	4	1	7	
PHC Kulai	5		4	1	1	14		5	10	

22. The State does not have a separate Specialist Cadre. In view of the difficult terrain and hard to reach areas, the CMO, Dhalai would like to have more MPW (Males) for improving out-reach services.

H. Utilisation of Rogi Kalyan Samiti and untied funds

23. The Rogi Kalyan Samitis for all the SDHs, and PHCs have been registered, bank accounts opened and untied funds transferred to the Societies. The GPs are actively involved in the affairs and functioning of the Societies. User charges were being charged for only certain diagnostic tests at SDH Kamalpur & PHC Kulai.
24. The RKSs at the SDH/PHCs were primarily dependent on the untied funds and maintenance grants received. Some of the activities undertaken by the RKS include general cleanliness, cleaning of water tank, minor repairs, water filter, whitewashing, boundary fence, furniture, bed repairs, sign boards etc
25. At the Sub-centre level, the ANMS were using the funds for general cleanliness, signboards, registers, health mela expenses, etc.
26. It was observed that the RKS functionaries had inhibitions in spending funds for the welfare of the patients. Suggestions were given to them on the various options and alternatives that the funds could be used like BP instruments and baby-weighing scale at the Sub-Centre and life-saving drugs at the SDH/PHC level for the benefit of the vulnerable groups.

I. Involvement of PRI in the functioning of health system

27. The team interacted with the Panchayat Members along with the other members of the RKS. They were enthusiastic and supported the activities in the health system. They were involved in the preparation of the health plans.
28. The Village Health and Sanitation Committees have yet to have their bank accounts opened and this is impeding the transfer of the untied funds earmarked for them.

J. Process of preparation of DHAP and quality of District Health Mission meetings

29. It was observed that the various stakeholders were consulted while preparing the Village, Block and District plans. This process needs to be further strengthened and institutionalised so that the ownership of the IDHAP is with all the stakeholders and internalised.

K. Systems of financial management

30. The record keeping of financial records in the facilities visited was satisfactory. However, as NRHM has led to maintenance of several types of financial records, registers and book of accounts, it is over-loading the existing personnel. The DPMU has only a DPM and DAM and the responsibility of accounts maintenance and record keeping is being done by him. The statement of receipts and expenditure prepared by the DAM is attached at the end of this annexure.
31. The State is considering engaging a Data-cum-Accounts person at the Block/PHC level to facilitate the flow of physical and financial information. This may be expedited to ensure timely preparation of accounts and flow of financial performance reports.

L. HMIS and its effectiveness

32. The State has distributed the Integrated MIES Format for flow of physical performance data to the lowest functionary, that is, the ANM. The DPMUs are responsible for ensuring that the data flows to the State HQ and onwards to the Centre. The view of the State Govt is that there is multiplicity of forms that are required to be filled up and which not only leads to confusion and ambiguity, but also requires a lot of time. There is scope for rationalising the number of forms that are required to be sent to the various GOI agencies. The State Govt was informed that these are being rationalised and a web-based District data capturing portal is being designed by the Centre which is likely to be operational soon.
33. The SPMU and DPMU need to create local level monitoring indicators, like facility-specific IPD and OPD rates, performance growth rates, financial performance etc. The analysis from these indicators should then be shared with the other stakeholders as an effective monitoring tool.

M. Rational use of manpower at various levels for skill mix use

34. The staffing pattern of the medical and other positions in the District is given at para 4 above. It may be observed that there are a large number of vacancies at all levels and the position is similar for the State as a whole. The State is facing an acute shortage of doctors and paramedics and it was informed that the State is taking steps to bridge these gaps by increasing seats in medical colleges, revising the standards for paramedics and sending students to other States for formal medical education. However, the State needs to do a proper resource mapping of its manpower, the age/retirement profile, the pass outs from the colleges. As already noted earlier, there was a need for rotating the medical and paramedical staff across centres, especially for the non-bedded PHCs, so as to refresh their skills.

N. Thrust on difficult areas and vulnerable social groups

35. As can be seen from the Table below, the district is predominantly rural with a high percentage of tribal population.

	No of Households	Population	Population Ratios	Sex Ratio	% SC	%ST
Rural	57,788	2,89,001	93.9%	966	16.0%	56.8%
Urban	4,297	18,867	6.1%	951	18.2%	11.4%
Total	62,085	3,07,868	100.0%	965	16.2%	54.0%

36. The CMO desire that more MPW (Males) can be recruited for the hard to reach or inaccessible areas so that their reach increases.

FUNDS RECEIVED & UTILIZED INCLUDING PHYSICAL ACHIEVEMENT – DHALAI DISTRICT**UPTO AUGUST, 2007:**

SL. NO	NAME OF COMPONENT	TOTAL FUND RECEIVED	TOTAL FUND DISBURSED	FUND UTILISED	PHYSICAL ACHIEVEMENT	% OF UTILIZATION	CLOSING BALANCE
1.	JSY	33,50,000	27,36,800	21,53,000	3310	64.27%	11,97,000
2.	TRANSPORTATION COST FOR HIGH RISK PREGNANT MOTHER	2,43,500	2,24,500	1,54,600	326	63.50%	88,900
3.	TRANSPORTATION COST FOR HIGH RISK BABIES	2,60,000	2,55,000	2,28,650	492	87.94%	31,350
4.	STERILIZATION COMPENTATION	1,50,000	1,50,000	74,412	LL-821, VAS-16	49.60%	75,588
5.	24 HR DELIVERY	2,21,760	2,21,760	2,11,860	642	95.54%	9,900
6.	HEALTH CAMP	4,00,000	3,00,000	2,13,090	213	53.27%	1,86,910
7.	RURAL AMBULANCE SCHEME	3,25,000	2,40,000	2,07,700	431	63.90%	1,17,300
8.	ANNUAL MAINTAINENCE OF PHC	6,00,000	6,00,000	5,31,584		88.60%	68,416
9.	UNTIED FUND FOR PHC	3,00,000	3,00,000	2,58,223		86.07%	41,777
10.	ROGI KALYAL SAMITI	12,00,000	12,00,000	9,16,924		76.41%	2,83,076
11.	RCH CAMP	4,48,800	2,99,200	2,99,200	16	66.67%	1,49,600
12.	DHAI TRAINING	2,55,000	2,55,000	2,55,000	150	100%	0
13..	ASHA / LINK WORKERS TRAINING	17,78,150	17,78,150	Programme is going on	558		
14.	RENOVATION OF 1 SDH & 4 PHC	39,20,000	39,20,000	39,20,000		100%	0
15.	IDSP	4,76,000	1,62,785	1,62,785	1.Training under IDSP going on. 2.Installing of VSET under process	34.20%	3,13,215
16.	NBCP	1,95,000	1,95,000	Programme is going on		0%	1,95,000
17.	NVBDCP	20,33,021	16,10,749	16,10,749		79.23%	4,72,272
	TOTAL	1,61,56,231	1,44,48,944	1,11,97,777			32,30,304

District Report: TRIPURA WEST

CRM Team: 1. Dr. Charan Singh (Joint Director NVBDCP, MoHFW)
2. Mr. Gautam Chakraborty (Senior Consultant - Healthcare Financing)
State Government officers of DFW/DHS

Facilities visited

District Hospital	01	Tripura Sundari District Hospital, Udaipur (South Tripura)
Sub-Divisional Hospitals	02	Sonamura and Bishalgarh (West Tripura)
Community Health Centres	01	Mohanpur (West Tripura)
Primary Health Centres	06	Narsinghgarh, Bamutia, Anandapur, Bishramgarh, Kathalia (West Tripura); and Kakraban (South Tripura)
Health Sub Centres	04	Airport, Laxmilunga, Tulabagan, Bishalgarh, Bhabanipur (West Tripura); and Purba Mirza (South Tripura)
Training Institute	---	---
Village (Lady Pradhan)	01	Purba Mirza

A. DISTRICT PROFILE

West Tripura district is the largest district in Tripura. The district is bordered by Bangladesh on the north and west. Dhalai district borders east and South district borders south of this district. There are two small hill ranges in the district (Baramura and Atharamura), and three main rivers (Khowai, Howarah and Gumati) which flow into Bangladesh. The district has a tropical monsoon climate which is very hot and humid, making the population here susceptible to vector-borne diseases like **malaria**, and also water-borne diseases like **diarrhoea and gastro-enteritis**.

The headquarters of the district is located at Agartala, which is also the capital of the state. The district has 5 Sub Divisions and 16 RD Blocks. There are 223 Gram Panchayats and 185 ADC (tribal) villages in the district. **District Water and Sanitation Mission (DWSM) is being run in the district through Village Water and Sanitation Committees (VWSC)**, which have been formed in all panchayats. Under NRHM, these sanitation committees are being merged with health to form Village Health & Sanitation Committees. The administrative and demographic profile of the district is given in the table below.

Table 1: Administrative & Demographic Profile of West Tripura District

Characteristics/ Indicators	District	State
Geographic area (sq. km)	3048	10,491
CD Blocks	16	40
No. of villages (2001 census)		
Population 1-500	2	
Population 501-2000	85	
Population 2001-5000	263	
Population 5000+	58	
No. of towns	4	13

Characteristics/ Indicators	District	State
Total population (2001 census)	15,32,982	31,99,202
Urban (%)	4,10,067 (27%)	5,45,750 (17%)
Rural (%)	1,122,915 (73%)	26,53,453 (83%)
Sex ratio (females per 1000 males)		
Population sex ratio	951	948
Child sex ratio	967	966
Decadal growth rate (1991 – 2001)	18%	16%
Population density (per sq. meter)	512	305
Literacy rate		
Total population	77%	73%
Male	85%	81%
Female	70%	65%
SC population (% of total)	19%	17%
ST population (% of total)	25%	31%
BPL population (field survey for VAP)	53%	
Vital statistics (DLHS-II)		
CBR	16.6	15.0
CDR	8.5	5.5
TFR	0.9	2.2

As can be seen from the above table, the child sex ratio is higher than the population sex ratio, indicating that female foeticide may not be an issue in this district. Also, 70% female literacy is a good opportunity for health education of mothers and adolescent girls, and also provides opportunity to reach the population through mass media like poster, bill-boards, wall writing, etc.

It can also be seen that 25% of the population is tribal and 50% of the population is BPL. This necessitates special outreach programme and social protection schemes for these population segments. The district seems to have **achieved replacement level of fertility**, showing the effectiveness of family welfare services. A matter of concern is the higher than state average death rate, which might be compensating for the higher than average birth rate, resulting in TFR of less than one.

The health infrastructure of the west district is shown in the table below.

Table 2: Public Health Infrastructure in Tripura West

Health Facility	Number	Average population covered (based on 2001 census)
Medical College Hospital	2 (including one under PPP)	7,66,491
District Hospital (DH)	0	---
AYUSH Colleges and Hospital	0	---
Sub Division Hospital (SDH)	3	5,10,994
Rural Hospitals	6	2,55,497
UFWC	1	4,10,067
CHC	0	---
PHC	23	66,651
Sub Centre	199	7,703
Ayurvedic Dispensary	9	1,70,331
Homeopathic Dispensary	17	90,175
Total number of allopathic doctors (including specialists)	89	17,225
Staff Nurse	118	12,991
Total hospital beds	404	3,795

The data from the above table reveals that PHC, which as per national should not be covering more than 20,000 population are covering more than 60,000 population. The work pressure on health staff is also apparent with each doctor being responsible for almost 17,000 population and each nurse being responsible for almost 13,000 people. There is also great demand on the meagre resources as each hospital bed is catering to almost 4000 population. But, it seems, the nurse-bed ratio is a bit comfortable with one nurse per four beds.

The systemic interventions under NRHM are supposed to address the gaps in health services and health needs, as discussed above. The current CRM is focussed on reviewing whether the NRHM interventions are directed towards systemic corrections for filling-up those gaps.

B. FINDINGS OF THE MISSION

1. Functional facilities: *Establishing fully functional Sub Centres, PHCs/CHCs/Sub Division/District Hospitals*

(a) Sub Centres

- One Sub Centre (SC) was covering almost 15,000 population (Bishalgarh – 14,438 population) and one covering almost six thousand population (Laxmilunga – 5927)
- Each SC had at least two MPWs (one male and one female). Bishalgarh covering almost fifteen thousand populations had 3 MPW females, one MPW male and one Pharmacist.
- The SC records and registers were found to be up-to-date and properly filled up. They also had records of JSY beneficiaries in their area.
- Stock register showed frequent stock-out problems in all the SCs, especially for PCM. DOTS and malaria drugs were available in sufficient quantity.
- It was observed that stock of any particular medicine was allowed to fall below average monthly consumption and reach zero balance before new indenting.
- SCs were using disposable syringes for immunisation and were not using sterilisers.
- Although the MPWs had knowledge of correct way of administering injections, danger symptoms, DOTS, ANC services, most of them were referring delivery cases to health facilities and not actually conducting deliveries.
- The MPW females were not conducting IUD insertions and they said IUD is not preferred in this region. Preference was for OPs and CCs.
- Four of the six SCs were running in donated/rented buildings, but had adequate space, except one (Bhabanipur)
- All SCs had formed SC Committee and had received untied funds. The expenditure of untied funds varied from 60-80%, mostly on upkeep of building and purchase of furniture and equipment (BP apparatus, weighing machine, etc.). The senior MPWs and Supervisors could check BP.

(b) PHC

- All the PHCs visited were bedded PHCs with two or more doctors, providing 24x7 services.
- The coverage of the PHCs varied from 5000 to 1.2 lakhs (Anandapur).
- The OPD attendance was around 100 per day for all the PHCs. Functional bed strength varied from six to ten beds with bed occupancy being more than 100% in summer and monsoon seasons. Cases admitted at present were mostly fever cases.
- On an average the PHCs were conducting 20-50 deliveries per month.
- The labs in the PHCs were examining malarial slides and sputum examinations. Instruments and equipments are procured by respective RKS for conducting routine examination. SOP for examining malarial slides and sputum examination was displayed in two PHCs (Bishrampur and Bamutia)
- RKS was formed in all PHCs. Some PHCs (like Bamutia) were facing problems as the chairman of Block Panchayat was heading the RKS of more than one PHC in the Block and PHCs far from the Block HQ could not easily access the chairman for verifying/approving expenditure/vouchers.
- Panchayat was very active in PHC operations and the Panchayat had invested Rs. 62 lakhs in Kathailia PHC for renovations, construction of meeting hall and purchase of surgical instruments.

- Bishramgarh PHC had unscientifically dug burial pits for waste disposal. All PHCs had strelisers and needle destroyer, but colour-coded bins were not seen in any PHC for waste segregation. Nurses had received training in needle destroyers but comprehensive training in waste segregation and treatment had not given to all staff.
- No PHC had generator causing problems in maintaining cold-chain in case of power-cut for more than 24 hours.
- All medicine stocks were available in adequate quantity. They are not facing problems of drug expiry as drugs due to expire are consumed first or given to other institutions in need. Normally drugs are consumed in time as patient load is high and number of facilities less than required.
- Kathalia PHC had tele-medicine facility, linked with the state medical college in Agartala. This enables specialist consultation for required cases. This is being funded by state's own funds.

(c) CHC

- The CHC (Mohanpur) had 20 beds and a new bulding is being constructed with an outlay of 87 lakhs. The CHC will be a centre for PSM training for the medical college in Agartala. Quarters are also being built for the MOs.
- It is covering a population of around one lakh.
- It has fully functional lab (all routine tests, sputum and slide examinations), X-ray (60mA).
- It is not designated as FRU as OT is not functional and there are no Anaesthetists.
- RKS is functioning. They had received the untied funds and have made more than 50% expenditure. The PRIs demand extensive training on their role in various management structures under NRHM.
- It has a functional generator and ambulance.
- No waste management (segregation and disposal) system was observed.

(d) SDH

- Both SDHs (Sonamura and Bishalgarh) are being upgraded to IPHS standard. These have bed strength of around 30 beds and OPD load of 200plus patients per day and around 50 deliveries per month.
- Sonamura is declared FRU with both OBG and Anasthetist posted there and the OT is operational, with available ambulance services.
- SDH Sonamura in Melagarh Sub Division has tele-ophthalmology facility located in the SDM office nearby.
- AYUSH doctor, appointed under NRHM is co-located in Bishalgarh. She is the master trainer for ASHA in the Sub Division.
- RKS is functional and spending of untied funds is around 60%. The PRIs demand extensive training on their role in various management structures under NRHM.
- No waste management (segregation and disposal) system was observed.

(e) DH

- The DH is running with 35 beds. A new facility based on IPHS norms is coming up nearby with 100 beds.
- The DH has tele-cradiology with 6 bedded CCU, linked with Devi Shetty's hospital in Kolkata (Rabindra Nath Tagore Hospital).
- It has a functional blood bank and provides blood regularly to around 75 Thalassemia patients in the region.
- Fully staffed with specialists like Paediatrician, Anesthetise, OBG in place, apart from orthopaedic and Eye specialists.
- The wards did not have side table/locker facility for the patients.
- The PCB (Pollution Control Board) had certified the facility two years ago but no waste management (segregation and disposal) system was observed. The hospital officials also did not have the data of waste generated.

2. Human Resources (HR): *Increasing and improving human resources in rural areas*

- Specialists were found only in one SDH and the DH.
- Although MPW (Females and Male) were found in PHCs and SCs, there is need for more as, on an average, one MPW is covering more than one panchayat.

- Contractual posts not filled up fully as applicants not found in sufficient number. Of 400 posts of Nurses advertised only around 70 joined and of 300 posts of Doctors advertised only 67 turned up.
- No local “production” of doctors as state medical college will pass out the 1st batch in 3-4 years.
- Only two ANM training centres in the state, with one in south district. Both put together are producing 50 ANMs every 1.5 years. One MPW (Male) training centre functional in Agartala is expanding to 100 seats
- Two medical colleges running in the state with 100 seats each, with one under PPP. Only MBBS being offered apart from DNBE at the govt. medical college. No PG courses yet
- Nursing college started functioning under PPP for GNM courses.
- Regular doctors for Ayurveda and Homeopathy exist under state cadre. This is apart from AYUSH doctors recruited under NRHM and co-located at PHC/CHC/ SDH level
- Multi-skill training of doctors and MPWs underway. All Supervisors had received multi-skill training but only two MPW (males) and none of the MPW (Female) were found to have received the training. They are being trained at Agartala (medical college).
- RMP sensitisation to start for referral of TB cases in west district in December 07, it has not started yet.
- Alternatives in the form of private health providers non-existence, although some private laboratory and ophthalmology facilities were observed around some DH/SDH/ CHC
- Both the districts have one DPM, Accountant and Computer operator each. The state has issued appointment for computer operators to be posted in all facilities upto PHC level, including District H&FW Society and District Programme Offices.
- Contractual staff under NRHM not yet fully integrated with activities of other health programmes operationally. They are mainly being used for routine ministerial jobs and viewed as outsiders by most health staff. Other programme staff not fully cooperating MIS reports with NRHM contractual staff at district level.

3. Accountability: *Accountable health delivery*

- PRIs actively involved in management of facilities through RKS and Sub Centre Committees. Panchayat had invested Rs. 62 lakhs in Kathalia PHC for renovations and construction.
- Involvement of PRIs at PHC level is hampered (as in Bamutia PHC) as Block Panchayat Chairman has to head these RKS, which are spread across in the block. As a result PRIs are not always available for signing and approving vouchers/expenditures for RKS of PHCs which are located far from the Block HQ.
- JSY beneficiaries being certified for BPL/SC/ST by panchayats. The expenditure on JSY beneficiaries is discussed in the RKS meetings, in the presence of PRI and other members. JSY money for home deliveries is paid by the BDO, who receives funds from District H&FW Society.
- Household surveys for ascertaining local health indicators and disease burden not being undertaken. TB, Malaria targets based on national estimates and not on local disease burden

4. Empowerment: *Empowerment for effective decentralisation and flexibility for local action*

- Village Health and Sanitation Committees not formed yet in any panchayat.
- RKS formed in all health facilities along with SC committees at SC level.
- All facilities received untied funds and spending, mainly on facility renovation and purchase of needed instruments, furniture, etc. The spending of untied funds is in the range of 50 to 70%.
- Panchayat standing committee members involved in RKS and District H&FW Society
- PRIs were sensitised during micro health planning exercise undertaken during early 2007, but they did not receive formal training in NRHM and their role in planning, implementation and monitoring of various components.
- AWW involved in PPI and identification of JSY beneficiary along with ANM.
- ASHA selection completed, training in progress. One batch of 73 ASHA trained in west district. Another batch is to start by November end.

5. Maternal and Child Health (MCH): *Reducing maternal and child deaths and population stabilisation*

- Institutional deliveries 50-70% in the districts. It is better (around 74%) in west and lower (54%) in south.

- In west tripura, as institutional delivery is already over 70%, not major change was observed by introduction of JSY, between 2005-06 to 2006-07. But
- None of the facilities reported maternal deaths in their areas.
- No VPD (Vaccine Preventable Diseases) were reported among children. One PHC (Kathalia) reported two AFP cases a year ago, but none reported any polio case.
- JSY beneficiaries are receiving Rs 700 at the institution where they deliver (govt. facility as there are no private facilities).
- TBA training being undertaken in tribal (ADC) villages under various schemes under DM.
- No special initiative was observed for implementing IMNCI at facility and community level.
- Contraceptives available at all levels
- Sterilisation camps being conducted regularly by teams from SDH/DH in CHC/PHC.

6. Preventive & Promotive health: *Action for preventive and promotive healthcare*

- Malaria deaths were not reported in the last season from any of the facilities visited.
- The community is more open to impregnated bed-nets rather than DDT spray. Even if DDT spray covers all houses, not all rooms in the houses are covered, as reported by a survey under Bishalgarh SDH.
- There are no IDD cases in the region.
- Integrated IEC, especially Village Health Days monthly at every village, is being observed regularly. High enthusiasm was observed among all stakeholders regarding VHDs in Tulabagan SC village. Villagers interacted with in Purba Mirza also mentioned about the VHDs.
- School health is mainly focussed on eye test and distribution of glasses, coordinated by PHCs.
- Oral hygiene is not being promoted with special focus in health camps, although Dentists were found in all CHC/SDH and in two of the six PHCs.
- Common labs functioning, especially at PHC/CHC level for all health programmes (Malaria, TB, VCTC)
- Facilities across all levels display posters related to different health programmes, JSY, service package, etc. Although most IEC material is written and less pictorial, 60-70% literacy should not constrain reading of IEC material.
- Special de-worming campaigns being undertaken by the state in various pockets.

7. Disease Surveillance

- IDSP centres operating at all levels, registers being maintained. Training received by supervisors and MPW/ANMs
- PHCs received computers but software is not installed yet. Facilities waiting for data-entry operators to be placed
- No hospital is recording diagnosis in the in-patient registers in the wards except one PHC (Bamutia), which is hampering assessment of disease burden preventing preparation of epidemiological profile of the area. Medicines and tests administered on the admitted patient also recorded separately in the case sheet, which is available in the pile of data in medical records.

8. Hamlet to Hospital Linkage: *Forging linkage between hamlet and hospitals for curative services*

- Referral transport funds available with RKS for institution-to-institution referral, based on negotiated rates with local transport operators. The cap of the rates is Rs. 500 per case, but as in some interior places (like Kathalia PHC) market rates are above Rs 700 per trip to Agartala. So, the cap of the rates are being upwardly revised.
- No ambulance service to pick up serious patients from villages. Villagers (in Purba Mirza) demanded funds at village level, which can be made available under untied funds for Village Health & sanitation Committee.
- RMPs orientation to start in December in west district, for referring cases of TB.

9. Health Information System (HIS)

- Multiple reporting, under different programmes. Copies of reports sent above are not being maintained at SC level.

- Reporting under NRHM being undertaken by the contractual staff, normally anomalies exist vis-à-vis other reports
- District and facility profiles prepared but not published for general public.
- District health reports not being prepared

10. Planning & Monitoring: *Planning and monitoring with community ownership*

- Village plans prepared based on household health data and with involvement of PRIs
- Facility surveys conducted but without involvement community/PRI
- Community monitoring not in place yet, but PRIs involved in sanctioning expenditure of untied funds across all facilities.

11. Equity: *Work towards women's empowerment and securing entitlements of SC/ST/OBC/ Minorities*

- Disaggregated data by population groups do not exist.
- Helicopter service for one-day health camp in tribal pockets with no access by road.
- Mobile medical units yet to be procured.
- Increasing trend observed in number of JSY beneficiaries but no visible increase in institutional deliveries observed before and after introduction of JSY.

12. Convergence: *Convergence of programme for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing safe drinking water, etc. with community support*

- Societies merged at state and district level, accounting and reporting still maintained separately
- Construction of health facilities (SC/PHC) being undertaken from funds under different schemes under DM
- Representation of all departments in District H&FW Society
- MOs participate in meetings of other departments chaired by DM/SDM
- PRIs participate in DDT spray by certifying coverage of households and providing volunteers
- HIV/AIDS activities still being conducted separately under SACS
- Village sanitation committee not yet merged to form health & sanitation committee

13. Chronic Diseases: *Addressing burden of chronic diseases*

- Integrated IEC being conducted, especially through Village Health Days, which is generating huge response. Two such events were witnessed by the CRM team. There was enthusiasm among women and children on various competitions for which prizes were distributed in the form of impregnated bed-nets, soaps, etc.

14. Social Security: *Social security to poor to cover for ill health linked impoverishment and bankruptcy*

- No community health financing/demand side financing initiatives being under taken at community level.
- Hospitals, with current bed capacity are not equipped to guarantee hospitalisation of all needed.

Presentation made by the CRM to the State Government on 21.11.2007

Additional Documents

1. Letter of GoTripura communicating the State's **budgetary provisions/support** for health sector
2. **GoTr OM dated 20.11.2007 giving the incentive structure for payment to ASHAs**
3. GoTr OM dated 28.07.2007 giving the check-lists for field visit inspection
4. A Compendium of Government Orders/Guidelines for NRHM
5. Profile of Dhalai District
6. Profile of West Tripura District
7. Presentation made by the State Government