

Third

# Common Review Mission

State Report

## West Bengal



**Government of India**  
**Ministry of Health & Family Welfare**  
**National Rural Health Mission**  
**Common Review Mission-III**  
**Report of West Bengal**  
**(3<sup>rd</sup> to 13<sup>th</sup> November, 2009)**

## **Introduction**

a) CRM-III Team visited the State of West Bengal from 3<sup>rd</sup> to 13<sup>th</sup> November, 2009. On 4<sup>th</sup> Nov, 09, a detailed presentation on the NRHM implementation in the State was made by Shri Sunil Kumar Gupta, MD(NRHM), Commissioner (H & FW) of the State. The meeting was also attended by Shri Samar Ghosh, Addl. Chief Secy. (Health) along with JDs and DDs of the Directorate of Health of the State. The presentation gave the detailed account of the new initiatives taken by the State along with the implementation of the continuing programme of RCH, and Disease Control Programmes. Some of the significant steps taken by the State, as shown in the presentation include-

- Steady enhancement in Health State Budget over years
- Setting up of State Medical Supplies Corporation
- Enhancement in drugs budget over years
- Opening of NTSs – 11 in PPP mode & 3 in Govt. facilities.
- Ratio of Nursing staff revised from 5:1 to 4:1.[Since 2005]
- Placement of 2<sup>nd</sup> ANM in the sub-Centres
- Placement of ASHAs at village level
- Starting of medical/nursing courses in medical institutions on PPP/Private basis
- Introduction of Referral Transport/ diagnostic services on PPP basis
- Counselling of MOs before joining – to arrest attrition.
- DNB course started in 2 non- medical colleges.
- 82 BPHCs upgraded to Rural Hospitals with at least 30 beds
- Existing BPHCs with high no. of deliveries, OPD attendance, etc identified for upgradation by construction of new hospital bldg, renovation of existing hospital bldg& construction of MO & nurses' qtrs
- Additional 3 posts of specialist MO [1 G&O, 1 Paediatrician, 1 Anaesthetist] created for upgraded BPHCs
- Additional posts of nursing staff created- @ 1:4 + 3 [for OT /Labour room]
- X-ray technician posts created @ 1 per facility -176
- Setting up of GP level AYUSH dispensary by engaging part time MOs
- Identification of malnourished children (Specially GR II, Gr III & Gr IV Children) & improve their Health Status by giving Nutritional Supplement

through ICDS to Reduce Morbidity & Mortality among under 3 children in 11 blocks of Nadia district y & another 2 districts (Purulia & Uttar Dinajpur) identified for the purpose.

Development of Dynamic Website for DH&FWS in Howrah & Murshidabad  
Standard Treatment guidelines for Primary Health Care in North 24 Pgs. & South 24 Pgs

Jibon Jyoti Sahayata Prakaalpa for rendering medical care to Lodha and Sabar population in Paschim Medinipur with the objective of improving health seeking behaviour of ex-criminal tribes. Activities include health camps in Lodha/Sabar villages and free transport & outdoor/indoor treatment for the members of the targeted community.

For testing the quality of drinking water sources all over the state, the existing resources of PHE Deptt, P & RD Deptt and NRHM have been pooled together to set up some new labs run by NGOs and strengthen the existing Labs of PHE deptt. Panchayats have been given the responsibility of arranging for sending samples from village wells to these labs for testing to ascertain their fitness.

Public Health and Administrative Service Cadre established

Non-Medical Superintendent posts created for all hospitals

224 reserved PG seats for 'in service' candidates for working in difficult areas

Recruitment of 500 HA(M) this year

Starting a course for Nurse Practitioner ( training already started)

b) The state of West Bengal is bounded by the Orissa, Bihar and Nepal in the west, Bay of Bengal in the south, Sikkim and Bhutan in the north and Assam and Bangladesh in the east.

c). The state of West Bengal has an area of 88752 sq. km. and a population of 80.18 million. There are 19 districts, 341 blocks and 40782 villages. The number of gram panchayats are 3354. The State has population density of 903 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 17.77% (against 21.54% for the country). The population of the state is growing at a slower rate than the national rate.

## 2. Teams and Districts Visited

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\* **Team-1:** Visited district Purulia; # **Team-2:** Visited district Cooch Bihar

## 3.. Public Health System in the State

### i. Infrastructure

#### **Tertiary Care**

Medical Collage 9

#### **Secondary Care**

District Hospital- 15

Ayurvedic Hospital 4

Ayurvedic Dispensary 295

Unani Hospital 1

Unani Dispensary 3

Homeopathic Hospital 12

Homeopathic Dispensary 1220

#### **Primary Care**

Community Health Centre – 349 (Shortfall-149)

Primary Health Centre-924 (Shortfall-1069)

Sub-center- 10356 (Shortfall-1745)

ii. a) Human Resources

Public Health Staff	Required	In position
Doctor at PHCs	924	810
Obst. and Gynec. At CHCs	349	38
Physicians at CHCs	349	107
Padiatricians at CHCs	349	25
<b>*Specialists at CHCs</b>	<b>1396</b>	<b>186 (13.3%)</b>
Radiographers	349	127 (36.3%)
Pharmacist	1273	830 (65.2%)
LTs	1273	441 (34.6%)
<b>#Nurse /Midwife</b>	<b>3367</b>	<b>5215 (154%)</b>
LHV/HA (Female)	924	300 (32.4%)
ANM	11280	6051 (53.6%)
HA(Male)	924	225 (24.3%)
MPW(Male)	10356	4215(40 %)

\*tremendous shortfall

#Excess numbers

b) DPM Unit

- 1 Distt Program Coordinator
- 1 Distt Statistical Manager
- 1 Distt Accounts Manager
- Block Program Management Units (BPMUs) have been set up in all the blocks

c) Block Programme Management Unit

- Block Accounts Manager
- Data Entry Operators
- ❖ *Further powers for selection of specialists delegated to District samities*
- ❖ *Specialists and GDMOs being engaged for up-graded BPHCs and PHCs through walk-in interviews*
- ❖ *State needs to think innovatively for getting specialists*
- ❖ *Excess number of nurse/midwife makes to think of making primary curative care nurse centric*
- ❖ *Powers of recruitment are decentralized to Taluka Health Officer(THO).*
- ❖ *For vacant posts, walk- in- interviews are conducted on every Tuesday.*

### iii. Indicators

Crude Birth Rate-	17.5
Crude Death Rate-	6.2
IMR-	35
MMR-	141
TFR-	1.9
Sex Ratio	934
Female Literacy Rate	59.6
SC Population	18.45 million
ST Population	4.41 million

### iv. Selected Indicators

Indicator	NFHS- 1	NFHS-2	NFHS-3
IMR	75	49	48
TFR	2.9	2.3	2.3
Current use of any contraceptive method	57.7	66.6	71.2
% with total unmet need for FP	17.4	11.8	8.8
Delivery by trained staff	33.9	44.2	45.7
% of children age 0-5 months exclusively breastfed			58.6
Fully vaccinated children	34.2	43.8	64.3
% of children underweight ( less than 3 yrs)	54.8	48.7	43.5
Any antenatal care	78	91	93
Institutional Delivery	32	40	43

## 4. Status of the PRI framework in the State

3354 Gram panchayats in 40782 villages and 333 Panchayat Samitis  
**Out of 40782 villages, VHSCs established in only 13312(32.6%) villages. Bank accounts opened only in 6670 (16.3%) villages. (It is to be taken note of in view of robust PRIs existing in the state)**

Cooperation from Panchayat Samiti and Zilha Parishad officials is total. Sabhadhipati, Zilla Parishad is the Chairman of the District Health Society District MPs, MLAs, ADM(health), Karmadhakshayas, Sabhapatis, Dy.CMOH I/II/III, SDOs, BDOs, DP&RDO, line deptts & NGOs are members of the District Health Society

PRI involvement is very evident. ( Discussion was held with shri Anandomay Patro , Saha Sabhapati – Raghunathpur-I)

Hiring of MOs by GPs to provide one medical officer of Ayurvedic/ Homeopathic/Ayurvedic/Unani discipline in each uncovered GP (where no formal health facility exists)

To train and enhance capacity of the members of Panchayati Raj Institutions (PRI) including GUSs & SHGs to own, control and manage public health services, block level orientation camps organised.

The responsibility of maintaining and constructing SC / PHC / BPHC is with PRIs

Provide technical support to the Block Samiti in planning and implementing different health programmes by providing 2 trained professionals in each of the 341 Block Health and Family Welfare Samiti.

## 5. Other Indicators

Total Population- 80.18 million

Rural Population- 57.7 million

Urban Population- 41101 (42.4)

Female literacy-59.6%

Sex Ratio-934

Population density-903

SCs-18.45 million

STs- 4.41 million

### Basic Amenities (NFHS-3 )

House holds	Urban	Rural	Total
Availability of electricity	89.6	34.9	52.5
Use piped drinking water	67	9.5	27.9
Accessibility to toilets	90.5	44.8	59.5
Availability of pucca house	83	18.2	39

### Nutrition and food security

- Children under 3 years who are stunted-33%
- Children under 3 years who are wasted- 19%
- Children under 3 years who are underweight- 43.5%
- Women whose body mass index is below normal- 37.7%
- Men whose body mass index is below normal- 31.6%

## **6. Findings of the 3rd CRM at the State level**

### **Progress of operationalisation of Institutional Framework of NRHM (Village Health & Sanitation Committees, Rogi Kalyana Samitis at various levels, State and District Health Missions etc)**

A Rogi Kalyan Samiti has been constituted in every health facility from Medical College to Primary Health Centre for improved functioning of the institutions which in turn leads to better services to the patients

The RKSs are mandated to look into all aspects related to management and proper functioning of the health institutions

So far RKS has been constituted in 1406 facilities (9 Medical Colleges, 15 District Hospitals, 45 Subdivisional hospitals, 34 State General Hospitals, 33 other hospitals, 96 rural hospitals, 253 Block primary health Centres and 921 Primary health Centres)

RKS meetings are regularly organised

There is no user charge collected from primary health Centre level till Rural Hospital level.

Village Health and Sanitation Committee (VHSC) have been constituted with PRI members, ANM, primary school teacher, AWW and SHG members.

State Health Mission Headed by the Hon'ble Chief Minister, West Bengal as the chairperson and the Hon'ble MIC Health & FW as co-chairperson. It has 32 members consisting of other ministers, secretaries, public representatives, NGOs, UNICEF, WHO and experts

District Health Mission Headed by the Sabhadhipati, Zilla Parishad as chairperson, District Magistrate as executive chairman cum MD & CMOH as member-secretary & convenor. District MPs, MLAs, ADM(health), Karmadhakshayas, Sabhapatis, Dy.CMOH I/II/III, SDOs, BDOs, DP&RDO, line depts & NGOs as members

## **7. Progress against the Approved PIP of the State**

Filled-in Checklist for the State of West Bengal is attached.

## 8. Findings of CRM

### PART-I Change in Key Aspects of Health Delivery System

#### 1. Infrastructure Upgradation

##### a) Base line resource mapping

. A detailed Health Facility Survey is being conducted across the State at present. All health facilities from PHC onwards would be mapped on three major criteria: physical infrastructure, human resources and equipments vis-à-vis norms. Majority of the Sub Centres do not have telephone or electric connection, but are well connected through roads. Equipments have been upgraded in PHCs and BPHCs from time to time through various programmes and the deficits would be augmented from NRHM. Residential quarters for staff do exist but are not in good condition due to poor maintenance.

***Recommendation-*** It is important to note that all facilities in West Bengal is based on 1991 census population. Hence there is a serious inadequacy of facilities in the State. For instance, around 12,000 Sub Centres would be required to match 2001 census population. The shortfall in the number of Health Centres has been negatively contributing to the quality of health care. Immediate policy decision to set up health centres (through rationalization) as per 2001 census be taken with due care of accessibility.

##### b) Infrastructure upgradation

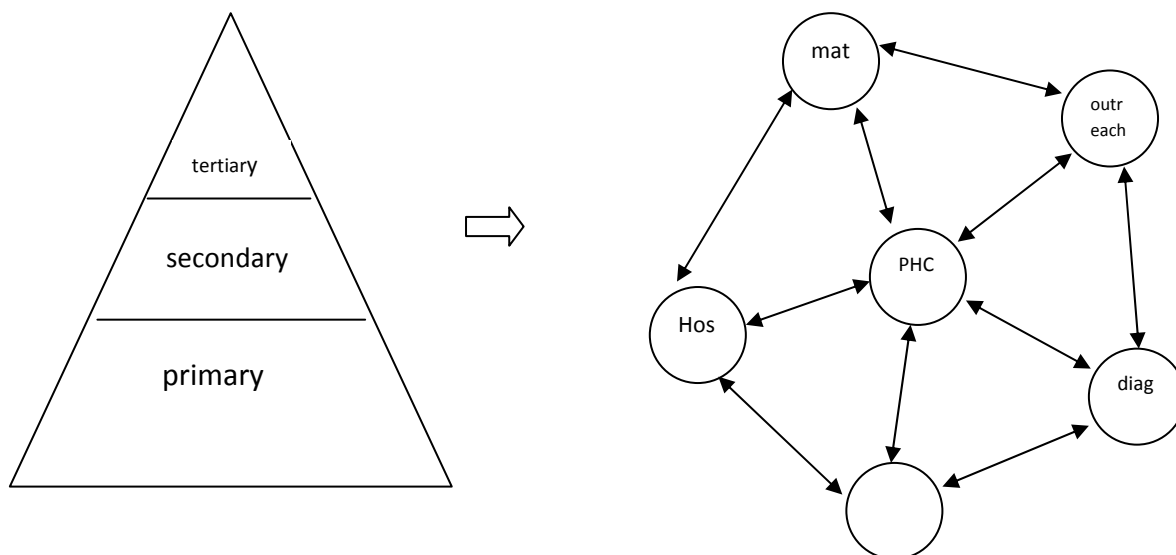
Following NRHM guidelines, the district Purulia well along in a process of upgrading 14 PHCs to BPHCs. This involves expanding the number of beds from 15 and 30 and establishing or upgrading OTs and birthing. Whether the District will be able to recruit specialist and establish quality birthing and surgical services in the facilities is an open question. International experience suggests that few countries have been able to maintain these facilities. Further, once IPD services are introduced in the heretofore ambulatory units (PHCs), there will be a tendency to focus on inpatient services to the detriment of outreach, preventive and public health services, including support for the village health workers. The upgrades may also strengthen an already hospital centric system which India would find unaffordable in the future. International experience also suggests that small facilities will be bypassed (for IPD) by the populations they are meant to serve as road networks improve and educational and income levels rise.

The current infrastructure needs overhauling with repair, whitewashing etc.

**It is very surprising to see the general apathy towards cleanliness not only by the patients but by the staff too. Even though ample water was available in the toilets, they were dirty. The cleaning service as told has been outsourced to an agency. Wherever it was tried to be cleaned it was looking (also ascertained) to be cleaned for the day.**

**Recommendation:**

Given the very good (and improving) road network in the District and difficulties in posting of specialists in rural areas, the state may want to consider a network based model of to rationalize infrastructure expansion in which scarce and expensive specialty services are strategically placed in larger facilities (100 bed+) where economies of scale and scope can be obtained. These facilities should be located in sites where populations have relatively good physical access. These facilities should be linked to ambulatory “gatekeeper” units which channel patients to these larger facilities using call centers and electronic bed reservation and surgical appointment systems (see figure below). Emergency and non-emergency transportation systems will also be needed to support access to and between the facilities in the network. Importantly, and unlike the current pyramid structure which favors tertiary care, the proposed network model places PHC at the center of the primary health care universe that “directs patient traffic” to other facilities comprising the network and providing follow-up care. The district may want to consider a master plan approach based on projections of demand and supply and road improvements to convert from a pyramid- to a network-based system.



**c) Health Infrastructure (physical & human) and Service Utilization:**

There is severe shortage of health infrastructure and human resources in Purulia district at all levels. According to current population there should be more than 30 CHCs & 100 PHCs but only 51 PHCs, 20 Rural hospital/BPHCs are available. There is a crunch of human resources almost in all the categories and more so in specialist categories.

Service utilization at the government facilities in the Purulia district has increased after inception of NRHM. Percentage increase of last year figures over the corresponding years since inception of NRHM are-

% growth	OPD	IPD	ID
In 2008 over 2005	64%	28%	33%
In 2008 over 2006	2%	27%	14%
In 2008 over 2007	-2%	14%	5%

- Pace of service delivery slowed down since 2006
- With current trend district will not be able to achieve the status of 90% Institutional Deliveries by to 2015

## Deployment of Human resources is not compatible with service delivery

Following table depicts the case load of the BPHC/SDH/RH and availability of human resources in the district of Purulia -

Institution / Service		Ragunathpur	Manbazar	Bansgarh	Kotshila	Harmasdi
% share in block figures	OPD	6.5	7.5	7.4	6.6	2.7
	IPD	10	5.4	6	4.4	2.8
	ID	9.5	6.5	6.6	3.8	2.9
<b>Availability of Human Resources (in numbers)</b>						
M.O.		13	5	5	5	1
Specialist		14	3	1	2	3
Nurses		26	12	11	9	8

The availability of human resources at the facility is not attuned with the case load. Similar irrationality exists at PHC level in terms of service utilization (OPD, IPD & ID) and availability of the human resources.

PHC	Annual OPD	Annual IPD	Institutional Deliveries	MO	Addl. MO	Staff Nurses
Biltora	14446	0	0	2	1	2
Kesowa	39933	0	0	2	1	2
Hutwara	65891	722	203	2	1	4

At some of the institutions bed occupancy rate is very high like in Hura Rural hospital it is 200%. Some of the institutions have two Lab technicians one for RNTCP & another for Malaria whereas testing load is not enough and can be managed by one lab technician.

Although the productivity is generally high, there are large variations among the facilities. These variations can respond to both demand and supply variables. Not shown in the table, institutional deliveries per nurse in BPHCs as well as OPD/MD/day in PHCs also show huge variations. Some physicians see over 75 patients per day suggesting that they spend but a few minutes “dispatching” the

patients with only cursory diagnosis. Not surprising, OBD and emergency productivity of specialists (who mainly attend OBD) in the subdistrict hospital was only a fraction of their colleagues in BPHCs and PHCs.

Greater rationalization of scarce physician and nurse resources are needed. The potential for “burn out” is high and doing a good job is nearly possible when demand is very high. The current policy of assigning physicians and nurses according to norms may be misguided, resulting in huge work burdens for some staff and relatively light burdens for others.

### **Recommendation:**

It should be ensured that availability of human resources be correspondingly matched with the service delivery. State may set up a cell that monitors the facility wise service delivery particularly OPD, indoor admission & institutional delivery and rationalize the availability of human resources accordingly.

Analyze the production and productivity of physicians and nurses from both supply (real service hours) and demand standpoints. Consider demand as a criterion for assigning physician and nurse staff to facilities rather than simply following population-based norms.

Lab technician of RNTCP & Malaria should be trained in both types of testing and they should be deployed in accordance to testing load at facility. State may plan to extend lab facility at the level of PHC by deploying the spared Lab technicians.

## **2. Human Resources Planning**

### **a) Availability of HR and gap analysis**

An upgraded block PHC had 1 BMOH and 2 GDMOs. Additional 3 posts of specialist MO [1 G&O, 1 Paediatrician, 1 Anaesthetist] have been created for upgraded BPHC. The total number of additional posts sanctioned thus become 528. Ratio of doctors to nursing Staff has been revised from 5:1 to 4:1 thus creating additional posts @ 1:4 + 3 [for OT /Labour room]. X-ray technician posts created are @ 1 per facility -176. The upgraded BPHC staff becomes

- BMOH/Super-1
- GDMO-2
- Specialists-3
- Nursing staff-11
- MT lab-2
- MT X-Ray-1
- GDA-9, Sweeper-6

Similarly, for upgraded PHCs additional post of one MT Lab has been created. In the Sub-centres, second ANM and ASHA has been placed. Some human resource gaps have been met through PPP by outsourcing security and scavenging services for medical colleges and other hospitals and diet services to self help groups (SHG) at primary health care level. Same has been outsourced to private agencies in government hospitals at secondary and tertiary levels

**b) Pre-service training capacity**

9 state medical colleges and 1 private medical college have 1255 MBBS seats increasing from 1105 seats in 2007

15 PG Teaching Institutes

- PG degree seats from 281 in 2007 to 490 in 2008
- Post Doctoral Seats from 24 in 2007 to 36 in 2008
- DNB seats from 0 in 2007 to 24 in 2008
- PG Diploma Seats – 479 in 2008

Nursing Training

- MSc Nursing seats increased from 25 in 2007 to 40 in 2008
- 4 new Nursing Colleges set up enhancing intake of BSc Nursing from 50 (2007) to 255 in 2008
- ANM schools increased from 38 to 41
- Additional 76 recognised seats for the state medical faculty earmarked in 10 government and 18 non-government colleges for Para-medical courses

PPP in Medical Education

- ✓ Medical College – 1
- ✓ Dental College – 2
- ✓ Nursing Colleges – 18 (GNM – 10, BSc - 7, MSc – 1)
- ✓ Nursing Schools increased from 12 (2007) to 19 (2008)
- ✓ **Training of Second ANM**
  - 1st batch:** 3527 discontinued due to court case/pregnancy and other illness including those disqualified for final exam, 766 appeared in final exam, 2761 passed, 2751 already engaged in respective sub-centres
  - 2nd batch** of 969. Final exam has been held and they would be deployed soon
  - 3rd batch** of 3100. They would be deployed in September 2010
  - 4th batch** of 1285. Started from 30.10.2009

**c) Recruitment and cadre management Plan, augmentation of health HR skill, quality of health HR (physician accountability, recruitment and retention)**

Accountabilities: Lack of physician commitment to rural service as manifested by persistent vacancies, absenteeism and work shirking is the number one issue raised by Purulia district health officials, District Magistrate, NGOs, villagers and even physicians themselves. Lack of accountability threatens citizen satisfaction with the public systems and is the main reason for their abandonment when options are available. A number of examples were voiced to the team: (i) general unavailability of physicians at PHCs after 12 noon (ii) low production and productivity of specialists at district and sub-district hospitals (iii) difficulty to secure commitment from specialists to staff new born sick child centers (iv) irregular comings and goings of outstation specialists at district and sub-district hospitals (v) inability to retain contracted doctors and (vi) a dysfunctional suspension system.

The reasons for these shortcomings are complex and simple solutions are evasive. Physicians themselves point to long delays in the recruitment process, the lack of clinical management particularly at hospitals, absence of merit pay, the non-transparency of postings and transfers, lack of opportunities for career development and to gain new knowledge, and poor work conditions (broken equipment, dirty facilities, absence or non-enforcement of work rules, etc). One informant suggested that an inverse work rule was in effect: senior physicians earned more (because of their seniority) but worked less (due to their ability to manipulate the system to their advantage). Others suggested that rural posts lack the basic services and educational facilities for their families thus creating demand for postings closer to urban centers. Interestingly, few stated that salary is a main issue regarding the recruitment, retention and performance of physicians. With time many doctors lose their commitment to the public sector.

**Recommendation:**

The lack of accountability for performance is nothing new. It is a well known problem, but few have been willing to systematically address it due to the sensitivities involved and difficulties related to altering work rules. As NRHM moves forward to hire additional physicians, the above-mentioned issues need to be addressed to successfully recruit and retain physicians while securing effective performance from them. The state needs to consider a package of reforms, incrementally implemented, to improve accountability and commitment to rural service. These can include: -

- (i) reserve X% of PG seats for MBBS doctors after X years in rural service (upon completing PG physicians sign bond for X more years of public service);
- (ii) institute a counseling program in which personal and family needs are considered for posting;

(iii) for contracted MBBS doctors; pay salaries if one gains PG seats (upon completing PG physicians sign bond for X more years of public service);

(iv) standardize and make transparent posting and transfer rules that guarantee favorable postings after X years in rural service;

(v) pilot a merit pay system in which a percent of pay is linked to performance;

(vi) pilot greater decision-making autonomy for hospitals but with accountability for results (through a management contract);

(vii) invest in technologies that provide rural physicians access to teleconferences, tutorials, and information and training services to upgrade their knowledge; and

(viii) for distant areas consider establishing rural medical corps in which well trained and dedicated physicians rotate on a quarterly basis so no single doctor spends more than three consecutive months (six months a year) in a distant rural post. The communities benefit from full-time posting of a physician throughout the year. This would allow physicians' families to remain in urban areas. While not in the field physicians can take training courses on rural and public health, upgrade their medical skills, develop programs to target specific diseases or communities, and provide support to their colleagues in the field through teleconferencing. After X years participating in this program, they should be given priority for entrance into speciality residency programs.

**Supervision:** The site visits demonstrated that little supervision occurs in Purulia District. Village health workers, PHCs and block PHCs receive infrequent visits from block supervisors and district and state officials. Local staff mentioned that they are “dumped and forgotten” in rural facilities. Several stated to the CRM team that nearly all visits concern outsiders. There is no regular and systematic supervisory system under implementation.

Evidence collected by the District suggests that lack of supervision has negatively impacted the skill levels and quality of work conducted by village health workers. A noteworthy innovation by the District is the contracting of the Department of Community Medicine of B S Medical College to monitor the skill levels and performance of village health workers (AMNs, AWWs and ASHAs) in regards to IMNCI. Between Aug. 2008 and January 2009 nine (of 20 blocks) and 18 (of 290) subcenters were monitored by teams from the medical college. Results from six visits are presented in Table 2.

TheTable displays the results in terms of the respondents who were fully knowledgeable or conducted a complete process according to guidelines. With the exception of assessment of immunization status, the findings suggest that village health workers are ineffective in conducting their duties. In some cases, their skill levels are insufficient (assessment and classification) and in others they simply are not on the job (conducting home visits in the case of ANMs and AWWs). Record keeping is seriously deficient calling to question these workers as a source of

--“Skills

**Table 2: Performance of Village Health Workers  
Percent of Respondents by Worker Category  
(2008-2009)**

for

<b>Performance Indicator</b>	<b>ANM N=26</b>	<b>AWW N=72</b>	<b>ASHA N=28</b>
Correct recording	23	15	11
Correct child assessment	31	14	18
Correct child classification	35	19	11
Correct identification of treatment	42	21	21
Appropriate treatment	35	24	21
Correct assessment of immun. Status	77	68	71
Appropriate counseling	23	7	4
Timely newborn visits (as per record)	23	49	54
Recorded visits matched with actual visits	27	42	71
Adequate facility support	73	17	0
Good record keeping	46	21	57

Source: Dept. of Community Medicine, B S Medical College

recording, assessment, classification and identification of treatment are grossly deficient . [village health workers] seem to lack the motivation to practice the skills routine.”

---“Most case they are not consulting or following chart booklets. As a result systematic approach is lacking.”

--“Counseling seems to be the most neglected part.”“Discussion with mothers does not seem to be friendly in many cases.”

--“Record registers are either not available or maintained properly.”

Even more disconcerting, the monitoring team found that no systematic supervisory system existed and therefore village health workers jreceived no feedback on their reports for completeness, timeliness or completeness. Many village workers appear to have not received any in-service training. These results cast doubt on the entire model of local health workers. For example, much has been said about the importance of the ASHA worker in improving MCH at the village level. However, under conditions in which monitoring and supervision are non-existent, it is unlikely that ASHAs will fulfill their intended role

***Recommendation:***

The District should be commended for taking the initiative to track the performance of village health workers. Although it is noteworthy that the district plans to continue to use the medical college team to monitor AMNs, AWWs and ASHAs, only 18 of 290 subcenters have been monitored by the team over the last year. At this rate it will take 16 years to reach all the village health workers. It is unclear how the district (and state) plans to strengthen supervision of AMNs, AWWs and ASHAs. We recommend that the state form a task force to reform and strengthen supervision state-wide. Resources from flexifunds should be allocated (or reallocated) to forming a strong and well-staffed supervisory cell within each district. The initial focus should be on PHC personnel, AMNS, AWWs and ASHAs. We would also recommend that this cell be formed in partnership with local medical colleges and academic institutions.

**3. Assessment of the case load being handled by the public system**

The institutional delivery rate seems to be closer to 60% in the state. In Purulia district the institutional deliveries has increased from 55% to 62% from 2008 to 2009.

- Janani Suraksha Yojana - (JSY) uptake has improved during 2008-09. There has been almost 33% rise in numbers of beneficiaries in 2008-09 over that in 2007-08.
- Referral Transport - From 2.03 lakh beneficiaries in 2007-08, the number of beneficiaries of referral transport has increased to 2.88 lakh in 2008-09. In 2008, 10,924 mothers have been benefited by the Voucher Ambulance scheme on in 3 districts.
- Under Ayushmati Scheme private facilities are being accredited for improving institutional delivery. As in 2008-09, the scheme is being implemented in 68 private nursing homes across 16 districts. During 2008-09, no. of deliveries conducted is 6608. This is significantly higher compared to 1225 deliveries in 47 accredited private facilities during 2007-08.
- GP Based Mobile Health Camps are being organized regularly at GP HQ Sub Centre where there is no PHC / BPHC / RH. More than 55,600 camps were held during 2008-09 in which more than 44.3 lakh patients were treated.
- Head Quarter Sub-centre at each Gram Panchayat has become the centre for supervision and monitoring of all units in GP area.

Increase in the case load has not resulted in commensurate improvement in the infrastructure neither in the basic provisions at the health facilities. In all the health facilities visited, one bed had been occupied by 2-3 patients. In Raghunathpur Sub-divisional hospital extra beds were laid on the floor. All the pathways in the hospital were used for putting extra beds. This huge demand for services is unmatched by the supply of quality health care. In fact the state has lost the opportunity to give impetus to public health system in spite of NRHM funds being made available for augmenting the supply side.

Now while considering the upgradation of the facilities the state must take into account the rise in demand and upgrade the infrastructure accordingly. (The Raghunathpur sub-district hospital with 100 sanctioned beds has the occupancy of 150-300 everyday. Wherever possible the extra beds have been put up. The proposal is for upgrading it to 150 beds which still will be insufficient.) Rationalisation of the upgradations to be done required.

#### **4. Preparedness of health facilities for patient care services**

Infrastructure needs repairing as well as overhauling as the buildings look too old. Overcrowding of the health facilities puts tremendous demand on the facilities. Number of beds are not sufficient compared to the load of in-door patients. All corridors and passages are full of extra beds put up for patients. The increase is not only because of JSY but even otherwise. In addition, lots of condemned items seen to be lying down in the spaces in between. It was told that the approval of CMO sought who in turn has sought state approval an year back.( At state level it was informed that the facilities have the authority to dispose them off with due process which is not followed due to fear of being questioned). Same is the case with the repairing of ambulance. The outsourced agency for repairing has a person at the state level which keeps the ambulance non- functioning in want of repair. The scavenging and security contract for sub-distt hospital has been awarded for as little as with Rs. 600/- per person per month for cleanliness. One can hardly expect the level of cleanliness with such a meager amount. **These are management issues needs to be sorted out by the health deptt.** Functioning emergency unit seen in the sub-district hospital. Drugs are sufficient in quantity. All basic lab investigations are conducted. Untied funds are utilized for contingency, cleaning of facilities etc. ( Noted that the fund is used for purchasing

cidex solution which is necessary for laproscopic sterilization operation and the solution is not in the list of Central Medical Store for Sub-div. hospital). Funds for maintenance are given by the district office from 60% corpus fund of user fees. RKS corpus at the facility level consists of the seed fund plus 40% of user fees . User fees collection is not commensurate with the number of patients as most of them are treated free as they produce certificate from some or the other authority . User fees for donated equipments are also made to exempt from. Food for the patients is outsourced .

## **5. Thrust on Difficult areas and vulnerable social groups**

Under Tribal RCH, innovative programmes have been taken up in Jalpaiguri and Bankura through NGO and Purulia and Paschim Midnapore by the DoH&FW. Some special programmes such as additional nutrition programme, community impregnation of bed nets with deltamethrin, ,improvement of signage system for information of patient and patient parties about facilities available in the hospitals, opening of Rogi Sahayata Kendra at D.Hs/ S.D.Hs, development of dynamic website for DH&FW, standard Treatment Guidelines for primary health care and Jibon Jyoti Sahayata Prakalpa for rendering medical care to Lodha and Sabar population are being implemented.

## **6. Quality of services provided**

There were complaints of breakfast not being provided to a delivered mother at the Sub-district. Hospital Purulia. For keeping of partograph in the labour room no directions are issued by the state government. **It is good that at least 24 hours stay after delivery is strictly followed.**

Illness Assistant Fund started with a noble idea of helping BPL people by reimbursing the expenditure incurred on medicines and tests. The utilization of Illness Assistant by BPL families is very low.

### **Recommendation:**

Low off take from Illness Assistant Fund need to be investigated and essential measures may be put in place to reach the dividends to all the BPL patients in desired number.

Procedure of reimbursement may be replaced with free services/medicine by the selected establishments. MOU may be signed at the facility level to provide free services/medicine to BPL patients and reimbursement may be claimed directly from the facility.

## **7. Diagnostics**

In the Sub-distt and distt hospital, three OTs are very well maintained and equipped. X-ray, ultrasonography are available at Sub-distt hospital.

## **8. Logistics and Supply chain management**

A procurement cell is established & functional at district level in Purulia headed by a Dy. CMO. Computerized supply chain management system is in place at the cell. On an average proposal for procurement is finalized within 20-45 days after getting sanctioned / budget from state H.Q. and order is placed within a week time after the proposal is approved by DHS. Order is received within 7 days to 1 month period and within a three month time medicines are further channelized to peripheral institution. 5-10% of the samples taken for quality check fail. Facility level tracking of the consumption of the medicine supplied is lacking at district/block level. Four samples tested for quality check failed last year but the medicine were already distributed & consumed before getting testing report by peripheral institutions..

### **Recommendations:**

Consumption of sub standard medicine by the peripheral facility because result of quality test are not received in time is a serious lag and this process need to be streamlined on priority to avoid further risk to the health of people.

System of black listing should be made more practicable & robust to ensure effective deterrence for the sub standard drug manufacturer.

Facility level tracking of the consumption of the medicine may be adopted to have an idea of utilization, expired stock etc.

## **9. Referral Transport Scheme**

It is good initiative where referral transport is being provided upto the PHC level under PPP. Private ambulances are stationed at PHC and government is stationed at BPHC. Referral vouchers are given in advance. Referral slip does not have mobile number of ambulance. Publicity of the scheme is lacking. Service utilization of the ambulances is low as compared to case load. Refusal rate is not properly monitored at the facility level.

### **Recommendation:**

Refusal rate should be monitored at facility level. System may be devised that necessitates the detailed probing from the patients not availing ambulance services.

State may think to have an EMRI model for optimal utilization of the pool of ambulances. To have a toll free number all over the state may be a great push in effectiveness of RTS and it will facilitate the awareness and publicity.

Service utilization of the ambulances is not commensurate with the case load. Formative evaluation of the scheme may also be undertaken and efforts should be made to enhance the service utilization.

## **10. Decentralised Planning**

Decentralized planning appears to exist in name only. As currently practiced, the process is mechanistic and entails “filling in the blanks” of a template provided by the state. Planning appears to remain a top down process. The same situation holds for the blocks. The focus is on providing the information requested in the template and local officials have little time, capacity or inclination to think strategically in terms of analyzing local needs and addressing them in the plan. In the block action plan examined by team, the new activity sections – where teams can insert local initiatives – was blank. The district simply clubs the block templates into a single template (e.g., the district action plan) and forwards it to the state. As mentioned earlier, even though the District has performed some robust analyses, the findings don’t seem to make their way into plans. Finally, even in the hospitals equipment planning appears to be top down. Bottom-up assessments and prioritizing of equipment needed by hospital staff are rarely conducted. It is a

mystery to some staff how equipment purchases are organized and executed.

**Recommendation:**

The state should consider creating a health innovation challenge fund in which districts (and blocks) submit ideas and plans for some innovation or initiative that addresses local needs and problems. Technical assistance should be provided to local teams to help develop the proposal and craft an implementation plan.

**Decentralized Local health action**

Village Health and Sanitation Committee (VHSC) have been constituted with PRI members, ANM, primary school teacher, AWW and SHG members. The role of the VHSC is to undertake activities like cleaning of drains, improving water sources, disinfecting water, bleaching, IEC. Annual untied fund is released for the functioning of VHSC. The responsibility of maintaining and constructing SC / PHC / BPHC is with PRIs

**11. Community Processes under NRHM**

**a) Village Health & Nutrition Day**

VHNDs are not properly functioning in the Purulia district. VHNDs are in the purview of Women & Child Deptt with no proper linkages/coordination with health deptt. One day orientation training is proposed to sensitize all the health supervisors, ANMs, ICDS supervisors, AWWs and ASHAs of the block before launching the program. On a fixed day of each month a set of issues selected from 19 identified points of women & child care and public health would be discussed with AWW & ASHA.

However such meetings were not taking place. As there are some problems like arrangement of meeting for such a large participants, and provision of training material for these workshops and further reference material on 19 points to be covered for AWW & ASHA to maintain uniformity among the workshops.

**Recommendation:**

- State should develop a standard reference material for the block/district level awareness workshops for AWW & ASHA.

- Reporting on VHND should be an integral part of the routine reporting of the health department.
- Mechanism for effective coordination between W&CD and health deptt should be developed at all levels. Reporting mechanism should also have details of underweight children.
- Instead of providing additional nutritional package for countering malnutrition, the grade IV child should be managed under direct observation of health functionary because giving package to carry may not serve the purpose as it does not ensure that the child will eat it.

## 12. ASHA

ASHA intervention have not been effectively established in Purulia district as majority of ASHAs are yet to be selected and trained. Role of selected ASHAs is limited in visiting number of households, reporting of possible outbreaks/epidemics and institutional deliveries. The monitoring format of ASHA itself has got limited scope in monitoring her effectiveness in health care. ASHAs role in some of the activities like DOTS provider, radical treatment for malaria, blood slide collection for malaria, adolescent counseling, motivation for adoption of family planning method, hygiene and sanitation issues etc. is lacking. Incentive package of ASHA is based on fixed remuneration for carrying out predefined activities. As per guidelines each ASHA has to visit 7-8 households per day. Taking advantage of this state can devise a monitoring mechanism to have updated health profile of the entire state population every quarter.

At some of the visited facilities trained Dais are involved in the institutional deliveries. Trained Dais are conducting deliveries at sub-center at Kuchiya sub-center of Bandwan Block. In Hutmara PHC area ASHAs are not posted and trained Dais escort the pregnant women to PHC, assist staff nurse in delivery & also make first post natal visit though there is no incentive for this work to the trained Dai.

ANWESHA clinics for adolescents are functioning at theBPHCs. The number of girls coming for counseling at the clinic of visited facilities is very low.

### **Recommendation:**

All the post of ASHAs should be filled in and training of ASHA needs to be geared up. State has to develop next module for ASHA training where ASHAs have been trained in all the five modules as per the state specific requirement. State should develop a standard reference material for the block/district level awareness.

Strategy to incorporate the trained Dais where ASHA is not available may be considered as well as provision for some incentive for them to be made.

Scope of services offered by ASHA and incentive package for ASHA should have provision for radical treatment for malaria, blood slide collection for malaria, adolescent counseling, motivation for adoption of family planning method, hygiene and sanitation issues etc. Performance based incentives required to be encouraged.

Monitoring of ASHA needs to be strengthened at block & district level.

Counselor at ANWESHA may be given the responsibility of capacity building of the ASHAs as ASHAs are the first contact at village level for these issues.

## **13. National Disease Control Programmes**

### **13.1 Overall Effectiveness of NDCPs**

### **13.2 NVBDCP**

### **13.3 RNTCP**

### **13.4 NBCP**

### **13.5 NIDDSCP**

### **13.6 IDSP**

Protocol for maintenance of malaria lab is lacking. Standard treatment protocols of Malaria and Tuberculosis are not followed. Laboratory Technicians under RNTCP & NVBDCP are not optimally utilized. Despite the low volume of lab tests both the technicians are placed at one facility. Presumptive treatment is very much prevalent; RT is not given in all the cases. Second line drug (Artisunate) is available with ASHA which is not in accordance to guidelines. RDK is in short supply and the kits supplied are for detection of PF cases only.

#### **Recommendation:**

Training for medical personnel on RNTCP & NVBDCP.

Standard treatment protocol of RNTCP & NVBDCP should be followed at all levels.

Second line of drug for Malaria (Artisunate) should be more judiciously used under the guidance of M.O.

RDK provided should be able to detect PV & PF cases.

Malaria & TB lab facility is very much needed at PHC level. Necessary guidance may be taken from RNTCP & NVBDCP to determine the number of slides checked / day by a LT before his/her deployment to PHC level.

## 14. RCH II

### **(Maternal Health, Child Health and Family Planning Activities)**

Pululia District has conducted several analyses, including an in-depth maternal and infant death audits in 2007 and 2008 and a base line survey of JSY assistance (2008). Each drew on relatively large samples. The JSY survey found that 68% of eligible births received JSY payment (66% of eligible home births and 70% of eligible institutional births). Unfortunately, the survey did not inquire regarding why eligible mothers did not access JSY. However, the survey did inquire about reasons for home delivery which could serve as a proxy for understanding access to JSY. Nearly two-thirds of respondents (women who had home deliveries) stated that lack of knowledge of scheme (“communication problems”) and lack of birth preparedness (no ANC registration) were the reasons for failing to access JSY.

The District has conducted maternal audits every year since 2005 based on a sample that averages 82% of reported deaths. Eclampsia, hemorrhage and malaria represented 57% of deaths in 2008. Over two-thirds were post-natal deaths with 39% being Gravida 1. Over half the deliveries occurred in government institutions.

Infant mortality audits were conducted in 2008 and 2009. Prematurity, low birth weight, asphyxia, ARI and feeding problems were the main culprits. About 27% occur in the first 24 hours while another 27% take place during the first 7 days. Home and government facilities were the place of birth for 53 and 42% of infant deaths respectively.

It is praiseworthy that the District conducts rigorous JSY beneficiary surveys and maternal and child audits annually. It is this type of data and analysis that serve as a basis for evidenced-based interventions to improve performance. However, it is unclear how the District systematically puts this knowledge into practice. The data suggest that the system needs to strengthen access to post-partum care. During the site visits, local workers reported that purported 48 hour post partum stay policy does not appear to be enforced. Follow-up monitoring of newborns and their mothers by village health workers is very weak.

Purulia is relatively poor district located in the western region of the State of West Bengal, but displays performance indicators that approximate state averages. Upon comparing DLHS-2 and DLHS 3 data, the district has made significant head way in institutional births, full immunization of children, women receiving one TT injection and children with diarrhea receiving ORS. In terms of full immunization of children, the district exceeds the state average. These data are commendable given standard of living which is much lower than the state average. However, the district lags the state in ANC registration, ANC-3 check-ups and institutional births. According to the DLHS data, institutional births declined between round 2 and 3. This is worrisome given the increasing number of JSY beneficiaries. For example, in 2006-07 and 2007-08 the state reported 11,148 and 19,113 JSY beneficiaries respectively. Would these women have sought an institutional birth even without JSY? Nevertheless, District ledgers show that institutional births reached 62 percent in 2009.

Although these figures require validation, block level data show there has been a significant increase in institutional births in 2008-2009. More troublesome, is the apparent decrease in ANC-3 check-ups when one compares DLHS-3 finds with district registers. OBD has significantly increased by 38% between 2005 and 2008 suggesting that access and demand are on the rise. Finally, the district has done a commendable job of detecting and controlling malaria in high incidence blocks. Awareness of the use of bed nets among populations in these areas has increased as evidenced by the demand for bed nets.

### **Recommendation:**

Based on the findings of the JSY surveys and MMR/IMR audits, the District Purulia should prepare a focused action plan to address the main causes of deaths. The plan should focus on post-partum and newborn follow-up care particularly at the village level. Regarding the MMR/IMR audits, an attempt should be made to collect data on unreported deaths. This would provide valuable information on populations which have little contact with the health system.

### **Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health**

Areas of Convergence with various departments are as below-

#### **P & RD Deptt.**

- For operationalization of VHSCs
- For Capacity Building of members of PRI and VHSCs
- For organizing Medical Camps by hiring the services of Medical Officers
- Fourth Saturday meeting at the Gram Panchayat Offices with ANMs, ICDS Supervisors, Gram Panchayat Members.
- Construction of Sub-Centres and Primary Health Centres from other sources being done by Gram Panchayats (lowest tier PRI) and Panchayat Samities (middle tier PRI), respectively
- Setting up of GP level AYUSH dispensary by engaging part time MOs
- Awareness generation for mothers through Sahayikas of SSKs

#### **WCD & SW Deptt.**

- Third Saturday meeting with ANMs & AWWs
- Village Health & Nutrition Day – on 4th Tuesday
- Certification camps for physically disabled persons
- Providing drug kits to AWWs consisting of Paracetamol, IFA tablets, deworming tablets.
- AWWs as depot holders for condom and oral pills.

#### **PH & E Deptt.**

- Quality Testing of Drinking Water

#### **School Education Deptt.**

- School Health Programme

#### **Hiring of MOs by GPs**

- To provide one medical officer of Ayurvedic/ Homeopathic/Ayurvedic/Unani discipline in each uncovered GP (where no formal health facility exists)

#### **Capacity Building of the VHSC members and members of PRI**

- Train and enhance capacity of the members of Panchayati Raj Institutions (PRI) including GUSs & SHGs to own, control and manage public health services.

### **15. Nutrition**

No separate programme for malnourished children in place. A nutritional packet of food provided by the AWW to the mother to feed the malnourished (grade-IV) child at home. There is no monitoring of the food being given to the same child.

## **16. Non-governmental partnerships**

With the objective to promote community participation, awareness and involvement and particularly to ensure outreach of health services in respect of immunization, promotion of family welfare and MCH services including increasing the efficiency of delivery of the services in identified underserved areas 5 NGOs have been engaged for implementing several programmes. They are – (i) Kasba Shed Foundation for I.E.C programme on Immunization, Breast feeding, Nutrition of mother & child, Institutional safe delivery, etc. and introduction & distribution of Paushi in Murshidabad (12 Blocks), Uttar Dinajpur (9 blocks) south 24 Pgs. (7 Blocks); Thalesemia Society of Medinipur for project on thalesemia awareness in Paschim Medinipur; Jukti badi Sanskritik Sansthya of Canning for sensitization programme on snake, snake bite & it's remedies in South 24 Pgs. (8 Blocks); Central for studies in social sciences/ Eastern Regional Centre, I.C.S.S.R for gender hygiene programme for the village women of the State and Liver Foundation for intervention strategy for improvement in rural health care delivery system in 6 Blocks of Birbhum district.

## **17. Overall Programme Management**

Pululia District has established an adequate PMU consisting of 4 program officers and 3 program managers, 2 data entry operators. This is complemented by 20 block account managers and 40 block data entry operators. A public health group consisting of Deputy CMOH and 4-person PMU oversees public health programs. They are complemented by an HIV/AIDS cell, a district leprosy officer and a district TB officer. DPMU is more or less limited to routine work and emphasis on supervision/monitoring are getting back seat. Observation of the field visits are not properly documented. Follow up of facilities which are lagging is not upto mark.

### **Recommendation:**

Despite the adequacy of the aforementioned personnel, the analytic capacity of the PMU requires strengthening through the recruitment of an epidemiologist and a statistician. As suggested above, a supervisory cell is sorely needed to craft and implement a continuous monitoring and supervisory system. A sanitary or environment engineer would be a good addition to support work on improving the sanitation conditions of most villages.

## 18. Financial Management

The procedure for transferring the sums to different subheads from DHS account is such that it entails a delay of 7-10 days. Further delay at disbursement to block result in money reaching at block level after few weeks to months as it depend on receiving of Utilization Certificates. Funds for 2008-09 have been received by district on 20-7-09 & 20-10-09 though same was not yet released to any block till date. Funds are transferred from state to district through e-banking and through Cheque / Draft down below the district level. There is no formal mechanism of reconciliation of accounts though occasionally it is being looked into by the District Account Manager/Account Officer during their visit to concerned facility. Observations of such visits are not formally documented and monitored.

Involvement of Sabhapati/Pardhan and Sub Assistant Engineer/Nirman Sahayak has delayed the expenditure for the facility as it is difficult to organise a meeting of these two functionaries with M.O (In-charge) of the facility. In some cases even though meeting was convened but estimate was not prepared by the Sub Assistant Engineer/Nirman Sahayak. At Hutmura PHC the procedure of undertaking work was not appropriate/ proper documentation was lacking.

Income from interest is not monitored. At district level there is Approx Rs.80 lakh generated from interest income. Activities not supported/planned in PIP are taken up from this income. Some of these activities are electrification & bore well at sub-centers, hiring of driver for ambulance at Hospital, AC for computer room at block etc. Tally is not in use for financial accounting at the district level. Untied fund utilization is very low in Purulia district. For 2008-09, it was 33.5% at PHC level, 51% Sub center, 43% & 37% as annual maintenance grant to PHC & BPHC. RKS funds to BPHC – Bandwan, Manbazar & Hura (RH) were fully utilized.

### **Recommendation:**

Monitoring needs to be strengthened. Three inspection reports of Accounts Officer, Purulia revealed discrepancies in maintenance of cash book, bill register, cash balance, contingency purchase. Similar inspection may be carried out on regular basis and compliance report should also be monitored at the district level.

Interest income should be monitored as it is a byproduct of the financial inefficiency. The Interest income should be adjusted in the next PIP of the Block/District/State.

Need based re-appropriation at facility level should be encouraged for smooth functioning as it happen that funds in one head is exhausted though funds are lying in other head.

Inter-sectoral convergence at the planning & execution level is not upto mark. Work assessment and estimate procedure should not be delayed. Sub Assistant Engineer/ Nirman Sahayak should be made more accountable in preparing estimate in time. Steps may be taken to strengthen the intersectoral convergence through capacity building of PRIs. Ceiling on expenditure by M.O (In-charge) alone may be relaxed for better utilization.

## **21. Data Management**

The HMIS system is still complied manually due to lack of connectivity in most blocks. Most data is collected and forwarded to the state and is not used locally for decision making. However, the most serious challenge in terms of data management is the validity of data submitted by the blocks. As mentioned earlier in this report, record keeping by ANMs and ASHAs is far from optimal. The same probably can be said of some PHCs and BPHCs. In the sub-district hospital, staff had yet to compile an annual report for 2008 on basic statistics. What little hospital data that were available were at district headquarters. It was clear that said hospital does not rely on any data to make decisions or to plan service improvements. With the exception of a couple of public health programs, evidence-based performance assessment is non-existent in the District.

### **Recommendation:**

Contract a local medical college or university to conduct spot validity checks on data submitted to the HMIS. Based on the results correct the data and develop a training program to improve record keeping and reporting. Provide training on data management and use in hospitals.

The district Purulia needs to investigate discrepancy between DHLS-3 and district registers regarding institutional deliveries. Also, if institutional deliveries are indeed increasing (as well as ANC registration), we recommend investigating why ANC-3 checkups are

decreasing. Is this a distortion created by JSY-induced focus on institutional births?

## **23. Common Review Mission- Methodological Concerns**

The findings reported here require a few caveats. The modus operandi of the CRM entails briefings with state and district officials, short field visits to a small sample of facilities, interviews with personnel (ASHAS, AMNs, nurses, physicians and administrative staff) and meetings or focus groups with villagers and/or NGO representatives. Also, the teams are expected to review 22 key components related to the organization, management and delivery of health care, including public health programs. Given the time and logistical constraints it is nearly impossible to conduct an in-depth assessment of any single component, validate data provided by health authorities, or broaden the sample to make robust, evidence-based inferences of system performance. Moreover, most of the field visits are planned to afford a favorable impression to the field team. Staff are mandated to be present; facilities are cleaned; records are updated, etc. In a sense, unless the team forces an unplanned visit, the site visits are often “dog and pony” shows and are not representative of the day-to-day activities and services which the typical patient faces. In one case, facility staff privately informed the team that the premises were cleaned; guards were placed at doors; gates were closed; and staff were called to duty in anticipation of the team’s visit. State officials accompanied the team at all times which limited the forthrightness of district officials in voicing their concerns. In more than one case, the team had to request that state officials do not to prompt or reinterpret responses from district and local staff. At the same time, district (and state) officials accompanied the team to facility visits which also limited the candidness of local health workers. As such, triangulation to validate information received from any one source was not always possible. Finally, the CRM is not viewed by local officials as something that can contribute to improving the health system. Rather, and given the reprimand culture evident in public service, local officials seek to paint an overly rosy picture of the health system, and are somewhat defensive when responding to questions about performance. In sum, under these conditions one has should be cautious about making inferences regarding NHRM performance in West Bengal or even elsewhere.. The team attempted to secure data to support the findings reported here, but robust data were not always available.

## **Recommendation:**

The MOHFW should reconsider the approach and methods applied to future CRMs. We would recommend a more focused and “rolling” approach in which teams direct their attention to limited number of components or issues in one or two districts for a longer period (5-8 days). We would recommend the following themes: supervision/monitoring, process quality, human resource management and accountability; HR skill levels; and decentralization plan including data analysis utilization. Districts should prepare data ledgers and tables in standardized formats in anticipation of the visit. All site visits should be unplanned and unaccompanied by higher level state and district officials.

## **24. Important State specific Issues/Observations/Innovations-**

Monitoring and Supervision is lacking right from the top, resulting in low accountability at all levels. More so in Purulia.

District officers not conversant with objective of district health planning, template based planning process requires supervision & scrutiny at all levels.

### **Serious lack of cleanliness**

#### **-Toilets dirty even though ample water available**

Overcrowded facilities- huge demand but not matching delivery of service / infrastructure.

No use of HMIS data for local analysis. Old formats are in use.

ASHA not paid (as she did not fill up the form) (Purulia). No ASHA in Cooch Behar.

- Financial Management : UC linked transfer process, low level of utilization, interest income, need based re-appropriation at peripheral level, Tally.
- Reduction in IMR, MMR etc, made the system relaxed.  
Poor not getting desirable basic health care. Low level of FP services vis-à-vis birth order 3+ is very high
- 100% user fee not retained at the respective facility
- Absenteeism, lack of interest in work
- Standard treatment protocols of Malaria and RNTCP lacking
- Poor Maternal health services and low outreach
- No delivery facility at sub centres.
- Late ANC registration (16-20 wks)
- No check on consumption of given IFA tablets
- IMNCI not implemented

- Pregnancy kits available but not used
- No specialists available at BPHCs
- Dais training is still undertaken at BPHC / SCs
- Annual maintenance funds at the disposal of BDO-low priority to works of health deptt.
- Lack of proper OT table and Labour room tables at BPHCs
- No diagnostic facilities at BPHCs-tie up with pvt. labs
- ANMs not staying at Sub Centres
- VHSC scheme not yet implemented
- RKS formed but not meeting regularly
- Delay of 1-3 months in giving JSY assistance (3 ANCs)
- Records of SC/ST beneficiaries maintained
- Not much NRHM contractual staff
- Annual MMR and IMR audits and a survey of JSY beneficiaries.

### ***Appreciable initiatives of the state***

SNBCU- Sick newborn care unit in the District hospital. This is model for evidence-based, high quality neonatal care. The dedication of the staff working under tough conditions is simply amazing Reduction in mortality of LBW babies from 506 to 84 from 2003-08 and VLBW from 632 to 217 is commendable in Purulia BUT needs to be extended to other than at nine places at peripheral level.

IMNCI in place BUT ten years more to cover all sub-centers (Purulia).

PPP & Voucher scheme for Referral Transport BUT awareness in community to be created.

Illness assistance fund BUT utilization is low.

Independent certification for Quality improvement

Cold chain maintained at all levels

Use of AD syringes

2 doses of TT immunizations to ANC

Received only terminal-1<sup>st</sup> Saturday of Month

Outsourcing of bio-medical waste management

Supervisory visits by PHNs to sub centres once a month

The Malaria Control Program has introduced a Cycle messenger system for collection of blood slides for Microscopic examination in 8 high risk blocks. It has reduced the time lag between blood slide collection and examination.

The Malaria Control Program has also introduced a monitoring and data management system to enable timely tracking of and response to outbreaks.

Adolescent Anemia Control Program is issuing a weekly table of IFA to adolescent girls, which has reduced the incidence of anemia.

**25. On the basis of above facts, the following recommendations are made:**

Strengthening of monitoring & supervision at all levels including surprise inspections.

Capacity building for planning.

Management of hospitals is a serious issue

Social Audit/CBM for planned activities.

For getting specialists, innovative solution through Family medicine program/DNB, short term focused courses required.

Formative evaluation of all PPPs.

Need based Up-gradation of BPHCs may be undertaken.

Paramedicalizing the Primary health care viz RMP course.

Systematic measures for improving HR performance

HR performance has relationship to enabling environment linked to quality of facilities, quality of care in turn linked to achieving standards

Performance based incentives

Rationalization of HR

Evolve ways to attract skilled HR.

Broad policy initiatives at Medical education and recruitment level for making specialists available in rural areas.

Local level analysis of HMIS data – feedback to GPs and ZPs to empower them for action

Quality improvement of facilities be geared up with IPHS as reference point. (NHSRC guidelines for 24 additional parameters to ISO be used to consolidate the standards)

Flexibility to shift funds among facilities to maximize efficiency.

VHNDs be held in desirable form.

**26. Overall Recommendations:**

Maintaining “Family Friendly “ atmosphere.

Assured water supply particularly in the delivery rooms, bathrooms and **toilets** – and as an absolute necessity **clean toilets**.

Ensure power supply particularly at night by battery and solar back-up. This is vital to ensure 24 hour stay by the patients.

A clean and perhaps nicely decorated women’s wards with daily changed bed-linen. Perhaps also a few nice picture calendars donated by local companies and a little perfume!

Clean and well equipped delivery rooms with **absolute privacy** with a simple baby warmer.

Clean and rust-free equipment in the operation theatres with proper equipment, shadow less lamp and ideally an A/C.

Bright and clean reception rooms, with nicely designed and framed IEC material, a roster of doctors and nurses with their phone numbers, and also a TV set, which plays popular local programmes.

Supply of good hot meals to delivery, abortion & sterilization patients .  
Tight monitoring of performance especially in terms of outpatient per doctor per day, inpatients per bed, institutional delivery and sterilizations on a monthly basis.

A regular inspection by superior officers who visit the Centres both in the day and **at night**. An inspection format of standard design be made available. Copy of the inspection note should be available in the PHCs so that it could be perused by successive inspection authorities.

## List of the Facilities Visited

### Name of the State: West Bengal

Facility	Cooch Behar	Purulia
District Hospital	Cooch Behar	Purulia
SDH	Tufanganj	Raghunathpur
RH	--	Hura
BPHC	Boxirhat , Pundiburi	Borabazar, Bandwan
PHC	Moradanga Panaguri Pakhinaga	Hutmura
GP(HQ) SC/SC	Cooch behar-I, Chilakhana Mansai Moradanga, Pundibari	Kutchia, Borabazar Bandwan, Hutmura.
Villages/ Hamlets/ PRI members/ Community	Chilakhana-(pradhan) Hazrahat (pradhan & community), Bhangamal (Community) Pundibari (Pradhan & Community), Ambari (Community)	Sh Anandmay Patro Saha-Sabhapati Raghunathpur-I Panchayat