

# Tripura



## Report of Sixth Common Review Mission

3<sup>rd</sup> to 9<sup>th</sup> November

2012

National Rural Health Mission

Government of India

# SIXTH CRM

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## PROCESS AND METHODOLOGY OF THE SIXTH CRM IN TRIPURA

The Sixth CRM team, during its visit, interacted with officials, health personnel, people's representatives and personnel of other departments at the state, district, sub-district, and block and panchayat/village levels. The itinerary of the CRM visit was as follows-

| <b>Day</b> | <b>Place</b>                        | <b>Programme</b>  | <b>Persons interacted with</b>  |
|------------|-------------------------------------|---|---|
| <b>1</b>   | State Capital-<br>Agartala          | State Briefing  | Mission Director NRHM, Director Health Services and state nodal officers of various programmes and other state level officials.   |
| <b>2</b>   | Districts-<br>Tripura,<br>Tripura   | North<br>South<br>District Briefing and Facility visits | Collectors of both newly formed districts as well as the old district, in both North Tripura and South Tripura, CMHO and other district level officials.  |
| <b>3</b>   | Districts-<br>Tripura,<br>Tripura   | North<br>South<br>Facility and village visits           | CMHO, SDHMO, Nodal officers, MOICs, Staff Nurse, AYUSH MOs, ANM, ASHAs, community members, people's representatives etc.  |
| <b>4</b>   | Districts-<br>Tripura,<br>Tripura   | North<br>South<br>Facility and village visits           | CMHO, SDHMO, Nodal officers, MOICs, Staff Nurse, AYUSH MOs, ANM, ASHAs, community members, people's representatives etc.  |
| <b>5</b>   | Districts -<br>Tripura &<br>Tripura | North<br>South<br>District debriefing                   | CMHOs and other district and block level officials.   |
| <b>6</b>   | State Capital                       | Report writing  | CRM Team  |
| <b>7</b>   | State Capital                       | State debriefing  | Chief Secretary – Govt. of Tripura, Secretary – Health, Govt. of Tripura, Mission Director NRHM, Director Health Services and state nodal officers of various programmes and other state level officials. |

**FACILITIES VISITED BY SIXTH CRM IN TRIPURA**

| <b>District</b>                  | <b>District Hospitals</b>   | <b>CHCs/SDHs (FRU/Non FRU)</b>   | <b>PHCs (24x7)</b>   | <b>SCs (Delivery/Non Delivery point)</b>  |
|----------------------------------|---|--|--|---|
| <b>North Tripura<sup>1</sup></b> | Rajiv Gandhi Memorial Hospital, Unnakoti  | Kanchanpur (SDH)<br>Panisagar (SDH)<br>Dharam Nagar (SDH)              | Dasda<br>Dhamcharra<br>Kadamtala                                 | Shantipada<br>Satnala<br>Lakshmipur - (Delivery point)<br>Rajnagar<br>Krishnapur<br>Churibari<br>Deochara |
| <b>South Tripura<sup>2</sup></b> | TS District Hospital, Gomati  | CHC Monubazar<br>SDH Belonia (FRU)<br>SDH, Subroom<br>CHC Nautan Bazar | Rupaichari<br>Rajnagar<br>Kakarabal<br>Silachari<br>Shanti Bazar | Rani<br>Radha Nagar<br>East Jalepa<br>Ailmara<br>Chotakhill   |
| <b>Total</b>                     | 2   | 6  | 8  | 12  |
| <b>Others</b>                    | Newly constructed buildings of DH, PHCs, SCs, Anganwadis, Schools, Villages, Meetings with ASHAs, VHND sites, MMUs, Training Centres etc. |  |  |   |

<sup>1</sup> The new North Tripura district was taken up for the field visits, but the district hospital of Unakoti was visited as it serves both present North Tripura district as well as the new Unakoti district.

<sup>2</sup> Undivided South District was visited which includes the newly formed districts of Gomati and South Tripura

## BACKGROUND AND STATE PROFILE

Tripura a princely state during British rule, acceded to Indian Union with effect from October 1949, and attained full statehood in January 1972.



**MAP OF TRIPURA**

It is the 2<sup>nd</sup> smallest state in terms of area, but the 2<sup>nd</sup> most populous state in the North Eastern Region, with a density of 350 persons per sq. km (Table-3). The decadal growth rate of the state at 14.75% is much less than the national average of about 21 %. Bengali and Kokborok are two principal languages of the state, with English, Hindi, Manipuri and Chakma being other major languages. The average rainfall of the state is 2500 mm per annum.

Tripura is a landlocked state that shares borders with Bangladesh, Mizoram and Assam, but is surrounded by Bangladesh on its north, south and west: with international borders making 84 per

cent of its total border. The state's access with the rest of India is difficult as it is connected by only one road (NH-44) that runs through Assam, Meghalaya and North Bengal and connects to Calcutta.

The state had been historically been a predominantly tribal state, with tribal population making up about 53 % of the total in 1901, but by 1981 census tribal population has dipped to 28 % due to demographic changes brought about by influx from neighbouring populations. The state has a vibrant structure of Autonomous District Councils (ADC) for tribal areas based on 6th schedule of the Indian constitution, which cover about 68.10% of the state's territory. Rest of the state has equally strong Panchayati Raj Structure established under the 73<sup>rd</sup> amendment. Both of these local self-governance structures of the state actively participate in the social development and health care mobilization processes. Table 1, 2 and 3 presents the demographic indicators and literacy rate of Tripura.

**Table-1<sup>3</sup>**

| <b>INDICATORS</b>         | <b>NUMBER/ PERCENTAGE</b> |
|---------------------------|---------------------------|
| Total Area                | 10486 Sq Kms              |
| Total Population (2011)   | 3671032                   |
| Population Density (2011) | 350/ Square Kilometer     |
| ST Population (2001)      | 31.1%                     |
| SC Population (2001)      | 17.4%                     |
| 0 – 6 years population    | 12%                       |
| Rural Population (2011)   | 74%                       |
| Number of districts       | 8 <sup>4</sup>            |

<sup>3</sup> The information on state profile compiled from information provided by state govt., state govt.'s official web-site and Census 2011.

<sup>4</sup> w.e.f. 21<sup>st</sup> January 2012, the existing four districts as have been further divided to make a total of eight districts.

|  |      |
|--|------|
| Number of Sub Division/Talukas                       | 23   |
| Number of Blocks                                     | 45   |
| Number of Villages (Gram Panchayats + ADC villages ) | 1038 |
| Number of Anganwadi Centers                          | 9906 |

### **PROGRESS MADE IN KEY DEMOGRAPHIC AND HEALTH INDICATORS**

Tripura is considered one of the high performing states with certain indicators much better than the country average. For example, India's IMR (44) as per SRS 2011, is one and a half times higher than Tripura's (29). Tripura also has a higher literacy rate (87.75%) than India average (74%). Significantly, the sex ratio of Tripura has increased by 13 points in the last decade (Table -5).

However, there seems to be stagnation in the last few years with indicators improving only marginally. The IMR, which had decreased by four points between 2009 and 2010, has increased by two in 2011, that too in the rural areas (Table-4).

**Table-2**

| <b>Indicator</b>    | <b>SRS 2009</b> | <b>SRS 2010</b> | <b>SRS 2011</b> |
|---------------------|-----------------|-----------------|-----------------|
| Crude birth rate    | 14.8            | 14.9            | 14.3            |
| Death rate          | 5.1             | 5               | 5.0             |
| Natural growth rate | 9.7             | 9.9             | 9.4             |
| IMR                 | 31              | 27              | 29              |

**Table-3**

| <b>Indicator</b>    | <b>Census 2001</b> | <b>Census 2011</b> | <b>Pattern</b>    |
|---------------------|--------------------|--------------------|-------------------|
| Sex ratio           | 948                | 961                | Increase of 13    |
| Decadal Growth rate | 16% (1991-2001)    | 14.75% (2001-2011) | Reduction of 1.25 |
| Literacy rate       | 73.19%             | 87.75%             | Increase of 14.56 |

[http://censusindia.gov.in/2011-prov-results/prov\\_data\\_products\\_tripura.html](http://censusindia.gov.in/2011-prov-results/prov_data_products_tripura.html)

**Table-4**

**Present status of RCH Indicators as per the HMIS reporting (Figures for FY 2011-12)**

| <b>Indicator</b>   | <b>Status</b> |
|--|---------------|
| 3 ANC Check ups against ANC Registrations                              | 56%           |
| TT2/ Booster given to Pregnant women against ANC Registration          | 67%           |
| 100 IFA Tablets given to Pregnant women against ANC Registration       | 79%           |
| Reported Deliveries against Expected Deliveries                        | 92.5%         |
| Institutional Deliveries against Estimated Deliveries                  | 79.0%         |
| Institutional Deliveries against Reported Deliveries                   | 85.4%         |
| Home Deliveries( SBA& Non SBA) against Estimated Deliveries            | 13.5%         |
| Home Deliveries( SBA& Non SBA) against Reported Deliveries             | 14.6%         |
| C Section Deliveries against Institutional Deliveries( Pvt & Pub)      | 18.3%         |
| Newborns weighed against Reported Live Births                          | 91%           |
| Newborns weighed less than 2.5 kgs against newborns weighed            | 12%           |
| Newborns breastfed within one hr of Birth against Reported live Births | 85%           |
| Fully Immunised Children against Expected Live Births                  | 81%           |

|  |     |
|--|-----|
| Fully Immunised Children against Reported Live Births      | 87% |
| Immunisation Sessions held as percentage of required VHNDs | 53% |

**Table 5. A Comparison of State and National Health Indicators**

| <b>Indicator</b>                   | <b>Tripura (DLHS III 2007)</b> | <b>India (DLHS III 2007)</b> |
|------------------------------------|--------------------------------|------------------------------|
| ANC Check-up in first trimester    | 39.6                           | 45                           |
| 3 or more ANC Check-up             | 43.9                           | 18.8                         |
| Atleast 1 TT received              | 62.7                           | 73.4                         |
| 100 IFA Tablets                    | 49                             | 46.6                         |
| Institutional Delivery             | 46.2                           | 47                           |
| Home Delivery                      | 53.7                           | 52.3                         |
| Home Delivery by SBA               | 1                              | 5.7                          |
| Early initiation of breast feeding | 40.8                           | 40.5                         |
| Full immunisation                  | 38.2                           | 40.5                         |
| IMR                                | 36                             | 50 (SRS 2009)                |
| MMR                                | Not Available                  | 254 (SRS 2004-05)            |

## FINDINGS OF THE SIXTH CRM IN TRIPURA

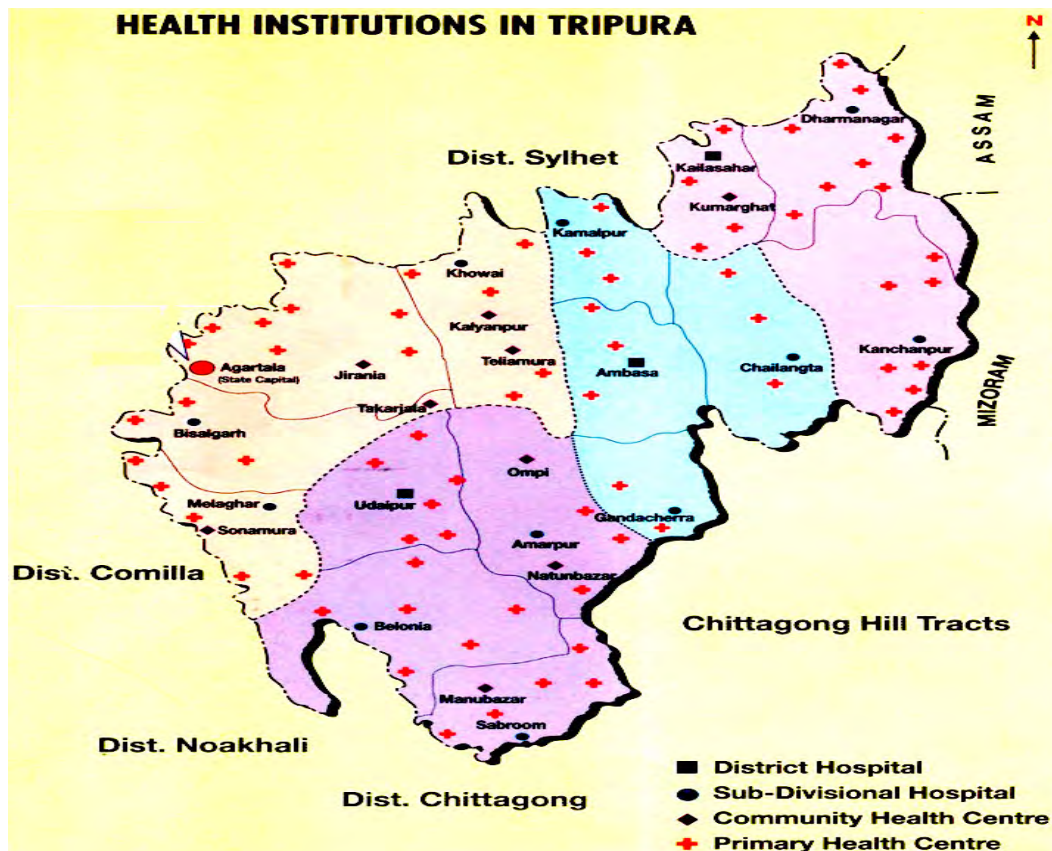
The unique feature of Tripura's healthcare system is that it's mainly the public health system that provides health services. Private hospitals are very few and are concentrated mainly in the state capital.

### TOR 1: Facility based curative services: access, affordability and quality

As the health care services in Tripura are mainly publicly provisioned, the public health facilities are catering to a huge patient and disease load. Therefore the challenge is great of strengthening of infrastructure and improving the quality and range of services in order to respond to the demand. The State seems to be alert to this issue and is gradually improving coverage of its facilities, and upgrading them. User charges are not levied on most services. However, there are issues related to provision of the full range of services at all levels, availability of drugs and consumables and high out of pocket expenditure.

#### Detailed Observations

##### *Adequacy of health infrastructure*



- Tripura has 2 medical colleges, 1 paramedical training institution, 2 nursing colleges, 2 ANM training centers, 5 state hospitals including AYUSH, 3 district hospitals, 13 sub-divisional hospitals, 4 First Referral Units, 15 Community Health Centers, 82 Primary Health Centers of which 65 are 24X7 PHCs and 767 sub-centers (Table-).
- An additional 239 health facilities in the state are in the process of being constructed and added to the existing pool of health infrastructure. This will result in a total of 1200 public health facilities servicing the 3.6 million state population
- At current population estimates, the state's plans for health infrastructure development is in line with the population based norms.
- In the districts visited, accessibility of facilities seemed good. It was observed that on an average, the farthest village from a PHC is about 12-15 Kms.
- Efforts were observed in improving coverage of facilities in remote/underserved areas. In one area in Gomati, a PHC had been sanctioned below the population norms in order to serve the remote and tribal population living there.

**Table - 6: Health Infrastructure**

| Sl. | Category                       | 2005-06 | 2012-13 Sept'12 | Under Progress | State Target | Remark                   |
|-----|--------------------------------|---------|-----------------|----------------|--------------|--------------------------|
| 1   | Medical Collage & Hospital     | 1       | 2               | 0              | 02           |                          |
| 2   | Nursing Collage                | 0       | 2               | 0              |              |                          |
| 3   | ANM training Inst.             | 1       | 2               |                |              |                          |
| 4   | State Hospital including AYUSH | 5       | 5               |                |              |                          |
| 5   | District Hospital (DH)         | 2       | 3               | 0              | 03           |                          |
| 6   | Sub-Division Hospital (SDH)    | 11      | 13              | 02             | 17           | Against 17 Sub-divisions |
| 7   | First Referral Unit in SDH     | 2       | 5               | 05             | 17           |                          |
| 8   | Community Health Centre        | 10      | 15              | 04             | 30           | Against 40 Blocks        |

|    |                       |     |     |     |      |  |
|----|-----------------------|-----|-----|-----|------|--|
| 9  | Primary Health Centre | 74  | 82  | 28  | 125  |  |
| 10 | 24 X 7 PHC            | 54  | 61  | 05  | 125  |  |
| 11 | Health Sub-Centre     | 539 | 767 | 195 | 1038 |  |

(Data from State Government Tripura)

### Status/Quality of Infrastructure

- In the districts visited it was observed that new building infrastructure was coming up at all levels: DH, SDH, CHC, a few PHCs & many SCs.



### ***BRAJENDRANAGAR HSC UNDER CONSTRUCTION***

- However, the data shows that there is an overall shortfall of 41% and 29% respectively in the targeted construction of building for new Sub Centres and Sub Centres being run in rented buildings (as approved under NRHM during the years 2009-10 to 2011-12).
- Shortfall of 100% was also observed in the construction of neo-natal intensive care units in DH/SDH approved under NRHM for the year 2011-12.
- Only 2 out of 5 training institutes approved for up- gradation under NRHM in the year 2010-11 had been completed indicating shortfall of 60%.
- There were serious concerns with the status of District Hospitals in both districts. Though new buildings had been constructed and ready for some time now, the District Hospitals in both districts had not been shifted. The status of the current District Hospitals is a

concern as the team observed very poor maintenance and upkeep along with overcrowding, resulting in unsanitary and unhygienic conditions. Many female Patients at Gomati DH were seen to be lying on mattresses on the floor.

- In North Tripura, the CRM team was informed by the community member that acute shortage of drinking water in the facilities (RGM Hospital Kailashsahar).

### **Ancillary services**

- Diagnostic services are available in DH, however in PHCs and CHCs diagnostic services are limited & only tests available are: HB, Urine Albumin, MP, AFB & HIV testing wherever ICTC centres exist.

- Well functioning blood bank and blood storage facilities were available in DH & SDH in both districts visited.
- Availability of resuscitation equipments like Ambu-bag was found inadequate in emergency, labour room, and wards in DH,
- Oxygen cylinders were not available adequately in wards in DH Unakoti, and Mechanical Suction Machine and Defibrillator are not available.
- Oxygen cylinders were available in 50% of PHCs visited.
- Essential Drug List is displayed only in 50% facilities, and availability of drugs and consumables was found inadequate in most of the facilities visited resulting in patients purchasing drugs prescribed by doctors.
- Non-availability of essential drugs included Magnesium Sulphate, Misoprostol and Dextrose.
- Consumables like the gloves, cotton, gauze and IV sets also found to be in short supply in most facilities visited.

### **Utilisation of Services**

The team found a range of services being provided at the CHCs, SDHs and DHs, including ICTC centres, MCH clinics and well functioning AYUSH clinics. People were accessing these facilities and sometimes this also led to overcrowding due to lack of space in certain facilities.

Deliveries were happening in PHC and above facilities, however, c-section could take place in only the DHs and a few SDHs. There is a lack of specialized services including cardiology, burns etc. for which patients have to go to the state facility. Certain specialised services related to ophthalmology and cardiology was observed in DHs through tele-medicine.

### **Infection control and waste disposal**

General waste disposal and Bio-medical waste management including hospital infection control systems were found to be inadequate in all facilities visited.

### **Cost of care**

- Interaction with patients revealed high out of pocket expenditure incurred by them despite the state government's stated policy of no user charges for most IPD and OPD services. Patients were found to be incurring high expenditure on purchase of drugs, and consumables.
- Women undergoing institutional delivery revealed that they had to incur atleast Rs. 2000-3000 as out of pocket expenditure on drugs, consumables and informal payments.
- It was found that certain RKSs had levied user charges, eg. in DH of Gomati, and SDH Kanchanpur (North Tripura). Though these user charges were for non-BPL families, proof of BPL identity remains difficult.

### **Supportive services**

Citizen charter was displayed in 2/3 of the facilities visited. But in some facilities it was placed in wrong locations

## **TOR – 2: Outreach & Transport Facilities**

Tripura has attempted a significant increase in outreach through increasing the number of health sub-centers. The state is in the process of ensuring one health sub-centre per panchayat/ADC Village. The state hopes to cover each 1038 GP/ADC villages with HSC and seems to have a road map for convergence of infrastructure with human resource with a focus on interior and tribal areas. Although significant no of SCs have been established in 69% GP&ADC villages (720/1038) but the ANC coverage by SCs is still very weak. Linkages between service delivery and demand generation need to be strengthened. Moreover a robust emergency and patient

transport system needs to be established. Tripura's good road infrastructure would prove valuable to a patient transport system.

It is commendable that the state is carrying out the outreach services on its own, without involvement of private players, however, there is scope for involving community leaders and community based institutions and PRIs for improving outreach in underserved areas.

#### **Adequacy of Sub Centres (Infrastructure and HR)**

- The number of HSCs is adequate and higher than the national population norms. The plan of the state is to establish one HSC per panchayat/ADC village. However, infrastructure and availability of equipments like surgical scissor, fetoscope, as well as 24/7 power and drinking water was found to be insufficient.
- As per the state, the number of HSCs has increased from 539 in 2005-06 to 767 till September 2012. However there are only 549 ANMs posted in the HSCs. It was observed during visit to a remote area (Silachari PHC) that the availability of ANMs was further reduced in such areas with only three out of seven HSCs having an ANM. The rest have MPWs (male). The state shared that the Cabinet had sanctioned posts of 100 ANMs recently and the finance division has created 148 posts of MPW (M).
- In terms of infrastructure of HSCs, the state shared that 356 HSC building had been approved of which 222 had been completed, 81 are ongoing and in 53, construction is yet to start. The reason, as articulated by the state, was that only 40% funds released in 2011-12 and therefore the Rural Development department constructed only that many HSC buildings. The sanction of balance funds has since been approved and released in August 2012. Additionally, the state government from other funds like the border area funds has approved few buildings.
- Though the state seems to be focusing on adding new HSCs in tribal and interior areas, in few places visited, factors for prioritization of HSCs buildings for construction was not clear. For example, in East Jalepa HSC, which was not on-road and was seen to have a good OPD, was housed in a tin shed and the building construction had just been approved while the building of Brajendranagar HSC which was on-road and only a couple of kilometers from the adjoining well constructed HSC (Chotokhil), was near completion.

- In addition to the approved and constructed buildings, more than 223 HSCs in the state are functioning in Gram Panchayat offices/rented building and these need to be covered over a period of time.
- The up-gradation of 50 HSC to IPHS standards is ongoing with construction of room extensions and quarters. Out of this 35 have been completed and 15 are left.

#### **Package of services provided at sub centre**

- 1<sup>st</sup> Trimester registration has increased 11% & three ANC check-up 17% has increased in last 4 years (2008-09 to 2011-12 as per HIMS).
- The services offered by the HSCs visited included ANC registration, IFA dispensation, Post Natal Care, Malaria slide collection, basic medicine dispensation, family planning counseling and services, immunization, de-worming and provision of pregnancy test kits.
- However, in the HSCs services being provided were found deficient with respect to completeness of ANC and IUD insertion. As a result, much of the ANC and all of the IUD insertion were happening at the higher facilities.
- Essential examinations and tests like Hb test, BP measurement, Abdominal Examination was not happening in most HSCs visited.
- In nearly half of the HSCs visited, the BP machine was not working and there was no HB meter available. In Satnala HSC, where both were available, and the ANM seemed to be well versed in using them, the readings were off-mark, most probably indicating poorly calibrated equipment in case of the BP machine and poor quality reagents in case of the HB meter. The ANM in this HSC was also not clear on how to use the Fetoscope.
- Though in most HSCs visited, there was private space (room or curtained examination table) for examination, in certain HSCs like Shantipur HSC in North Tripura, there was no private space for check-ups.
- The ANMs reported shortages in drug supply and stock outs. This seemed to be a perennial problem with anti-malarials (ACTs), and paracetamol.
- There seemed to be a lack of training and effective supportive supervision.

### Village Health and Nutrition Days (VHNDs)

- In 2007-08 2690 VHNDs were observed, reaching up to 56600 in 2009-10. In 2011-12 43204 VHNDs had been held.
- The services being provided during VHND are mainly immunisation, general OPD services, OP & Condom distribution and distribution of IFA and TT injections to pregnant mothers. However, VHNDs are being used effectively for social mobilisation, and convergence with ICDS and other departments.
- In one month, four VHNDs are planned in each gram panchayat, covering various ICDS centers/schools. However in some places it was observed that recently there has been a change in the way the VHNDs are scheduled. The dates and place for VHNDs was decided upon each month in order to cover all the ICDS centers/schools in the GP over a period of time. For example, if in a GP with say 12 ICDS centers, a center in which VHND has been held this month, its turn for holding the next VHND will come only after 3 months. The lack of a fixed day for a specific VHND venue each month has scope for creating confusion among the ASHAs and beneficiaries and could also lead to incomplete immunization for some children.

### Immunisation

- The State has adopted fixed day approach for Immunization.
- Immunisation coverage has been increasing in the state (Table 7). As per the coverage reported in HMIS data, immunization appears to be one of the strongest components within the Child Health programme (66% in 2008-09 to 81% in 2011-12). Weekly fixed day (Wednesday) immunization is done in all MCH clinics including SCs.

**Table – 7: Immunisation Coverage in state**

| Source of Data  | NFHS 3  | Coverage Evaluation Survey |      |      |
|-----------------|---------|----------------------------|------|------|
|                 |         | 2005                       | 2006 | 2009 |
| Year            | 2005-06 |                            |      |      |
| Fully Immunized | 49.7    | NA                         | 60.0 | 66.0 |
| BCG             | 81.1    |                            | 85.1 | 74.2 |
| OPV 3           | 65.3    |                            | 67.3 | 71.3 |
| DPT 3           | 60.2    |                            | 67.8 | 70.6 |
| Measles         | 59.9    |                            | 65.6 | 68.8 |

- Vaccines were in stock at all the facilities visited; however there were reports of stock outs for DPT in one CHC. The cold chain equipment is in place and temperatures maintained as per the guidelines. The downtime for the cold chain equipment was about 48 hours. However, vaccines stock register at Cold chain points needs urgent intervention. GoI formats are not being used at all CC points.
- In none of the places visited were micro plans available for RI.
- The team in south district found the immunization card for mother and child with all the beneficiaries visited. However, no Due List was available with the ANMs at Sub centres.
- There is no proper mechanism for disposal of waste generated during Immunisation session.
- Use of tickler bag, counterfoil checking has been abolished and immunization related information was found to be updated in MCH registers and MCTS tracking sheets. However, printed MCTS registers with all columns were not available in all places and MCTS generated plans and due list were not found either with ANM or ASHA.
- No plan is available at district level for Supportive supervision by DIO and other officers.
- Training- 98.8% Health workers, 124% Cold chain handlers, and 30% Medical Officers have been trained in RI (as on 19th April 2012, reported by State Government, compiled at NIHFV). However during field visit, MPW, MPS and medical Officers reported that many were not trained. There is need to prioritise training of MOs posted in MCH clinics. Similarly refresher training of MPS, MPW needs to be conducted by PHC MOIC.

### **Medical Mobile Units**



***MMUS PARKED AT GOMATI DH***

- Currently four 4 MMUs are functional in the state, conducting about 20 camps per month in each district. The Ram Krishna Mission operates one MMU.
- The MMUs were seen providing OPD services, and diagnostics including Ultrasound and dental services.
- MMUs are being used to good effect by integrating it with VHND. In one VHND visited by the team, MMU was providing various services including Ultrasound test for pregnant women.
- The state has also been able to cover certain unreachable villages through regular camps using helicopters.

### Emergency and patient transport system

Institutionalised Emergency and Patient Transport Services do not exist in state. The transport used by patients is mainly private vehicles. Though ambulances were available at quite a few PHCs, SDH and DH and were used to transport very serious patients, for referral. They were also found to be engaged in transporting doctors, health personnel, equipment and medicines for VHNDs and health camps. The state submitted that available funds were inadequate for the maintenance of the ambulances. The state is looking to improve its system of patient transport services through call center etc. and requested the CRM team for support on this.

### TOR 3: Human Resources for Health

Table 8 presents status of health human resource in the state.

**Table 8: Status of Human Resources in Health across districts**

| SL | Name of Dist / Unit | MPW (M) | AN M | Staff Nurse | Pharm assist | Lab. Tech | Radio grapher | Medical Officer |        |        |
|----|---------------------|---------|------|-------------|--------------|-----------|---------------|-----------------|--------|--------|
|    |                     |         |      |             |              |           |               | Allo            | AYUS H | Dental |
| 1  | West                | 71      | 111  | 90          | 57           | 13        | 2             | 38              | 49     | 11     |
| 2  | Sipahijala          | 65      | 94   | 124         | 29           | 11        | 4             | 45              | 28     | 12     |
| 3  | Khowai              | 52      | 55   | 94          | 15           | 5         | 3             | 34              | 19     | 6      |
| 4  | Gomati              | 59      | 98   | 157         | 36           | 16        | 4             | 68              | 28     | 12     |
| 5  | South               | 55      | 89   | 185         | 49           | 19        | 3             | 53              | 25     | 10     |

|    |   |            |            |             |            |            |           |            |            |           |
|----|---|------------|------------|-------------|------------|------------|-----------|------------|------------|-----------|
| 6  | Unokoti                                   | 22         | 56         | 99          | 17         | 9          | 2         | 39         | 16         | 8         |
| 7  | North                                     | 34         | 48         | 113         | 20         | 16         | 2         | 46         | 22         | 10        |
| 8  | Dhalai                                    | 65         | 39         | 138         | 27         | 16         | 3         | 55         | 22         | 7         |
| 9  | Medical<br>College &<br>State<br>Hospital | 0          | 21         | 617         | 29         | 44         | 21        | 337        | 13         | 14        |
| 10 | Other                                     | 0          | 90         | 16          | 20         | 0          | 0         | 25         | 3          | 1         |
|    | <b>Tripura</b>                            | <b>423</b> | <b>701</b> | <b>1632</b> | <b>299</b> | <b>149</b> | <b>44</b> | <b>740</b> | <b>225</b> | <b>91</b> |

- Grossly inadequate availability of specialists in DHs, SDHs & CHCs is affecting the quality and range of services like Caesarian Delivery, Specialised Newborn Care and Ultrasound Services.
- Shortfall of HR at all levels: up to 50% of allopathic medical officers, 10% of staff nurses, 30% - MPW – male, 22% of MOs (AYUSH), 28% of Pharmacists, 9% of Radiographers, 33% - Lab Technicians, and 10% of ANMs in SCs. (State Data)
- Presently state has 258 specialists, out of that 68% are required in medical college and state hospital including cancer hospital.
- HR Shortfall is affecting the quality and availability of services and hindering expansion of health services.

Other than PG and Diploma, 09 doctors are trained on Life Saving Anaesthetic Skill (LSAS) and 11 on Emergency.

- Existing manpower is by and large evenly distributed in health facilities, and availability of doctor including MBBS doctor and basic staff has been ensured.
- Interaction with MOs and health staff revealed perception of lower salary and lack of clear cut HR policies and promotional avenues.
- Good Practice for career development of medical officers in form of sponsorship of PG studies after 3 years of service.
- Staff for DPMSUs for newly created districts is yet to be recruited.
- Gender Equity not observed in programme management units and leadership positions.

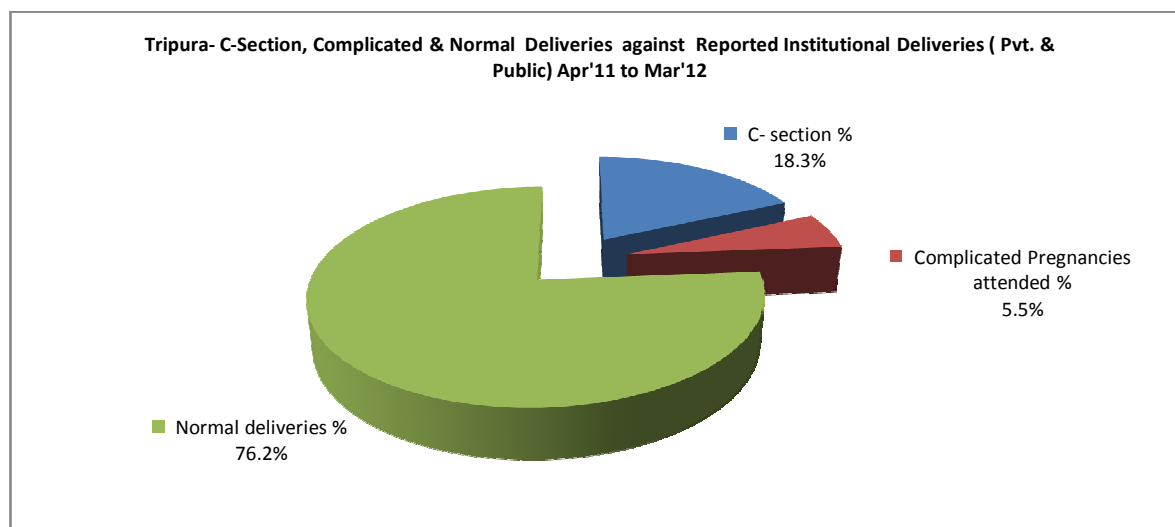
## TOR 4: Reproductive and Child Health Programmes

### Institutional deliveries

Institutional delivery is being conducted in all DH, SDH and CHCs, out of 8 PHCs visited 6 are functioning as 24/7 delivery points. Both DHs visited are conducting C-section, but two SDHs out of four visited do not do c-section and none of the CHCs visited are doing it.

**Table 9: Pattern of Deliveries against reported deliveries (from HMIS data)**

| <b>Tripura- C sections &amp; Complicated Deliveries Apr'11 to Mar'12</b> |  |                                       |                                       |
|--|--|---------------------------------------|---------------------------------------|
|  | <b>Institutional Deliveries (Public)</b> | <b>Institutional Deliveries (Pvt)</b> | <b>Total Institutional deliveries</b> |
| <b>Total Deliveries</b>  | 41,779                                   | 2,016                                 | 43,795                                |
| <b>C Section</b>   | 6,088                                    | 1,909                                 | 7,997                                 |
| <b>C Section%</b>  | <b>14.6%</b>                             | <b>94.7%</b>                          | <b>18.3%</b>                          |
| <b>Complicated Pregnancies attended</b>                                  | 2,412                                    | 1                                     | 2,413                                 |
| <b>Complicated Pregnancies attended %</b>                                | <b>5.8%</b>                              | <b>0.0%</b>                           | <b>5.5%</b>                           |



**Table 10: Tripura - Facility wise % of C sections & Complicated Deliveries (Apr'11 to Mar'12 - from HMIS data)**

|  | PHC          | CHC         | SDH/DH       | Other State owned institution | Private Facilities | Total |
|--|--------------|-------------|--------------|-------------------------------|--------------------|-------|
| <b>Complicated deliveries managed (Reported)</b>               | 458          | 102         | 1,852        | -                             | 1                  | 2,413 |
| <b>Complicated deliveries managed as %ge of total reported</b> | <b>19.0%</b> | <b>4.2%</b> | <b>76.8%</b> | <b>0.0%</b>                   | <b>0.0%</b>        |       |
| <b>C Section (reported )</b>                                   | -            | -           | 6,088        | -                             | 1,909              | 7,997 |
| <b>C Section as percentage of total reported</b>               | <b>0.0%</b>  | <b>0.0%</b> | <b>76.1%</b> | <b>0.0%</b>                   | <b>23.9%</b>       |       |

- One HSC visited in North Tripura is conducting deliveries. This was more of an exception than the norm as it is the only HSC delivery point in the state. Between December 2009 and November 2012, a total of 158 deliveries have been conducted by the ANM stationed at the health facility who seemed very dynamic, meticulous and knowledgeable.
- The state has trained 265 SN and 195 ANMs on SBA training. The training on SBA and NSSK has not been completed for all Staff Nurse of facilities visited. The trained staff did not have a 100% overlap with the delivery points.
- Maintenance of labour room was satisfactory in most of the health facilities visited except the DHs. Toilets were not found attached to most of the labour rooms. Visual privacy was compromised at places. Infection Control Protocols were found to be lacking in all the OTs and Labor rooms visited specially in District Hospital, Gomati.
- Gloves, cannulas, gauze, syringes, IV sets and bandages are in perennial short supply and in most cases the patient has to bear this cost.
- Non-availability of essential drugs in few facilities included Magnesium Sulphate, Misoprostol and Dextrose

**Emergency obstetric care** is available only in DH and some of the SDHs. It was observed with concern that BEmOC services with personnel competent to deal with complicated pregnancies such as forceps/ vacuum delivery and manual extraction of placenta were not available in any of the 24X7 PHCs, which the team visited. Further, in the south district there was a single FRU providing CEmOC as laid out in the guidelines. The lack of BEmOC and CEmOC care facilities in this part of the State is underscored as a serious gap for which the State has to take immediate remedial action. This is more a reason for concern due to the increasing institutional delivery rate, which according to HMIS data was 85% in 2011. There is need to enhance training of EmOC & LSAS for MOs atleast in all SDHs and CHCs.

**Safe abortion facilities-** This service was found to be neglected. Only district hospitals and one FRU at Belonia was found to be providing this facility and that too to a very small number of clients. Even in these facilities, the OT (minor OT) needs strengthening as well as cleanliness

and proper instruments/ appliances. It was noted with concern that abortion services were not available in many Sub District facilities, and none of the CHCs and PHCs visited.

### **Status of Newborn care units at various levels (SNCU, NBSU, NBCC)**

The Infant Mortality Rate (IMR) of the State which has been decreasing earlier, has seen an increase in the last year from 27 (SRS 2010) to 29 per 1000 live births (SRS 2011). This is a concern and could be related to the poor status of new born care observed at all facilities.

**SNCUs-** Health facilities are lacking completely in terms of Neonatal Stabilization/ intensive care units in the facilities visited. SNCUs were not available in any of the facilities visited. The team did not find any of the SNs and ANMs posted at the delivery points visited to be trained in NSSK, however, some of the MOs got NSSK training. This could be one of the reasons for the unpreparedness observed with respect to essential newborn care.

### **Newborn Corners:**

- Newborn Care Corners are present at most health facilities but are not equipped as per the guidelines or specifications and need to be made more functional and better maintained. The protocol on newborn resuscitation was not displayed or available at any of the facilities. Nutan Bazaar CHC had no NBC, and urgent repairs are needed for defective Radiant Warmer in Shantirbazar PHC.
- As per the state's submission, 5 sick newborn care units (SNCUs), 05 (neo-born stabilisation unit) and 2 Nutritional Rehabilitation Centre (NRCs) are in process and will be functional by March, 13.
- Given the high delivery load at some of the facilities, it is essential that new born care facilities be planned systematically. While Newborn Care Corners should be established at each delivery point, at least one SNCU per district should be operationalised at the level of FRU. The State should prioritise low performing districts for setting up SNCUs. Further, NSSK trainings to be prioritised for MOs, ANMs and SNs posted to labour rooms, delivery points.

### **Tackling Severe Acute Malnutrition through MTCs (Malnutrition Treatment Centres)**

According to NFHS 3, Tripura has a very high percentage of severely malnourished children under the age of five years. It shows (24.6%) of wasting among children below five years, within

which 8.6% is SAM. Also high are stunting below -3SD is 14.7% and underweight below -3SD is 15.7%. Therefore, appropriate institutional arrangements to tackle SAM and other forms of severe malnutrition are needed. However, currently, the state has one operational MTCs/NRCs at the state capital. As per the state's submission, two Nutritional Rehabilitation Centre (NRCs) will be functional by March 2013.

**Table 11: Child Health Indicators**

| Indicators  | DLHS -2 (2002-04) | DLHS-3 (2007-08) |
|---|-------------------|------------------|
| <b>Child feeding practices (%)</b>  |                   |                  |
| Children under 3 years breastfed within one hour of birth   | 53.0              | 41.9             |
| Children age 0-5 months exclusively breastfed   | NA                | 38.3             |
| Children age 6-9 months receiving solid/semi-solid food and breast milk                               | NA                | 83.1             |
| <b>Awareness about Diarrhoea and ARI</b>  |                   |                  |
| Women aware about danger signs of ARI (%)   | 21.1              | 26.9             |
| <b>Treatment of childhood diseases (%)</b>  |                   |                  |
| Children with diarrhoea in the last 2 weeks who received ORS  | 53.7              | 58.8             |
| Children with diarrhoea in the last 2 weeks who were given treatment                                  | 68.9              | 57.3             |
| Children with acute respiratory infection of fever in last 2 weeks who were given advise or treatment | 65.5              | 73.2             |

**Quality assurance** - No Quality Assurance Committee formed.

**Community level care for ARI, Diarrhoea, PNC, Home deliveries-** Substantial number of Home delivery takes places in the districts visited. State % of Home delivery is 53.5% (DLHS-III). The home deliveries are being conducted by untrained Dai. ORS and Zinc tablets available in all facilities. However, Essential drugs like cotrimoxazole and metronidazole were not available with all ASHAs.

### Janani Shishu Suraksha Karyakram (JSSK)

JSSK is being implemented throughout the State. However it was observed that facilities were reimbursing these expenses at a fixed rate instead of giving free entitlements to the pregnant women's and neonates, resulting in significant out of pocket expenditure for beneficiaries. Free diagnostics, free blood transfusion and free diet facility are being provided in most of the facilities visited, however free drugs and referral transports are yet to become a reality. Informal payments were also reported for some facilities.

- **Status of Free drugs:** Few drugs are available in the facilities but outside prescriptions are still commonly in practice. Interaction by the team with pregnant women in the maternity wards revealed that outside prescriptions are still commonly in practice. The team noted that across the facilities staff are not fully aware of the entitlements of a pregnant woman and her child under the JSSK scheme.
- **Status of Free Referral Transport:** There is no robust mechanism for free referral transport to the pregnant woman and Neonates. Facilities are reimbursing the cost of transport to the beneficiaries instead of giving free transport facility, and that to upto a predefined limit. During interaction with the villagers and beneficiaries, it was revealed there is a huge out of pocket expenditure to be borne by the beneficiaries for transport and they them self have to arrange the mode of transport their own.
- Considering the increased load, a mechanism to ensure uninterrupted supply of drugs and consumables should be in place wherein State monitoring teams should provide a handholding support to the district. Citizen charter also needs to specify the range of services which should categorically mention the newborn services.

### Janani Suraksha Yojana (JSY)

**Table – 12: Physical Progress of JSY**

| Year    | Institutional Deliveries | JSY Beneficiaries |
|---------|--------------------------|-------------------|
| 2005-06 | 29247                    | 2247              |
| 2006-07 | 30867                    | 3000              |

|                            |       |       |
|----------------------------|-------|-------|
| 2007-08                    | 30908 | 15547 |
| 2008-09                    | 31557 | 20000 |
| 2009-10                    | 36571 | 20402 |
| 2010-11                    | 29000 | 14000 |
| 2011-12<br>(Upto December) | 31934 | 13867 |

**Table – 13: Pattern of JSY deliveries and payments**

| <b>Tripura - JSY Paid to Mothers as % of reported deliveries - Apr'11 to March 12</b> |                   |                            |  |
|---|-------------------|----------------------------|--|
|   | <b>Deliveries</b> | <b>JSY Paid to mothers</b> | <b>%age JSY paid against reported deliveries</b> |
| <b>Home</b>   | 7,503             | 128                        | 1.71   |
| <b>Institutional (Public)</b>   | 41,779            | 19,280                     | 46.15  |
| <b>Institutional ( Accredited - Pvt )</b>   | 2,016             | -                          | -  |

(All Figures on JSY taken from state govt.)

- There is an increase in institutional deliveries, however, interactions with women revealed that all beneficiaries have to incur out of pocket expenditure of around Rs. 2000-3000 and more when delivering at any facility.
- Payments under JSY are being made by cheque to all the beneficiaries. JSY entitlements are displayed in some of the facilities visited. Discharge slips issued by the health facility as well as the Mother Baby Protection Card are used for confirming and making payments to beneficiaries.
- Large numbers of beneficiaries are receiving their entitlements after a delay of 6 days to 30 days. Mothers are forced to come to the facilities repeatedly for receiving entitlements

under JSY. This results in beneficiaries spending money on transport and lost wages which negate the basic purpose of providing cash incentives under JSY.

- Payment of JSY incentives to ASHA was found to be made by bearer cheque and not A/C Payee. In this case too payments were inordinately delayed for periods ranging from 6 days to 30 days.
- There is no grievance mechanism set up in order to address complaints such as delayed payments etc.

#### **Referral transport mechanism-**

- Through hired vehicles and mostly reimbursement to the clients. However state needs to build an institutionalized referral / patient transport system, with a centralized call centre.
- No set of rules for contractual hiring of vehicle present in district.
- Interaction with beneficiaries revealed high Out of pocket expenses on transport.

#### **Family Planning services**

The State has lower TFR (1.7) than the national average of 2.5. Nevertheless, it is important to ensure that services for spacing and permanent methods are readily available for families, especially women, to choose from. Fixed day services are not in practice. Spacing methods are not being delivered regularly due to lack of counseling skills of service providers. Across the facilities visited, it was found that the approach towards family planning services are seasonal and target oriented activity especially in sub-district hospital facilities. Uptake of OCPs and Condom is much below the expected level and needs a comprehensive plan to create demand using appropriate strategies.

**OCPs and Condoms** - Distribution of OCPs and Condoms are being done by ASHA, ANM and all the facilities. however there seem to be gaps in the supply chain of these items especially at the HSC and PHC levels. Distribution of contraceptive through ASHA is in place, however the uptake is low.

**IUCDs-** The current IUCD insertion rate is low. The feedback from MOs, and ANMs and from state officials indicates that community has low acceptance on IUCD insertion. However, it was found that though in the last few years 342 ANMs had been trained on IUCD insertion, nowhere were they doing it. All IUCD insertions were always being done at the higher facilities (PHC and above) by MOs. Interaction with trained ANMs revealed that many were not confident of doing

the procedure even after training. This could be easily resolved through supportive supervision by placing ANMs by rotation at the PHC/CHC during MCH clinics. Having this service available at the HSC and therefore closer to the community, would help in building awareness among the community on this method and also facilitate its utilization.

**ECPs-** ECPs were available with ANMs however there were issues in its supply.

**Permanent methods-** The fixed-day approach for permanent methods is not followed in whole of the state. The health department has an MOU with the Tripura Doctor's Association that organizes camps in various facilities (CHCs and above). During the visit to a remote area, the team found high unmet need due to issues of access and distance. However, often problems in access may be overcome by regular and assured provisioning of services. Therefore, this strategy needs to be relooked at with the aim of making regular and assured services available to the community.

The data (Table-14.) shows that while focus is on female sterilization, there had been an increasing trend of male sterilizations. However this trend is decreasing currently. The reasons for this could not be explored by the team, however, this too could be a consequence of the types of camps held.

**Table 14: Pattern of Sterilisation**

| <b>Services</b>         | <b>06-07</b> | <b>07-08</b> | <b>08-09</b> | <b>09-10</b> | <b>10-11</b> | <b>11-12</b><br>(Upto<br>Dec.) |
|-------------------------|--------------|--------------|--------------|--------------|--------------|--------------------------------|
| Male Sterilisation      | 1            | 5            | 1151         | 593          | 285          | 115                            |
| Female<br>sterilisation | 3149         | 3064         | 6228         | 3137         | 1885         | 3982                           |

**Table 15: Pattern of Sterilisation across facilities**

| <b>Tripura- Facility wise % of Sterilisations &amp; IUDs - Apr'11 to March 12</b> |                   |            |            |               |                                      |                           |
|---|-------------------|------------|------------|---------------|--------------------------------------|---------------------------|
|   | <b>Sub center</b> | <b>PHC</b> | <b>CHC</b> | <b>SDH/DH</b> | <b>Other State owned institution</b> | <b>Private Facilities</b> |
| <b>NSV as % of total reported</b>   |                   | 72.8%      | 10.7%      | 16.5%         | 0.0%                                 | 0.0%                      |
| <b>Laparoscopic as % of total reported</b>  |                   | 39.6%      | 3.9%       | 56.2%         | 0.0%                                 | 0.2%                      |
| <b>MiniLap as % of total reported</b>   |                   | 0.0%       | 0.0%       | 79.2%         | 0.0%                                 | 20.8%                     |
| <b>Post Partum as % of total reported</b>   |                   | 0.0%       | 0.0%       | 77.4%         | 0.0%                                 | 22.6%                     |
| <b>IUD inserted as % of total reported</b>  | 8.8%              | 53.2%      | 12.9%      | 25.1%         | 0.0%                                 | 0.0%                      |

- **Implementation of ARSH programme-** ARSH counselors were appointed in most higher facilities visited, except in DH Gomati. However, the State needs to strengthen their training. BCC/IEC for ARSH program is weak resulting in low attendance in ARSH clinics. Sufficient referrals are also not received through ANMs and ASHAs. There is weak follow-up of the adolescents attending the clinic.
- ARSH services were not being provided in the district hospital in south district due to non-availability of counselor. ARSH clinics are not found to be functional in most of the

SDHs and CHCs except in Belonia SDH in the south district. It was informed that ICTCs were also meant to provide services to adolescents as ARSH Clinics. However this was not found to be happening. ICTC counselors need to be trained under the 5 day module for ANM/LHV and sensitized on how to deal with adolescents before they can deal with adolescent clients.

- The team observed a functional ARSH clinic in SDH Belonia with a dedicated counselor but require sensitization and training on the WIFS and ARSH issues. Otherwise ARSH services were not visible at all in the facilities visited in the south district. State needs to emphasize the importance of a functional ARSH clinic in every health facility. Further training of MOs and ANM/LHV on AFHS module has to be emphasized by the State.
- At Kanchanpur SDH in North Tripura, the ARSH clinic on the premises was manned by a counselor who had been in position since December 2010. The counselor had been provided two orientation trainings of 2 and 1 day duration respectively. The counselor was counseling an average of 2-3 patients per day (though no records were being maintained for the same to validate performance) for mental health issues, sexual abuse, and unwanted pregnancy and MTP. On an average, 4 hours were devoted by the counselor to the clinic—this included conducting school health programs for Std VI to X children in 10 programs/month and participating in approximately 12 Village Health and Nutrition Days per month. In the remaining time, he was being used by the SDMO to process payments for JSY and JSSK and incentives for ASHAs. There were no referrals from the ICTC clinic to the ARSH clinic or vice-versa.
- **Weekly Iron Folic Acid Supplementation (WIFS)** is in the process of being implemented in the state. IFA supplies had reached most anganwadis and schools in both districts. However, identification and training of Nodal teachers is yet to be completed. Most of the ASHAs and ANMs are not aware about the programme.
- **Maternal death Review**- It was noted that maternal death review committees have been set up in south district. However, only facility based maternal death review is conducted while community based MDR through ANM & ASHAs is not yet in place. Further verbal autopsy needs to be conducted more intensely.

## **TOR 5: Disease Control Programme - Communicable and Non Communicable Diseases**

### **IDSP**

- Each PHC has surveillance team comprising MO I/C, MPW and MPS. However, no IDSP unit had been constituted for the new North Tripura District.
- All PHC Medical Officers and DMO trained in reporting on 'S, P, L' forms, identification, notification and response.
- Capacity of ANMs in filling S-form, MO I/Cs at PHC/DH needs enhancement since variable reporting was seen in terms of completeness and timeliness.
- For improved reporting on the 'S' form as well as reporting, a more consistent and rigorous training must be provided to ANMs. Of course, it is imperative to rationalize the workload of the ANM with support, based on demonstrated demands of care, while adding this responsibility.
- Reporting on the Presumptive 'P' forms from the PHCs and SDH and District Hospital was being done. While PHCs report on both OPD and IPD data, the SDH and District Hospitals are not going so. In the recent past other than one major food poisoning episode, no major outbreaks were reported from the district. Both Dasda PHC and Kanchanpur SDH indicated that weekly 'P' forms were being compiled by the Multi-purpose Supervisor or MIS assistant and communicated to the District Health Office, Dharmanagar each Monday using messenger. The recent episode of mass food poisoning and response from district teams was reconstructed.
- The District Hospital, Unakoti is reporting on the Laboratory 'L' forms on a weekly basis. However, since no samples are being collected, it is unlikely that any relevant data is being collected and reported in the 'L' forms.
- Lack of Computers, poor electricity and internet connectivity make on-line reporting or portal entry difficult. For similar reasons, online reporting or updating portal is not possible even at Kanchanpur SDH (which is soon to be upgraded to a DH).

- In the absence of the Data Assistant, there is no analysis of IDSP data, which should inform IEC interventions and other preventive management decisions.
  - No reports are being submitted on a weekly basis.
  - Human specimen samples and food samples not collected for laboratory analysis for lack of supporting lab facilities.
  - Fund flow mechanisms established though delayed release of partial funds results in delayed procurement of antigens, test kits and consumables.

### **NVBDCP**

- Revised NVBDCP 2011 guidelines are being followed in the state.
- Large numbers of PF and PV cases have been detected by the health facilities in last 2-3 years in the endemic areas.
- IPD patients included PF cases in facilities visited by team even during this low transmission season.
- The team observed issues in adequacy and availability of RDT Kits and anti-malarials. Health facilities were not well equipped to treat malaria patients as many facilities reported stock outs of anti-malarial drugs, particularly adult ACT. ASHAs had also not been provided with RD kits at some places. ACT and Chloroquine for EDPT was not available with many of the ASHAs even in endemic areas as a result of stock outs.
- 40,000 LLINs were distributed to state and supplied to PHCs for distribution through MPWs to community and Gram Panchayats. In areas with very high API (eg. Silachari Block) LLINs distributed were not found sufficient. No LLINs were being used in health facilities. Dasda PHC claimed they did not have any LLINs. Equitable distribution of LLINs has to be monitored and ensured and in endemic areas prioritised for 100% coverage. Impregnation of bed nets not done since 2009, on account of no liquid or funds supplied for same.
- A Lot Quality Survey in November 2011 in North Tripura indicates that 70% of the community is using LLINs.
- No cases of Japanese Encephalitis, Dengue, Chikungunya and Kala Azar reported from districts in the recent past.

- DDT spraying- In 2011, only Round 1 of spraying had been completed. In 2012, 1<sup>st</sup> round of training was completed for mandated 75 days in March-May; while only 25/75 mandated days of Round 2 completed till September due to insufficient funds.
- Single DMO holds dual charge of both new districts Unnakoti and North Tripura districts. Supported by MPW for clerical work. DMO holds four additional charges.
- No district program management unit in both districts.
- ASHA incentives for blood slides and course completion delayed.
- Feedback on poor quality of RD Kits and expired or soon-to-expire anti-malarials received from PHC doctors and ANMs.
- MPW and MPSs using VHND for BCC and IEC on vector control.

### **RNTCP**

- District management units for program established and functional.
- Sufficient training provided to district officials and management unit in TB/ HIV, DOTS+ and STLS.
- Excellent reporting on program observed at SDH Kanchanpur in North Tripura.
- Strong M&E mechanisms established for periodic review.
- All lab and treatment protocols being followed judiciously.
- No default cases logged in 2011-12.
- RNTCP financial guidelines being adhered to.
- All consumables (lab consumables and reagents) for the program are procured at the district level once a year. The District Purchase Committee facilitates and approves the tendering and supply of orders for consumables and reagents.
- There has been no shortfall in supply of DOTS.
- No patient of MDR –TB has been identified to date—this could be on account of no testing facilities in the state and the linkage with the MDR testing lab at Guwahati yet to be made functional.

### **NPCB**

- DBCS established and functional in North Tripura district.
- Delayed release of partial fund requirement by 3 quarters a bottleneck.

- Under the aegis of DBCS, four eye camps are conducted in the district in each month, with a focus on cataract screening. Eye camps are conducted within a maximum radius of 100 kms. A maximum of 150 patients per month are serviced by these camps.
- Patients are remunerated INR 100 per patient for transportation costs to the District Hospital
- A 100 % success rate of cataract surgeries (SICS/Phaco) is claimed by the District Ophthalmology Deptt. In North Tripura, however data for the same was not reviewed.
- Spectacles for patients are available at a subsidized rate from an optical shop established within DH premises and outsourced to a private provider at a pre-agreed rate of INR 125 per pair of spectacles.
- An average of 9-10 schools per month are targeted for a school health program in the district where children are screened for refractive errors and spectacles are provided.

#### **National Iodine Deficiency Program**

Though 60000 test kits from MOHFW provided to ASHAs in 2012 for peripheral testing, no kits were found to be available with ASHAs the team interacted with.

#### **National Leprosy Elimination Program**

Leprosy eliminated from state in 2002.

#### **Thalassemia, Sickle Cell Anemia and Genetic Disorders**

Small pocket of Thalassemics in state; being provided blood transfusion in small numbers; visited districts did not have these vulnerable groups.

### **TOR 6: ASHA and Community Processes**

#### **ASHA Programme**

State has total 7367 ASHAs out of which 7311 have been trained up-to 5<sup>th</sup> module and 7009 ASHAs have been trained upto 2<sup>nd</sup> round of 6<sup>th</sup> & 7<sup>th</sup> module.

386/400 ASHA facilitator are working in the field.

State government has declared 33.33% additional performance incentive to ASHA from state funds.

There are 912 ASHAs in North dist. However, there are 1249 AWCs in the dist. and so there is this gap in terms of number of ASHAs and number of AWCs. This needs to be bridged soon as it is a backward and has large tribal population. For the ASHAs to be effective it is important to provide her with knowledge and skills through training, and on the job support, and keep up her motivation through providing her regular incentives and a drug kit and other equipments enabling her to help the community. The team found that the ASHA as a community worker is playing pivotal role at community level in promotion of positive health care practices, access to services and mobilisation for VHND in the state of Tripura.

### **ASHA Training**

- ASHA trainings have been quite regular and has been completed up to Module 6&7, round 2. In the state, out of 7367 selected ASHAs, 7367 ASHAs have been trained up to 1<sup>st</sup> module, 7367 ASHAs trained up to 4<sup>th</sup> Module, 7367 ASHAs are trained up to 5<sup>th</sup> Module and 7257ASHA has been trained in 6<sup>th</sup> & 7<sup>th</sup> Modules.
- All the ASHAs in the North Tripura district have been trained in Module 5 and the first and second phase of the 6<sup>th</sup> and 7<sup>th</sup> phase completed. The third phase of 6<sup>th</sup> and 7<sup>th</sup> Module has been started. Since no direct observation of the training could be made during the visit of the CRM team, comments on training quality could not be made. The ASHAs, however, found to be informative and thus, it can be assumed that, their trainings had been effective.

### **ASHA Facilitators**

- ASHA Facilitators have been selected a few months back and are in position. However, they require adequate training and supervision in order to contribute to the ASHA programme. There is also not much role clarity among the ASHA Facilitators and they expressed their dissatisfaction over the reduced amount of payment to them. State officials later clarified that the original amount announced had to be reduced due to certain mistaken approval in states ROP, however their original payment amount will be reinstated at the earliest.

- The biggest gaps in the programme was with respect to the drug kit replenishment and timely disbusal of incentives.

#### **ASHA drug kit and other equipments**

- The Team observed that after the first ASHA drug kit had been given about two years back, replenishment of it has been adhoc and inadequate. There did not seem to be a plan for regular and adequate replenishment of the drug kit. The ASHA's are supposed to take the drugs from HSCs, PHCs, and other facilities. However, it is not possible for these facilities to supply the whole list of drugs in the required amounts as they themselves have to deal with stock outs and inadequate supplies. This was seen with regards to all the drugs, especially Cotrimoxazole and paracetamol. In the absence of listed drugs, in some villages the team found that the ASHAs had been given Norflox and Furanidazole. It is crucial that the state plans and budgets annually for ASHA's drug replenishment as separate from drugs supplied to the various facilities.
- The ASHAs are supplied with some communication materials like Charts, Posters, Flip Charts, etc.
- ASHAs in a particular area informed that infant weighing machines were being given to them without the baby sling, so they did not take it. Overall most of the ASHAs are not confident about the use of baby weighing machine, as the practice sessions during the training were quite inadequate.

#### **ASHA payments**

Generally ASHAs receive their payments through Cheque. There has been a general complaint that, the payment of Incentives is occasionally delayed. For example, the incentive for Malaria slides had not been paid for nearly a year in South Tripura.

#### **Performance monitoring:**

- Though formats for performance monitoring are available with ASHA, no specific mechanisms are in place to monitor the performance of the ASHAs. The ASHA Facilitators (there are 39 ASHA Facilitators in place in North district out of 49) are to monitor the activities of the ASHAs and apprise the District ASHA Prog. Manager and SDMO and CMO of the district. It may be mentioned that, North Dist. does not have a DAPM. It was, however, found that, in many cases the ASHAs appeared to be more

accomplished than the ASHA Facilitators. Some ASHA Facilitators had undergone three days Induction training only. ASHA Facilitators also do not regularly visit the ASHAs.

- No Indicator based performance monitoring of the ASHAs is practiced. On interactions with the community members and also ASHAs it could gathered that, the ASHAs, by and large, carry out the desired tasks like making home visits, attending new born, community awareness activities, etc.
- There is no District or Block Community Mobiliser in the state. To help the Administration, particularly for organizing IEC/BCC activities, support of a Mother NGO named “Sanghadeep” with four other NGOs have been requisitioned in North District.

### **Grievance Redressal**

- For their grievances ASHAs usually approach their Facilitator, then the Extension Educator and the APM and the MO I/C. as per the ASHAs who interacted with the CRM team. The 24<sup>th</sup> of every month is observed as the ASHA BHAROSA Divas when the ASHAs gather in the PHC to discuss about their work and also about their grievances.
- Some common problems highlighted by the ASHAs related to: delayed payment of Incentives, undue demand for money and harassment by some paramedical staff in the facilities, ill-treatment by some staff of the facilities, Non-receipt of the SMSs under MCTS. In some facilities there is no ASHA rest room (like in Kanchanpur SDH)

### **VHSNCs**

- Involvement of PRIs in various bodies like VHNSC, RKS, DHS, etc is strong. In most of these bodies the PRI representatives are assigned a leading role. In Governing Bodies of RKSs and DHSs the PRI representative (usually the Vice Chairperson of Panchayat Samitees and Zilla parishads) are the Chairpersons. These PRI members more or less regularly attend and participate in the meetings and other activities.
- Altogether 1038 VHSNCs have been formed against all the 1038 revenue Villages. All of these VHNSC have their Bank Accounts. Fund release is regular. The major items of expenditures include expenses for organizing meetings/awareness activities, for meeting occasional referral expenses of poor patients when the general fund is exhausted, meeting

expenses for some survey done through the ASHAs, etc. The minutes of the meetings are usually maintained.

- ASHAs are enrolled as Members and not Member Secretary of the VHSNC. They are assigned specific role particularly to ensure maternal and child health services and to assist the ANMs and coordinate with the AWWs. However, in some villages it was observed that the ASHA did not have a leading role in the VHSNC or a say in the way the funds were being spent and simply followed orders given at those meetings. It was felt that at the present level of maturity, the ASHAs could perform the role of Member Secretary and be added as a signatory to the bank account.
- In North district 180 members of VHSNC have undergone one-day training in six batches where two/three members from each VHSNC participated. The training was conducted by the district level officials of Health Department. The trainers use different Training materials for training.

**Community based monitoring** is not being implemented in Tripura despite good scope for it in terms of an active and aware PRI.

## **TOR 7: Promotive Health Care, Social Determinants, & Inter-Sectoral Coordination, Equity Concerns**

### **Gender equity**

- Tripura has an improving sex ratio (Table-....) and high literacy levels, which reflect substantial advances in gender equity and education. However, gender equity was not observed in leadership and management positions in the health department.
- No regular gender sensitization activity was undertaken. Last such initiative was a Workshop organized in 2011 at district level.
- No mechanisms available for addressing gender based violence at community and facility level.

(Date from – Census 2011)

### Inter sectoral convergence

**Table 16 - Sex-Ratio for State and Districts: 1901-2011**

| Sl. No. | State/District         | Sex-ratio since (Number of females per 1000 males) |      |      |      |      |      |      |      |      |      |      |      |
|---------|------------------------|--|------|------|------|------|------|------|------|------|------|------|------|
|         |                        | 1901   | 1911 | 1921 | 1931 | 1941 | 1951 | 1961 | 1971 | 1981 | 1991 | 2001 | 2011 |
| 16      | Tripura                | 874  | 885  | 885  | 885  | 886  | 904  | 932  | 943  | 946  | 945  | 948  | 961  |
| 01      | West Tripura District  | 877  | 891  | 893  | 891  | 881  | 908  | 937  | 946  | 954  | 944  | 951  | 964  |
| 02      | South Tripura District | 873  | 883  | 880  | 872  | 877  | 908  | 938  | 948  | 946  | 951  | 945  | 957  |
| 03      | Dhalai District        | 867  | 878  | 877  | 881  | 893  | 898  | 914  | 920  | 938  | 931  | 935  | 945  |
| 04      | North Tripura District | 864  | 873  | 876  | 886  | 902  | 893  | 918  | 938  | 931  | 943  | 951  | 967  |

- Coordination and convergence with the services of ICDS, Rural Development, in particular, is fairly good in terms of planning and implementation of services.

Convergence initiative is part of routine, in that, the officials of these allied Departments are members of different joint committees at state, district and other levels. These members usually attend meetings for planning, monitoring and review. This was also observed at all state and district meetings with the CRM team where officials from WCD, School Department, Social Welfare and others were present

- ICDS set up is particularly helping/supporting in VHND, immunization, awareness generation, etc.
- However, the officials of these Departments are seldom involved in trainings of health/NRHM functionaries. On the other hand, Medical Officers reportedly often act as resource persons for training of grass-root level ICDS functionaries.
- PRIs are playing an effective role in health issues. However there is space for further engagement of PRIs with the health system. In order to enhance their involvement in planning and monitoring of health, quality trainings could be planned for PRI members at all levels

### **IEC and BCC**

- Involvement of ASHAs and VHSNCs in water and sanitation is seen
- IEC/BCC strategy is mostly confined to printing information leaflets and display boards at strategic places. More community specific BCC activities need to be encouraged.
- The focus areas of IEC/BCC interventions include general areas – family planning, JSY, JSSK, Malaria, Adolescence Issues, etc. Visible outcome - reduction in Malaria infection rate in North district, Use of medicated mosquito net is on the rise, increase in institutional delivery, utilization of other services,
- ASHAs, ANMs, AWWs require skill trainings in communication/ interpersonal relation

### **School Health Programme**

- School Health Services look to be hazy at present; wherever it is implemented, it is in the form of providing just an iron tablets. Coverage under School Health Programme is low (approx. 30%).
- There is a need to develop a comprehensive tool to detect common health problem. The teachers including para-medical personnels, ASHAs, even local volunteers comprising a team need to be given quality training to detect the problem of serious nature and to refer

it at the school level itself. The package of services should be designed or made available and it must be found as a routine activities of the schools.

- CRM team's interaction with School Teachers revealed their willingness to make the health services as a practical reality in terms of screening, maintaining the records, identifying a particular teacher and distributing the general medicines to the required beneficiaries in the schools. The children (beneficiaries) also need to be properly educated about the rationale and the consumption of the medicines, rather than ordering them to consume.
- Education department needs to be involved in school health programme at all levels

### **Equity in access to health facilities**

- In tribal areas in Gomati an equity issue was observed related to HR where in 7 SCs only 3 ANMs are available. In the same district in a positive initiative to improve access in a tribal area, a PHC is being established going well below the population norm.
- Efforts are reportedly made to reach out to the marginalized sections through VHSNC and ASHA. VHSNCs and ASHAs are mostly involved in awareness generation activities with regard to water and sanitation programme in the village.

### **Malnutrition and response of ICDS**

- ICDS has been, by and large, effective in identifying malnourished/at risk children and their further follow-up. There is, however, no Nutrition Rehabilitation Centre as yet. It is being planned to set up one in North district. At present, such children are receiving Double Ration in AWCs and are referred to nearest facilities as and when necessary.
- Mid-day-meal implementation is good with eggs being given twice a week and eggs could be added in ICDS too. ICDS centres could also provide community based rehabilitation of severely malnourished in convergence with sub centres and PHCs.

- **PCPNDT Committees** are in place. These Committees meet quarterly. Ultra-sound machines in the district are registered. A team consisting of Rep. of DM, CMO and US Technician inspect the units. Besides, CMO is authorized to conduct monthly check and report.
- No mechanisms for **social audit** reportedly available in the district. DVM Committee in the district does not meet regularly and is not very effective. RKSs are however, monitoring in facilities.

### **TOR 8: Programme Management**

- Structure and function of SPMU/DPMU and its integration with DHFW: Very good integration between PMU and DHFW was observed at all levels. But DPMUs and Sub-divisional PMUs need strengthening in the newly created districts as the
- Technical component in SPMU needs strengthening.
- Supervision and monitoring schedule has been made by SPMU and DPMUs.
- Drug supplies process
  - Drug supplies are observed to be interrupted and seems to be not much responsive to the utilisation pattern
  - Drug and equipment procurement
  - Most of the Medicines, Medical Equipments and General Items are procured through open national bidding. There are two steps being followed in the open tender namely opening of technical bid and opening of financial bid.
  - Only 1 drug warehouse has been constructed though 3 have been sanctioned from NRHM.
  - Procurement Management Information System (Pro MIS) has been introduced in the state.
- There is a regulatory system in place for registering and ensuring quality care in private health facilities through clinical establishment act.
- A system is in place for accreditation of private providers for JSY and at present two private health facilities are accredited in Agartala only.

- State is one of the few who are doing facility based reporting for all the facilities, though data entry is done from the CHC level.

### TOR 9: Knowledge Management

State does not have its State Institute of Health and Family Welfare (SIHFW). The SIHFW for the state has been sanctioned and the construction of building is underway.

**Table 17 : Status of Medical Education and Training Institutions**

| SL.No                                  | Name of the Institute                                      | No. of Seats | Remarks   |
|--|--|--------------|-----------|
| <b>Medical Colleges (2)</b>            |  |              |           |
| 01                                     | Agartala Government Medical College                        | 100          | Govt.     |
| 02                                     | Tripura Medical College                                    | 100          | PPP model |
|  | <b>Total</b>   | <b>200</b>   |           |
| <b>BSc Nursing Colleges (2)</b>        |  |              |           |
| 01                                     | Tripura College of Nursing, Hapania                        | 60           | PPP model |
| 02                                     | Tripura Sundari College of Nursing, Agartala               | 60           | Private   |
|  | <b>Total</b>   | <b>120</b>   |           |
| <b>Post Basic BSc Nursing (1)</b>      |  |              |           |
| 01                                     | Inst. of Nursing Science, Agartala Hosp. & Research Centre | 40           | Private   |
| <b>GNM School (4)</b>                  |  |              |           |
| 01                                     | Dr. BRAM Nursing School , Agartala                         | 50           | Govt.     |
| 02                                     | NTI , AGMC & GBP Hospital                                  | 50           | Govt.     |
| 03                                     | Institute of Nursing Science, Durjoynagar                  | 50           | Private   |
| 04                                     | School of Nursing , ILS                                    | 40           | Private   |
|  | <b>Total</b>   | <b>190</b>   |           |
| <b>Male MPW Training Institute (1)</b> |  |              |           |
| 01                                     | Male MPW training Institute, Agartala                      | 100          | Govt.     |

| <b>ANM Training School (3)</b> |                                    |            |           |
|--------------------------------|------------------------------------|------------|-----------|
| 01                             | ANM Training Institute, Udaipur    | 40         | Govt.     |
| 02                             | ANM Training Institute, Kailasahar | 25         | Govt.     |
| 03                             | School of Nursing , TIPS           | 60         | PPP model |
|                                | <b>Total</b>                       | <b>125</b> |           |

- The data above shows that the state has training institutions of all levels, and apart from the govt. institutions, new institutions are being set up in collaborative ventures under PPP model, as well as in private sector.
- ANMTC at Unakoti visited by the team is very well functioning, with a committed team, clean and well maintained campus and hostel. Its Kitchen was particularly clean and well kept. It also had latest training aids and mannequins.
- Regional Resource Centre for North East (RRC-NE) of GOI provides technical support for developing the state plan and SPMU provides support for the district level planning process.
- Training Programme of service providers are ongoing but gaps exist. Upto second quarter of current year the expenditure on training is only 3.6% (as per FMR). State needs to expedite training on SBA for staff nurses / ANMs and B-EmOC and LSAS for MOs.

**Table 18: Training Status across different categories of personnel**

| <b>Sl. No</b> | <b>Name of the trg.</b> | <b>Category</b> | <b>Target (2012-13)</b> | <b>Achievement 2012-13 till Sep 2012</b> | <b>Cumulative Achievement till Sep 2012</b> |
|---------------|-------------------------|-----------------|-------------------------|--|---|
| <b>1</b>      | EmOC Training           | MO              | 3                       | 0  | 11  |
| <b>2</b>      | LSAS Training           | MO              | 3                       | 0  | 9   |
| <b>3</b>      | B-EmOC 10 days Training | MO              | 86                      | 5  | 44  |
| <b>4</b>      | SBA                     | SN              | 84                      | 20                                       | 265   |
|               |                         | ANM             | 40                      | 0  | 198   |
| <b>5</b>      | NSSK                    | MO              | 48                      | 0  | 147   |

| Sl. No | Name of the trg.                 | Category | Target (2012-13) | Achievement 2012-13 till Sep 2012 | Cumulative Achievement till Sep 2012 |
|--------|----------------------------------|----------|------------------|-----------------------------------|--------------------------------------|
|        |                                  | SN       | 24               | 0                                 | 0                                    |
|        |                                  | ANM      | 24               | 0                                 | 0                                    |
| 6      | IMNCI                            | SN       | 48               | 0                                 | 20                                   |
|        |                                  | ANM      | 48               | 0                                 | 328                                  |
| 7      | F-IMNCI                          | MO       | 12               | 0                                 | 32                                   |
|        |                                  | SN       | 12               | 0                                 | 0                                    |
| 8      | Immunization                     | MO       | 48               | 0                                 | 76                                   |
|        |                                  | MPW      | 48               | 0                                 | 901                                  |
| 9      | ToT IUD                          | MO       | 0                | 0                                 | 30                                   |
| 10     | IUCD                             | ANM      | 190              | 0                                 | 342                                  |
| 11     | NSV                              | MO       | 4                | 0                                 | 16                                   |
| 12     | LL                               | MO       | 0                | 0                                 | 7                                    |
|        |                                  | SN       | 0                | 0                                 | 7                                    |
| 13     | MTP                              | MO       | 10               | 0                                 | 5                                    |
| 14     | Trg. On RTI/STI                  | MO       | 100              | 0                                 | 0                                    |
|        |                                  | SN       | 100              | 0                                 | 97                                   |
|        |                                  | LT       | 50               | 0                                 | 0                                    |
|        |                                  | ANM      | 0                | 0                                 | 97                                   |
| 15     | Training of School Teacher: WIFS | teacher  | 870              | 0                                 | 0                                    |

- State is reporting facility based data on web-portal, despite huge challenges in internet connectivity observed during the visit. Data entry is done at sub-divisional level.
- Data entry of MCTS faces difficulty because data errors are quite high in data reported from ANMs and ASHAs and also it reports dates of LMP / EDD in local calendar.
- Printed MCTS registers have not been provided in some of the facilities.

**TOR 10: Financial Management****Table 19: Year wise Funds Released and expenditures under NRHM in state (In Rs. Crores)**

| Year                | Fund Approved by GOI | Opening Balance | Fund Received | Total Available | Exp. Incurred | % of Exp |
|---------------------|----------------------|-----------------|---------------|-----------------|---------------|----------|
| 2005-06             | 14.34                | 0               | 9.11          | 9.11            | 0.95          | 10.38    |
| 2006-07             | 26.72                | 9.58            | 24.51         | 34.08           | 10.85         | 31.84    |
| 2007-08             | 77.09                | 23.23           | 56.36         | 79.59           | 18.27         | 22.96    |
| 2008-09             | 86.07                | 61.16           | 64.15         | 125.30          | 45.91         | 36.64    |
| 2009-10             | 142.82               | 79.39           | 108.59        | 187.98          | 58.12         | 30.92    |
| 2010-11             | 116.12               | 129.93          | 71.26         | 201.19          | 76.80         | 38.17    |
| 2011-12             | 128.95               | 124.28          | 69.45         | 193.73          | 92.26         | 47.62    |
| 2012-13 upto Sept., | 170.26               | 101.47          | 12.23         | 113.70          | 43.73         | 38.46    |

**Table 20: Expenditure upto Sept., 2012-13 F.Y. (In Rs. Cr.).**

| Sl. No. | Name of the programme      | Fund approved by GOI | Opening Balance | Fund received | Total  | Exp. incurred | % of Exp | Closing Balance |
|---------|----------------------------|----------------------|-----------------|---------------|--------|---------------|----------|-----------------|
| 1       | RCH-II                     | 36.35                | 33.44           | 0.00          | 33.44  | 8.07          | 24.13    | 25.37           |
| 2       | Additionalities under NRHM | 86.48                | 62.48           | 11.17         | 73.65  | 34.41         | 46.72    | 39.24           |
| 3       | Immunization               |                      |                 |               |        |               |          |                 |
| 3.1     | Routine Immunization       | 3.51                 | 0.71            | 0.00          | 0.71   | 0.26          | 36.62    | 0.45            |
| 3.2     | Pulse Polio Immunization   | 0.00                 | 0.61            | 0.00          | 0.61   | 0.56          | 92.56    | 0.05            |
|         | Sub-Total                  | 126.34               | 97.24           | 11.17         | 108.41 | 43.31         | 39.95    | 65.10           |

|  |   |        |        |       |        |       |       |        |
|--|---|--------|--------|-------|--------|-------|-------|--------|
| 5  | NDCP  | 23.75  | 4.23   | 1.06  | 5.29   | 0.42  | 7.86  | 4.87   |
| 5.6  | NIDDCP  | 0.45   | 0.00   | 0.00  | 0.00   | 0.00  |       | 0.00   |
| 5.7  | Infrastructure<br>Maintenance (Treasury<br>Route) | 19.72  | 0.00   | 0.00  | 0.00   | 0.00  |       | 0.00   |
| Grand Total Including<br>Treasury Route & NIDDCP |   | 170.26 | 101.47 | 49.65 | 151.12 | 43.73 | 28.94 | 170.26 |

**Table 21: State Share Contribution: (in Rs. Crores, as per data provided by state govt.)**

| Sl.          | Year    | Fund received<br>by State | State Share<br>per fund received | State Share<br>as received | State Share<br>Outstanding |
|--------------|---------|---------------------------|----------------------------------|----------------------------|----------------------------|
| 1            | 2007-08 | 72.91                     | 12.87                            | 0.00                       | 12.87                      |
| 2            | 2008-09 | 74.53                     | 13.15                            | 7.00                       | 6.15                       |
| 3            | 2009-10 | 117.72                    | 20.77                            | 10.25                      | 10.52                      |
| 4            | 2010-11 | 87.71                     | 15.48                            | 15.00                      | 0.48                       |
| 5            | 2011-12 | 56.72                     | 10.01                            | 28.75                      | -18.74                     |
| Sub-Total    |         | <b>409.59</b>             | <b>72.28</b>                     | <b>61.00</b>               | <b>11.28</b>               |
| 6            | 2012-13 | <b>34.72</b>              | <b>3.86</b>                      | <b>0.00</b>                | <b>3.86</b>                |
| <b>Total</b> |         | <b>444.31</b>             | <b>76.14</b>                     | <b>61.00</b>               | <b>15.14</b>               |

## Untied Fund - RKS / AMG - & their Expenditure – up to Sep. 2012

(Rs. Lakhs)

| Activity   | Financial Target | Fund Available | Exp. Sept (Fig. & %) | Exp. April to Sept (Fig. & %.) |
|--|------------------|----------------|----------------------|--------------------------------|
| Untied Fund for SC, PHC, CHC, SDH & VHNSC                      | 16.43022         | 16.43022       | 2.66526              | 2.66526<br>(16.22%)            |
| RKS for PHC, CHC, SDH, DH                                      | 13.94            | 13.94          | 4.66                 | 4.66<br>(33.42<br>%)           |
| Annual Maintenance Grant for SC(Kcp-14+DNR-22), PHC, CHC & SDH | 10.03            | 10.03          | 2.22906              | 2.22906<br>(22.22%)            |

- As the data shows and as has been confirmed by the state officials as well, state's share contribution has been done regularly and in time.
- There are vacancies in HR under FMG. SFM: 1; DAM: 5; BAS: 24). Action to fill up this gap may be taken.
- There is a shortfall of Rs 15.14 crore in the contribution of state share for the years 2007-08 to 2012-13, as per the state's records.
- The absorption of central assistance released under NRHM is not satisfactory as the programme was having unspent balances in excess of RS 100 Crore at the end of each financial year 2010-11, 2011-12 and 2012-13 (up to September 2012). This excludes unspent balances observed at district / sub-district levels.
- Action for improving utilization of funds released need to be ensured for achieving programme objective.

- Audit reports on the accounts for 2011-12 due to be sent to GoI by 31<sup>st</sup> July 2012 is still pending.
- Utilisation certificates for an amount of Rs 54.40 crores under RCH 2010-11 and Rs 74.71 crores under mission flexipool for the year 2009-10 and 2011-12 are pending.
- Usage of customized version of Tally ERP software has not been adopted in the state till date for technical reasons. The issues may be sorted soon for improving financial management controls in the state.
- Physical Progress under financial management reports are not being reported.
- Timely release of NRHM funds has been reported from both districts visited for state to district and from district to facilities.

### **State Innovations and best practices**

- Free Tele- Tele Medicine services in periphery facilities
- Tele Ophthalmology initiative in a no. of facilities providing both eye-testing services and counseling by senior doctors sitting in the state centre.
- State's initiative for organizing VHNDs in remote villages by taking the health teams by helicopter service.
- State Govt's policy of sponsoring PG studies for medical officers after 3 years of mandatory rural service
- 33.33% additional performance incentive to ASHA by state government
- 10% seats reserved for ASHAs in ANM training course
- Mainstreaming of AYUSH is very strong.

## RECOMMENDATIONS

Based on the observations and findings of CRM team following recommendations are made to improve implementation of NRHM in state of Tripura.

- Phased up-gradation of CHCs into FRUs needs to be expedited.
- Prioritization of renovation and up-gradation of facilities should be focused on delivery points.
- Capacity building and supportive supervision of ANMs is required to ensure optimal service delivery at sub centre level.
- Involvement of Medical College (involving residents) in supportive supervision and training of the programmes should be done.
- Incentivisation for attracting human resources for effective service delivery is required.
- Establishment of hospital infection control committee and periodic reviews in all DHs, SDHs, and CHCs.
- Strengthen equipment maintenance and supply-chain management system for drugs, consumables and equipments.
- Training at all levels for bio medical waste management needs to be taken up urgently and systems should be put in place for bio medical waste management.
- Need to explore ways for robust emergency transport services in support of strong referral mechanisms through consultative process
- Community based monitoring needs to be initiated leveraging strong PRIs.
- Cleanliness is a cause of concern in all the facilities. Urgent initiative needs to be taken to ensure basic cleanliness and hygiene in the facilities
- Measures for proper management of general and bio-medical wastes in the facilities to be revamped.
- Safe drinking water to be made available for the patients as it is not available in all the facilities
- Power back-up Generators should be made functional in all the facilities. At present they are non functional in almost all facilities.

- Essential drugs and other items should be made available in the facilities, and essential drug lists should be displayed prominently.
- Shifting of the facilities: where a new building has been built, facility should be shifted to their newly constructed buildings soon.
- Although involvement of PRI members is very strong, yet, with some capacity building interventions of these members shall be in a better position to contribute to the implementation of different programmes of NRHM.
- While the ASHAs in the state are performing in a commendable manner, there is a need for developing a mechanism to monitor the performance of the ASHAs as also to support them in their needs and problems.
- The ASHA Facilitators should be comprehensively trained. The Induction training that they have gone through does not seem adequate and the ASHA Facilitators with whom the team interacted in North District were not confident enough about their roles and responsibilities. Therefore, a comprehensive training module for the training of ASHA Facilitators is required.
- Regular replenishment of the ASHA Drug Kit should be ensured
- Incentives for the ASHAs should be made more regular and prompt as some of the ASHAs reported irregular and delayed payment of their incentives.
- A system of Community Based Monitoring should be developed and made functional to ensure greater community participation and better service delivery.
- Since NRCs are being set up in two districts, a well coordinated referral link should be developed, involving the AWWs, ASHAs, ANMs, PRI bodies, etc. so that, SAM children are identified and referred through the concerned MOs to the NRC and later on also followed-up on discharge.
- Gender Sensitization activities should be undertaken on a systematic and sustained basis.

# **DISTRICT REPORTS**

## DISTRICT PROFILE SOUTH DISTRICT

### DEMOGRAPHY AND HEALTH INFRASTRUCTURE:

| SL No             | INDICATOR                                    | NUMBER                  |
|-------------------|--|-------------------------|
| <b>Demography</b> |  |                         |
| 1                 | Total Revenue Blocks (as per Census 2011)    | 45                      |
| 2                 | Total Health Blocks                          | 15<br>(Sub-Division)    |
| 3                 | Number of GPs                                | 90                      |
| 4                 | No. Of Revenue Villages (as per Census 2011) | 1038                    |
| 5                 | No. of ADC village                           | 70                      |
| 6                 | Total population                             | 444517<br>(Census 2011) |

### Health Infrastructure:

Details of health infrastructure in the district are as follows:

| SL. No. | Name of the Health Inst. | Type | Category | No. of GP/ ADC Vill. | Functional SHC | SC Under Construction |
|---------|--------------------------|------|----------|----------------------|----------------|-----------------------|
| 1       | Belonia                  | SDH  | FRU      | 5                    | 5              | 0                     |
| 2       | Sabroom                  | SDH  | 24X7     | 15                   | 7              | 3                     |
| 3       | Manubazar                | CHC  | 24X7     | 21                   | 13             | 4                     |
| 4       | Hrishyamukh              | CHC  | 24X7     | 17                   | 11             | 1                     |
| 5       | Jolaibari                | CHC  | 24X7     | 15                   | 8              | 6                     |
| 6       | Niharnagar               | PHC  | 24X7     | 6                    | 6              | 0                     |
| 7       | Rajnagar                 | PHC  | 24X7     | 7                    | 4              | 0                     |
| 8       | Barpathori               | PHC  | 24X7     | 9                    | 7              | 1                     |
| 9       | Nalua                    | PHC  | 24X7     | 4                    | 3              | 0                     |
| 10      | Ratanpur                 | PHC  | Non      | 1                    | 1              | 0                     |

|              |   |     |          |            |            |           |
|--------------|---|-----|----------|------------|------------|-----------|
|              |   |     | 24X7     |            |            |           |
| 11           | Santirbazar                                       | PHC | 24X7     | 20         | 20         | 2         |
| 12           | Muhuripur   | PHC | 24X7     | 8          | 6          | 1         |
| 13           | Baikhora  | PHC | Non 24X7 | 0          | 0          | 0         |
| 14           | Kowaifung   | PHC | 24X7     | 1          | 1          | 0         |
| 15           | Srinagar  | PHC | 24X7     | 10         | 4          | 3         |
| 16           | Kalachara   | PHC | 24X7     | 7          | 3          | 3         |
| 17           | Manubankul  | PHC | 24X7     | 9          | 6          | 3         |
| 18           | Rupaichari  | PHC | 24X7     | 5          | 4          | 1         |
| 19           | Matai   | PHC | 24X7     | 0          | 0          | 0         |
| 20           | B C Manu<br>Shahid Smriti<br>Memorial<br>Hospital | PHC | 24X7     | 0          | 0          | 0         |
| <b>Total</b> |   |     |          | <b>160</b> | <b>109</b> | <b>28</b> |

### STATUS OF SERVICE DELIVERY IN THE HEALTH FACILITIES:

#### A. OPD & IPD load:-

| Name of Institutions | OPD attendance |                        | IPD attendance |                        |
|----------------------|----------------|------------------------|----------------|------------------------|
|                      | 2011-12        | 2012-13<br>(Up to Sep) | 2011-12        | 2012-13<br>(Up to Sep) |
| Belonia SDH          | 43845          | 26291                  | 8017           | 4486                   |
| Sabroom SDH          | 31896          | 18240                  | 9455           | 5401                   |
| Hrishyamukh CHC      | 15715          | 7428                   | 3352           | 1192                   |
| Manubazar CHC        | 37606          | 20034                  | 2794           | 1905                   |
| Jolaibari CHC        | 10087          | 6043                   | 5596           | 4442                   |
| Muhuripur PHC        | 15755          | 15817                  | 1018           | 549                    |
| Niharnagar PHC       | 6991           | 4187                   | 1124           | 632                    |
| Santirbazar PHC      | 15361          | 10609                  | 5250           | 3156                   |

|                |        |        |       |       |
|----------------|--------|--------|-------|-------|
| Rajnagar PHC   | 9134   | 5938   | 1106  | 1090  |
| Nalua PHC      | 12337  | 5530   | 300   | 538   |
| Baikhora PHC   | 11325  | 8119   | 0     | 0     |
| Barpathori PHC | 20013  | 9261   | 698   | 819   |
| Ratanpur PHC   | 1348   | 579    | 0     | 0     |
| Kowaifung PHC  | 3213   | 1611   | 0     | 343   |
| Srinagar PHC   | 19882  | 10034  | 1552  | 1612  |
| Kalachara PHC  | 6724   | 4271   | 2545  | 1775  |
| Manubankul PHC | 11232  | 7064   | 3089  | 2196  |
| Rupaichari PHC | 12265  | 7218   | 1053  | 679   |
| Total          | 284729 | 168274 | 46949 | 29918 |

**B. Facility wise Service Delivery (Situation of Maternal Health)-**

| Health Institutions | 2011-12  |                |               | 2012-13 (up to Sep) |                |               |
|---------------------|----------|----------------|---------------|---------------------|----------------|---------------|
|                     | ANC Reg. | 3 ANC Coverage | 100 IFA given | ANC Reg.            | 3 ANC Coverage | 100 IFA given |
| Belonia SDH         | 666      | 307            | 316           | 283                 | 174            | 213           |
| Muhuripur           | 602      | 212            | 336           | 352                 | 114            | 230           |
| Niharnagar          | 368      | 218            | 283           | 154                 | 90             | 137           |
| Rajnagar            | 747      | 506            | 399           | 269                 | 180            | 196           |
| Santirbazar         | 1461     | 661            | 1092          | 627                 | 254            | 833           |
| Jolaibari           | 807      | 385            | 390           | 462                 | 217            | 432           |
| Hrishyamukh         | 608      | 322            | 551           | 319                 | 146            | 269           |
| Barpathori          | 136      | 71             | 118           | 240                 | 131            | 177           |
| Nalua               | 104      | 58             | 104           | 89                  | 36             | 87            |
| Sabroom             | 998      | 587            | 917           | 303                 | 275            | 349           |
| Manubazar           | 727      | 601            | 659           | 383                 | 290            | 334           |

|            |     |     |     |     |    |     |
|------------|-----|-----|-----|-----|----|-----|
| Srinagar   | 290 | 142 | 290 | 144 | 65 | 124 |
| Kalachara  | 390 | 156 | 304 | 165 | 74 | 167 |
| Manubankul | 408 | 139 | 290 | 198 | 58 | 181 |
| Rupaichari | 193 | 71  | 116 | 84  | 39 | 48  |

C. Situation of Inst. & Home Delivery:

| Name of the Institutions | Institution | Home        | Institution            | Home       |
|--------------------------|-------------|-------------|------------------------|------------|
|                          | 2011-12     |             | 2012-13<br>(Up to Sep) |            |
| Belonia SDH              | 773         | 16          | 351                    | 10         |
| Hrishyamukh CHC          | 141         | 108         | 46                     | 38         |
| Jolaibari CHC            | 632         | 99          | 306                    | 61         |
| Manubazar CHC            | 121         | 98          | 61                     | 48         |
| Muhuripur PHC            | 121         | 45          | 35                     | 18         |
| Niharnagar PHC           | 126         | 123         | 39                     | 38         |
| Santirbazar PHC          | 687         | 103         | 394                    | 40         |
| Rajnagar PHC             | 123         | 139         | 104                    | 46         |
| Barpathori PHC           | 9           | 6           | 20                     | 35         |
| Nalua PHC                | 6           | 2           | 6                      | 4          |
| Sabroom SDH              | 659         | 170         | 291                    | 68         |
| Srinagar PHC             | 102         | 8           | 58                     | 24         |
| Kalachara PHC            | 236         | 46          | 128                    | 16         |
| Manubankul PHC           | 192         | 59          | 127                    | 28         |
| Rupaichari PHC           | 44          | 24          | 39                     | 8          |
| <b>TOTAL</b>             | <b>3972</b> | <b>1046</b> | <b>2005</b>            | <b>482</b> |

**STATUS OF NRHM IMPLEMENTATION IN SOUTH DISTRICTS:**

**District specific issues in implementation of NRHM in the district are elaborated under two sections for each component of NRHM such as status of implementation which includes area of concern and recommendations for the same.**

**1. Health Infrastructure:**

Many new health facilities in the district are coming up and many facilities are already completed construction but not yet functioning. Construction works are in full swing. However, many old and high case load facilities need repair and up gradation work urgently. Infrastructure gap analysis for the district is presented in following table.

**Gap Analysis:**

| <b>Sl No.</b> | <b>Health Facility</b> | <b>No. Required</b> | <b>No. Present</b> | <b>Under Construction</b> | <b>Completed/ taken over but Not Functioning</b> | <b>Plan</b> | <b>Total</b> | <b>Gap</b> |
|---------------|------------------------|---------------------|--------------------|---------------------------|--|-------------|--------------|------------|
| 1             | DH                     | 1                   | 0                  | 0                         | 0  | 0           | 0            | 1          |
| 2             | SDH                    | 3                   | 2                  | 1                         | 0  | 0           | 3            | 0          |
| 3             | CHC                    | 6                   | 3                  | 1                         | 0  | 0           | 4            | 2          |
| 4             | PHC                    | 18                  | 15                 | 3                         | 0  | 0           | 18           | 0          |
| 5             | SHC                    | 156                 | 109                | 8                         | 20   | 19          | 156          | 0          |

**2. Health Human Resource in the district:**

Facility wise availability of health man power is adequate and rational deployment is more or less followed in the district. However, as in the other districts of the county the dearth of specialists is felt in the CHC/ SDH level health facilities.

**Facility wise Manpower Status in the district is as follows:**

| Sl. No | Name of the SDH /<br>CHC/PHC                   | MO<br>Allo | MO<br>AYUSH | Dental<br>Surgeon | SN | Phar<br>Allo | Phar<br>AYUSH | Lab.<br>Tech |
|--------|--|------------|-------------|-------------------|----|--------------|---------------|--------------|
| 1      | Sabroom SDH                                    | 5          | 2           | 2                 | 21 | 2            | 1             | 3            |
| 2      | Belonia SDH                                    | 8          | 2           | 1                 | 23 | 3            | 2             | 3            |
| 3      | Manubazar CHC                                  | 3          | 2           | 1                 | 10 | 1            | 0             | 2            |
| 4      | Hrishyamukh CHC                                | 3          | 1           | 1                 | 7  | 1            | 0             | 1            |
| 5      | Jolaibari CHC                                  | 3          | 1           | 0                 | 8  | 4            | 0             | 1            |
| 6      | Kalachara PHC                                  | 2          | 1           | 1                 | 6  | 1            | 1             | 1            |
| 7      | Srinagar PHC                                   | 2          | 1           | 0                 | 8  | 1            | 0             | 1            |
| 8      | Rupaichari PHC                                 | 2          | 1           | 1                 | 6  | 1            | 1             | 1            |
| 9      | Manubankul PHC                                 | 2          | 1           | 0                 | 7  | 2            | 0             | 1            |
| 10     | Niharnagar PHC                                 | 2          | 1           | 1                 | 5  | 1            | 1             | 1            |
| 11     | Rajnagar PHC                                   | 2          | 1           | 0                 | 7  | 1            | 1             | 1            |
| 12     | Barpathori PHC                                 | 2          | 1           | 0                 | 6  | 1            | 1             | 1            |
| 13     | Nalua PHC                                      | 2          | 0           | 0                 | 6  | 1            | 0             | 1            |
| 14     | Santirbazar PHC                                | 6          | 1           | 1                 | 13 | 2            | 0             | 1            |
| 15     | Muhuripur PHC                                  | 4          | 0           | 1                 | 5  | 2            | 1             | 1            |
| 16     | Kowaijung PHC                                  | 2          | 1           | 0                 | 5  | 1            | 0             | 0            |
| 17     | Baikhora PHC                                   | 1          | 1           | 0                 | 5  | 1            | 1             | 1            |
| 18     | Ratanpur PHC                                   | 0          | 1           | 0                 | 2  | 1            | 0             | 0            |
| 19     | Matai PHC                                      | 2          | 0           | 0                 | 3  | 0            | 0             | 0            |
| 20     | B C Manu<br>Shahid Smriti<br>Memorial Hospital | 1          | 0           | 0                 | 5  | 0            | 0             | 0            |

**3. Maternal Child Health:**

**Janani Shisu Suraksha Karyakram (JSSK):** In the south district it was observed that facilities reimbursing these expenses at a fixed rate instead of giving free entitlements to the pregnant women's and neonates, resulting in significant out of pocket expenditure for beneficiaries. The

team noted that across the facilities staff are not fully aware of the entitlements of a pregnant woman and her child under the JSSK scheme. There is no robust mechanism for free referral transport to the PW and Neonates in the south district. Facilities are reimbursing the cost of transport to the beneficiaries instead of giving free transport facility (i.e. also up to a predefined limit) that is not as per the JSSK guidelines. Free diagnostics & free blood transfusion and free diet facility are being provided in most of the facilities of the south district. However free drugs and referral transports are yet to become a reality.

**ANC/ PNC and utilisation of Sub centers:** ANC and PNC services are regularly provided by MOs and ASHAs are creating good demand for MH, CH, FP and Immunization services in the PHCs and CHCs but ANC services are lacking in SCs. However, SCs are only giving IFA and TT injection in terms of ANCs. Although significant no of SCs have been established in 69% GP&ADC villages (720/1038) but the ANC coverage by SCs is still very weak. None of the SCs visited are functioning as a delivery Point in the South District.

The institutional delivery % has gone up from 48.9 % (NFHS-III) in 2005-06 to 85% in 2011 (HMIS). It was observed with concern that BEmOC services with personnel competent to deal with complicated pregnancies such as forceps/ vacuum delivery and manual extraction of placenta were not available in any of the 24X7 PHCs which the team visited. Further, in the south district there was a single FRU providing CEmOC as laid out in the guidelines.

The lack of BEmOC and CEmOC care facilities in this part of the State is underscored as a serious gap for which the State has to take immediate remedial action.

**General maintenance and infection control in facilities:** Maintenance of labour room was satisfactory in most of the health facilities visited except DH Gomati. Toilets were not found attached to most of the labour rooms. Visual privacy was compromised at places. Infection Control Protocols were found to be lacking in all the OTs and Labor rooms visited specially in District Hospital, Gomati.

**Equipments:** Equipments were also found to be adequate and largely in working condition in most of the facilities except at the PHC at Shanti Bazar where the available warmer were not functioning and needed repairs. Routine and Emergency drugs were available in all facilities which is appreciable.

**Abortion services:** This service was found to be neglected. Only district hospitals and one FRU at Belonia was found to be providing this facility and that too to a very small number of clients.

It was noted with concern that abortion services were not available in Sub District facilities, CHCs and PHCs.

**Maternal death Review:** It was noted that maternal death review committees have been set up in south district. However, only facility based maternal death review is conducted while community based MDR through ANM & ASHAs is not yet in place.

**Janani Shuraksha Yojana (JSY):** Payments were being made by cheque to all the beneficiaries. JSY entitlements are displayed in some of the facilities visited. Discharge slips issued by the health facility as well as the Mother Baby Protection Card are used for confirming and making payments to beneficiaries. Gaps in the implementation of the scheme as well as recommendations are as follows:

- Large numbers of beneficiaries are receiving their entitlements after a delay of 6 days to 30 days. This is on account of various reasons such as non-completion of documents i.e birth certificate, marriage certificate etc, lackadaisical approach on the part of office staff such as clerks etc. Mothers forced to come to the facilities repeatedly for receiving entitlements under JSY. This results in beneficiaries' spending money on transport and lost wages which negate the basic purpose of providing cash incentives under JSY.
- Payment of JSY incentives to ASHA was found to be made by bearer cheque and not A/C Payee. Further payments were inordinately delayed for periods ranging from 6 days to 30 days.

**Recommendations:** Beneficiary list needs to be displayed in the health facility on a monthly basis so that fraudulent and fictitious payments can be checked. A grievance mechanism needs to be established in order to take care of complaints such as delayed payments etc.

***Status of Newborn care units at various levels (SNCU, NBSU, NBCC)***

In terms of Essential Newborn Care units in South District, Newborn Care Corners are present at most health facilities but are not equipped as per the guidelines or specifications. The protocol on newborn resuscitation was not displayed or available at any of the facilities. In terms of provision of Neonatal Stabilization/ intensive care units, it was noted that health facilities are lacking completely in terms of Neonatal Stabilization/ intensive care units in the district of South. However, establishment of 5 sick newborn care units (SNCUs) and 05 neo-born stabilisation units are in process and 2 Nutritional Rehabilitation Centre (NRCs) will be functional by March,

13 as conveyed by State data. The team did not find any of the SNs and ANMs posted at the delivery points visited to be trained in NSSK; however, some of the MOs got NSSK training. This could be one of the reasons for the unpreparedness observed in respect to essential new born care.

**Recommendations:** Given the high delivery load at some of the facilities, it is essential that new born care facilities be planned systematically. While Newborn Care Corners should be established at each delivery point, at least one SNCU per district should be operationalised at the level of FRU. The State should prioritise low performing districts for setting up SNCUs. Further, NSSK trainings to be prioritised for MOs, ANMs and SNs posted to labour rooms, delivery points.

***Tackling Severe Acute Malnutrition through MTCs (Malnutrition Treatment Centres)***

- None of the facilities visited have MTCs in the south district, 2 Nutritional Rehabilitation Centre (NRCs) will be functional by March, 13 (State data).

***Immunisation***

- As per the coverage reported in HMIS data, immunization appears to be one of the strongest components within the Child Health programme (66% in 2008-09 to 81% in 2011-12). Weakly fixed day (Wednesday) immunization is done in all MCH clinics including SCs.
- Vaccines are in stock at all the facilities visited, the cold chain equipment is in place and temperatures maintained as per the guidelines. The downtime for the cold chain equipment was about 48 hours. The immunization status of mother and children were being closely tracked.
- The team visited villages in south district and found the immunization card for mother and child with all the beneficiaries visited. Immunization related information was found to be updated in MCH registers and MCTS tracking sheets. However, routine Immunization micro plans (co signed by CDPO) were not available at SC. The Due List was not available with the ANMs at Sub centres.

**4. Family planning:**

Fixed day services are not in practice. Spacing methods are not being delivered regularly due to lack of counselling skills of service providers. Across the facilities visited, it was found that the approach towards family planning services are seasonal and target oriented activity especially in sub-district hospital facilities. Another area in family planning services which needs focus is

postpartum sterilization and IUD insertions. Uptake of OCPs and Condom is much below the expected level and needs a comprehensive plan to create demand using appropriate strategies. Door steps distribution of contraceptives has been started by the ASHAs, but the uptake is very less.

### **5. Adolescent Sexual Reproductive health**

*ARSH clinics:* ARSH clinics are not found to be functional in most of the SDHs and CHCs except in Belonia SDH in the south district. It was informed that ICTCs were also meant to provide services to adolescents as ARSH Clinics. However this was not found to be happening.

**Recommendations:** ICTC counsellors need to be trained under the 5 day module for ANM/LHV and sensitized on how to deal with adolescents before they can deal with adolescent clients. State needs to emphasize the importance of a functional ARSH clinic in every health facility. Further training of MOs and ANM/LHV on AFHS module has to be emphasized by the State.

*Weekly iron folic acid supplementation (WIFS):* WIFS has been implemented in the State. Supplies of IFA have been reached in schools and AWCs but the identification and training of school nodal teachers is not yet started. Most of the ASHAs and ANMs are not aware about the programme.

### **6. PRI's involvement and Achievement in Family Planning**

Many young women in the district who got married at the age of about 19-20 years have got strong desire for one child. Their need for contraception was also found to be very high. However, their choice for IUD is nominal, even for the use of condom, the preference is very low. They prefer to have permanent sterilization.

The emphasis on family planning in the district need to have a balance approach and focus has to be only in those areas and community where the TFR is high. Otherwise, it is quite possible that the state may enter into difficulty if the decline of TFR continues fast.

## 7. ASHA and ASHA Facilitator



***ASHA IN UNIFORM, SABROOM NAGAR PANCHAYAT***

Total 898 ASHAs are working in the villages of the district. Selection of ASHAs in the district is a smooth process. There is a tough competition. The ASHA's have to show their performance to remain in the department for longer period. As per record 10% ASHAs have been dropped or kept of system based on their poor performances. This shows the political commitment in the selection of ASHAs in district is in place. ASHAs were found knowledgeable, motivated to learn more and do more for the people. However, there is a strong discontentment to the concept of honorarium under different heads. They strongly argued during the discussion that they must get this money at one time in every month like other personnel in the department. Performance Based honorarium is a part of designing of NRHM, it is a matter of creating some financial provision under different heads, this is only an administrative mechanism, which should not serve as a barrier to the beneficiary. The argument made by the ASHAs was that money come in the bank at the different point of time and we feel that we are hardly getting anything. If all honorariums are credited at one time we will be very happy. This is a matter of concern and we should not unnecessarily roam around our fix guidelines and create discontentment among the

human resource, who are playing valuable role and likely to play even more important role in future in cementing the bridge between the community and health institutions. Their demand is not for more benefit, it is demand for getting the benefit once in every month.

The state need to be advised to develop single window with the support of Panchayat and should provide all honorarium at one time.

In the state of Tripura, the availability of ASHA facilitator is as per guideline. However their functioning is not clear. Their relations with ASHA are also not very clear. The provision of financial benefit to ASHA facilitator is highly inadequate to meet the requirement of 10 visits as per guideline. The provision of 1000 Rupees for making 10 visits is a most deficient because as they explained they have to spend more than Rs 1000 if they judiciously complete 10 visits. They strongly feel that they in terms of financial benefit are placed at an inferior point than the privileges that ASHAs avail under different component of Health. Such burn out would defeat the purpose of introducing the concept of ASHA facilitator if it is not taken notice for the action.

#### **8. School Health Programme:**

School health Programme is run through a camp based approach and screening is done once in the year. The team has visited 5 School, out of five schools the health camps are under taken only in 2 schools during the current financial year. No, school Health cards is being maintained at school level and the data maintained at facilities have no linkage with the earlier screenings. The children have been screened for vision, skin diseases, disabilities, hearing problems, dental conditions, and symptoms like fever or cough and immunization. Height and weight is not being recorded and there were no guidelines with regards to action to be taken where the children had lower weight for age or low BMI. No plan of action is being prepared in the facilities i.e. where and when to organize the health camps in which schools. IFA tablets have been reached in schools visited, but till now no IFA tablets have been distributed to school children. The issue of concern is that there is no identified school nodal teacher for WIFS and training has not yet started. Secondly there did not seem to be a clear plan as to the management of children with severe anaemia.

A detail schedule for school visits with all details of dates and schools visited with the designated team need to be developed. Plan to manage severe anaemia and low BMI cases need to be place. The Human resource crunch is very high and this is one of the general explanation to make the

school health services functional and dynamic in nature. The school health services need to be debated at length and an effort has to be made to design it in a manner which could be run mainly by the para-medicals in cooperation with the school teachers. The doctor's role has to be just facilitator. There is a need to develop a comprehensive tool to detect common health problem. The teachers including para-medical personnel, ASHAs, even local volunteers comprising a team need to be given quality training to detect the problem of serious nature and to refer it at the school level itself. The package of services should be designed or made available and it must be found as routine activities of the schools.

There is a need of developing grading system of the schools on health indices and recognise them by creating social incentives of different nature. There is need to create a competition between the schools under a block between the schools under district and state; and the officials should be integral part of school health programme at a different level. Teachers have suggested that they need an order from the inspector of school to make the health services as a practical reality in terms of screening, maintaining the records, identifying a particular teacher and distributing the general medicines to the required beneficiaries in the schools. The children (beneficiaries) also need to be properly educated about the rationale and the consumption of the medicines, rather than ordering them to consume.

### **9. Integration with PRI**

Panchayat members from Zila Parishad president to ward members at the village level are highly responsive to the health status of the people and therefore, they have got a serious concern towards health services. The serious orientation of non-official elected members towards different aspects of health, prevention, promotion and treatment can create exemplary example of mobilizing the community for good health by PRI. It was felt that PRI members can contribute to bring more dynamism in the health delivery system provided they are clearly explained what is their role as individual member and what is their role as a PRI institute. The health personnel however, appear to be apprehensive and perhaps they avoid complete involvement of PRI members in the health care delivery system.

Community also need to be explained about the services available at different level in order to create a realistic expectation among the community. Citizen's charter of service facilities and privileges need to be made available at all level. IEC personnel have to play a vital role. If PRIs are willing to contribute to meet the additional cost from its own resources, the guideline of sub-

centre and PHC would require re-looking in re-designing rather than always putting the departmental administrative constraints to the people. Flexibility in the guide-line is required. From the discussion it was evident that Zila Parishad Presidents need quality sensitization on preventive, promotive and treatment aspects of health. They need to be explained the activities and the road map to strengthen health services to make the people healthy.

**10. Supportive supervision by DPMU staffs:**

Chief medical officer, District immunisation officer, District family welfare officer, District Programme manager and other DPMU staffs regularly conduct facility visits on an average 5-6 per month and provide supportive supervision to health facilities in the district.

**11. HMIS/ MCTS Reporting:**

Facility based reporting is followed in the district. However, it was observed that one data assistant manage data of two or more facility as each PHC do not have data assistants in place. Most of the facility visited did not have printed MCTS register.

**12. Controlling out of Pocket expenditure:**

The discussion with some beneficiaries at the hospital level was however shocking; the cost of delivery in Hospital has in fact increased. In many cases, the privileges provided under different categories of health services, look to be an ideological reality rather than reducing the cost against Institutional delivery of poor women. The panchayat is unaware of it. The health department has shared its own difficulties, which look to be justification of problem rather than a genuine effort to accomplish the objectives laid under NRHM. This opens an another platform to involve panchayat into monitoring and vigilance system under NRHM which can ensure that mothers from the day of pregnancy to the last day of delivery and PNC care do not expend a single pie other than self care.

This requires genuine sensitization to the entire machinery involved in the process of safe delivery. Every effort has to be made to make the delivery free, fair and fine. Role of RKS has to be brought into monitoring system.

## FACILITYWISE FINDINGS SOUTH DISTRICT

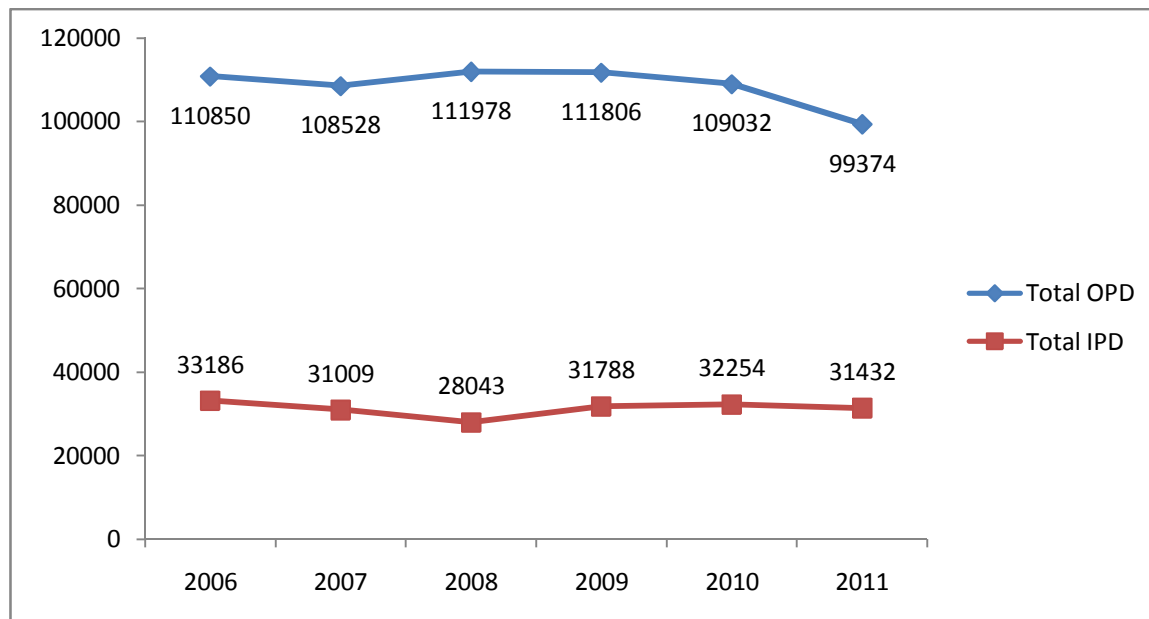
### 1. Tripura Sundari District Hospital

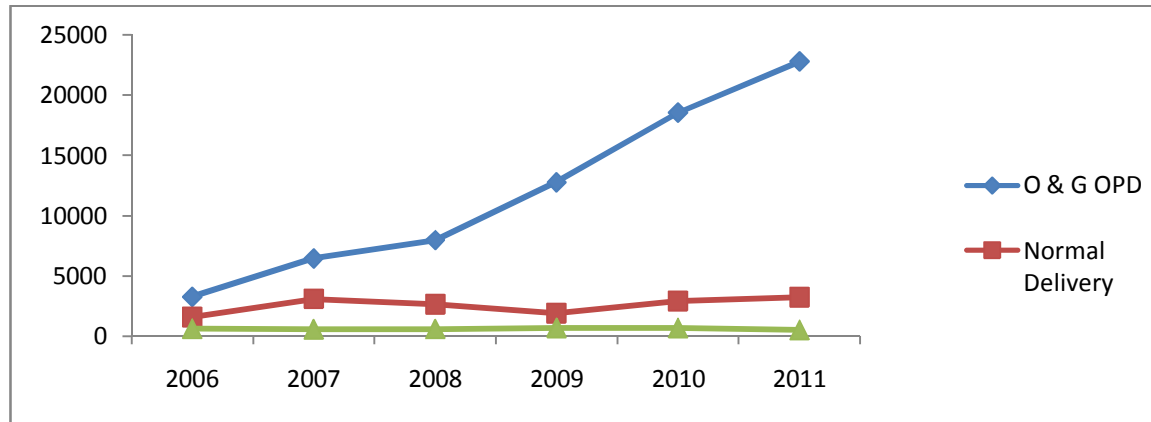
This District Hospital is a FRU.

#### *Service availability:*

Critical services such as Caesarean section, Newborn care, Blood transfusion services are available 24\*7. Other services such as 24 hrs delivery, management of PPH, administration of parental Oxytocin, antibiotics, all kind of family planning services, safe abortion, care of sick neonate and children, immunization, essential laboratory services and referral services are available in the District Hospital. There is adequate supply of drugs and consumables and power has been delegated to MO I/C to spend the RKS funds for purchase of drugs during emergency, for transport for referral of patients to higher facilities and immediate compensation of death.

#### *OPD AND IPD CASE LOAD:*



*MATERNAL HEALTH SERVICES:**Human Resource:*

Specialist: All specialists posted are regular staffs. Two O &G specialist, two anaesthetist, two pediatrician and one surgeon.

Medical officers: 10 regular Medical officers.

Nurses: 71 Nurses

Lab technician: 6 technicians

44 other supporting staffs

However few health staffs found to be trained in required types of training,

*Equipments:* Inside OT equipments such as OT table, OT light, air conditioners, Boyles apparatus, CS equipments, oxygen cylinder and laparoscopes are available. Over all condition of OT is found to be good. ILR, deep freezer and generator are installed and functional.

*Waste management:* Colour coded buckets are available for segregate wastes. Infectious and biological wastes disposal done by bury in a pit method. However, non-infectious waste is thrown inside hospital compound.

***TELE-CARDIOLOGY UNIT IN THE  
TRIPURA SUNDARI DISTRICT  
HOSPITAL***

*Best Practices:* Tele-cardiology unit is functioning in the district hospital which provides specialized cardiac care to patients in the district hospital following tele-consultations with specialists at designated tertiary care centers.



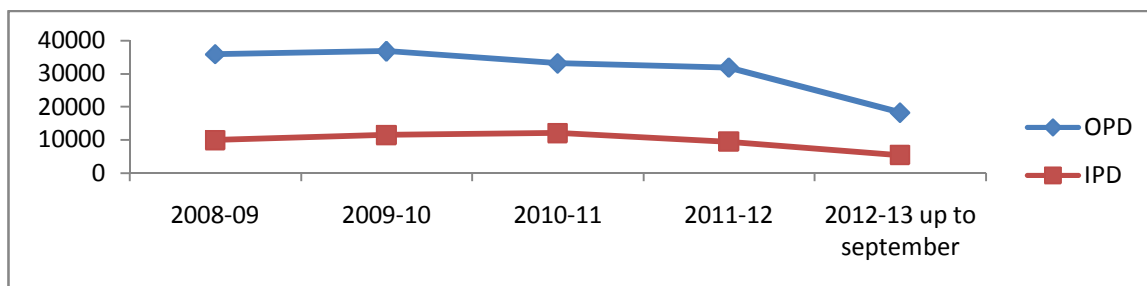
**2. Sabroom SDH:**

**Population Coverage:**

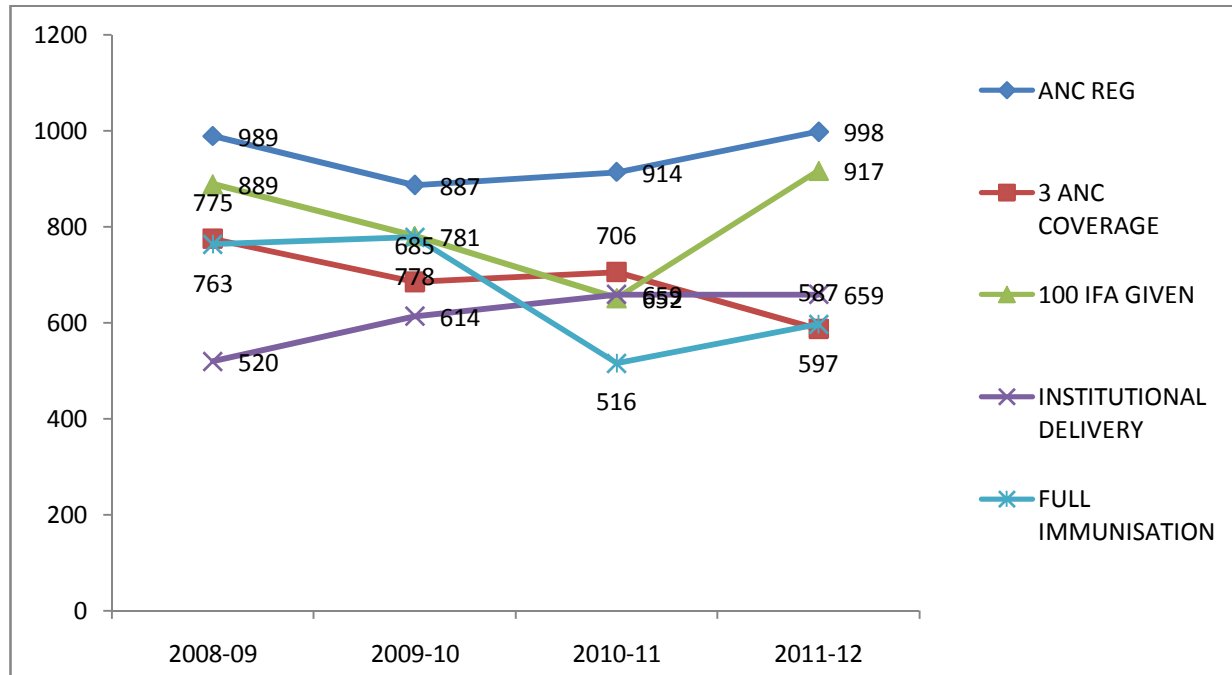
**Facility Type: 24\*7 Sub District Hospital**

*Service delivery:*

***OPD AND IPD LOAD:***



## MATERNAL AND CHILD HEALTH



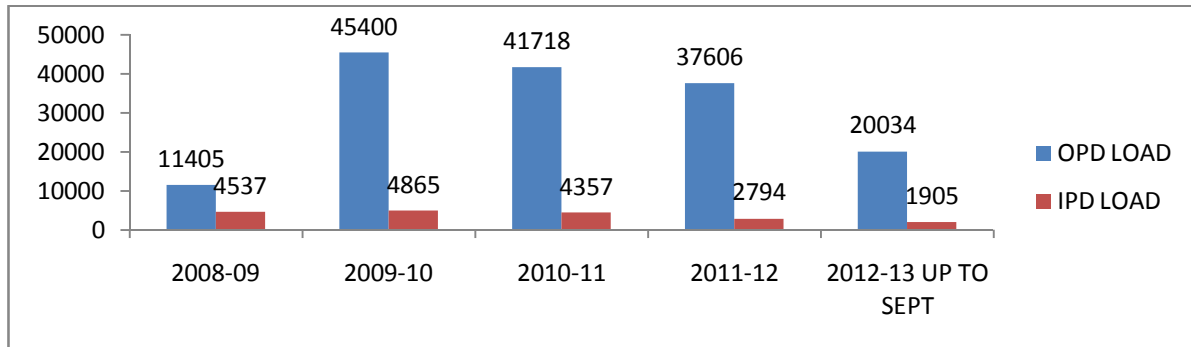
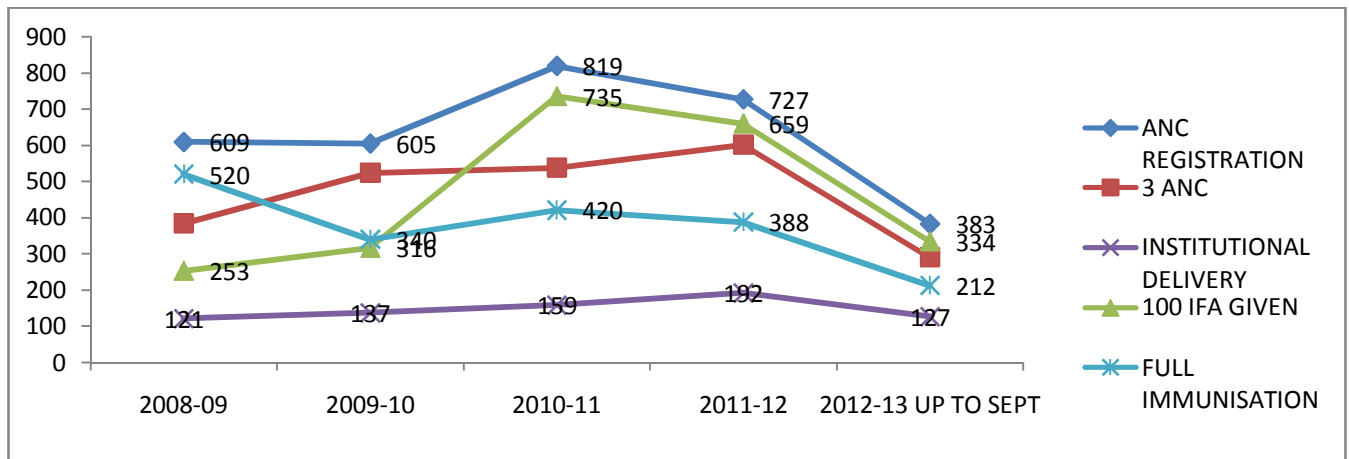
*Health Human Resource:* 1O& G specialist, 5 MO Allopathic, 2 MO AYUSH, 2 dental surgeon, 21 Staff nurses, 2 Allopathic Pharmacist, 1 AYUSH Pharmacist, 3 laboratory technician, 1 HMIS assistant, 2 STD/ ICTC counsellor, 12 MPW and 49 supporting staffs.

### 3.Manu Bazar CHC

**Total population served: 45446**

**Total family: 10780 out of which 4822 are BPL**

**Type of Facility: 24\* 7 CHC**

*Service delivery***TOTAL OPD AND IPD LOAD****MATERNAL AND CHILD HEALTH:**

*Human resource:* 3 Allopathic medical officers, 1 Ayurvedic medical officer, 1 dentist, 11 staff nurses, 2 lab technicians, 1 allopathy pharmacist, 16 MPW, 1 adolescent counselor, 1 clerk, 1 accounts assistant, 1 HMIS assistant, 23 other supporting staffs.

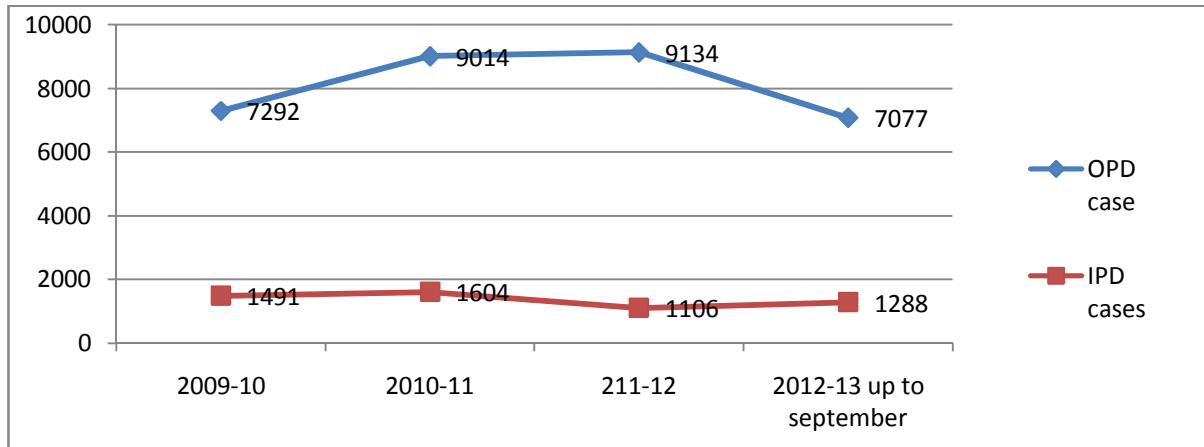
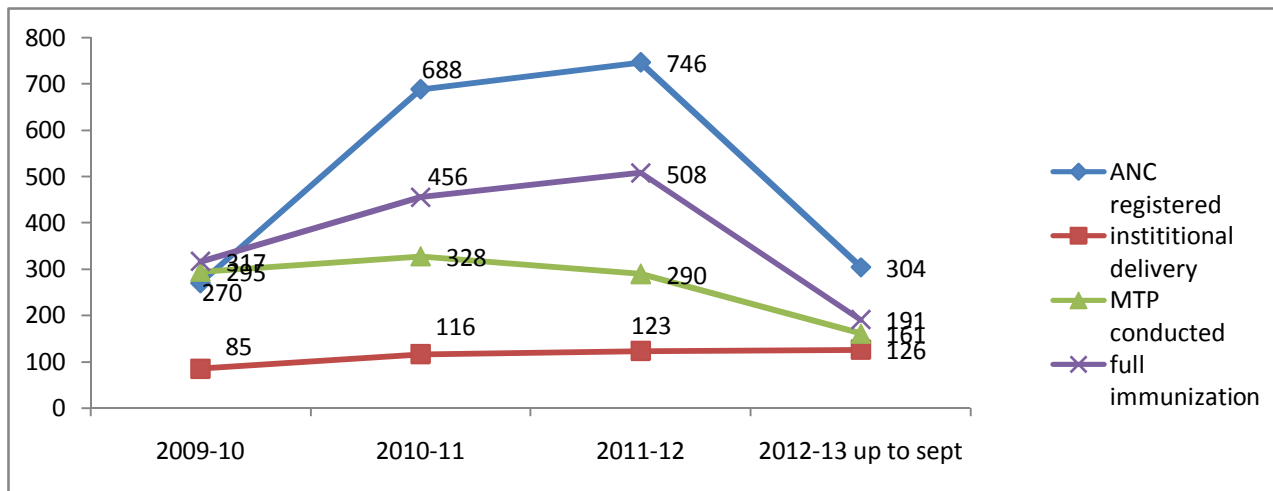
**4. Rajnagar PHC**

**Population coverage: 28174**

**Total school: 29**

**Type of facility: 24\*7 PHC, Delivery Point**

*Service delivery:* OPD services, 24 hours emergency services including referral service, in-patient service, antenatal care, institutional delivery, post natal and neonatal care, family planning services, safe abortion services, management of RTI/ STI, nutrition services, school health, adolescent health, basic laboratory services, AYUSH services, National health programs such as malaria, RNTCP, DMC etc.

*OPD and IPD**MATERNAL CHILD HEALTH*

*Human resource:* 2 allopathic Medical Officer, 2 homoeopathic Medical Officer, 1 ayurvedic Medical Officer, 7 staff nurse (1 regular, 6 contractual), 3 allopathic pharmacist, 2 homoeopathic pharmacist, 1 laboratory technician, 2 MPS, 2 MPW, 1 LDC, 1 HMIS assistant, 1 Accounts assistant, 7 supporting staffs.

*Infrastructure and equipment:*

OPD rooms, Wards, Labour room, minor OT, cold chain room, laboratory, room for AYUSH doctor, Office room, Residential accommodation for MO and Staff nurse are available.

*Waste disposal* done by burial pit method.

**5. Rani Sub Center:****Population coverage: 4680****Type of Facility: Health Sub Center**

*Service delivery:* Services such as OPD treatment, ANC, normal delivery and immunization services and outreach services are available. On an average 8-9 OPD cases and one or two delivery/ month are conducted in this SC.

*Human resource:* Two ANMs out of which one is SBA trained.

*Infrastructure, Equipment drugs and consumables:* Number of rooms found to be adequate for the case load and the building is also in good condition. One room is used for purpose of residence Equipments such as BP apparatus, weight machine and thermometer are found in functional condition. Drugs and consumable supposed to be available at SC level was found to be sufficient.

## DISTRICT PROFILE NORTH DISTRICT

Recently North Tripura district has been divided into two district named Unakoti and North District. The undivided north district had District Hospital Unakoti where as newly formed North District doesn't have designated DH. For field visit purpose DH of Unakoti and peripheral facility (SDHs, CHCs, PHCs, SCs) of newly created North district were visited.

**Demographic Profile:** The North Tripura District has a geographical area of 1422.19 sq KM and is divided into three sub-division, namely, Dharmnagar, Kanchanpur and Panisagar. The main tribes of District are Tripuri, Koloï, Halam, Chakma. Two hill ranges, namely Jampui, Sakan run almost parallel to each other in the district. 'Betling Chip' the highest point of the State is located in the district in the Jampui range. The district is divided into two sub division i.e. Dharmnagar and Kanchanpur.

| Category           | Sub division |            | Total in the district |
|--------------------|--------------|------------|-----------------------|
|                    | Dharmnagar   | Kanchanpur |                       |
| Population         | 318953       | 102712     | 421665                |
| Number of GP       | 52           | 0          | 52                    |
| Number of ADC Vill | 7            | 45         | 52                    |

### Health Institution:

North Tripura district has 2 divisional hospitals, 1 CHC, 13 PHCs (24x7). Only single SDH working as FRU. Currently 73 subcentres are functional in the district.

| Sr. No | Name of the Facility | Type | Category | No. of GP/ADC Vill. | Functional SHC | SC under Construction | Gap |
|--------|----------------------|------|----------|---------------------|----------------|-----------------------|-----|
| 1      | Dharmnagar           | SDH  | FRU      | 10                  | 7              | 3                     | 0   |
| 2      | Kanchanpur           | SDH  | Non      | 13                  | 6              | 5                     | 2   |

|              |                       |     |            |            |           |           |          |
|--------------|-----------------------|-----|------------|------------|-----------|-----------|----------|
|              |                       |     | FRU        |            |           |           |          |
| <b>3</b>     | <b>Kadamtala</b>      | PHC | 24x7       | 9          | 6         | 2         | 1        |
| <b>4</b>     | <b>Panisagar</b>      | CHC | Non<br>FRU | 6          | 3         | 2         | 1        |
| <b>5</b>     | <b>Tilthai</b>        | PHC | 24x7       | 7          | 5         | 2         | 0        |
| <b>6</b>     | <b>Uptakhali</b>      | PHC | 24x7       | 7          | 4         | 2         | 1        |
| <b>7</b>     | <b>Jalebasa</b>       | PHC | 24x7       | 4          | 3         | 0         | 1        |
| <b>8</b>     | <b>Bungnung</b>       | PHC | 24x7       | 7          | 7         | 0         | 0        |
| <b>9</b>     | <b>Sanicharra</b>     | PHC | NN PHC     | 5          | 4         | 1         | 0        |
| <b>10</b>    | <b>Brajendranagar</b> | PHC | 24x7       | 5          | 3         | 1         | 1        |
| <b>11</b>    | <b>Dasda</b>          | PHC | 24x7       | 9          | 8         | 1         | 0        |
| <b>12</b>    | <b>Damcharra</b>      | PHC | 24x7       | 4          | 3         | 1         | 0        |
| <b>13</b>    | <b>Khedacharra</b>    | PHC | 24x7       | 3          | 2         | 1         | 0        |
| <b>14</b>    | <b>Anandabazar</b>    | PHC | 24x7       | 7          | 4         | 1         | 2        |
| <b>15</b>    | <b>Jampui</b>         | PHC | 24x7       | 7          | 8         | 1         | 0        |
| <b>16</b>    | <b>Machmara</b>       | PHC | 24x7       | 1          | 0         | 1         | 0        |
| <b>Total</b> |                       |     |            | <b>104</b> | <b>73</b> | <b>24</b> | <b>9</b> |

District is in dire need of upgrading FRU SDH to District hospital and making all the equipments and services available at the facility. There is short fall of 9 HSC in the district. Full fledged Operation theatre building of SDH Kanchanpur was locked and lying idle since two years. There was no boundary wall in the SDH to prevent stray cattle and dogs. SDH doesn't have waiting area. More beds can be added to the facility. The Dharamchera PHC has well built waiting area but it has been constructed non strategically (not near the entrance or OPD). This facility was also overcrowded with IPD patients where as three rooms in the PHC was locked and lying idle.



(At Damcharra PHC: Large part of building lying idle)

The pit for burying biomedical waste was located near waiting area and stray pigs were found wandering over biomedical waste pit. The none of the HSC was functioning as delivery point except Laxmi Nagar. All the subcentres visited were functioning in the buildings either donated by Panchayat or rented. The infrastructure available at HSC was not uniform across all the subcentres. The subcentres Krishnapur had three big and spacious rooms whereas SC Panikhet didn't even have space to conduct ANC checkup. During visit roof of Panikhet SC was found to be leaking and consumables like cotton had been drenched. The only subcentre which was functioning as delivery point has no cemented roof. The ANM residential building was not found in the premises of all the SCs visited where as doctors quarters at CHC and PHC located in the facility premises. A new full fledged bulding for DH inaugurated by District Magistrate was lying idle in the district since 6 months.

### Recommendations:

- ✓ Upgradation of SDH to DH and equipping it with the all equipments should be done on priority basis.

- ✓ Under utilisation of existing infrastructure need immediate attention and issue can be resolved by adding more beds to the facility and making non functional/idle part of building into functional.
- ✓ The construction of new subcentres, upgradation of existing SCs building and converting them into delivery points.
- ✓ Construction of ANM residential building in the SC premises.

#### Human Resource:

| Sr. No. | Name of SDH/CHC/PHC | MO (Allo) | MO (AYUSH) | Dental Surgeon | SN | Pharma (Allo) | Phar (AYUSH) | Lab Tech |
|---------|---------------------|-----------|------------|----------------|----|---------------|--------------|----------|
| 1       | Dharam Nagar SDH    | 7         | 2          | 1              | 26 | 4             | 2            | 5        |
| 2       | Kanchanpur SDH      | 4         | 2          | 1              | 16 | 3             | 1            | 3        |
| 3       | Kadamtala PHC       | 2         | 1          | 1              | 5  | 1             | 0            | 1        |
| 4       | Panisagar CHC       | 2         | 2          | 1              | 6  | 2             | 0            | 1        |
| 5       | Tilthai PHC         | 2         | 1          | 1              | 6  | 2             | 1            | 1        |
| 6       | Uptakhali PHC       | 2         | 1          | 1              | 4  | 1             | 0            | 0        |
| 7       | Jalebasa            | 2         | 1          | 1              | 6  | 1             | 0            | 0        |
| 8       | Bungnung PHC        | 2         | 1          | 0              | 4  | 1             | 0            | 0        |
| 9       | Sanicharra PHC      | 1         | 1          | 0              | 1  | 1             | 1            | 0        |
| 10      | Brajendar Nagar PHC | 2         | 1          | 0              | 3  | 1             | 0            | 1        |
| 11      | Dasda PHC           | 2         | 2          | 1              | 6  | 1             | 0            | 1        |
| 12      | Damcharra PHC       | 2         | 1          | 1              | 6  | 0             | 0            | 1        |
| 13      | Khedacharra PHC     | 2         | 1          | 0              | 4  | 1             | 1            | 0        |

|           |                            |   |   |   |   |   |   |   |
|-----------|----------------------------|---|---|---|---|---|---|---|
| <b>14</b> | <b>Anandabazar<br/>PHC</b> | 2 | 2 | 1 | 6 | 1 | 0 | 1 |
| <b>15</b> | <b>Jampui PHC</b>          | 2 | 1 | 1 | 9 | 1 | 1 | 1 |

There is a need of rational deployment of skilled HR across the facilities available in the District. The Sanicharra PHC is a non 24x7 functional facility due to availability of single MO (Allo) where as SDH Dharamnagar SDH (FRU) and Kanchanpur SDH (Non FRU) have 7 and 5 MO (Allo) in place respectively. Shifting one doctor from either of SDH can make non 24x7 facility into full time operational. Jampui PHC has 9 Staff Nurses where as Sanicharra PHC has only 1 Staff Nurses. All other 24x7 PHCs have 3 to 6 Staff Nurses in place. Dharmanagar SDH has 3 laboratory technician where as there are 5 PHCs which doesn't have single laboratory technician. The non 24x7 PHC Sanicharra can be easily made 24x7 operational by rational deployment of HR. Newly formed district doesn't have district programme manager, Distt. ASHA programme manager.

#### **SERVICE DELIVERY IN HEALTH FACILITIES:**

##### **A. OPD and IPD load of facilities:**

| <b>Name of Institutions</b>           | <b>OPD Attendance</b> |                | <b>IPD Attendance</b> |                            |
|---------------------------------------|-----------------------|----------------|-----------------------|----------------------------|
|                                       | <b>2011-12</b>        | <b>2012-13</b> | <b>2011-12</b>        | <b>2012-13 (upto Sep.)</b> |
| <b>Ragib Gandhi Memorial Hospital</b> | 56773                 | 29803          | 22377                 | 11347                      |
| <b>Dharmanagar SDH</b>                | 45546                 | 28379          | 10171                 | 6257                       |
| <b>Kanchanpur SDH</b>                 | 14561                 | 8100           | 5089                  | 3114                       |
| <b>Panisagar CHC</b>                  | 18645                 | 7622           | 8321                  | 2564                       |
| <b>Dasda PHC</b>                      | 6430                  | 2568           | 1846                  | 1257                       |
| <b>Damcharra</b>                      | 5754                  | 2895           | 1846                  | 991                        |

|                          |       |       |       |      |
|--------------------------|-------|-------|-------|------|
| <b>PHC</b>               |       |       |       |      |
| <b>Kadamtala<br/>PHC</b> | 28106 | 16220 | 12874 | 6954 |

**B. Situation of Maternal Health:**

| <b>Health<br/>Institution</b> | <b>2012</b>                                   |                           |                          | <b>2012-13 (up to Sep)</b> |                           |                          |
|-------------------------------|---|---------------------------|--------------------------|----------------------------|---------------------------|--------------------------|
|                               | <b>ANC<br/>Reg.</b>                           | <b>3 ANC<br/>Coverage</b> | <b>100 IFA<br/>Given</b> | <b>ANC<br/>Reg.</b>        | <b>3 ANC<br/>Coverage</b> | <b>100 IFA<br/>Given</b> |
|                               | <b>Ragib Gandhi<br/>Memorial<br/>Hospital</b> | 211                       | 108                      | 11                         | 111                       | 31                       |
| <b>Dharmanagar<br/>SDH</b>    | 571   | 45                        | 58                       | 334                        | 50                        | 50                       |
| <b>Kanchanpur<br/>SDH</b>     | 495   | 287                       | 437                      | 259                        | 188                       | 254                      |
| <b>Panisagar<br/>CHC</b>      | 261   | 178                       | 234                      | 141                        | 130                       | 134                      |
| <b>Dasda PHC</b>              | 172   | 117                       | 108                      | 84                         | 61                        | 67                       |
| <b>Damcharra<br/>PHC</b>      | 263   | 65                        | 275                      | 109                        | 28                        | 109                      |
| <b>Kadamtala<br/>PHC</b>      | 821   | 543                       | 584                      | 414                        | 226                       | 321                      |

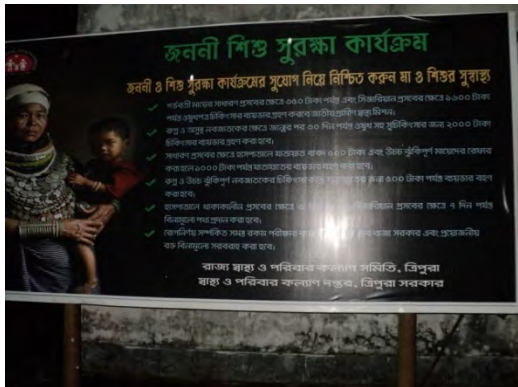
**C. Situation of Inst. & Home delivery:**

| <b>Name<br/>of<br/>Institution</b>            | <b>Institution</b> | <b>Home</b> | <b>Institution</b>           | <b>Home</b> |
|---|--------------------|-------------|------------------------------|-------------|
|   | <b>2011-12</b>     |             | <b>2012-13 (Up to Sept.)</b> |             |
| <b>Ragib Gandhi<br/>Memorial<br/>Hospital</b> | 2119               | 0           | 912                          | 0           |
| <b>Dharmanagar</b>                            | 763                | 169         | 372                          | 79          |

| SDH            |     |     |     |     |
|----------------|-----|-----|-----|-----|
| Kanchanpur SDH | 544 | 61  | 274 | 32  |
| Panisagar CHC  | 56  | 55  | 30  | 15  |
| Dasda PHC      | 339 | 52  | 119 | 24  |
| Damcharra PHC  | 225 | 54  | 133 | 29  |
| Kadamtala PHC  | 144 | 541 | 71  | 165 |

**FIELD OBSERVATIONS REGARDING IMLEMENTATION OF NRHM IN THE DISTRICT:**

1) Display boards of Signgace, JSY, JSSK entitlement, Citizen charter were available at facilities ie. DH, SDH, PHCs and SCs. Citizen charter at SCs was found to be in English language instead of local language.



(DH)



(DH)

At Subcentre Laxmi Nagar

At PHC Damcharra



2) Security of the all the facilities DHs, SDHs, CHCs, PHCs, SCs premises was found to be seriously compromised. Stray cattle and dogs in the main premises were observed in the facility.

**(Please add photo of DH taken by Mr. Arun)**



(At Kanchanpur SDH)

3) List of drugs to be distributed free of cost in the facilities (DH, SDH, PHC) was evident but discussions from beneficiaries revealed high out of pocket expenditures on the drugs during OPD and on consumables used during IPD admission at each level of facility. The supply of drugs was found to be interrupted at SDH Dharamnagar. Antimalarial drugs were out of stock since two months.

4) Functional ARSH clinic at DH and SDHs reported to have very less number of beneficiaries attending the clinic. There was no record of outreach activities at each level. No referral has been reported from peripheral institutions, ANMs and ASHAs. There was no follow up mechanism put in place for the beneficiaries referred to RTI/STI clinics. Discussions with Counsellors showed expressed need of training for counselling.

5) Quality, Privacy and Hygiene were found to be seriously compromised. Observations from IPD ward of facilities (DH- Unakoti, SDH- Kanchanpur) showed that ward was over flowing with inward patients and many of patients were lying at floor. The condition of attached toilets in ward was pathetic. None of the patient bed had hospital linen. Patients were using their own bed sheets. Privacy in the toilets was completely absent. No Quality Assurance committee exists for monitoring quality services at the facility.



(Patients in Sugerical Ward of DH)



(Patient in male Ward of SDH Kanchanpur)

6) Lay put of Operation Theatre was not as per the quality standards in DH. Complete sterilisation in OT was almost absent. Linens and sheets being used during OT procedures were hanging at the entrance of main door of OT for drying up.

(DH: Clothes hanging at entrance of OT)

(DH: Post Operative Table Sheet )



Major OT has found to have a garbage room within it. Post operative table linen was infested with fungus. The roof plaster of OT was peeling off and exposed electric wiring was located near the OT table. There was no elbow tap and cleanliness of the basin to be used for hand washing hands was seriously compromised.



(DH: Garbage Collected within Major OT)



(DH: Wash basin available in Major OT)



(DH: Laproscopic OT room with Plaster peeling off)



(DH: Exposed Wiring just above the OT table)

7) At each facility maternity ward was also full of beneficiaries. The conditions of ward toilet were very poor and it seemed like toilets were never washed. Clothes napkins being used by mothers were lying around in the toilet. No proper mechanism to dispose off these napkins was put in place.



(DH: Clothes Napkins in Maternity Ward)  
Kanchanpur)



(Condition of Maternity ward toilet of SDH,

While discussions with the beneficiaries, it was found to have awareness regarding benefits of JSY but none of the beneficiary was aware of JSSK entitlements. Almost every beneficiary reached to the hospital by hired vehicle. Beneficiaries were reported to incur high out of pocket expenditure on transport.

8) A delay of about a month in payment of JSY beneficiaries was reported from the JSY registers. Beneficiary has to make repeated visits to hospital to get their JSY benefit. This questions the role played by the ASHA and hospital authorities. Discussion with ASHAs showed discontent over reducing the payment of JSY from Rs. 600 to Rs 350.

9) There was no SNCU available in the DH facility. Only New born care corner with radiant warmer was evident in the DH facility and found to be functional. Both size ambu bags and masks for resuscitation were not available in the labour room at PHC Damcharra. At some places radiant warmer was present but not in either labour room or in new born corner. It was found to be in Pharmacy room.



(DH: New Born Corner)



(Functional Radiant warmer located at Pharmacy at SDH)

10) District Hospital had separate AYUSH wing with facilities of Punch Karma. But there was no Punch karma Specialist despite existing setup for panchkarma in the facility. State has single MS (Ayu) available in the Unakoti but no ayurvedic surgeries are being conducted. However, patients are referred from other parts of Tripura. Dedicated bed has not been allocated for AYUSH IPD. Homeopathic drugs were found adequately available but supply of Ayurvedic drugs was found interrupted. The significant number of patients was attending AYUSH clinics. AYUSH drugs were also available at SDH and PHC. A significant number of AYUSH OPD at SDH and PHC level was evident.

11) Despite 3 BLS ambulances available at DH, only one dedicated ambulance was being used for referral transport at DH. But it was reported to be used majorly for outreach activities and camps. Mechanism of referral transport was almost absent. During the time of emergency, private vehicles are hired by the patients. Facility incharge of each level of facility was found to have capacity to spend on referral transport. Similarly ambulance at PHC Damcherra was also available but it was not being utilised for referral transport. Ambulance is being utilised for only outreach service in remote area for transport of staff.

12) DH has well functioning 24x7 blood bank with all the equipments, reagents and refrigerators put in place. AS per GoI guidelines unit has approval of NACO. SDH Kanchanpur doesn't have blood storage unit. SDH Dharam Nagar has functional blood storage unit.

14) District Hospital had well functioning Ophthalmic OT. Teleophthalmology units were also found fully functional at SDH and PHC level with good number of patients attending these vision centres at PHC level.

15) Availability of 24 hours laboratory services was also questionable. Despite availability of 3 lab Technician, laboratory services was being delivered in two shifts only at DH level. Range of laboratory services available at PHC and SDH level is very limited. While discussion with Laboratory technician, need of training was expressed. Though Damcharra PHC has been designated as 24x7 but availability of 24x7 laboratory services was questionable as there was only one laboratory technician available at the facility.

16) Protocols regarding biomedical waste management was not displayed anywhere at different level of the facilities. Segregation of wastes was not being done properly at each level.



Either one or two coloured buckets were found in each ward but sharps was found to be mixed with biodegradable wastes at each level.

### **Subcentre Functionality:**

Subcentres visited were found deficient in basic instruments required for ANC checkup. It was evident from the discussions from the ANM available at Panikhet Subcentre that No ANC was being conducted at the SC. ANM available at Rajnagar HSC was not trained in SBA and NSSK. ANC register available at Rajnagar HSC was showing each prospective mother having Hb 10 gm

and B.P. 120/180 since March 2012 to October 2012. No screening of High risk pregnancy was being conducted. ASHA was found unaware of JSSK entitlements. At subcentre Panikhet ANM was distributing 6 months expired condoms. At HSC Krishnapur it was found from register that 29 deliveries happened in the area of respective SC but 16 deliveries were home deliveries. No IUCD insertion was happening at all the SCs visited. None of the SCs (except one) had Surgical scissors, Fetoscope. HSC Noangang, East Hurura, Panikhet don't have examination table in place. Only One SC out of 5 SCs visited had 24 hour electricity.

## **FACILITY WISE FINDINGS**

### **1. District Hospital- Ragib Gandhi Memorial District Hospital**

**Population** = 22,362

**Service delivery:** Critical services such as Caesarean section, Newborn care, Blood transfusion services are available 24\*7. Other services such as 24 hrs delivery, management of PPH, administration of parental Oxytocin, antibiotics, safe abortion, care of sick neonate and children, immunization, essential laboratory services and referral services are available in the District Hospital. There is adequate supply of drugs and consumables and power has been delegated to MO I/C to spend the RKS funds for purchase of drugs during emergency, for transport for referral of patients to higher facilities and immediate compensation of death. The observations made by team are following:

#### **Maternal Health:**

#### **JSY implementation:**

- Number of institutional deliveries has been recorded in the JSY register but delay in payment has been found to be the major issue.
- While analyzing the data available, it was found that average delay in payment was 2 to 3 months.
- While discussion it was found that delay in payment is arising out of inability of beneficiaries to produce the requisite document. It questions the role being played by ASHA s facilitating the beneficiary to get incentives.

#### **JSSK implementation:**

- The IEC material was displayed in the DH for JSSK entitlement. But all the components of JSSK was found to be weekly implemented in the district hospital. Free delivery

services are being provided in the facility. But beneficiaries reported to have spent money on syringes and needles.

- Referral transport is the weakest component of KSSK implementation at district hospital.
- While discussion with beneficiaries, unawareness was reported about referral transport both (reach and dropback). Beneficiaries were found to be spent huge out of pocket on referral.
- There was no facility available for cooked diet to the mothers.
- There is no proper system in place for grievance redressal mechanism. No information was available for grievances recorded and action taken on it.

#### **Labour Room Status:**

- Overall condition of labour room was poor. Labour table was present but without McIntosh sheet. There was proper mechanism to maintain privacy.
- Labour room doesn't have Autoclave or sterilizer available.
- Labour room doesn't have attached toilet. Condition of toilet available for labour room was very dirty.
- Many of drugs which labour room supposed to have in emergency drug tray was found missing e.g. Diazepam, magnesium Sulphate injection, Nifedipine.
- The walls were not satisfactorily cleaned and seepage was found near water basin available within the labour room.
- There was no supply of sterile drip set in the labour room since 15 days.

#### **ARSH**

- ARSH was found functional but very less number of people coming to the facility.
- ARSH counselor expressed the need of training for counseling. Outreach activities are taking place at the facility.
- There is no proper system of follow-up in case any beneficiary is referred to the STI clinic.

#### **Child Health:**

- The ILR has been maintained and immunization services are being delivered effectively.
- District hospital has dedicated new born corner. The radiant warmer was available and found in working condition. Ambubag with mask was not available in the NBCC.

- District Hospital doesn't have Sick New Born care Unit (SNCU). The cleanliness of BCC was found compromised.

**Biomedical Waste management:**

- Biomedical waste management protocols were displayed anywhere in the facility.
- Staff hasn't not received any training for bio medical waste management practices.
- Quality Assurance committee was present but no record of action taken during Quality Assurance meeting was available.

The service- wise (OPD/IPD, Institutional deliveries, ANC Coverage, IFA Tablet distribution) is annexed at **Annexure –I**.

**2. Sub Divisional Hospital (SDH), Kanchanpur**

**Population Coverage:** 1,02,712

**Facility Type:** Non FRU 24\*7 Sub District Hospital

**HR Status:** The facility has 4 Medical officer (Allo), 2 Medical officer (Ay), 1 dental Surgeon, 16 Staff Nurses, 3 Pharmacist (Allo), 1 Pharmacist (Ayush) and 3 laboratory technician. The following are the vacant positions: 1 Gynecologist, 1 Pediatrician, 1 Anesthesiologist, 7 Staff Nurses, 3 Sweeper.

**Critical Services:**

Normal delivery services and Blood transfusion services are available 24\*7. Other services such as 24 hrs delivery, management of PPH, administration of parental Oxytocin, antibiotics, safe abortion, care of sick neonate and children, immunization, essential laboratory services and referral services are available in the SDH.

- NBCC was partly functioning because Radiant warmer was not available in the new born care corner.
- Family planning services was found be very deficient. The FP services like Tubectomy, NSV are not being provided. Cooper T was not in supply since 7 months.
- Though ambulance is available at the facility abut it is primarily used for outreach activities. Referral transport is largely dependent upon hired vehicles.
- The essential record for neonatal deaths, no. of maternal cases given blood transfusion has not been maintained.

- The discussion with beneficiary reported use of hired vehicle to reach the facility.
- Operation theatre was found locked and not being utilized. The wards were overflowing with the patients.
- Biomedical waste management protocols were not available at the facility.

**Service delivery:**

| Services                 | 2011-12 | 2012-13 |
|--------------------------|---------|---------|
| ANC Reg                  | 495     | 259     |
| 3 ANC Coverage           | 287     | 188     |
| 100 IFA given            | 437     | 254     |
| Institutional deliveries | 544     | 274     |
| Home Deliveries          | 61      | 32      |
| OPD                      | 14561   | 8100    |
| IPD                      | 5089    | 3114    |

**3. PHC, Dhamcherra**

**Population Coverage:** 20,854

**Facility Type:** 24\*7 Primary Health Centre

**HR Status:** The facility has 2 Medical officer (Allo), 1 Medical officer (Ay), 1 dental Surgeon, 6 Staff Nurses, and 1 laboratory technician.

**Service delivery:** OPD services, 24 hours emergency services including referral service, in-patient service, antenatal care, institutional delivery, post natal and neonatal care, family planning services, safe abortion services, management of RTI/ STI, nutrition services, school health, adolescent health, basic laboratory services, AYUSH services, National health programs such as malaria, RNTCP, DMC etc.

**Critical Services:**

- Normal delivery services are available 24\*7. But assisted (forcep/Vaccum) delivery services are not being provided. No data for recording of high risk pregnancies is being maintained.

- For management of Post Partum Hemorrhage/ other complications, patients are referred to higher facility.
- Operational expenses for running ambulance were not available with facility. The MO/Ic has also not been delegated any power to spend on referral.
- Acute shortage of IUD 380A, OP has been reported. The Emergency Contraception is not available in the facility since 5 months.
- Laboratory service has very limited range of services. Blood Sugar, Urine Albumin and Sugar test are not available.
- Reporting format issues have been identified in case of recording low birth weight, neonatal death in the facility, and maternal cases given transfusion.

**Service delivery:**

| Services                 | 2011-12 | 2012-13 |
|--------------------------|---------|---------|
| ANC Reg                  | 263     | 109     |
| 3 ANC Coverage           | 65      | 28      |
| 100 IFA given            | 275     | 109     |
| Institutional deliveries | 225     | 133     |
| Home Deliveries          | 54      | 29      |
| OPD                      | 5754    | 2895    |
| IPD                      | 1846    | 991     |

**3. Sub Center, Shanti Pada**

**Population coverage:**

**Type of Facility: Health Sub Center**

**Service delivery:** Services such as OPD treatment, ANC, immunization services and outreach services are available. Deliveries are not being conducted at the Subcentre.

**Human resource:** One ANM and haven't received any SBA and NSSK training.

**Infrastructure, Equipment drugs and consumables:** Adequate space was not available for conducting ANC and deliveries. Subcentre was running in panchayat building and roof was

leaking. Equipments such as BP apparatus, weight machine and thermometer are found in functional condition. Drugs and consumable supposed to be available at SC level was found to be sufficient.

- ANC register is available but majority of ANC are referred to PHC.
- NO family planning register was being maintained. Expired Condoms were still being distributed.
- There was no examination table and labour table available in the Subcentre.