8th CRM Findings

West Bengal
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WB 8th CRM TEAM

- Dr. Sila Deb
- Dr. Biswajit Das
- Dr. Silajit Sarkar
- Dr. Sunita Paliwal
- Dr. Hitesh Deka
- Ms. Tripti Chandra
- Lt. Aseema Mahunta
- Ms. Sudipta Basa
- Mr. Moni Mohan Manna
- Mr. Amrit Lal
- Dr. Sudhir Gupta
- Dr. Satyajit Sen
- Mr. Prasanth K S
- Mr. Jay Prakash
- Dr. Pooja Passi
- Dr. Sathish Kumar
- Dr. Nisha Singh
West Bengal: visit details

- Districts covered – Bankura and Uttar Dinajpur
- No. of facilities covered
  - District Hospital and Medical College Hospital - 2
  - SGH/Rural hospital/SDH - 4
  - Block PHC – 12
  - PHC – 5
  - Sub centre - 11
  - Leprosy Hospital -1
  - PPP hospital -1
  - MMU - 1
  - Schools – 2
  - AWC – 2
  - VHND – 2
  - Community interactions – FGD – 4
- Visit to KMC
Service delivery

- Increased utilization of health services, more so at district and block levels
- Availability of health facilities – inadequate as per norm, HPD has 2 CEmOC (33%) and state needs further differential plan at district/sub-district level
- Infrastructure – lack of boundary wall, average to poor maintenance of hospital premises, and immediate attention needed for maintenance of buildings (OT and labor room)
  - Expanding but slow pace of work
- Frontline workers (ANMs, ASHA, AWW, LHV) - well conversant and focused
  - HBNC kits not available with ASHAs
- Bankura MMUs- On PPP mode- functioning well as per prefixed micro plan.
  - GPS tracking, daily web based reporting

- PPP mode – Diagnostics, Ambulance, MMUs, Fair price medicine shops, BMWM, Rogi Sahayata Kendra, Ayusuhmati –PPP hospital
Service delivery

- Ambulance - Not yet adopted NAS model; Referral Transport through Nishchay Yaan with district level Call Centre
  - RT under JSSK- PPP mode, available to beneficiaries on call, poor information in community on drop-back facility
- IEC at health facilities available, mostly at facility levels and on latest schemes
  - Need comprehensive and systematic dissemination plan
- Printed protocols (BEMoC, CEMoC) were not found to be in place as per GOI programme guidelines
- Equipment maintenance - AMC in place, non-functional equipments seen
  - Real time monitoring /coordination gap between management and service delivery units
- BMW- color coded bins available - storage and disposal (outsourced) proper-emphasis to be laid on segregation of waste at source
- Tele-ophthalmology is catering to the needs of the community (Bankura)
Human Resources for Health

- HR constraints noted, primarily among Specialists (rational deployment is an issue)
  - Despite constraints, HR available across all levels of facilities putting in earnest efforts to provide services

- HR policy not in place, which otherwise would serve the purpose for state monitoring its
  - HR need/requirement, attrition rate, competency assessment, incentives and promotion, and Transfer policy

- Frontline health workers -ASHA, AWW and ANM are working as the backbone of the system. However, the field level activities needs to be strengthened, especially in areas related to disease control

- Male MPW for health services to be considered at peripheral level

- Slow pace of multi skilling training particularly EmOC, IMNCI and CAC

- Review the policy of SBA training to ANMs, as the state do not intent to use them for delivery
RMNCH+A

- Partograph available, EmOC protocols not displayed but staff able to explain steps
- JSY - A/c payee cheque to beneficiaries, challenge: <18yrs mothers, few occasions delays in payment to ASHA -DBT
- JSSK- Expansion of newborn services from 1 month to 1 year (GO-8/11/14)
  - Ambulance –Nischayyan available – delays in pickups reported
- Beneficiaries and relatives reported informal payments and OOPE
- Family Planning Counseling – women aware of FP options
  - PPIUCD – yet to start
  - Safe abortion services - recent methods MVA not practiced, CAC training is recent
- PCPNDT – committee exist, meetings and follow-ups needs to be regularised
RMNCH+A

- MDR- in place- records (District MDR committee) available- DM review is held quarterly. CDR workshop was held in November 2014.

- SNCU – man power shortage and overcrowding - effective utilization - resources for infections diagnosis (C&S) is needed
  - Follow-up after discharge needs strengthening at SNCU

- Treatment protocols or diarrhea/AGE management is not strictly followed at sub-district level

- Immunisation - AEFI response mechanism not in place, Hep B birth dose is not practiced

- ARSH clinics with lady counselor available and effective

- School health program - workload of RBSK is huge
  - WIFS implemented through schools , Menstrual hygiene program is yet to start

- NRC – effective regimen, high case load of malnourished children
  - Follow-up and coordination with AWW needs strengthening
Disease control programs

- Kala-azar – declining incidence, DDT spray available, strengthening field based activities must be focused
- JE - Incidence and death rates are increasing in both districts, vaccination available
- Malaria - Falciparum incidence is increasing
  - *Artemisinin monotherapy* (banned by DCGI) is still continued
- TB – Diagnosis and treatment as per guidelines, quality checks done, deaths audited by STS
  - Pediatric drugs – non-availability of appropriate dosage + slide disposal to follow BMWM guidelines
- Leprosy – declining incidence but still endemic, Dx and Rx as per guidelines
  - Appropriate rehabilitation not done, social stigma mitigation not effective
- IDSP - Manpower shortage, Utilization of IT, visibility of RRTs, and data usage – needs improvement
Information and knowledge

- All health facilities are reporting regularly
- Data quality issues - data generation and data validation
  - Documentation available but not reported – high risk pregnancy cases
  - Lack of clarity in reporting – obstetric complications data
  - Errors in data entry
- BMOH and BPHNs are not well versed with compilation and validation of data
- Data is used for planning at state and districts
  - Allocation of untied funds for facilities linked with performance
  - Analysis of RMNCH+A activities at the districts on the basis of score card made from HMIS data
  - Block wise score card analysis from HMIS data done for HPDs (High Priority Districts)
  - Monthly meeting at the districts- block wise performance assessment
Drugs and Diagnostics

- Drug and equipment procurement managed through IT - Store Management Information System (SMIS) – need to be real time in order to be effective
- Quality check on part of State has lag-time of approx 60 days by which time half the drug stock is disbursed
- Indent monitoring (validating demand generated from facilities as well as facility departments), storage and dispensing (availability of essential drugs) needs to be strengthened
- Fair price shop provide drugs at subsidized rate to the population
- Drug store in-charge/team can be trained on inventory management (ABC-VED technique etc.)
  - State may also consider use of bar code on all its drugs & equipments.
Community process and convergence

- State has highly motivated and committed field functionaries
- Convergence committee exists at each level from block, district to the State level
- VHND and the immunizations day are held on different days in the state
  - ANC check-up - abdominal examinations are not being done
- ASHA refresher training needs to be conducted
- Dedicated support structure for ASHA and VHSNC need to be established
- ASHAs have not been provided with the HBNC kit. They also do not have the supply of sanitary napkins
- Community engagement and participation was not evident
Finance and administration

- 93% posts filled, qualified and trained manpower in place, new staff need training
- Tally ERP (100% coverage), RTGS e-transfer in place, delegation of admin power
- Cash books maintained and recorded, irregularities noted in BSMCH
  - UC submitted, Issues with JSY payment – delays/few not received payment, <18 yrs old
- Consistent above 100% NHM expenditure by state (interest+ state share)
  - Delays in fund transfer from State Treasury to State Health Society
- Auditors appointment as per GOI guidelines – open tender
  - Statutory audit – completed, governing body meeting regular, report submitted to GOI
- IPAI report – state taking steps as per observations
- PFMS status – Registration of agencies are under process, 80% completion upto Sub centre level, DBT payment - pilot project in Howrah
Governance and management

- State and District Health Mission Constituted
- CMOH is acting DPM and handling several programs (Deputy CMOH positions are vacant)
- It is observed that all SCs in terms of reporting are not accountable to the PHC but directly to the BPHCs. This applies to fund flow b/w mentioned facilities
  - Lack of coordination observed between PHCs and SCs which are co-located (within a same boundary wall)
- Supportive supervision at the SC & PHC by GP supervisor and PHN needs to be strengthened for program and data quality
- QA committee in place
  - Meetings and support structure for ensuring quality not seen
  - Expedite establishment of skill labs for in service trainings
  - Strengthen supportive supervision at all levels
- Grievance redressal needs to be strengthened at all levels
Being scaled up on the pattern of central government NUHM program

Good models available within the State - KMC

It is recommended that the Municipal bodies are trained in-charge of NUHM be given orientation / training / exposure visit by KMC

Expedite expenditure of funds allocated in 2013-14 to be taken up on a priority basis

Thanks