State Monitoring Report: Uttar Pradesh

Apr-June 2013

National Health Systems Resource Center

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REPORT OF THE UP STATE MONITORING VISIT TO JHANSI

Executive Summary

UP can be any public health planner's waterloo as also an opportunity. There can be little doubt that the performance of UP is crucial to improve India's overall performance in health. Unfortunately, the problems peculiar to UP have proved to be too tenacious to be overcome in all the years since independence. The present state monitoring visit to UP was deliberately made to the better performing district of Jhansi with the purpose of identifying what was positive about the health system in the district that could hold some lessons for other districts of the state apart from making observations on the routine functioning of the district health system.

The secondary data from NRHM HMIS indicates that UP continues to lag behind the average national performance in terms of maternal health care (parameters of ante-natal care and institutional deliveries), child health care (primarily immunization), family planning indicators and the general service delivery indicators (O.P.D, I.P.D and major and minor procedures). More worrying is the fact that there has been a declining trend or stagnation in the achievements in all these spheres of service delivery over the last three to four years. Apart from that there are reasons to believe that even if the volume of services may have increased over the decades, but the quality of services remains very poor, which combined with issues like deficiency of manpower and infrastructure raises doubts regarding the sustainability of the modest achievements made so far.

Regarding the monitoring visit to Jhansi undertaken this time it would be desirable to begin with the reporting of positives. The secondary data for the district taken from the NRHM portal shows that there is little doubt as to Jhansi's better position vis-à-vis UP in terms of performance regarding maternal and child health care delivery; however, like the declining or stagnating trend in the performance of UP vis-à-vis that of India, the same is the case with respect to Jhansi as well.

Jhansi incidentally was also one of the CRM districts of UP in the last CRM. The brightest spot without doubt in the district health system has been the District General Hospital, Jhansi. The hospital has a compact but neat and affable campus. The general level of cleanliness of the wards and corridors of the hospital and availability of patient amenities like clean drinking water etc is appreciable; though the same cannot be said of the toilets. The facilities like the laboratory facilities, radiology diagnostic services of X ray and ultrasound do not exist merely in namesake and are regularly functional. There is a well equipped blood bank within the hospital campus. It was told that the hospital is even planning to make two of its bigger wards air conditioned. The O.P.D and the number of operations in some departments, especially in ophthalmology are reported to be even more than that of the Meerut Medical College.

Along with these positives, there was a set of negatives too. The proper segregation of waste and its safe disposal is doubtful even though it was not found to be littered around the hospital campus. Intact used syringes with attached needles were found to be thrown as such in the garbage in the OT. OT sterilization procedures are not maintained as per strict rules. There were complaints of all the patients not getting food and they are having to purchase many of the medicines from outside.

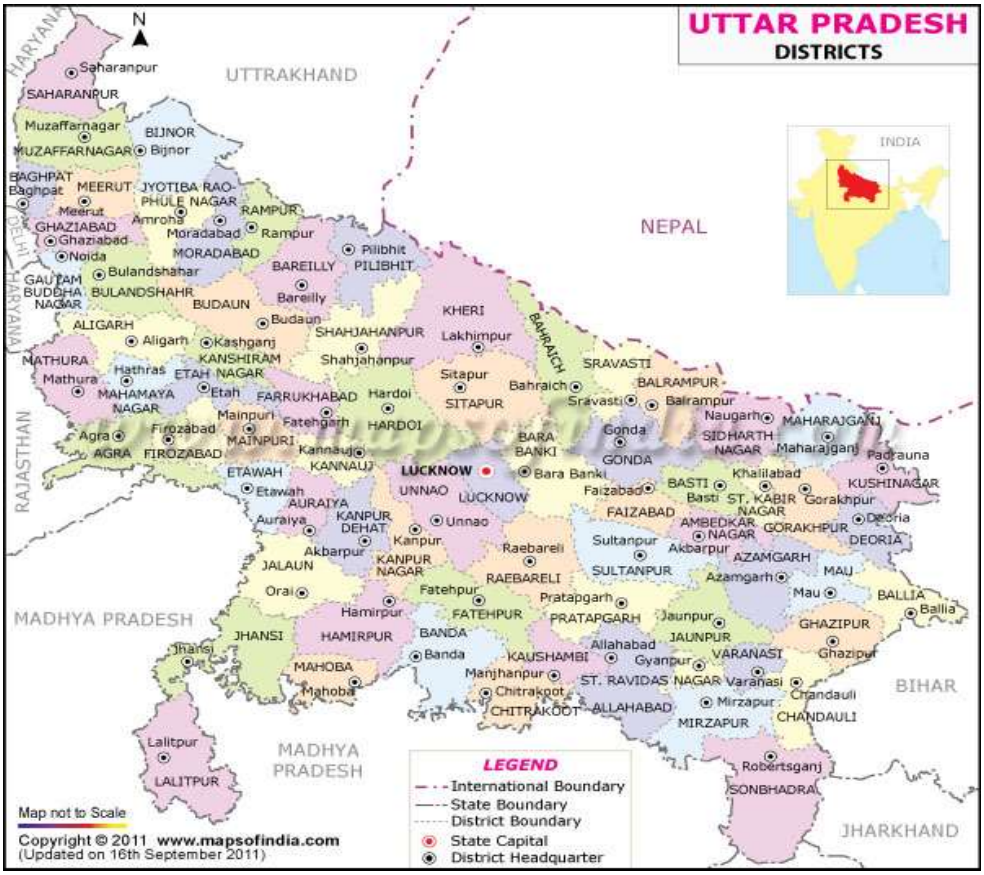
Compared to the District General Hospital, the District Women Hospital is a picture of mismanagement with poor quality of patient care, shortage of staff nurses and doctors, money being charged even from pregnant women for investigations and informal payments in the labor room. There is no blood storage unit and very few C sections happening; one of the reasons for this being that the blood services of District General Hospital are not available after 2.00 pm.

Outside of the city precincts, the story of rural healthcare of Jhansi district is no different from the rest of UP. There is acute shortage of medical, paramedical and frontline staff like the ANMs. There is under utilization of facilities, the levels of institutional care even under JSSK is abominable, the kind of ANC care is ridiculous and raises serious questions regarding the kind of functioning of our peripheral health services. The knowledge and skill levels of the health workers are poor. There are few medicines available in any; even medicines like iron and folic acid are not available either at the district headquarters or in the peripheral areas. It was told that situation regarding these provisions is the same across districts and the reasons for this are more a doing of the authorities in Lucknow than in the districts. Under the circumstances things like supportive supervision etc. would seem other worldly. All in all the struggle to make the health services deliver in UP seems as daunting as ever; may it be a bottom of the table district like Faizabad, or the top of the table district like Jhansi.

1. Introduction

Uttar Pradesh (U.P.) is the most populous state of the country with the population of 19,95,81,477 as per the census 2011. State has 18 divisions, 72 districts and 821 blocks.

Figure 1: **Political map of Uttar Pradesh.**



U.P. is to India what India is to the world. Uttar Pradesh health indicators can have the make or break impact on the national health indicators of India, and therein lays the challenge of improving the performance of the public health system in U.P. It is rather ironical and tragic that corresponding to the political weight of the state in national politics, the development indicators of the state, especially those concerning human development remain dismal.

It is in this context that for this quarterly state monitoring visit of UP the relatively better performing district of Jhansi was chosen. The following report is based on the secondary data on India and UP availed from HMIS portal of NRHM and the data collected during the visit to district Jhansi.

Figure 2: Location map of district Jhansi in UP.

2. Comparison of UP relative to India

Tables 1 to 7 and Figures 3 to 16 give a comparative picture of the performance of public health system in UP vis-à-vis the national average. These are divided into four sections – Maternal healthcare, Child healthcare, Family Planning and Service delivery.

2.1 Maternal Health

Even as the average national performance leaves much to be desired, the performance of UP is even more lagging behind in almost every aspect of maternal health. While the proportion of institutional deliveries is much below the national average and the proportion of home deliveries among the reported deliveries is as high as 21 percent, the proportion of unreported deliveries in the expected number of deliveries is as high as 44 percent. This in itself is a comment on the reach and the coverage of the health system in the state. There are a few issues that arise out of this and need be discussed.

Table 1: Comparison of maternal health care indicators – Uttar Pradesh versus India.

Performance between April 12 to March 13	India	Uttar Pradesh
Percent ANC registration against expected pregnancies	91	76
Percent 3 ANC checkups against reported ANC registration	74	75
Percent 2 TT injections against reported ANC registration	83	98
Percent of ANC women given 100 IFA tablets against total registration	79	66
Percent high BP cases detected against reported ANC registration	2.6	2.0
Percent of eclampsia managed against reported ANC registration	.23	.14
Percent of severe anemia (Hb<7) treated against reported ANC registration	1.8	1.0
Percent of home deliveries against expected deliveries	13	21
Percent of institutional deliveries against expected deliveries	59	35
Percent unreported deliveries against expected deliveries	29	44
Percent C-section deliveries against institutional deliveries	12	3.0
Duration of stay less than 48 hrs as percentage of reported institutional deliveries	49	73

2.1.1. **Functionality of ASHAs & ANMs**

ASHAs and ANMs are the peripheral most interface of the public health system with the community. As of March 2013, 136174 number of ASHAs were proposed to be put in place in UP. Of these 136094 ASHAs had been selected i.e. 99.94 percent of required ASHAs were in place. Theoretically this means that the public health system had reach to each and every person in the state. Since recruitment of pregnant women for ANC and institutional delivery is the most important of the tasks assigned to ASHAs and also the one for which they get the maximum incentive among all other activities; it is surprising that 44 percent of the expected deliveries ought to have gone unreported.

One needs to look into the reasons for this – is it that the ASHAs are not adequately trained to do their work with sufficient proficiency; or are they simply not carrying out their functions; is it

that many of these unreported deliveries are being diverted to the private sector, perhaps by the ASHAs and hence not being reported; or is it due to poor oversight of the work of the ASHAs?

There definitely seems to be a shortfall in the number of ANMs in the state. As per the 2011 census the rural population in the state stood at 15,51,11,022. Given the criterion of 1 ANM per 5000 population the total number of ANMs required for the state as per 2011 population norms would be 31,022, whereas the state PIP for 2013-14 informs that there were only 3,023 ANMs in the state as of 2012-13. The state had proposed to recruit another 6,737 ANMs to take the total to 9,760, which still is much below the required strength. In such a situation there is no question of there being a second ANM at the sub-centers.

Such a huge deficiency has obvious consequences for service delivery. Notwithstanding other services, this raises serious doubts regarding making sub-centers functional as delivery points. Besides, there can be little help to the ASHAs and supportive supervision of their work by the ANMs. Resultantly, the system remains at a loss to know as to what is happening to such a huge number of pregnant women and their babies in the state.

In as much as information is the key to public health planning, such debilitating shortfalls in the strength of even peripheral workers, let alone the more specialized ones, is a hindrance to effective public health planning in the state and needs to be attended to forthwith.

Apart from public health planning there are issues regarding the quality of care. Under the circumstances what do we make of 76 percent ANC registration – weather it is genuine or only on records; even if genuine what is the quality of such care. The answer can perhaps be had in the statistic that only 1 percent of the ANC registered women were found to be severely anemic in UP. Further, the proportion of C-section deliveries in the institutional deliveries is only 3 percent, meaning thereby that most probably a number of high risk cases are simply not being identified during ANC check-ups. We shall find further evidence of the poor quality of ANC and delivery services while discussing the findings of Jhansi district.

Table 2: Janani Suraksha Yojna performance indicators – Uttar Pradesh versus India.

JSY performance indicators between April 12 and March 13	India	Uttar Pradesh
Percentage JSY registration against reported ANC registration	58	63
JSY paid to mothers – percent of reported home deliveries	7.0	6.0
JSY paid to mothers – percent of reported institutional deliveries in	82	113

63 percent JSY registration of the total ANC registration of 76 percent of the expected deliveries actually translates to coverage of only about 48 percent of the expected deliveries under the JSY

scheme. For a high focus state like UP with a high proportion of BPL and SC population this figure is rather low and limits the overall impact that is desired of the scheme.

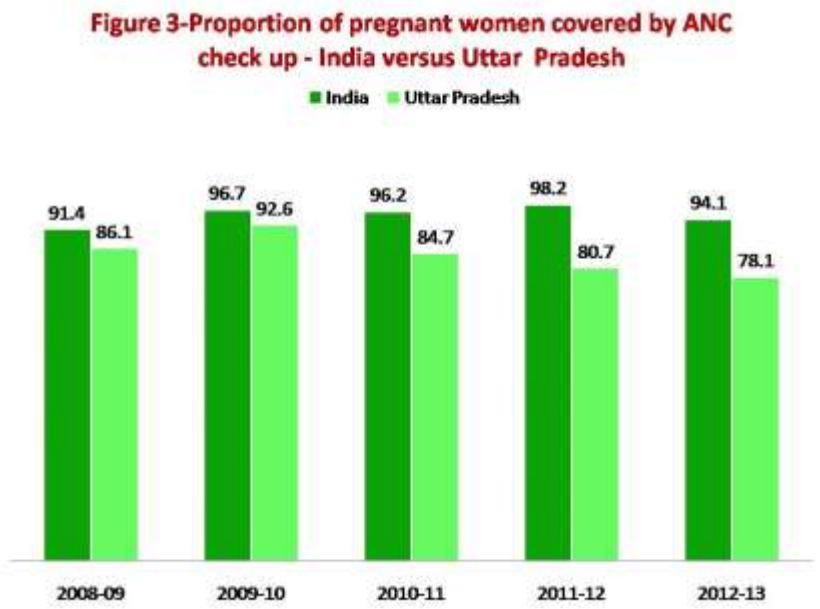
Table 3: Maternal deaths by cause.

Causes between April 12 to March 13	India	Uttar Pradesh
Abortions	3.24%	3.84%
Obstructed / Prolonged labor	5.31%	7.40%
Severe hypertension / Fits	10.5%	7.70%
Bleeding	15.0%	8.30%
High fever	4.35%	7.40%
Other causes	61.5%	65.4%

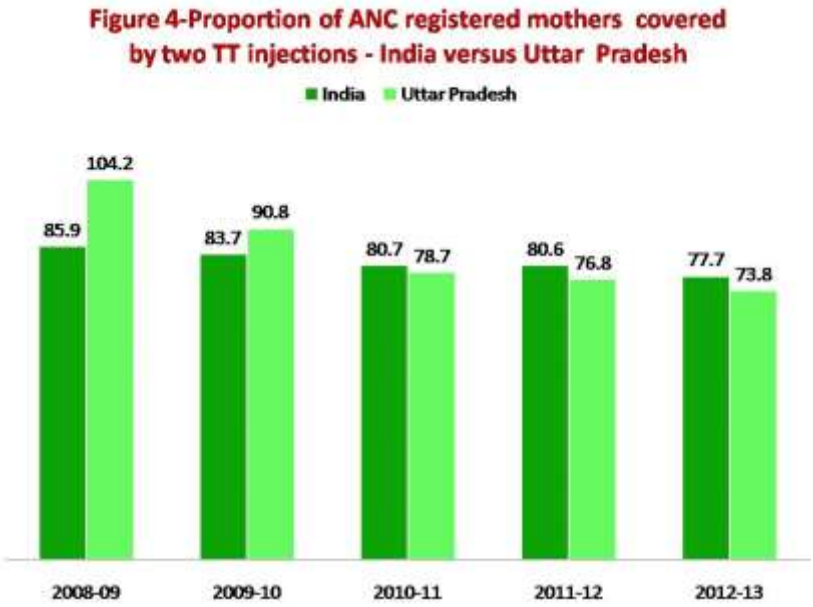
As to the causes of maternal deaths reported in table 3 it is very difficult to comment anything worthwhile given the fact that as high as 65 percent of the deaths have been ascribed to 'others' category. Even the proportions that are attributable to definite causes are circumspect as proper maternal death review is difficult to find in UP.

2.1.2 Five Year Trends

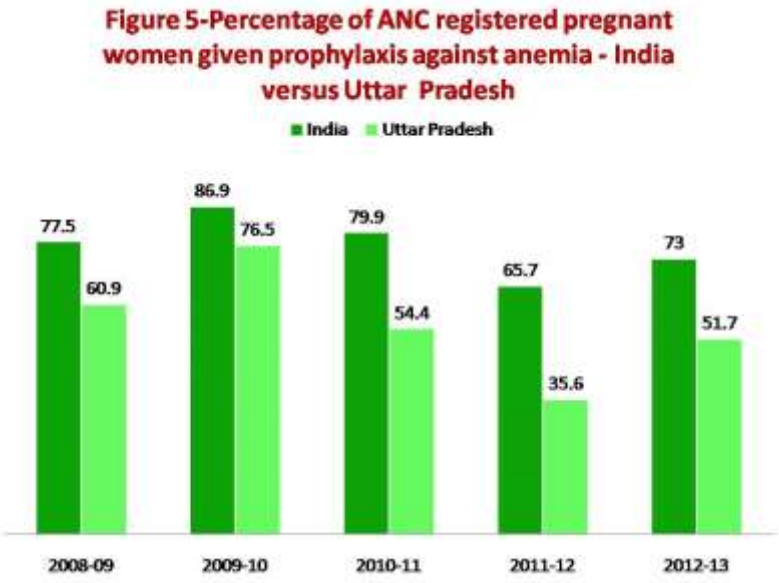
Figures 3 to 7 give the last five years trends in the maternal care indicators as per the HMIS data of NRHM.



Uttar Pradesh has consistently lagged behind the national average performance in the ANC registration of pregnant women as a proportion of the total expected pregnancies. Additionally what is observed is that the proportion of ANC registration itself has been falling over the years for UP.



Coverage of ANC registered pregnant women with two TT injections over the years offers no cheers either. Even as UP has been lagging behind India the TT coverage of pregnant women for both India and UP as a proportion of ANC registered women has been declining. This possibly bears out the result of the deficiency in the strength and training of the community level health workers in case of UP as has been pointed above; and inter-alia for India as the performance of UP heavily impacts on the national performance.



The performance for anemia prophylaxis follows the aforementioned trends except that the performance for UP has dipped more sharply in this case before making a marginal recovery in 2012-13. Even whatever coverage is there is circumspect for three reasons – one, the women are given iron and folic acid tablets which per se have bad side effects like lingering bad taste, constipation and gastritis. It has been historically known that for these reasons the women generally do not consume these tablets.

Secondly, if they were to consume these then it should reflect in the form of improvement in hemoglobin levels. However, the inspection of the ANC records, at least in case of UP, shows that in all probability hemoglobin levels are rarely done regularly and if done at all, they are never recorded on the ANC registered. The fact that just about 1 percent of the ANC registered women were detected with severe anemia in UP in last year only goes to support our contention because it is widely acknowledged through national surveys that iron deficiency anemia is a widely prevalent nutritional problem among women in India, especially pregnant and lactating women.

Thirdly, it was reported by the district officials at Jhansi during the visit that at least since October last there has been an acute shortage of iron and folic acid tablets throughout the state. The reason for this being that the rate contract passed by the state for the supply of these tablets was very low. Resultantly, the supplier to whom contract was awarded has been reticent in making the necessary supplies. It was also told that the awarded firm is so small that it does not have the capacity to supply medicines to the entire state. Repeated reminders on part of the district administration to the supplier for the supply of iron folic acid tablets failed to elicit any response from them and when the district authorities wrote to the state regarding the matter, they themselves were questioned on what measures had been taken by them in this regard.

These issues were flagged by the author for immediate attention of the UP NRHM MD in a hope that corrective action shall follow.

Institutional deliveries in UP is a potentially problematic issue. It is problematic on face of it because the proportion of institutional deliveries in UP has been declining over last three years from 43 percent in 2010-11 to 35.7 percent in 2012-13 i.e. from an already low level to an even lower level. Worse still, it is not clear if the reasons for this trend are clearly understood by either the state or the central level health planners. It had been pointed out by the author in the monitoring report for the last quarter that there is a rising trend of ASHAs taking the pregnant women to private facilities for deliveries throughout the state and that the private sector is systematically tapping into the ASHAs by offering pecuniary benefits to increase its clientele. Worse still, the state government's schemes like the 'Merrigold scheme' openly propagate that ASHAs take the pregnant women to private nursing homes to 'reduce the workload of the public sector facilities.'

There is no sign yet that these issues have registered on the authorities at the appropriate level.

Figure 6-Proportion of institutional deliveries of all reported deliveries - India versus Uttar Pradesh

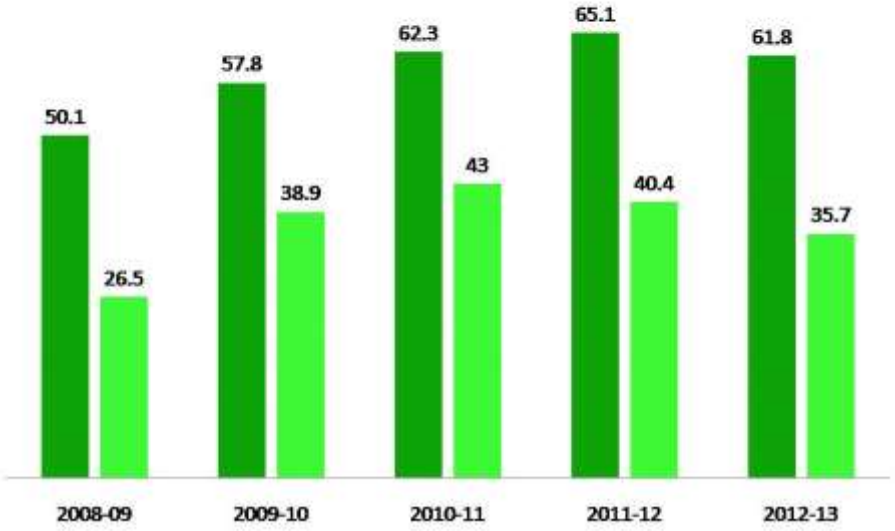
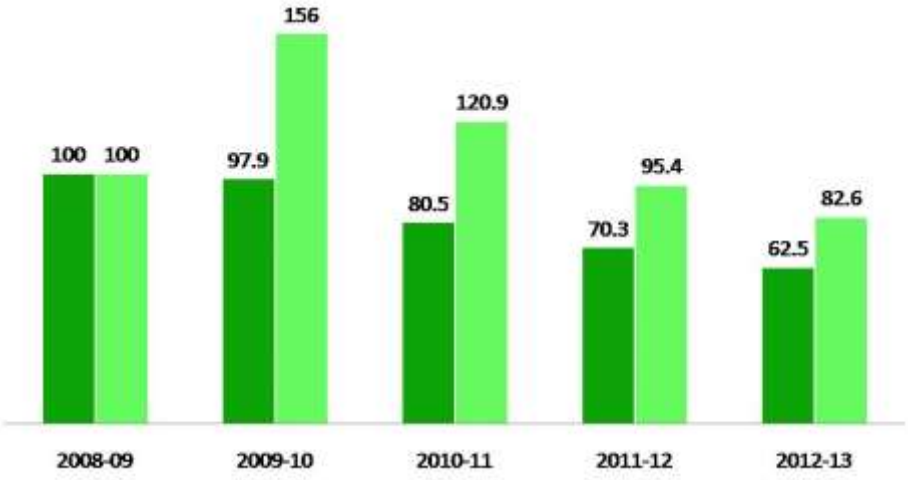


Figure 7-Home deliveries as a proportion of total reported deliveries taking figures for 2008-09 as the baseline - India versus Uttar Pradesh



With respect to home deliveries we have plotted the trends for the last five years taking the number of home deliveries in 2008-09 as 100 percent. While the proportion of home deliveries have been steadily declining for India, in case of UP there was sharp rise in home deliveries in 2009-10 after which there has been a declining trend with the number of home deliveries coming below the 2008-09 level in 2011-12. The trends in institutional deliveries shown above are overwhelmingly based on the data of public health institutions. If we place the declining

trend in home deliveries beginning 2009-10 and the declining trend in public sector institutional deliveries since 2010-11 together it points to the possibility that there are more institutional deliveries taking place in the private sector.

Any temptation to draw satisfaction from this by thinking that this is an increase in institutional deliveries nonetheless, would be shortsighted. Apart from benefits towards reducing maternal and infant mortality the one purpose of promoting institutional deliveries was to make safe maternity and child care services available to the poor free of cost or at very nominal rates as a matter of rights. What need be borne in mind is that if at all, these rights can only be honored in public sector while private sector shall entertain no shall obligation there by having adverse consequences due to huge out of pocket expenses and thereby defeating the entire purpose of incentivized institutional delivery scheme.

2.2 Child care

The state of child care indicators, especially those concerning neonates and infants couldn't be far removed from that of the maternal health indicators. Expectedly then UP has been lagging behind the national average here as well as per the relevant HMIS data given in table 4. As to the incidence of various infectious diseases given in table 5 one need only take the figures for whatever they are worth. The veracity of these figures becomes circumspect given that the incidence of diarrhea, malaria and respiratory infections is reported as considerably below the figures for India which is a highly unlikely scenario.

Table 4: Newborn care indicators (April 12 to March 13) – Uttar Pradesh versus India.

Indicator	India	Uttar Pradesh
Percent of reported live births against estimated live births	77	67
Percent newborns weighed against reported live births	89	75
Percent newborns breastfed within 1 hour of birth against reported live births	80	69
Sex ratio at birth	914	892

Table 5: Incidence of childhood diseases between April 12 to March 13 per lakh population – Uttar Pradesh versus India.

Childhood disease	India	Uttar Pradesh
Diptheria	0.41	0.90
Pertusis	0.16	0.22
Tetanus (neonatorum and others)	0.31	0.10
Polio	0.40	.00004
Measles	6.20	9.70
Diarrhea & Dehydration	315.5	87.9
Malaria	26.1	03.9
No. admitted with respiratory infections	116.1	04.8

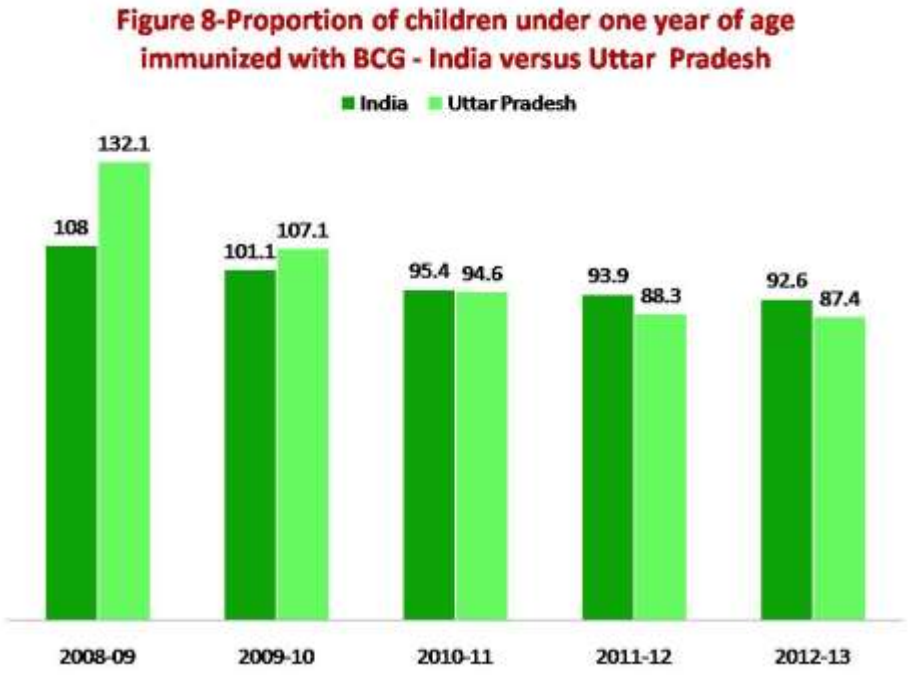


Figure 9-Proportion of children under one immunized with DPT - India versus Uttar Pradesh

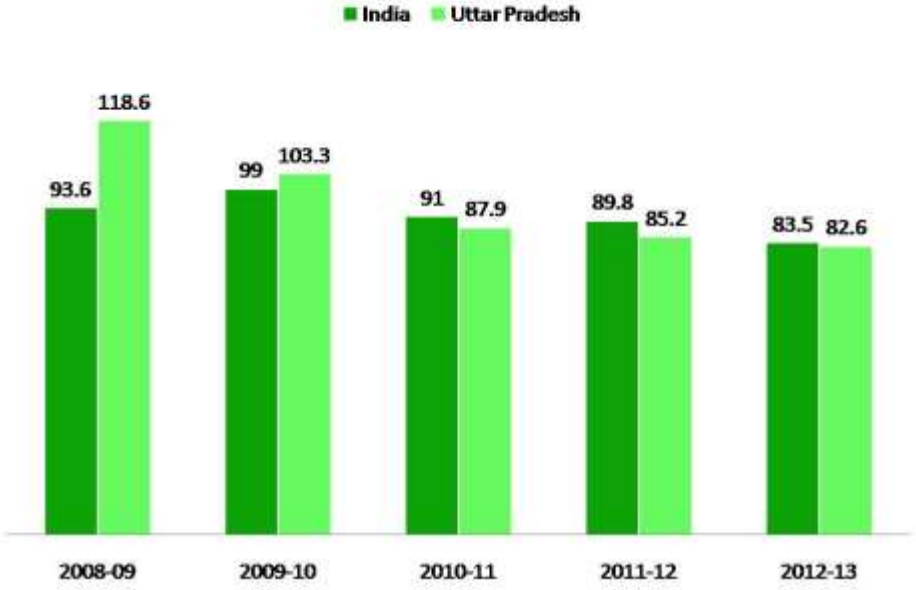
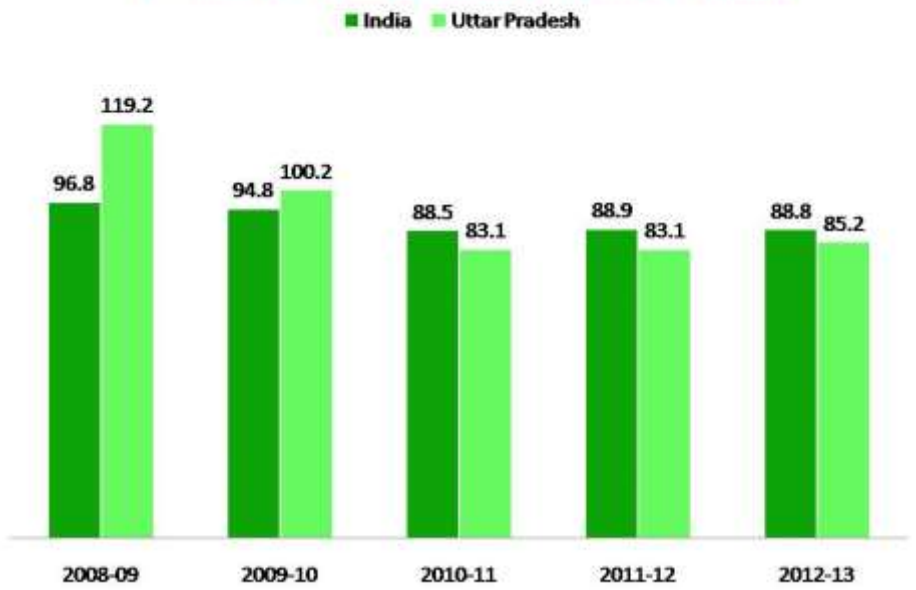
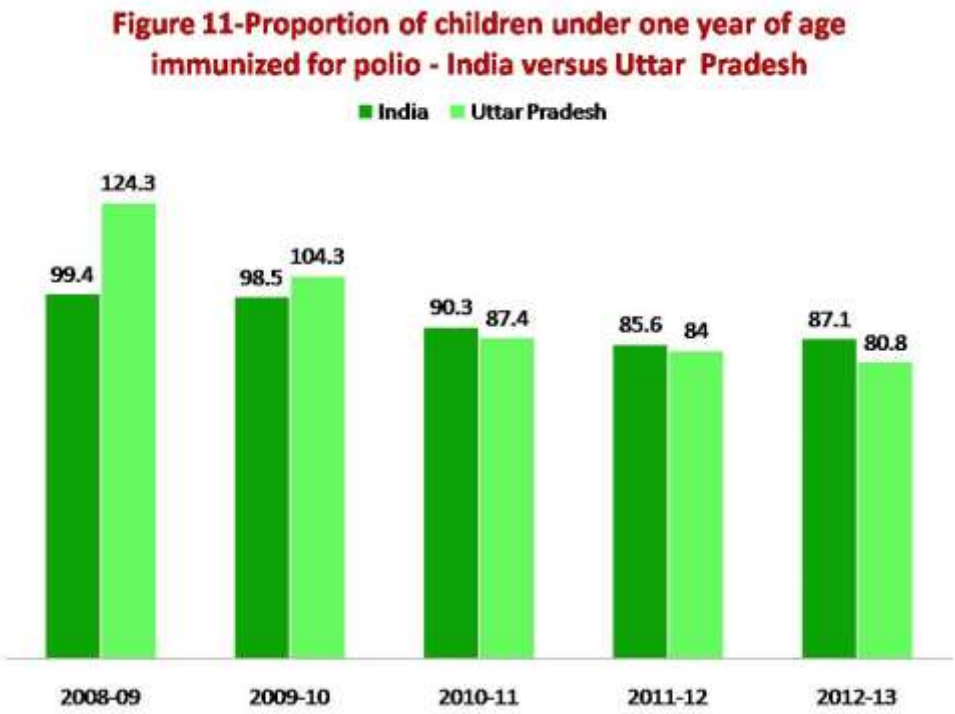


Figure 10-Proportion of children under one year of age immunized for measles - India versus Uttar Pradesh





The trends in immunization of children below one year of age are quite in line with the trends in the other indicators discussed above. However, what is of concern here is the decline in the proportional achievement of immunization targets in successive years both for UP as also for the country at large. This is something that should evoke immediate concern of the health managers both at the state and the national levels.

2.3 Family planning

Expectedly the proportion of those using spacing methods is more than the proportion of those using limiting methods; however, the differential between the two is much higher for UP as compared to the national average. This could possibly evoke the anxieties of those who privilege family planning methods over human development as the preferred route to population stabilization.

Table 6: Family planning performance (Apr 12 to Mar 13) – Uttar Pradesh versus India.

Indicator	India	Uttar Pradesh
Percentage of family planning users using limiting methods	24.07	11.53
Percentage of family planning users using spacing methods	75.93	88.50

Figure 12-Proportion of condom users among eligible couples - India versus Uttar Pradesh

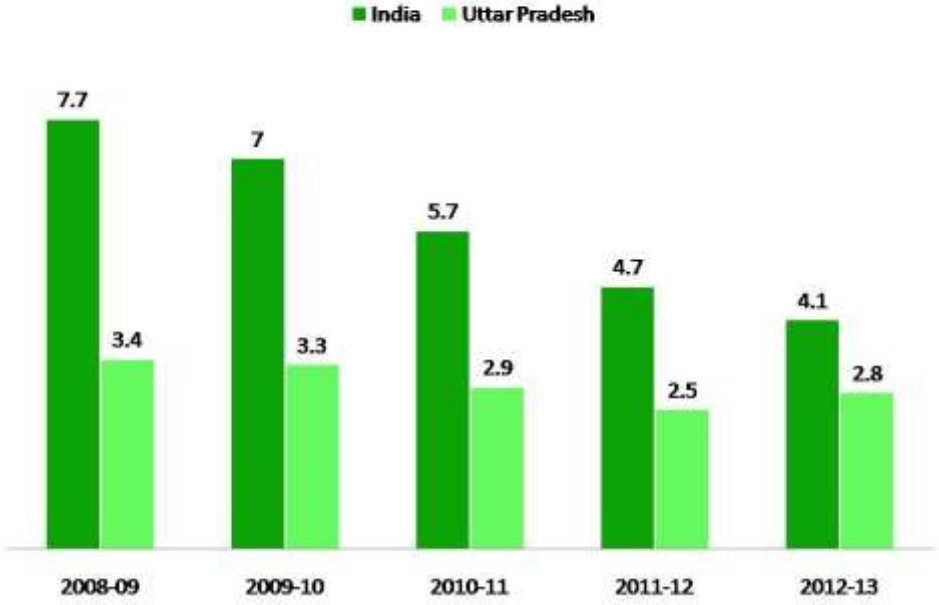


Figure 13-Proportion of IUD insertions among eligible women – India versus Uttar Pradesh

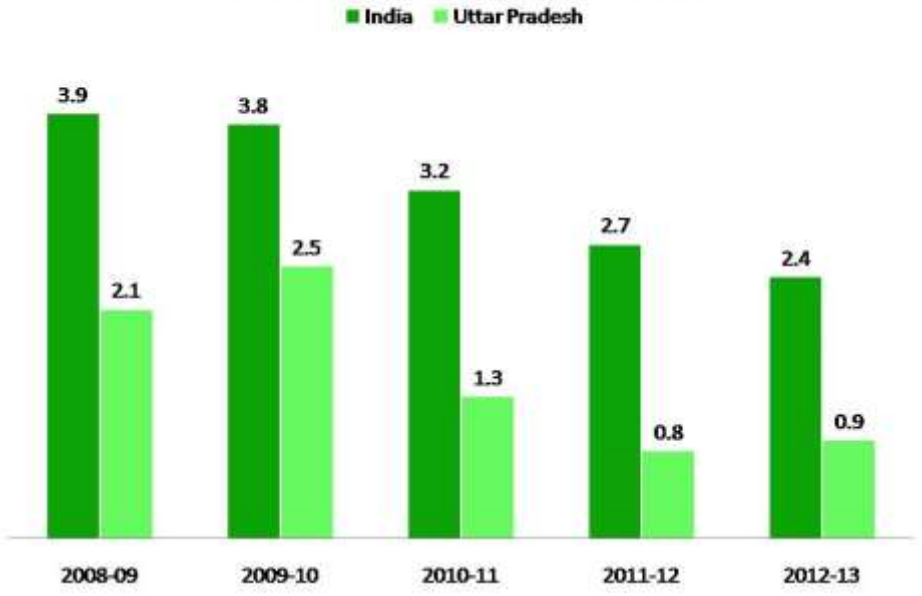


Figure 14-Proportion of sterilization among eligible couples - India versus Uttar Pradesh

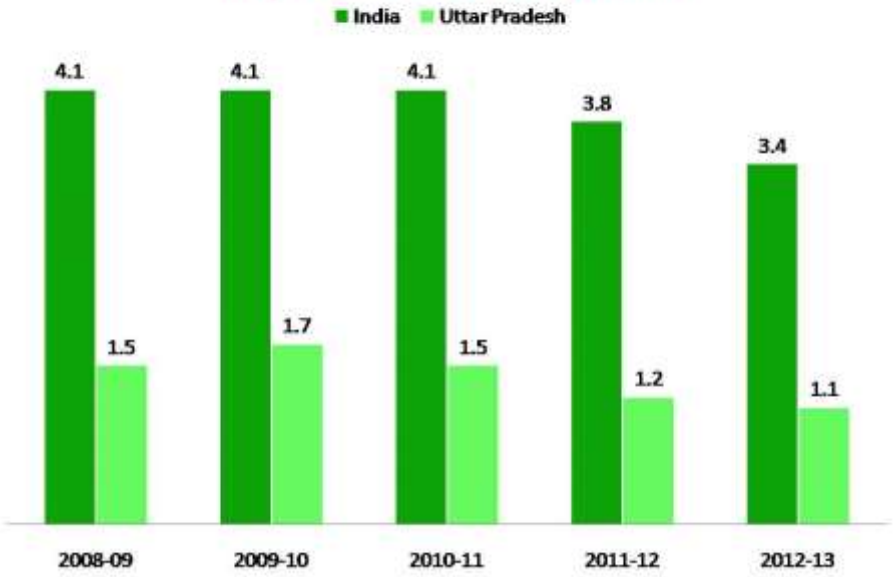
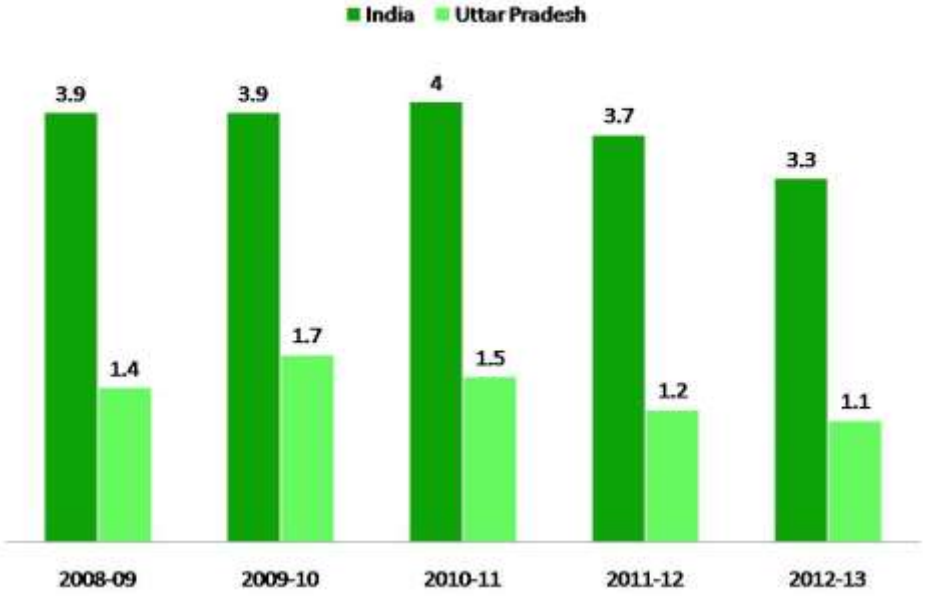
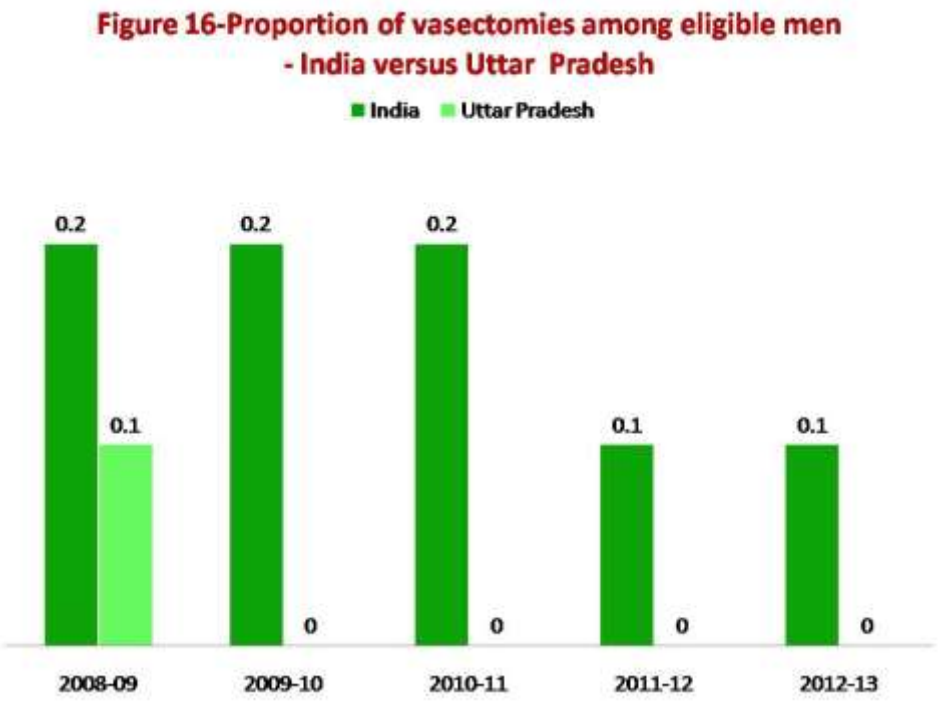


Figure 15-Proportion of tubectomies among eligible women - India versus Uttar Pradesh





It is not as though the national average performance is any great in terms of adoption of different family planning methods; however, that of UP lags far behind even these modest achievements. Nonetheless, the total fertility rate for both the country as also the state is falling; one only need wonder if this can be ascribed to these rather humble achievements of the family planning program in the country, or is it that the people have always known since eons how to control their numbers as and when they have felt the need irrespective of the modern family planning methods.

2.4 Service delivery indicators

One would really be hard put to make out a case that the people in UP are healthier than those in the rest of the country and thereby the service utilization is less in UP. The markedly lower service utilization for UP as compared to the national average is rather an indication of the poor quality of services being provided by the public health institutions. The O.P.D. visits per 1000 population is about 2.5 times more for India than that for UP while the national average for I.P.D is roughly the double that of UP.

Table 7: Comparison of service delivery indicators (Apr 12 to Mar 13) – Uttar Pradesh versus India.

Indicator	India	Uttar Pradesh
O.P.D. per 1000 population	685.36	264.27
I.P.D. per 1000 population	33.000	15.220
Major operations (general & spinal anesthesia) per 100,000 population	290.98	291.20
Minor operations as % of O.P.D.	00.580	00.410
AYUSH as % of O.P.D.	04.300	00.900

3. District health system, District Jhansi

Jhansi district is located in south-western border of the state in the Bundelkhand region of UP. The district is intersected or bounded by three principal rivers, the Pahuj, Betwa and Dhasn. At present Jhansi is a Divisional Commissioner's Headquarter including district Jhansi, Lalitpur and Jalaun.

Figure 17: District Map of Jhansi.

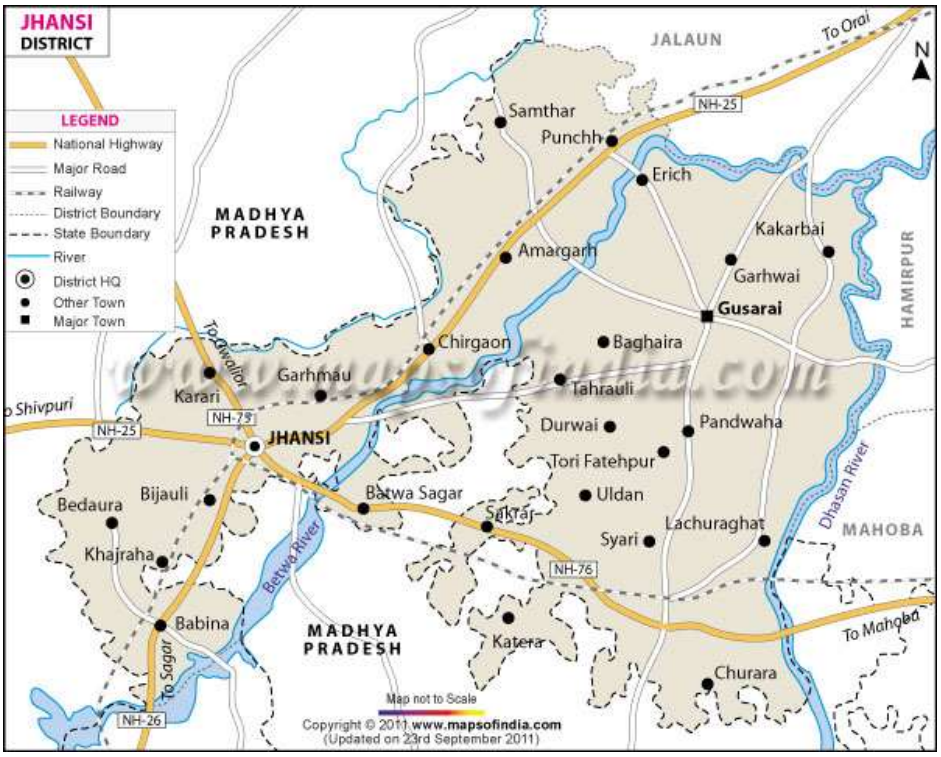


Figure 18: Map of Jhansi division of UP consisting of three districts of Jhansi, Jalaun and Lalitpur.

The district has one of the largest mining industries in the state. The more prominent towns are Mauranipur, Garautha, Moth, Babina, Chirgaon, Samthar and Gursarai. Bundelkhand region is one of the richest in terms of natural resources, but the area is grossly undeveloped. Major problems associated with the region are those of draught, development disparities due to very selective and limited industrialization, scarcity of potable water and declining economic and social status of indigenous population like the Saharias – a tribal community that inhabits parts of the district. In the past there have been well publicized instances of Sharias, especially their children dying due to starvation.

Lots of males are engaged in stone crushing industry while the women of the district are engaged in Bidi making. Agriculture however, is the predominant occupation for the overwhelming majority of the people in the district, but it s development remains neglected in terms of attention given to it and resources invested in it by the government.

Table 8 below provides the description of the administrative units of Jhansi, while Table 9 gives a description of the public health infrastructure of Jhansi district. Table 10 on the other hand presents a comparison of socioeconomic and development indicators between Jhansi and the parent state of UP.

Table 8: Administrative characteristics of Jhansi.

Administrative unit	Number	Name
Number of Tehsils	005	Garautha, Tehrauli, Jhansi, Moth, Mauranipur
Number of blocks	008	Badagaon, Chirgaon, Moth, Gursarai, Bamaur, Mauranipur, Bangra & Babina
Number of Gram Sabhas	437	-
Number of revenue villages	818	-
Number of Nagar Panchayats	007	Badagaon, Moth, Katera, Ranipur, Todi-Fatehpur, Erach & Garautha
Number of Nagar Palika Parishad	005	Chirgaon, Samthar, Barusagar, Mauranipur & Gursarai
Number of Nagar Nigam	001	Jhansi Nagar Nigam
Total number of Nagar & Nagar samuh	018	-

Source: Data provided by district health authorities.

Table 9: Public health infrastructure in district Jhansi.

Type of health facility	Number	Name
Super specialty hospital	0	-
Medical college hospital (allopathic)	1	Maharani Laxmibai Medical College
Medical college hospital (AYUSH)	1	Rajkiya Ayurvedic College
District Hospital	2	District Hospital & District Women Hospital
Women hospitals	3	At Garutha, Baruasagar & Samthar
Rural PPC Hospitals	2	Mauranipur, Samthar
CHCs (including Block PHCs & FRUs)	8	Mauranipur, Babina (FRU), Bangra, Gursarai, Moth, Badagaon and Chirgaon & Bamaur (BPHCs)
PHCs / Additional PHCs	36	-
Sub-centers	326 (311 in govt.	-

	bldg. & 15 on rent	
Ayurvedic hospitals / Dispensary	18 (in donated bldg.)	-
Homeopathic hospitals / dispensaries	9	At District Hospital, Nandanpura, Sipri, Chirgaon, Mauranipur
Urban Health Post	7	Itwari gang, Rajghat, Pulio No 9, Sipri, Jhokan Bag, Tehseel, Nagra
ESI Hospital	1	-
Railway Hospital	1	-
Military General Hosp.	1	-
Cantt Hospital	2	Jhansi Cantt & Babina Cantt
BHEL Hospital	1	-
Pariksha Thermal Hospital	1	-

Source: Data provided by district health authorities.

Table 10: Basic socioeconomic and demographic characteristics, district Jhansi.

Socioeconomic / demographic parameter	Uttar Pradesh	Jhansi
Total population (2011 census)	199581477	2000755
Rural population	155111022	1164749
Urban population	44470455	836006
Decadal growth rate (2001-2011)		
Total	20.09	14.66
Rural	17.81	12.74
Urban	28.75	17.46
Density of population (persons/sq km) (2011 Census)	828	398
Total literacy rate (2011 Census)	69.72	76.37
Male	79.24	86.58
Female	59.26	64.88
Proportion of school going children	-	66.69
Males	-	80.11
Females	-	51.21
Number of Anganwadi centers	-	1378

Percent of BPL population	63.5	24.8
Sex ratio (No of females / 1000 males) (2011 Census)		
Overall sex ratio	908	885
Child sex ratio	899	859
Infant mortality rate (AHS 2010-11)		
Total	71	42
Rural	74	50
Urban	54	30
Neonatal mortality rate (AHS 2010-11)		
Total	50	33
Rural	53	40
Urban	36	24
Under five mortality (AHS 2010-11)		
Total	94	61
Rural	101	76
Urban	68	43
Maternal mortality rate	359 (SRS)	241 (AHS 2010-11)
Crude birth rate (AHS 2010-11)		
Total	25.5	19.6
Rural	26.9	22.0
Urban	20.6	17.1
Crude death rate (AHS 2010-11)		
Total	8.6	6.9
Rural	9.1	7.7
Urban	6.9	6.1

Source: Data provided by district health authorities.

3.1. Performance of Jhansi vis-à-vis UP

Before we go on to describing individual facilities we shall have a look at the comparative indicators for Jhansi and UP with respect to maternal health, child health and family planning just as we did for UP with respect to India. The data for the district was as provided by the DPMU (District Program Management Unit) while that for the state was obtained from the NRHM HMIS portal. Due to limitations of data availability from the DPMU, Jhansi the following analysis is only as comprehensive as it could be under the circumstances.

3.1.1. Maternal health services performance

Figures 19 to 22 give us an abriged picture of maternal health services in the district as compared to that in the state. Even though the performance in terms of ANC services and institutional deliveries seems to be better for Jhansi as compared to UP, this still much to be desired.

Figure 19 - Proportion of pregnant women covered with TT – Uttar Pradesh versus Jhansi.

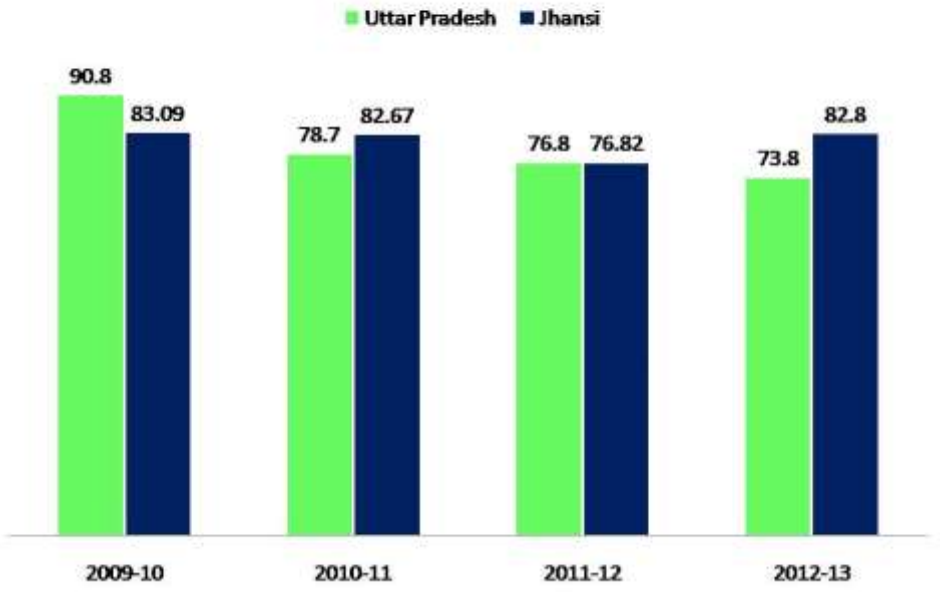


Figure 20 - Proportion of pregnant women covered for iron prophylaxis – Uttar Pradesh versus Jhansi

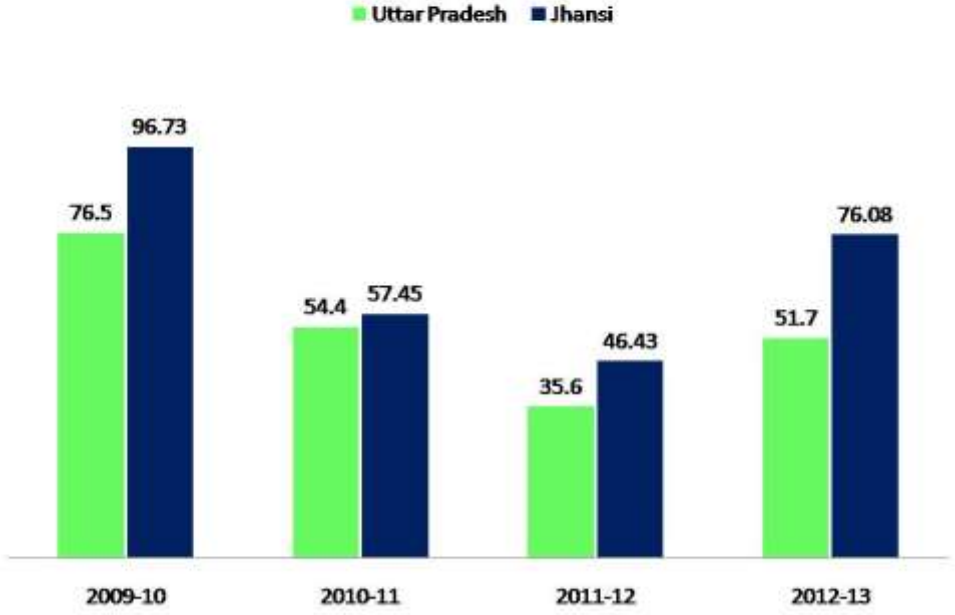
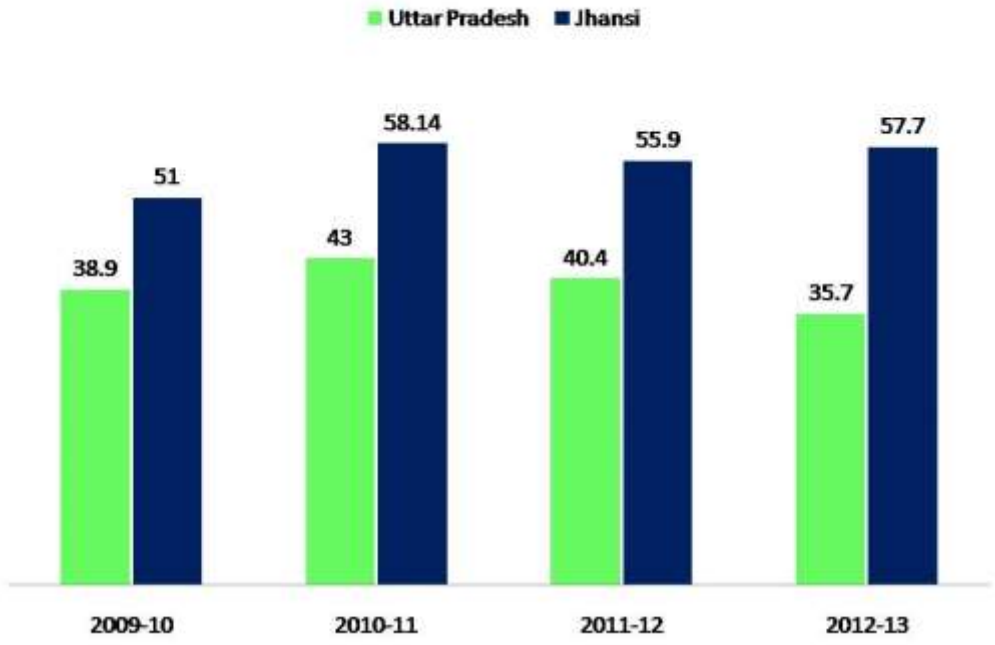
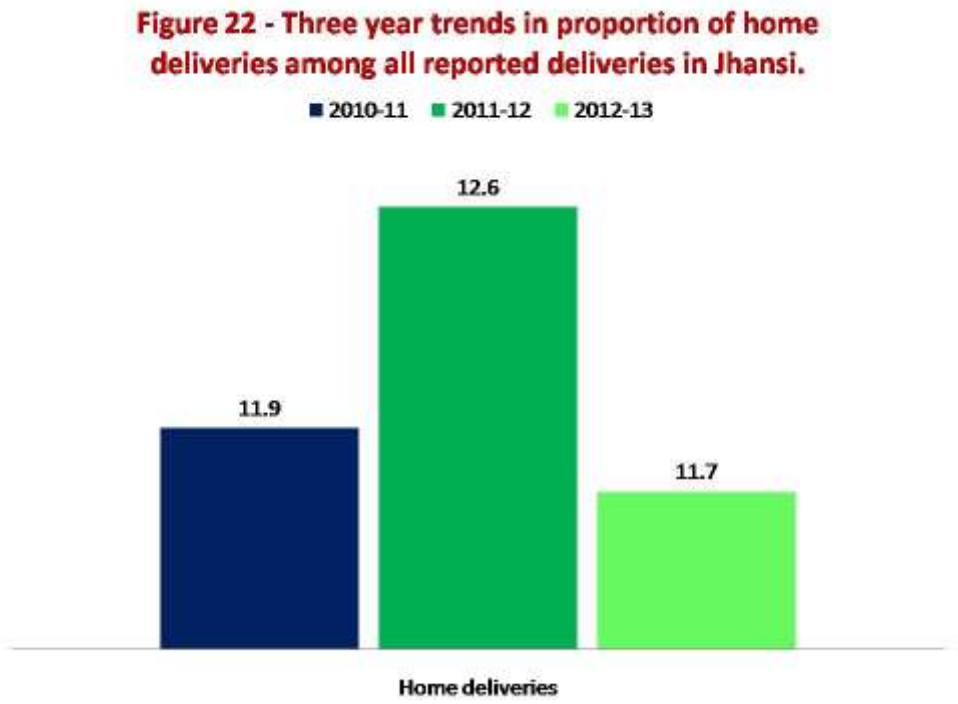


Figure 21 - Proportion of institutional deliveries in all reported deliveries – Uttar Pradesh versus Jhansi.





We have already noted above that even iron and folic acid tablets are not available in the state for distribution to pregnant women due to mismanagement of drug procurement in the state. TT injections however are available and the dates of giving the 1st and the 2nd dose are about the only other thing apart from the name and the age of the ANC registered woman that can be known from the ANC register. Invariably, at every facility that was visited in the district the ANC register was either not available on the spot or if it was available there was no noting on any of the investigations done, weight gain or blood pressure record leaving little to imagination as to the worth of such ANC care.

The institutional deliveries in Jhansi are ostensibly doing better than in the entire state. However, it need be noted that over last three years achievement in this regard has become stagnant as evident from figures 21 and 22. Apart from a stagnant proportion of institutional deliveries, the proportion of reported home deliveries also seems to be getting recalcitrant. Over and above this the quality of institutional deliveries is abominable.

Pregnancy and labor is a normal physiological process and would reach its outcome irrespective of medical oversight. The idea of institutional deliveries is that the delivery is medically supervised such that potential complication are timely taken care of and thereby reducing the threat to the life of the mother and the baby which are likely in countries like India due to the various kinds of socioeconomic deprivation faced by women. However, there was little to

observe from which it could be concluded that the pregnant women benefit from quality medical supervision.

At CHC Mauranipur and Badagaon the inspection of the case files of the mothers showed no clinical notes as to the health of the mother (general condition, pallor, weight, blood pressure etc), the baby in-utero or the progress of labor. On being asked to take the B.P. the nurse and the doctor at the labor room at CHC Mauranipur could not find a stethoscope which had to be procured from the ward. The ANMs, LHVs and staff nurses were found to be fumbling while answering simple questions like what should be the likely weight gain by the mother during pregnancy, or how would they assess that the baby was doing fine in the womb or what steps need be initiated if the baby did not cry after birth.

Even the conditions at the District Women Hospital were highly deplorable. This is only the second public sector facility in the district after the Medical College which is designated as level 3 delivery point. Table 11 below gives the status of total admissions in the labor room and the number of C sections performed at the District Women Hospital for different years. Going by the general observation that on an average 10 percent of the delivery cases require C section the number of cesarean sections performed by the hospital is too less. Given the situation, there is little scope for any other kind of gynecological surgeries like hysterectomy etc which do not happen at the hospital. This speaks of the level of referral services being provided by the hospital.

Table 11: Labor room statistics, District Women Hospital, Jhansi.

Year	Admissions	10% of total admissions	Cesarean sections performed
2010	5583	558.3	-
2011	5506	550.6	12
2012	5459	545.9	12
2013	2265	226.5	21

Source: Data provided by District Women Hospital, Jhansi.

The medical superintendent of the hospital told that part of the reason for such a low score of cesarean sections was that no blood is available at the hospital after 2.00 pm even though there is a fully functional and highly equipped blood bank right next door in the District General Hospital. The blood storage unit equipment that was supplied to the hospital has not worked even for a day since four years back when it was first supplied. The superintendent of the hospital seemed clueless on how to redress the situation.

The NBCC in the hospital major OT did not have a suction pump for the baby, which it was told is procured from the labor room in case of need. After 2 pm there is only one staff nurse in the

entire hospital to look after the labor, room, the OT and a 40 bed maternity ward. Little wonder then that the mothers admitted in the ward reported that no one had counseled them regarding breastfeeding or adopting family planning methods.

It was reported by some of the patients that they were charged up to Rs 20 even for blood investigations at the hospital and up to Rs 100 for ultrasound at the district general hospital when the USG machine was not functional at the Women Hospital. Surprisingly, the doctors at the hospital appeared not to be aware of this. The dietary supply to the women at the hospital was also in shambles. Most of the women reported to be getting only bread and milk once a day.

3.1.2. Child health services

Figures 23, 24, 25 and 26 give the status of child immunization in district Jhansi as compared to that in UP. As noted with earlier trends though the performance of Jhansi is marginally better than that of UP, the overall performance itself exhibits a marginal decline since 2009-10 except for BCG vaccination where the coverage climbed back to the 2009-10 levels after declining in 2010-11 and 2011-12.

Figure 23 - Coverage of children less than 1 year of age for BCG – Uttar Pradesh versus Jhansi.

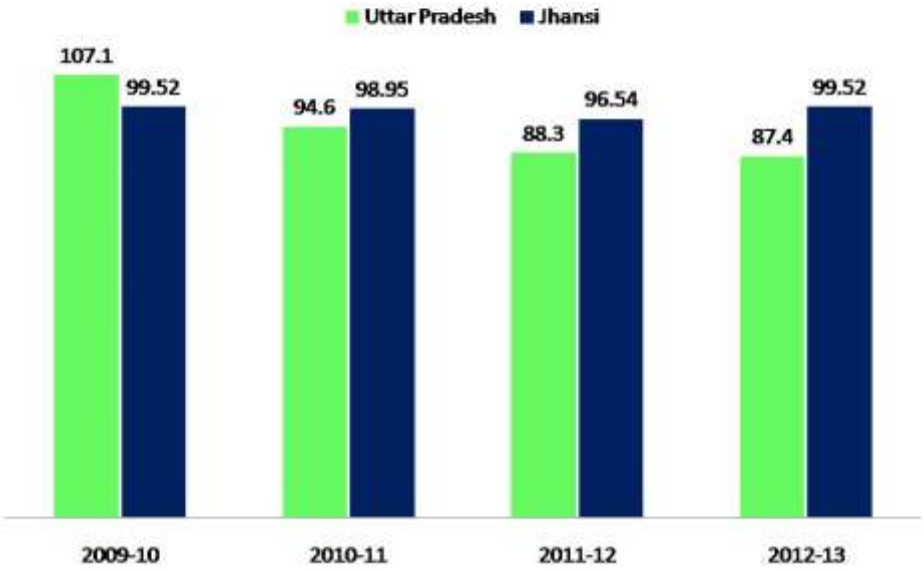


Figure 24 - Coverage of children less than one year of age for DPT – Uttar Pradesh versus Jhansi.

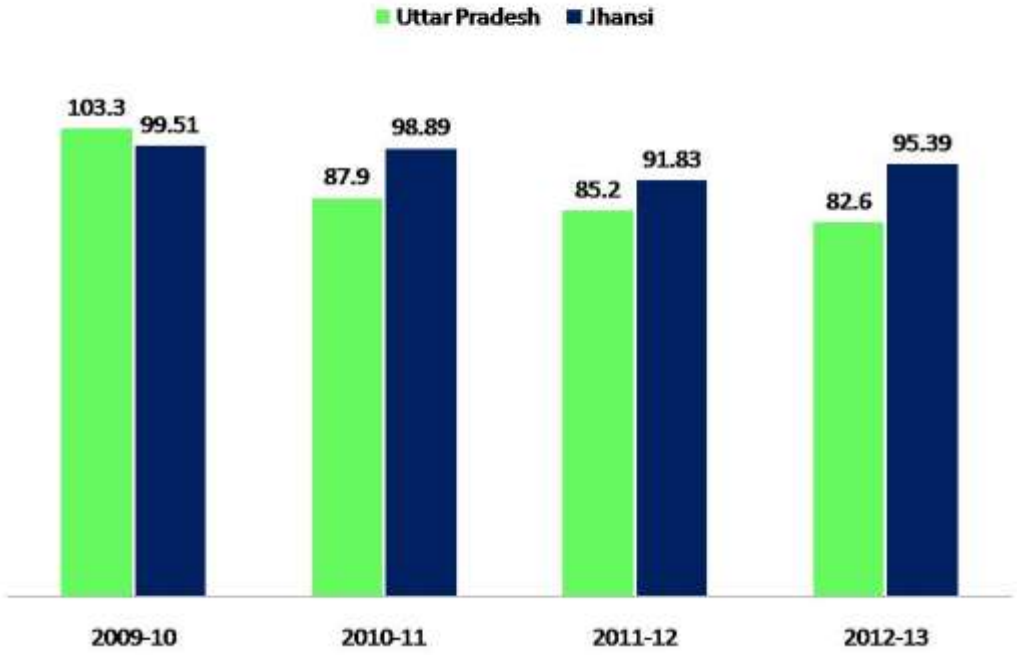


Figure 25 - Coverage of children less than one year of age for measles – Uttar Pradesh versus Jhansi.

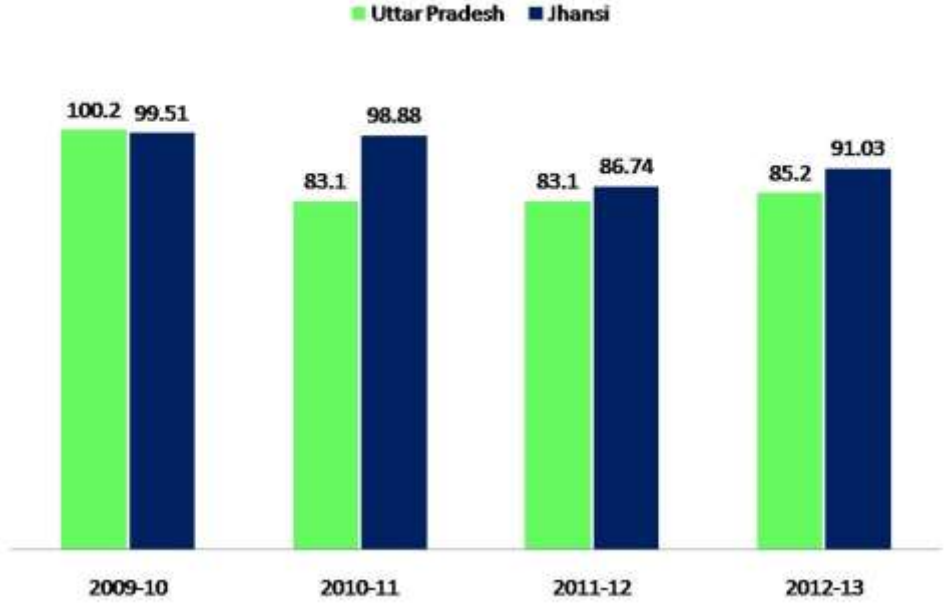
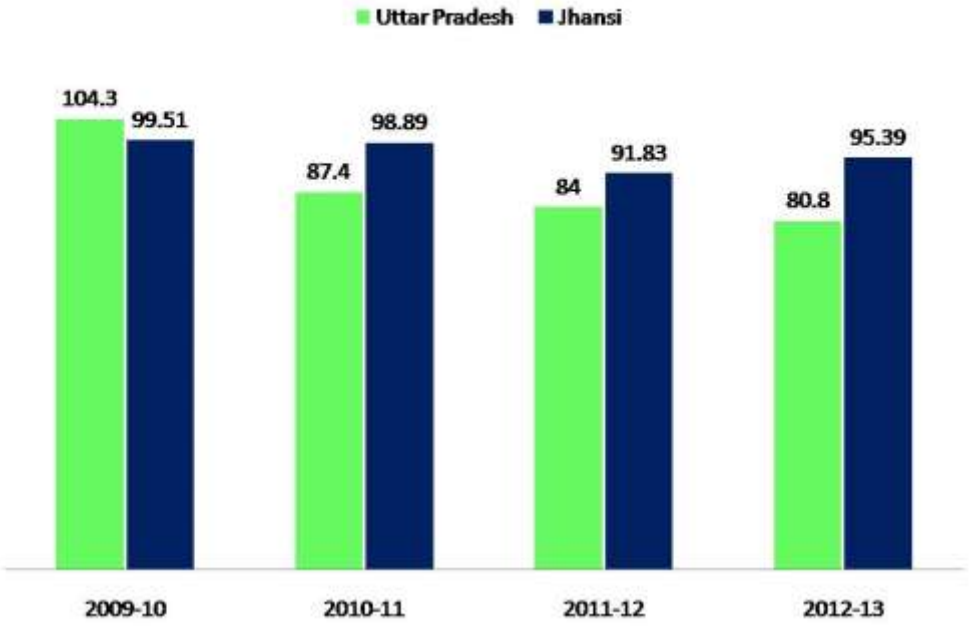


Figure 26 - Coverage of children less than one year of age for polio – Uttar Pradesh versus Jhansi.



3.2. Facility wise visits

Given the circumstances as they are, UP can be a very disappointing experience for any public health person. So in this report we shall begin with what was found to be positive in Jhansi district even as it is important to bring out the weaknesses as well with due seriousness to enable further progress in the development of the health systems.

The following health facilities were visited during the visit to the district:

1. District General Hospital
2. District Women Hospital
3. CHC Mauranipur
4. CHC Badagaon
5. PHC Ghatkotra

It could not be possible to visit a sub-center as it turned out that the sub-center at Kakarwara, under PHC Ghatkotra to which visit was planned did not have a regular ANM posted. The work

of the sub-center was being looked after by ANM from adjoining sub-center who happened to be on leave on the day of the visit. Visit to another sub-center at Barata under CHC Badagaon could not materialize due to heavy rain on the day of the visit to the CHC.

3.2.1. District General Hospital

Visit to the District General Hospital was the brightest spot during the entire visit and indeed one wondered that if this district hospital could function as well as it was functioning, then why can't the other district hospitals in the state function likewise? Located in the middle of the district hospital compound, the building housing the office of the district CMO could easily be among the most beautiful buildings in the city of Jhansi. The hospital compound per se was generally clean and affable.

The District General Hospital, Jhansi is a 256 bed secondary care hospital and is second only to the medical college hospital in terms of bed strength in the district. The daily OPD attendance of the hospital was told to be higher than even that of the medical college hospital. Among the specialist services being provided at the hospital are those of – internal medicine, general surgery, orthopedic surgery, dermatology, ophthalmology, ENT, cardiology, radiology and pathology.

Figure 27: Office of the district CMO, Jhansi.

Figure 28 - District Hospital Campus, Jhansi

Table 12 below gives the O.P.D and the I.P.D attendance at the hospital for the last three reporting years. For comparison Table 13 mentions the O.P.D. and I.P.D. attendance in other functional facilities providing curative care – the CHCs and the PHCs in the district.

Table 12: The O.P.D and I.P.D attendance at the District General Hospital for last three reporting years.

Month	2010-11		2011-12		2012-13	
	Indoor	Outdoor	Indoor	Outdoor	Indoor	Outdoor
April	4920	48852	4974	51825	4536	50434
May	4770	45762	4500	45871	4164	49099
June	3968	45700	4820	49699	4306	52237
July	4264	48348	4347	51786	4043	50598
August	4556	55782	4309	55773	4144	49830
September	4090	57214	4216	59454	5633	67360
October	3477	42589	4794	53148	4683	61850

November	3534	40329	4774	46277	3149	47353
December	4889	42778	6251	52045	2171	49824
January	4123	36804	6158	49935	5816	47702
February	4836	53873	6882	51066	7590	60830
March	4676	52335	6742	52125	8492	61516
Total	52103	570266	62767	618994	58727	648633
Per month	8294.17	47522.17	5230.58	51582.84	4893.92	54052.8

Source: Data provided by the District General Hospital.

As per the figures given in table 11 the average OPD and IPD for all years works out to 51582 and 5230.58 respectively. As per Table 10 above, 58 percent of the population in the district is rural. Given that fact that the incidence of poverty and malnutrition is higher in the rural areas than in the urban areas, the need for curative care is also higher in the rural areas. But here we find that the combined patient load of all the CHCs and PHCs providing curative care is much below the IPD and OPD patient load of the district hospital. This is an indicator not only of the functional status of the rural health facilities in the district but also of the continuing urban bias in the curative health services.

Table 12: Patient care load of different CHCs and PHCs in district Jhansi**.**

Parameter	Year	CHCs					PHCs			Total	Monthly
		Babina	Mauranipur	Moth	Gursarai	Badagaon	Bangra	Chirgaon	Bamaur		
O.P.D	Jan-Dec 2011	72405	67304	71653	63056	47639	44362	47267	35954	449640	37470
I.P.D.		13767	9126	2003	6276	1594	3208	3851	2617	42442	3536.84

3.2.1.1 General conditions at the district hospital

The corridors and the wards at the hospital were generally clean. Drinking water facilities could be noticed at more than one place in the hospital that was conveniently accessible to the patients and their relatives. There was a separate facility available for the stay of the out station patients and their relatives. However, the toilets were unclean and many of the wash basins did not have the attached drain. An added problem that was noticed was that there were too many attendants with the patients and they were even lying on the patient's beds.

Figure 29 – General conditions at the District Hospital Jhansi.

The general sanitation at the hospital is maintained by both regular employees as also the contract employees. The waste disposal at the hospital has been outsourced to a private agency.

The patients were provided food twice a day from the hospital. The kitchen services have also been outsourced to a private contractor who cooks food at a facility provided within the hospital complex. However, the services of a nutritionist are not available at the hospital. It was noticed that some of the patients were not being provided food apparently because no sanction had been obtained from the treating physician as had been made mandatory by some existing order. This issue was brought to the notice of the superintendent of the hospital and corrective orders were got issued from him.

3.2.1.2 Operation theatre

Figure 30 - Conditions at the operation theatre, District Hospital Jhansi.

There are three operation theatres available at the hospital; two are shared between orthopedics, general surgery and ENT, while there is a separate OT for ophthalmology. The OT are spacious, with patient waiting areas and recovery rooms. The cleanliness of the OTs left scope for improvement. It was told that fumigation of the Ots is done on weekly basis and carbolization is a daily procedure, but the log book for sterilization procedures was apparently kept in lock and key and was not available for inspection. The sterilization equipment in the OT was functional but no log book was maintained for the same.

The waste disposal procedures were not found to be strictly followed. Apparently, the syringes and needles are not destroyed before disposal as can be seen in Figure 30 above. Interestingly it was reported by one of the surgeons that he has been noticing an alarming rise in the incidence of hepatitis b antigen positivity in his patients as part of the routine pre-operative investigations. This matter was brought to the notice of the hospital authorities and orders were got issues for investigating at least 10 percent of the O.P.D patients coming to the hospital for hepatitis B antigen.

3.2.1.3. Diagnostic services and blood bank

The hospital has a functional laboratory for doing routine pathological investigations. Microbiological investigations beyond routine microscopy like culture and sensitivity are not available at the hospital.

Figure 31 - Diagnostic facilities at District Hospital Jhansi.

Among the radiological investigations all non-contrast studies and ultrasound is available at the hospital, while non-contrast C T Scan is available at the divisional diagnostic center. Divisional diagnostic center also provides other investigations like routine X rays, USG and specialized pathological investigations like liver enzymes, HIV testing and Hepatitis antigens. Even though the divisional diagnostic center is meant for all the three districts of the division, but there is not separate staff for the Center and it is manned by the doctors, technicians and employees of the district hospital only.

Blood bank at District Hospital is equipped with latest equipment and storage facilities. Facility for separation of blood component is also available at the blood bank. The problem however is that the blood bank functions only from 8.30 to 2.00 pm. This amounts to a huge wastage of such

an infrastructure which can be better utilized for emergency care if its facilities can be extended round the clock.

Figure 32 - Blood Bank, District Hospital Jhansi

3.2.1.4. OPD services

Figure 33 -Facilities at the OPD, District Hospital Jhansi

The District Hospital has a separate O.P.D block that is spacious, well lit and adequate waiting area for the patients. Signage guiding the patients to different facilities and providing information regarding health programs etc could be seen at appropriate places in the OPD building. There was a separate functional OPD for geriatric cases and for the screening of non-communicable diseases like cancers, diabetes, cardiovascular diseases and stroke that are covered by NPCDCS.

3.2.1.5. User charges

The state government has the policy of levying user charges on the patients for services provided from its health facilities. Even though the BPL patients are exempt from the charges, it is not infrequent to find that the few privileges that the poor are entitled to in the government system are practiced more in their violation than implementation. An example of this is provided by the following patient.

Figure 34: BPL patient in male ward of Dsitrict General Hosp, Jhansi.

Even though the patient in the photograph processed both the RSBY card and a BPL ration card he found it impossible to get his investigations done free of charge at the hospital; neither did his RSBY card work at a private hospital where he sought treatment prior to coming to the District Hospital. While many technical reasons can be found to explain why he could not avail of the facilities, the problem remains that in targeted interventions, invariably the persons for whom the relief is meant find it difficult to avail of it.

3.2.2. District Women Hospital

Though co-located with the District General Hospital in the same campus, the working of the District Women Hospital stands out in stark contrast to that of the former. We have already

discussed the functioning of the maternity care services at the hospital. Here we shall briefly mention the general conditions at the hospital.

Figure 35: District Women Hospital.

The state of cleanliness left much to be desired and things were generally disorganized. There is one laboratory at the hospital that does the basic pathological investigations. The USG machine at the hospital had been non-functional until 1 day before the visit when a new radiologist had joined the hospital. The Newborn Stabilization Unit (NBSU) of the hospital was not functioning as there was no pediatrician available at the hospital. However, one pediatrician has now been posted at the hospital and it was expected that the NBSU should soon be functional.

The operation theatre was thoroughly disorganized and had all the signs of not being utilized frequently. The sterilization equipment at the OT was out of order and the sterilization of instruments and linen was being done in the minor OT. There was no log book maintained for the sterilization procedures.

Figure 36 - Operation theatre, District Women Hospital, Jhansi.

Operation theatre, District Women Hospital

Non functional sterilization equipment

Figure 37 - Labor room at the District Women Hospital , Jhansi.

Essential drug tray in labor room

Labor room with NBCC

The labor room was spacious, clean and well equipped. The emergency drug tray was in place and the NBCC was in functioning condition.

3.2.3. CHC Badagaon

One observation that comes across from different monitoring visits is that the health facilities, especially the newer facilities, have been constructed at sites that minimize their utilization by the people of the area. CHC Badagaon is an excellent example of such a facility. Though situated on the highway it is still located at a place that majority of the people of the block do not prefer to access it. Anyone who comes on to the highway from the adjoining villages of the catchment areas of the CHC prefers to go straight to Jhansi Medical College hospital which is at a distance of barely 7 to 8 kms from the CHC. This aspect of the CHCs location has severely marred its

utilization by the people of the block. Similar issues were found concerning the location of new PHC at Ghatkotra and the PHC at Rewan under CHC Mauranipur.

Figure 38: CHC Badagaon.

While many reasons can be given for this, the point however is why adequate attention is found missing in making available the most suitable place for health facilities whose utility for the people remains unquestionable?

CHC Badagaon is a neat and clean facility but is virtually functioning as a dispensary with a daily OPD attendance between 35 to 40 patients. There are on an average 10 deliveries in a month. The ANC register at the facility could not be made available for inspection; however, the knowledge level of the LHV who was available at the facility did not inspire the confidence in her ability to do her job with some competence. Signage regarding JSSK was displayed outside the labor room.

There was one microscopy center at the CHC and the CHC laboratory was also located within the microscopy center indicating that there is not much load of lab investigations at the CHC. The microscopy lab technician also doubled as the pharmacist distributing the anti-tubercular drugs. There are no radiological tests available at the facility. The pharmacy at the CHC did not have the list of essential drugs as prescribed by the state; though the drugs available at the facility included antibiotics, cough syrup, paracetamol, anti-analgesics etc.

Cold storage equipment was available at the district but the proper technical hand to monitor the equipment was not there. One retired employee who has been engaged to look after the cold storage equipment did not even know that the thermometer in the iceline refrigerator had markings both on the positive and the negative side. A casual check of the thermometer at the time of the visit showed a temperature of 20 degrees centigrade rather than in minus as required. The temp log books were hanging by the ILRs but the temperatures were not updated in them.

3.2.4. CHC Mauranipur

Mauranipur is among the bigger blocks of the district and CHC Mauranipur is the biggest health facility of the block that provides inpatient care. It is designated as a level 2 delivery point and is the only public sector delivery facility in the block. All the inpatients are mostly delivery cases or short admissions for tubectomy. We have already discussed above the quality of ante-natal and delivery care provided at the facility. A NBSU has recently become functional at the facility with the posting of pediatrician.

Figure 39: CHC Mauranipur.

Rest of the work of the CHC largely comprises of running the daily OPD services. The daily OPD attendance is up to 150 patients. There are basic laboratory tests available at the facility. The microscope and the centrifuge were in functioning status.

Figure 40: Laboratory at CHC Mauranipur.

Figure 41: X ray facility at CHC Mauranipur.

The X ray equipment was functioning at the facility. About 20 to 25 X rays are performed daily at the facility.

The OT at Mauranipur is rather rudimentary, even though CHC is supposed to provide all matters of routine surgery. This was so inspite of the fact that MO in charge of the CHC is himself an orthopedic surgeon. But is only operations like tubectomies that are performed at the CHC. The sterilization equipment at the OT was said to be in functioning status though no log book either for the sterilization unit or for sterilization of the OT was maintained. Three ordinary stretchers lined up together served as OT tables which gave an impression that the OT was used more as a camp operation theatre for minor surgeries rather than for proper surgical procedures. There were no proper OT lights. Sanitary conditions were circumspect as we saw water collecting outside the OT after one rain that afternoon.

Figure 42b: Water collected outside the OT.

Figure 42a: Inside the operation theatre at CHC Mauranipur.

There was no essential drug list available at the pharmacy, neither the chart displaying the names of the drugs show the stock position. It was told that drugs are procured every month from Jhansi but the supply of all the drugs is not there. Most of the drugs prescribed by the doctors were said

to be available at the CHC, but some had to be purchased. However, the patients complained that they had to buy most of the drugs from outside. The cold chain equipment was properly maintained and temperature log maintained. When asked for immunization micro-plans, it was told that micro-plans were made at the level of the PHCs and sub-centers.

Figure 43: Drug chart at the pharmacy at CHC.

Figure 44: Cold chain equipment at CHC Mauranipur.

An important observation regarding Mauranipur block is that there is a shortage of health facilities and health personnel even at the peripheral most levels as per the population norms. We have already mentioned above regarding the shortage of ANMs in UP. In Mauranipur block there should be 47 sub-centers as per the population norms, but as of now there are only 42. Let alone a second ANM, there are sub-centers even without one ANM in the block. The result is that instead of expanding the reach of the health programs, the whole effort is concentrated on keeping the routine services going.

3.2.5. PHC Ghatkotra

The new PHC at Ghatkotra is another one of those forlorn facilities that might as well not have existed given the kind of public health work that is being performed by the PHC. There is M.B.B.S. doctor and one Ayurvedic doctor at the PHC. There is no pharmacist, ANM or staff nurse at the facility. The only lab technician does not perform any lab investigations but instead works as a pharmacist provided of course there are medicines to distribute.

Figure 45: The PHC at Ghatkotra.

The drug display board

The OPD patient register shows a daily patient attendance of 25 to 30 patients. The drug indents at the PHC provide a measure of its functioning. Both the doctors claimed that they give all medicines to the patients from the facility itself. However, the last two indents for medicines were made on 26th July 2012 and 18th April 2013 and the amount of medicines indented on the former date could by no stretch of imagination have lasted till April 2013 unless of course the PHC was attending to barely 4 to 5 patients a day.

Apart from lack of facilities, one of the reasons for the under-utilization of the PHC was its location which though within the village was about two km away from the main approach road of the area. Hence except for the patients of Ghatkotra village, patients from rest of the villages instead preferred to go straight to CHC at Mauranipur which is relatively better equipped and provides more services.