DEPARTMENT OF HEALTH & FAMILY WELFARE GOVERNMENT OF WEST BENGAL

Health Talk

VOLUME I, ISSUE II

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HIGHLIGHTS

- More than Rs. 7.89 Crore have been utilized towards JSY across West Bengal and Rs. 1.30 Crore utilized successfully towards referral Transport Scheme.
- More than 1 Lakh 12 thousand beneficiaries have been covered through JSY in the Quarter April – June 2007
- 38674 beneficiaries have benefited from the referral Transport Scheme for the same period
- More than 1.5 Lakhs patients have been treated througth 20014 GP based mobile health camps from April–July 2007

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State operationalises 20 rural FRUs

One of the critical pathways to reducing maternial mortality is improving the **accessibility utilization** and **quality** of services for treatment of complications during pregnancy and childbirth. Hence the Department is committed to improve access to institutional deliveries and quality Emergency Obstetric Care (EmOC). The Operationalization of the First Referral Units (FRUs) is one of the key strategies that has been taken up by the state to reduce pregnancy re la te d complication s and materinaldeaths.

A FRU should have the following requirements :

1. Bed strength of 20–30.
2. Fully functional operation theatre for undertaking anaesthetic and emergency procedures.
3. Fully operational labor room.
4. Area earmarked for New born care in a labor room and inward.
5. A fully functional laboratory.
6. Blood storage facility.

The delays caused during transit from the peripheral units to secondary health units and also at the health facility can be reduced by making the FRUs more functional.

REFORMS at a glance.....

- Janai Suraksha Yojana
- Referral Transport
- Provision of untied and flexible Fund
- Rogi Kalyan Samitis
- Computerization of BPHCs
- Block Accounts Manager placed for every blocks
- Appointment of ASHA
- Ayushmati Scheme
- Supervision of Sub Centers by Gram Panchayats
- Gram Panchayat Headquarters Sub Centres
- District Health Planning 2008-09
- Quarterly review meeting

The following list shows the public health institutions proposed to be upgraded into First Referral Units (FRUs) :

District	Proposed FRU
Coochbehar	Mathabhanga SDH, Dinhata SDH, Tufanganj SDH
Jalpaiguri	Birpara SGH, Falakata RH/SGH, Mal RH/ SGH, Maynaguri RH
Dakshin Dinajpur	Gangarampur SDH, Hili RH
Uttar Dinajpur	Karandighi RH, Kaliaganj RH
Malda	Chanchal RH/SDH, Gazole RH/SDH
Murshidabad	Domkal RH/SDH, Islampur RH
Darjeeling	Bijan Bari RH, Kharibari RH
North 24 Pgs.	Taki RH, Sandeshkhali RH
Nadia	Karimpur RH, Bethuadahari RH, Tehatta SDH
South 24 Pgs.	Baruipur RH/SDH, Canning SDH, Kakdwip RH/SDH, Sagar RH
Burdwan	Mankar RH, Memari
Bankura	Khatra SDH, Taldangra RH, Amarkanan RH
Purulia	Raghunathpur SDH, Manbazar, RH, Bansgarh RH
Birbhum	Lavpur RH, Muraroi RH
Purba Medinipur	Egra RH/SDH, Reapara RH
Hoogly	Reapara RH, Pandua RH
Howrah	Domjur RH, Jagatballavpur RH, Udaynarayanpur SGH
Paschim Medinipur	Chandrakona RH, Garbeta RH

26 facilities in **the first phase**, 19 in the second phase and 15 in the third phase have been identified to be operationalised as FRUs. Operationalisation of facilities as FRU entails infrastructural strengthening, planning for equipments and logistics, human resource development and capacity building.

Best Practices Symposium (April 18-19, 2007)

West Bengal Department of Health and Family Welfare (DHFW) is now into its second year of a five years reform and investment programme, the Health Sector Development Initiative (HSDI). With the opportunity ahead to implement best practices, and with some positive experience of its own to share with other states and countries embarking on this path, the Department together with one of its Development Partners, DFID and its Technical Assistance Support Team (TAST), invited participation in a two days symposium on Health Sector Reform.

The participants represented donor agencies (DFID, GTZ, UNICEF), NGOs, other organizations (CARE India, ICDDR – Bangladesh). Also, representative from other departments of GoWB (Panchayat and Rural Development Department, Child Development and social Welfare, Finance Department) participated in the symposium. Officials of Department of Health & Family Welfare from state and all districts of West Bengal. Other states like Chattisgarh, Uttaranchal, Andhra Predesh, Orissa, Gujrat and Karnataka joined the symposium.

Several themes were discussed in the two days on Framing policy, Strategy and evaluating change, Health Reforms for safer motherhood, Health financing, Decentralized Health Management, Health reforms for the benefit of the poor, Equity and Access, Health systems and quality strengthening, Moving from inputs to a results-based culture, Best practices by the districts of West Bengal, Convergence with other departments.

Eminent functionaries from different states presented the best practices pertaining to health sector reforms. Please find below some of the best practices from other States.

ANDHRA PRADESH

Dr. C. V. S. Venkataramana presented on the health reforms that has been brought in Andhra Pradesh adopting NRHM strategies. Some innovative schemes were undertaken in order to ensure health reforms :

- 800 PHCs have been converted to 24 hours services delivery facility.
- Free bus passes have been issued to 8 Lakh pregnant women for timely access.
- The State Government has also introduced Young Infant Health Assurance Scheme.
- Incentives are proved to identified Gram Panchayats which achieve 100% institutional delivery and no reported infant deaths.
- Health Resource Centre set up in all high schools to address issues related to Adolescent Health. Male and Female Teachers have been trained to function as counsellors.
- Mobile Medical Units has been operationalised to address health needs of remote tribal areas. The State Government has introduced II ANM training schools exclusively for tribal girls.
- The State Government has recruited women health volunteers who are incharge of urban health centres. These centres are run by the local NGOs under the supervision of a district committee headed by the District Collector.
- Around 1900 Hospital Development Societies have informed in different facilities. About Rs. 27 crores have been released for corpus funds and maintenance of the secondary and peripheral health units in the State.
- **Health Information Helpline** has been set up to provide any advice or guidance or any health problems, queries on health schemes or on health related data. Home management guidance are provided through the toll free helpline based on symptoms and advice for immediate shifting to hospital.
- In addition, the DHFW, GoAP has framed several schemes like "Sukheebhava Scheme" for institutional deliveries. "Arogya Raksha" - a hospitalization insurance scheme and "Arogya Sree" an universal health insurance scheme for high cost ill – health events.
- Another major initiative by the DHFW, GoAP is ensuring of blood testing for all pregnant women by 2007. About 70,000 Women Health Volunteers and Community Health Workers have been trained on HIV/AIDS.
- As specific health initiative for the school children is designed by the DHFW, GoAP. The scheme is named as "Sukheeibhava" and the major features are :

1. Health appraisals of all school children by the school teachers.
2. Half-yearly medical examination by doctors
3. First and treatment of minor ailments.

The purpose of the Best Practices Symposium was to provide a platform for sharing various evidence of Health Sector Reform programmes within and outside the state and from other countries and encourage for adoption of the best practices.

The Department of Health and Family Welfare (DHFW), Government of West Bengal (GoWB) organized a two-day symposium titled Implement-ing Health Sector Reforms - Sharing national and international Best Practice at Kolkata on 18-19th April, 2007. The symposium was organized by the DHFW with assistance from the Department For International Development – India (DFIDI) and the Technical Assistance Support Team (TAST).

School Health Program for Secondary School

School Health Program is being implemented in the state for the last few years, but mainly for primary school students. There wasn't any concerted effort to address the health needs of school students, who are in the age group of 10 years to 19 years. The Department under the RCH II Program Implementation Plan (PIP) has launched a framework for a comprehensive School Health Program for secondary and higher secondary school students.

The need is to move from health check ups to a comprehensive school health program, which promotes a health-supportive school environment, school-based health and nutrition services and health education. School Health Program should be able to prevent and reduce health related problems of the local school children.

The **objectives** of the school Health Program is to improve the health of school-going children through :

- Promotion of health education including adolescent health arising out of physical, emotional and different stresses and strains prevailing in the present social psyche.
- Prevention of diseases and promotion of immunization
- Early detection, diagnosis and treatment of diseases
- Provisions for referral services to higher health centres
- Building health awareness in the Community
- Development of habits on personal hygiene and cleanliness

Initially, the program has been launched in 147 blocks across 15 districts in West Bengal. These blocks have been identified on the basis of female literacy rate of the block.

Two GNMs would be assigned for each block specifically for school health. Referral linkages with government health facilities would be strengthened to cater to the needs of these school children.

The intervention would strongly involve the participation of students, Principals. Teachers, Parents and the community (SHGs/CBOs/ ASHAs etc). The ICDS functionaries, PRI representatives and NGOs would also actively support the initiative.

Major Activities :

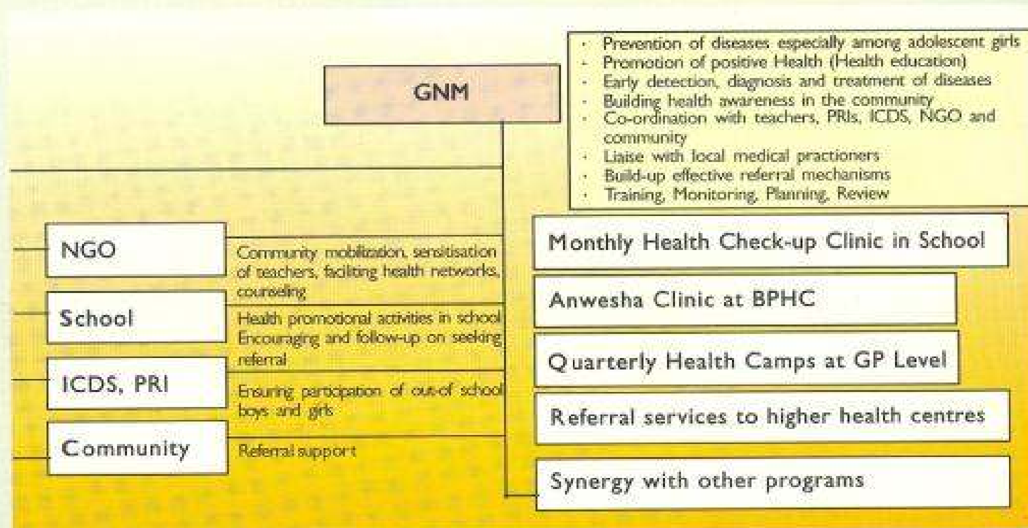
Preparation of a block level Calendar on School Health Camp and Quarterly Health Camps – After the listing of the schools in the block the two GNMs in each block would prepare their individual calendar and prepare a block level calendar. They also have to intimate the GP level functionaries about their tour plans. The plans with the dates would be shared with the respective school before hand.

Issuance of Student Health Cards – All students in the listed schools will be allotted a student Health Cards.

Monthly Health Check-up Clinic in School – Each school will organize a School Health Clinic, every month. The GNM will visit the school on that particular day and provide clinical service to all students. During the routine examination of students, health educaiton would also be been given at individual level and in a group. The GNM is expected to provide all preliminary medications and micronutrient supplementations to students-in-need. After screening, the students found to be suffering from any disease that needs to be referred would be referred to the nearest health facility.

Orientation of Teachers and parents – Teachers and parents have to be oriented on issues related to health, nutrition, sanction and hygiene from time to time. While teachers can undergo training workshops, parents have to be communicated through group meetings. This would be a key role of the NGOs.

Formation of Peer Leaders – Students would be oriented to act as peer leaders for the primary school students. They would be expected to conduct health education classes and also monitor personal cleanliness etc. They would also spearhead physical activities in school in the form of yoga, sports etc.



Know your State

Maternal Anaemia— A preventable killer

Anaemia is highly prevalent in West Bengal especially among women, pregnant women and young children. According to NFHS-3 2005-06 about 63% pregnant women and 69% children (0-3 years old) are anaemia. In fact anaemia in pregnant women has increased by 6% between 1999 and 2006.

Anaemia is a condition in which the Haemoglobin levels of blood are low.

Symptoms of anaemia : An anaemic person appears pale and tires easily. As the severity of anaemia increases there is breath- lessness - gasping for oxygen even on slight exertion and difficulty in performing physical labour. Advanced cases may also have swelling in extremities and nail defects. Even mildly anaemic persons show an increased susceptibility to infections.

Women in West Bengal become anaemic from the early stages of life - babies born to underage and/or anaemic mothers fail to overcome the birth deficits in body iron stores during infancy due to faulty, inadequate and often unhygienic feeding practices. The growing child and adolescent are nurtured on dietaries that lack iron and vitamin rich foods, leading to low dietary iron intakes and poor absorption of iron. Chronic Iron deficiency soon results in anaemia, which is aggravated by early, frequent and closely spaced pregnancies, malaria, hookworms, deficiencies of other micronutrients, diarrhoea and other infectious diseases.

The consequences of maternal anaemia are serious and life threatening.

Controlling maternal anaemia can help prevent loss of life

(22% maternal deaths are linked with anaemia) and improve the quality of development outcomes of offspring.

Universal supplementation of pregnant women with iron folic acid tablets is the easiest and most cost effective method to enhance iron intake and thereby prevent the ill-effects of anaemia on mothers and infants in the short term.

To reduce maternal anaemia All pregnant women must

- Report for Ante natal checkups regularly
- Receive IFA tablets from fourth month onwards during antenatal checkups/from village depots at AWC.

a. Consume one tablet daily for at least 100 days if non-anaemic

b. Consume two tablets daily for at least 100 days if non-anaemic

c. If a dose or more are missed, resume IFA consumption at the earliest

d. Receive preventive treatment for malaria in endemic areas – drugs and bednets.

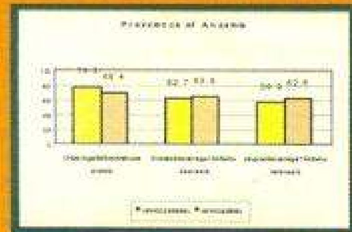
e. Be de-wormed in areas where worm infestation is high/sanitation is poor.

f. Receive counselling to include iron and vitamin C rich foods in their diets such as – Whole grain/sprouted cereals and pulses, green leafy vegetables, eggs, meat, jaggery, pounded rice (chura), guava, lemon and other seasonal fruits.

g. Receive counselling on benefits of IFA especially on intellect of child, discomfort due to side effect.

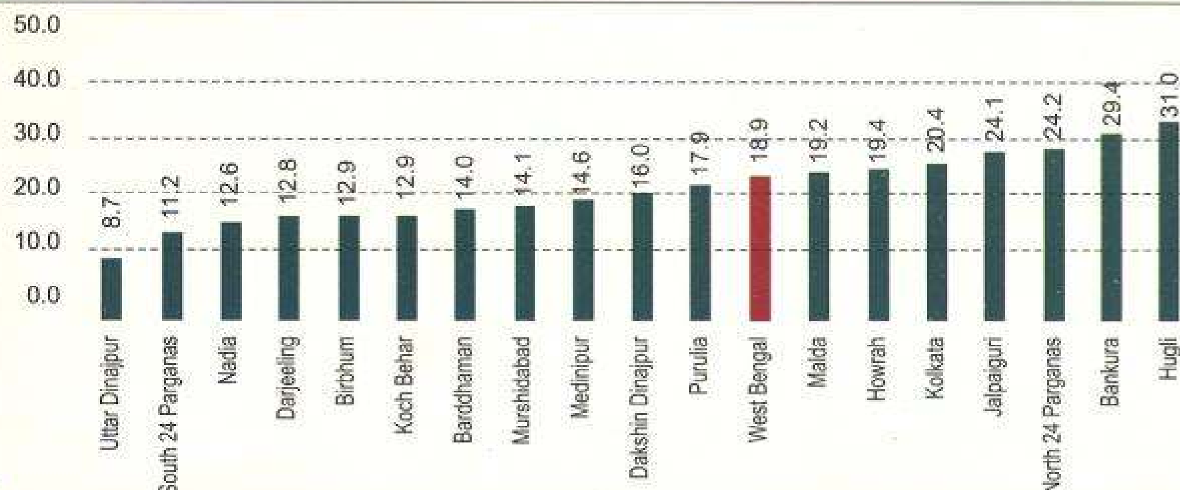
Status of iron supplementation to pregnant women in West Bengal

According to survey estimates of RCH-DLHS 2002-04, this intervention is available to only 19% pregnant women of the state, with wide variations among districts.



The National Nutrition Policy adopted by the Government had directed controlling micronutrient malnutrition particularly anaemia due to iron and folic acid deficiency, vitamin 'A' deficiency and iodine deficiency disorders through intensified programme.

Pregnant Women who received 100 or more IFA tablets during pregnancy



Reaching Basic Health Services to un-reached people through NGO Partnership in Jalpaiguri District

Good Practice # 2

Partnership with Family Planning Association of India (FPAI) has facilitated considerable impact in the well being of a small tribal settlement in a remote village Adma, of North Bengal. Adma is situated at the hilltop of about 2500 ft. high, surrounded by dense forest and is surrounded by three rivers "Dima", "Raidak, and "Singmari". The pocket has eleven villages which are scattered and situated on eleven different hilltops. There are also no approachable roads to these villages, The resident population experiences high seasonal migration. The literacy level is also very low. There is also dearth of health infrastructures, barring only few Sub Centres but that too catering to plain areas at the foothills, The health indicators were also not in a very encouraging state :

- High underage marriage
- Resistance to family planning – only 10% of the population have adopted to family planning measures.
- Institutional delivery is at staggering 15%
- High RTI/STI prevalence
- The area also experiences year found malaria events.

FPAI Kalchini Branch has extended support to the health care program of this area with financial and technical assistance from local BMOH and district CMOH. The total cost involved for the project was Rs. 4,26,200.

The baseline data collection was done by a NGO with active participation from local PRI representatives. 12 people were trained as Community Health Workers for 10 days. Also, 22 peer educators has been trained.

The major activities involved in this initiative are :

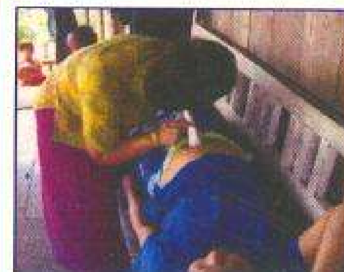
- Daily Home Visit [26 days in a month] by every worker in their individual villages.
- Maintenance of health register supplied by the branch like Immunization, ECCR and Contraception.
- Organizing People sensitization work
- Weekly health check up camps leaded by a doctor
- Organizing MCH cum Immunization Clinic by the Trained Field Workers - One per month per village.

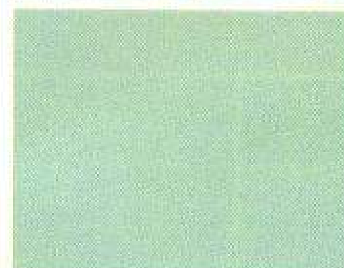
This collaboration has initially been planned for a year i.e. January-December '2007 with the following targets :

To increase access to RCH and other health services

- Reduce RTI prevalence
- Bring down Unsafe delivery from
- Reduce unmet need of contraception
- Promote Healthy Lifestyle
- Capacity building of Local Volunteers.

The Basic Health Care Project has augmented the overall health status at Adma village where the basic health care services was not available to the resident mass over years. This is the first time that the basic health care services are extended to the beneficiaries at their door step for the first time.





Measles surveillance - still more to go

Measles, in spite of available vaccination, remains a heavy public health burden worldwide especially in developing countries. This represents 50-60 per cent of the estimated million deaths attributable to vaccine-preventable diseases of childhood. Measles may be ultimately responsible for more child deaths than any other single agent because of complications from pneumonia, diarrhoea and malnutrition.

Measles is also the major cause of preventable blindness in the world, affecting the same disadvantaged populations. Of the deaths attributable to measles, 98 per cent occur in developing countries, where vitamin A deficiency is common. Case-fatality rates in some countries are usually estimated to be in the range 1-5 per cent but may reach 10-30 per cent in some situations.

In West Bengal, the measles surveillance in the current year has a lot to say so far as achievement is concerned. For the state the achievement in terms of case identification and treatment is about 26% . For some of the districts like Bankura, Paschim and Purba Medinipur, and Purulia have done fairly well (achievement is more than 30%) while other districts need to put more emphasis on measles surveillance. However, it is quite encouraging to see that many districts have enhanced their performances over the previous year. Overall increase in achievement over last year's performance in the state is 2.3%. During the period July-August 2007, the total number of deaths (II) as against the total measles cases reported (2057) is 0.5%.

District Health Plan-a bottom up planning approach

For any state decentralization process to be successful, two sets of policies need to be developed. First, a strong leadership and strategic conduction from the state as well as a strong support to communities and decentralized units are needed to secure consistency of the common efforts. Second, it is parallel required the development of a capable local (district) government, administration and representative bodies, so delegated responsibilities can be conducted, managed and held accountable at that level.

Decentralized Planning and Implementation is the major component of this Mission. The core guarantees to be achieved under the project are Immunization, all recommended Antenatal Checks of pregnant women, treatment of Common Disease and Action on Determinants of Health like Safe Drinking Water, Sanitation, Nutrition, etc. To address all the guarantees effectively, integrated district planning is needed. Therefore, planning guidelines and technical manpower support were provided to the districts for preparation of Integrated District Health Action Plans. Whilst the district will increasingly be the unit of implementation, policy and priority setting will need to be established by the State.

The DHP process started more than a year with the preparation of templates for each level (district, block and gram panchayat). Following preparation of templates, guidelines for the facilitators' and training modules were made to carry forward the DHP process in all the 18 districts of West Bengal.

Since the district planning exercise was taking place for the first time in the districts especially in such a huge scope and integrated manner, it was considered necessary to provide technical assistance to the district. All the 18 districts prepared District Health Plans for FY 2007-08, based on expected outcomes, with the current level of the districts' performance on critical health indicators acting as base line. Special focus was given to the six poor performing districts namely Uttar Dinajpur, Dakshin Dinajpur, Malda, Murshidabad, Purulia and Birbhum. The Plan allocation has been substantially up-scaled for these districts to enable them to catch up with the other districts.

The most remarkable feature of this district health plan is that it is a people's plan. Key people at the GP level (political representatives, health care professionals, representatives of all the health related line departments like DWCD&SW, PHED, Education, NGOs, private sectors local leaders, GP officials etc all participated and prepared the GP level plan. Inputs from professional planners like CARE, TAST, DH&FW were also made available in the preparation of the plan. Similar exercise was done at block level to formulate Block plans. Frequent consultative meeting in the districts with the key players were held, wherein the districts mapped out remote and inaccessible GPs and prioritized activities to reach-out to such unreached pockets with need-based health interventions.

Prepared District Plans are now being appraised at state level before disbursement of funds for implementation.

Health care services to your doorstep

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OUR MISSION

The Department of Health & Family Welfare is committed to provide healthcare to all, especially to the poorest and those in greatest need.
This would be achieved through a strategic planning and reform process focusing on the following four issues:

1. Increasing AVAILABILITY of services
2. Creating ACCESS for services
3. Improving QUALITY of services
4. Striving for EXCELLENCE in health education and management

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Editorial

For justifiable reasons, the health of women in India and particularly in West Bengal is presently an important public health concern. In 2007, available evidence indicates that very little progress has been made in achieving this goal. Current estimates indicate that in 1997-98 as many as 303 maternal deaths occurred per 100,000 live births in West Bengal. Even sin 200-03, the rate was still alarmingly high at 194. The medical complications that lead to maternal mortality are wellknown to us and these include hemorrhage,, eclampsia, postpartum infection, unsafe abortion, and obstructed labor. The complications are often poorly treated in our State, thereby leading to increase risks of maternal mortality. Thus, it is evident that it is not the pregnancy complications per se that kill women, but rather the adverse social conditions under which women become pregnant and experience pregnancy related complications. However, the Millennium Development Declaration gave further pre-eminence to the problem, with the enunciation of the Millennium Development Goals by World Leaders in 2000. Of the eight goals, one was specifically devoted to the promotion of maternal health, with a specific target to reduce maternal mortality by 75% by the year 2015. This maternal health goal, is often referred to as "the heart of the MDGs", because of the recognition that if it fails, the other goals will also fail, Effective interventions to promote maternal health and reduce maternal mortality are now wellknow. These include interventions that increase women's access to family planning, antenatal care, skilled birth attendants and emergency obstetrics care. They also include the promotion of women's education, elimination of extreme poverty, the eradication of harmful traditional practices and the economic, social and political empowerment of women.

In conclusion, the persisting high rate of maternal mortality in many developing countries is unacceptable, and is evidence of a continuing denial to the right to health for women in developing countries. The District Health Authorities are urged to prioritize the provision of maternal health as a major part of their developmental agenda. Clearly, future assessment of the quality of life and economic attainment in developing countries will be based on the extent to which governments guarantee the attainment of these basic human rights to women in their territories.

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