# An Evaluation of the

# Congregational Based Primary Health Care Program

# (2005-2009)

# of

# Mohulpahari Christian Hospital, Jharkhand

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## GLOSSARY OF ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Ante Natal Care |
| ANM | Auxiliary Nurse Midwife |
| BMO | Block Medical Officer |
| CARE | CARE India |
| CBHI | Community Based Health Insurance |
| CBPHCP | Congregation Based Primary Health Care Project |
| CD | Compact Disc |
| CEDPA | Center for Development & Population Activities |
| CHDP | Community Health Development Project |
| CHV | Community Health Volunteer |
| CMAI | Christian Medical Association of India |
| CMC | Christian Medical College |
| DCBI | Department of Community Based Initiatives |
| DLHS | District Level Health Survey |
| DOTS | Directly Observed Treatment Short-course |
| DTC | District Tuberculosis Center |
| ELCA | Evangelical Lutheran Church in America |
| HIS | Health Information System |
| HIV | Human Immunodeficiency Virus |
| HMB | Hospital Management Board |
| HRD | Human Resource Development |
| ICTC | Integrated Counseling and Testing Center |
| ICU | Intensive Care Unit |
| IEC | Information Education Communication |
| IGP | Income Generation Program |
| JSY | Janani Suraksha Yojna |
| MCH | Mohulpahari Christian Hospital |
| MCHDP | Mohulpahari Christian Hospital Development Project |
| MM | Mahila Mandal |
| MOHFW | Ministry of Health and Family Welfare |
| MS | Medical Superintendent |
| NELC | Northern Evangelical Lutheran Church |
| NGO | Non Governmental Organizations |
| NID | National Immunization Day |
| NRHM | National Rural Health Mission |
| OP | Out Patient |
| PHC | Primary Health Center |
| PRADAAN | Professional Assistance for Development Action |
| RNTCP | Revised National TB Control Program |
| SDC | Social Development Center |
| SGSY | Swarnjayanti Gram Swarozgar Yojna |
| SHG | Self Help Group |
| TB | Tuberculosis |

| | |
|---|---|
| TOR | Terms of Reference |
| TOT | Training of Trainers |
| VCTC | Voluntary Counseling and Testing Center |

**Appendix –** Comments of the CBPHCP team, Mohulpahari Christian Hospital

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## Executive Summary

### Background

Normisjon has been a long term partner of Northern Evangelical Lutheran Church (NELC) and Mohulpahari Christian Hospital. Normisjon supported Mohulpahari Christian Hospital Development Project (MCHDP) in an institution building process from 1998 to 2004, with technical support from Christian Medical Association of India (CMAI). The concept of Community Based Primary Health Care Project (CBPHCP) was adopted during this period with work in parts of Shikaripara block. Other community based projects initiated before this period by Mohulpahari Christian Hospital (MCH), became part of the project. CBPHCP continued from 2005 for a period of 5 years with support from Normisjon to expand the population covered and consolidate the activities.

Final evaluation of MCHDP in 2005 supported continuation of CBPHCP. The evaluation for current phase of CBPHCP was carried out from 24th November to 4th December 2008. The team consisted of a group of consultants from Christian Hospital, Bissamcuttack, Orissa and Christian Medical College Vellore, Tamilnadu; with the help of Santhali speaking interpreters.

### Findings

This initiative is the largest community based activity MCH has undertaken thus far. A large population of three adjacent blocks is covered by the project. The organizational structure was strong at the start of the project but has weakened in the recent years due to attrition of key staff. Staff of project multi-task as trainers, Self Help Group (SHG) organizers, health program coordinators and administrative workers. Technical expertise for community health program management is not developed adequately at the top hierarchy of the organizational structure leading to inadequate monitoring and supervision. This coupled with difficulty in implementing a community based program in inaccessible terrain has led to fewer achievements than anticipated.

Grass root workers are motivated but under utilized, functioning mainly as SHG (Mahila Mandals in CBPHCP) organizers. Health work is limited to awareness building on health issues mainly through Mahila Mandals (MM) and liaising between the community and the project personnel.

There is lack of clarity among all stake holders about their roles and responsibilities which has contributed to limited progress in internalization and dissemination of the project concept. Congregations have not developed capacity to be one of the owner-stakeholder of the project.

Technical support expected from CMAI decreased over time with change in personnel and the understanding of the role by CMAI. Project committee within the Hospital Management Board (HMB) was expected to provide technical guidance. This forum rarely had community health expert attending meetings after 2006. The project team and

staff of MCH have largely managed the project activities own their own based on their training and experience.

Women's groups formed through the project have a large number of members from very deprived settings. They have developed their capacity to varying level, with definite positive changes. Holistic development of the communities is possible through women's empowerment. This will be possible if the MMs become change agents for their own communities with awareness of self, rights and health issues; find economic independence, and are able to generate community response for social change. The most important achievement of CBPHCP is in the strength of women's groups started or supported by it.

Health activities for project communities have developed in the form of mobile clinics and subsidized hospital care for those coming to MCH. Vaccination and services for pregnant women are provided by the public health system. The project has not developed strong collaboration with existing Government health programs for provision of primary health care, especially maternal and child health though the volunteers and staff support and utilize many national health programs. HIV/AIDS awareness has been the focus of health education efforts. Different groups in the community and the congregation have been targeted for this. The hospital staffs have received training in order to develop an appropriate HIV/AIDS care center. Institutional preparedness has not been achieved as envisaged by project plan.

Special radio program for HIV/AIDS awareness in Santhali language is of good quality, but dependent on few individuals for development of the programs. *Program Reach* (dissemination to target population) is very poor locally and there is need for a planned strategy for improving *Reach* and for response to *Queries.*

Due to limited health activities in the community, Health Information System (HIS) is not in use and has failed to collect data for monitoring change in the health status of the community over the project period. Understanding of HIS, supervision by staff, and data management was found lacking at all levels. Monthly reports are routinely collected, without validation and not used for planning or monitoring. Lack of active participation of senior persons and other MCH staff in review meetings is of concern.

Collaboration with other NGOs, public health system and government agencies involved in development activities are limited.

The distance of the farthest project village from CBPHCP office is ~ 30 KM. The travel from Mohulpahari to all project villages scattered in three Community Development Blocks in Dumka district is very difficult due to poor roads. The staffs function out of the office on a day to day basis resulting in little input at the grass root. Moreover, there have been many changes in personnel and most of the time, all staff work as one team rather than individuals in a smaller geographic area resulting in less output.

Congregations have varying capacity to participate in the project. Members are involved more as individuals and there is potential for larger group involvement in all aspects of project planning and implementation. However, at this time *Congregation base* in CBPHCP is the least developed component. Understanding of the roles and responsibility towards the project, dissemination among members and participation in activities are not achieved adequately for expecting sustainability beyond project period.

**Recommendations**

The context in which MCHDP and CBPHCP started has changed since. Jharkahnd is a new state since 2001 and many changes are seen in infra-structure and programs. National Rural Health Mission (NRHM) is functional in the last few years making strides in vaccine coverage and antenatal care. There are efforts to improve services at Primary Health Center (PHC) and public hospital, which is changing health seeking practices among the local population. However, there is a gap between what is needed for overall development of the communities and what exists now. There is a need for all players in the field to join hand to make the difference. Therefore, MCH needs to continue the efforts to bridge the gaps.

The inputs from Normisjon have helped MCH to develop capacity to an extent, and infra-structure for community based health and development programs. The capital investment will be helpful in supporting community based initiatives of the hospital. There is a need to reorganize the program to focus on the strengths for consolidation, and work on weak areas.

The strengthening of women's groups and few men's groups should be the focus for the project. All groups need training and diversification in their activities to include social activities. They also need to be built up as human resource base in the villages to implement health related activities. They should become partners, getting involved in participatory planning and monitoring of all health activities in the villages, thus contributing to existing NRHM. They have the potential to be the largest advocacy group in the district if they are empowered with necessary knowledge and skills. Networking with other similar groups and NGOs is needed for these groups and issue based collaborations should be explored.

Public health system in Dumka district is developing under the NRHM. The program activities are reaching the community but there is a need for NGO hospitals to support the activities. MCH has the strength for providing emergency obstetric and pediatric care, which is currently not developed in the project blocks. An area where project can make a difference is by employing a community based strategy using volunteers to encourage antenatal care and safe delivery, identification and referral of women with high risk and sick newborns. The network of Mahila Mandals (MM) and Community Health Volunteers (CHV) will be helpful to implement such a strategy. Hospital can provide ambulance services for speedy transfer and support community based workers.

The other area of health need is in prevention and control of non-communicable diseases. Public health system is concentrating all efforts on communicable diseases while the burden of diseases such as diabetes and cancers is increasing. Program for HIV/AIDS is poorly developed in the district. MCH has an opportunity to bridge this gap through the project but it will need focus and a new strategy to make an impact.

Congregations and Church are integral part of the project and CBPHCP and MCH should work with the NELC leadership to develop a strategy to make this partnership stronger and mutually beneficial.

Functional sustainability of CBPHCP is possible with the participation of community, congregations, local leaders and Mahila Mandals. Project should utilize the opportunity to build on its strengths and develop and empower community based organizations.

**Follow up of recommendations of MCHDP final evaluation**

Three years after the completion of MCHDP, the hospital is able to maintain some systems designed to improve efficiency. The modifications in older buildings are more functional in general. The efficiency of some of the new systems has reduced primarily due to lack of supervision. MCH is able to reduce debt and has new schemes to attract more patients through multi pronged approach. The search for specialist doctors to join the team continues.

The hospital gives commendable level of subsidized care despite financial constraints and implementation of the special strategy to generate funds for this purpose is urgently needed.

Spiritual nurture program started during MCHDP benefited the staff and will be useful if revived. Staff morale is not very favorable for team work. Some of this is due to perceptions of inequitable benefits among different categories of staff and appropriate communication between staff and administration or governing council is needed. Few of the specific recommendations for staff welfare and benefits can be implemented if consultants on short term basis are available to develop the strategy and for fundraising.

Hospital management will benefit from periodic input by consultants on specific fields e.g. financial management. Delegation of responsibilities for different activities and monitoring by the whole team will benefit the hospital in day-to-day management, prioritizing areas of need for change, and also help in long term strategic planning.

Nursing school is able to retain good faculty at present with tremendous opportunity as the human resource for the hospital. Fee change for nursing education may help the school towards financial independence but this must be weight against the possible loss of candidates from economically disadvantaged background. Nursing school must have a strategy to overcome this.

# PART A

# Congregation Based Primary Health Care Program 2005-2009

# 1. Introduction

## *1.1 Purpose of the evaluation*

Mohulpahari Christian Hospital (MCH) is one of the oldest hospitals in Southern Santhal Pargana region providing surgical care and management for complicated medical diseases. It is the largest hospital of Northern Evangelical Lutheran Church (NELC) which has not only provided medical care but also developed human resource for the church and the tribal population through training of health care workers. Normisjon has partnered with NELC and MCH in supporting health and development initiatives for a long time. A major institution building process with reorientation of the focus for services took place through Mohulpahari Christian Hospital Development Project (MCHDP) from 1998 in response to the needs of the community and the hospital. Congregation Based Primary Health Care Program (CBPHCP) was a response of the hospital to the community to reach out. The technical partner for both these initiatives was Christian Medical Association of India (CMAI), based at New Delhi.

MCHDP completed in 2005 while CBPHCP continued from then on building on the previous community based initiatives in health and development, and it will complete five years in 2009. A mid-term evaluation in 2002 was done for CBPHCP component. Final evaluation of MCHDP in 2005 also included evaluation of some components of CBPHCP.

MCH is committed to provide quality health services and enable the local communities to achieve a state of complete well being through health and empowerment. In this endeavor, it would need the support of like minded partners.

The Normisjon requested Dr. Shantidani Minz of Community Health Department, Christian Medical College, Vellore, India to carry out an evaluation of CBPHCP along with a team of professionals, with the following objectives:

- to evaluate the objectives, performance and to the extent possible, the intended and unintended impact of the CBPHCP
- to provide an overview of the involvement of MCH and CBPHCP in empowering congregations for transformation of the local communities
- to identify steps to be taken by MCH and its initiatives for the local community, to achieve the planned objectives in the present context

*In addition,*

- to assess the extent to which the recommendations of the evaluation of Phase I are implemented and constraints if any

The aim of the evaluation is to help the community, congregation, project team, technical support team and the partners to continue this initiative in more justified, improved and appropriate way. This exercise has carefully considered the above points.

***1.2 TOR-*** Refer Annex 1

***1.3 Composition of evaluation team and their areas of expertise-***

*Field team-*

Dr. Shantidani Minz: Community health programs- organization and delivery of PHC, gender issues in health (Team Leader)

Mr. Chandrasekhar Ray: Community organization, development issues, Self Help Groups

Dr. Ravikumar Manoharan: Community health programs, training of health workers

Mr. Cecil Hembrom: Community development

Field research assistants/translators-
Mrs. Angelina
Mrs. Silwanti
Mr. Samson

Rev. John Lunn: Hospital Administration
(Note: Rev. Lunn of ELCA supported the field team in field work and with editing of the Final report)

*Consultants-*
Dr. Jayaprakash Muliyil: Epidemiology & Public Health

Dr. K. R. John: Health Economics, Hospital Administration

***1.4 Time schedule***

September 2008: Preliminary discussion with Mr. Oddvar Holmedal & visit by the team leader to Mohulpahari Christian Hospital and CBPHCP

November 2008: Submission of TOR

24$^{th}$ November 2008 to 27$^{th}$ November 2008: Preliminary planning and organization of the field work

27$^{th}$ November 2008 to 4$^{th}$ December 2008- Field work

3$^{rd}$ December: Debriefing with hospital and project personnel at Mohulpahari

4$^{th}$ December: Debriefing and discussion with Moderator S. Soren at Bandorjuri Mission, Dumka.

15th and 16th of December 2008: Interviews with current and ex-CMAI personnel

4th to 29th December 2008: Quality assessment of radio program by volunteers in various locations

10th December to 7th January: Data entry and analysis at Vellore

February 2009: Submission of report

***1.5 Methodology***: Annex 2 gives a table of various group/ persons surveyed and interviewed for the purpose of evaluation. The survey tools and interview guides are in Annex 10.

***1.6 Groups/persons met*** **–** Refer Annex 3

***1.7 Acknowledgements***- The evaluation team would like to thank Normisjon and Northern Evangelical Lutheran Church for the invitation to evaluate this unique program run by Mohulpahari Christian Hospital. The team would also like to thank all the staff of MCH and CBPHCP, congregations and individuals met, for their support and valuable information provided to the team during the course of evaluation. Special thanks to volunteers who helped in assessing the radio program and provided valuable feedback. Thanks to the support team at Community Health Department, CMC, and Vellore; for valuable suggestions, help with analysis and report writing.

The report contains the views of the evaluation team based on the findings of the evaluation process which do not necessarily correspond to the views of the project partners.

## 2. The Setting of the project

### *2.1 Context*

Dumka district in Jharkhand is a relatively backward district in terms of health indicators. All sources of health information indicate the need for better services for Maternal and Child Health, infectious disease control especially malaria and fast emerging need for diseases like Diabetes. Though temporary migration for livelihood is common, reported prevalence of HIV infectious is relatively low (<1% in pregnant women- source: Integrated Counseling & Testing Center, Dumka Sadar Hospital). Infra-structure development and maintenance in the whole region is at a state of neglect, affecting health care access and making health service delivery a challenge for all agencies.

### *2.2 Background and evolution of the project*

In this setting, Mohulpahari Christian Hospital started an exercise with the support of Normisjon and under technical guidance of Christian Medical Association of India (CMAI) in the year 1996-97 to look at the challenge of being relevant to the health care needs of the local population. The outcome of this exercise was the ***Mohulpahari Christian Hospital Development Project (MCHDP)***, and within its purview the ***Congregation Based Primary Health Care Program (CBPHCP)*** emerged. There was a paradigm shift from looking inward to outward, and internalization of a redefined vision of the hospital (MCH) working for the community. The project envisaged the local Christian congregations' becoming partners in the healing ministry of the church. It proposed the development of a unique relationship among the funding partner (Normisjon), a technical advisory group (CMAI), MCH, congregations around Mohulpahari and the communities. The MCHDP was for a five year period from 1998 to 2003 under the guidance of CMAI and leadership of Dr. Shailendra Awale, then the secretary of Doctor's section of CMAI. Community surveys for CBPHCP started in the year 2000 and the project developed over the next few years. MCH had some experience in community based health and development activities through ***CHDP (Community Health & Development Project)*** which was initiated in partnership with CMAI in 1995. A Mid-term evaluation in 2002 led to many modifications and fine tuning of the processes and systems. The project in its present structure exists since 2004. The reference documents for this evaluation are:

a. The Congregational Based Primary Health Care Program presented for the years 2005-2009 and

b. Annual plan 2004 of MCHDP (Annex 4)

List of all other documents reviewed is in Annex 5

### *2.3 Objectives of the project-*

The objectives of the project can be summarized as

At the community

- Increase awareness about antenatal care, immunization, malaria, HIV/AIDS, other locally endemic diseases and accessing health care
- Improve access to health care available through Government programs, CBPHCP and MCH
- Develop Community Health Volunteers from the villages, as a resource within the community for building holistically healthy communities
- Empower women economically and socially by organizing them into groups
- Ensure equitable access to health care through promotion of Community Based Health Insurance (CBHI)

At the hospital and project office

- Develop a system to provide appropriate counseling and care for HIV/AIDS affected
- Capacity development of the staff in community health and development

At the congregation

- Build awareness about health and development needs of the local communities
- Develop capacity of the congregations and its members to respond to the specific needs

Special Programs-

- Develop and financially support a Santhal language radio program on HIV/AIDS
- CBPHCP for selected neighboring villages inhabited by Mal-Paharia tribe
- HIV/AIDS and Life Skill education for school children

## 3. Project Planning

### *3.1 Planning and organization*

CBPHCP was the outcome of an exercise at MCH to look at the challenges faced by the hospital. This process was supported and guided by two agencies, the Norwegian Santhal Mission and CMAI. CMAI was closely involved in the conceptualization and planning of the projects, the MCHDP and CBPHCP and continued to provide intensive technical input through 2005. A unique partnership developed between a funding partner, a technical group and the implementing agency, the hospital.

The MCHDP (1998-2003/4) envisaged the establishment of community based PHC program in 25 villages in Shikaripara block of DUMKA district, to achieve the long term goal of improving the status of women and children. The component of congregational involvement in the project came in subsequently. As the project developed, the area under the project increased to 110 villages and 11 congregations in 3 different

Community Development Blocks of Dumka district. CBPHCP continued at this level of involvement in the community from 2005 covering 56,816 people. (Annex 6, maps 1 & 2, 6.a Survey report)

A separate group within MCH was given the responsibility of day to day implementation and monitoring of the project activities. This included a senior doctor and project staff with special training. This group later came under the purview of the Department of Community Based Initiatives (DCBI Annex 7 Organogram) of the hospital which could give better visibility to all such initiatives of the hospital.

### *3.2 Monitoring and evaluation*

Hospital Management Board (HMB) of MCH and CBPHC committee is responsible for overall monitoring of the project activities. The technical oversight is provided by CMAI who is also a member of CBPHC committee. External evaluation was planned at the end of the project. The mid-term evaluation in 2002 specifically looking at the CBPHCP component of MCHDP brought in valuable input for project development.

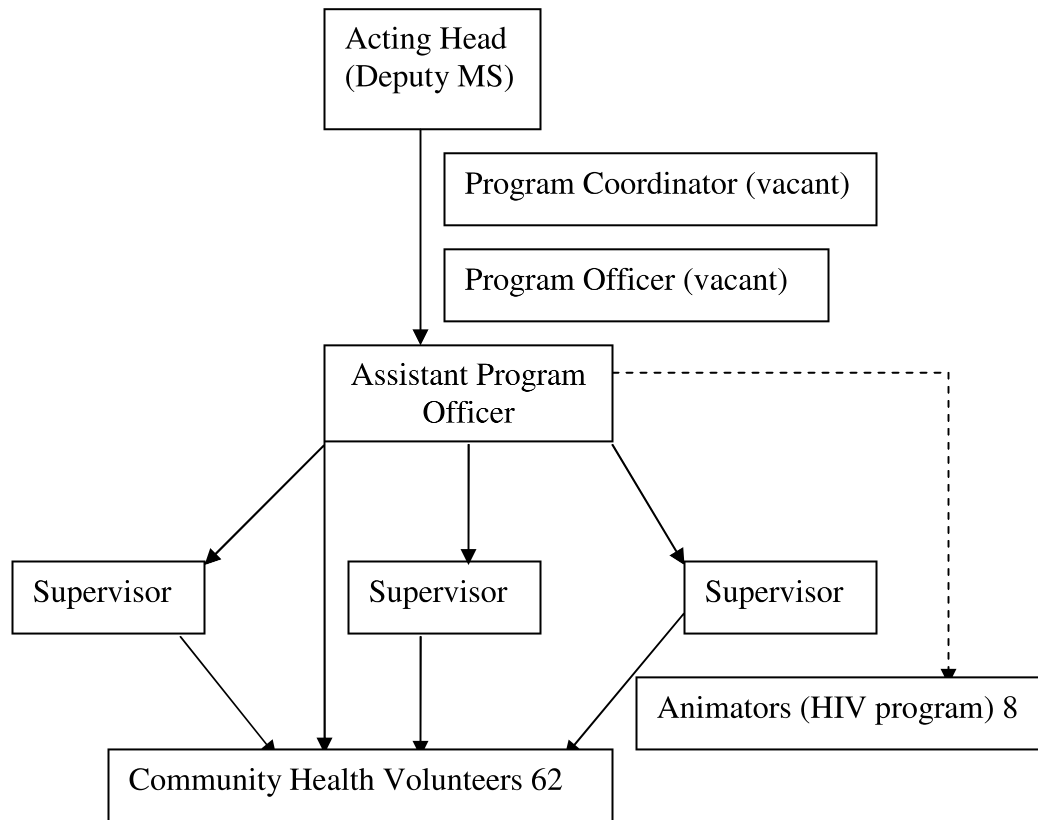
The role of CMAI is envisaged as "*to provide the overall vision guidance, technical oversight, access appropriate resources, and facilitate orderly progression towards the desired objectives*". CMAI was also involved in scrutinizing the quarterly and yearly reports. In addition there was special role envisaged for consultants with grass-root experience to help facilitate development of interventions in detail.

## 4. PROJECT DESCRIPTION

### *4.1 Organizational model*

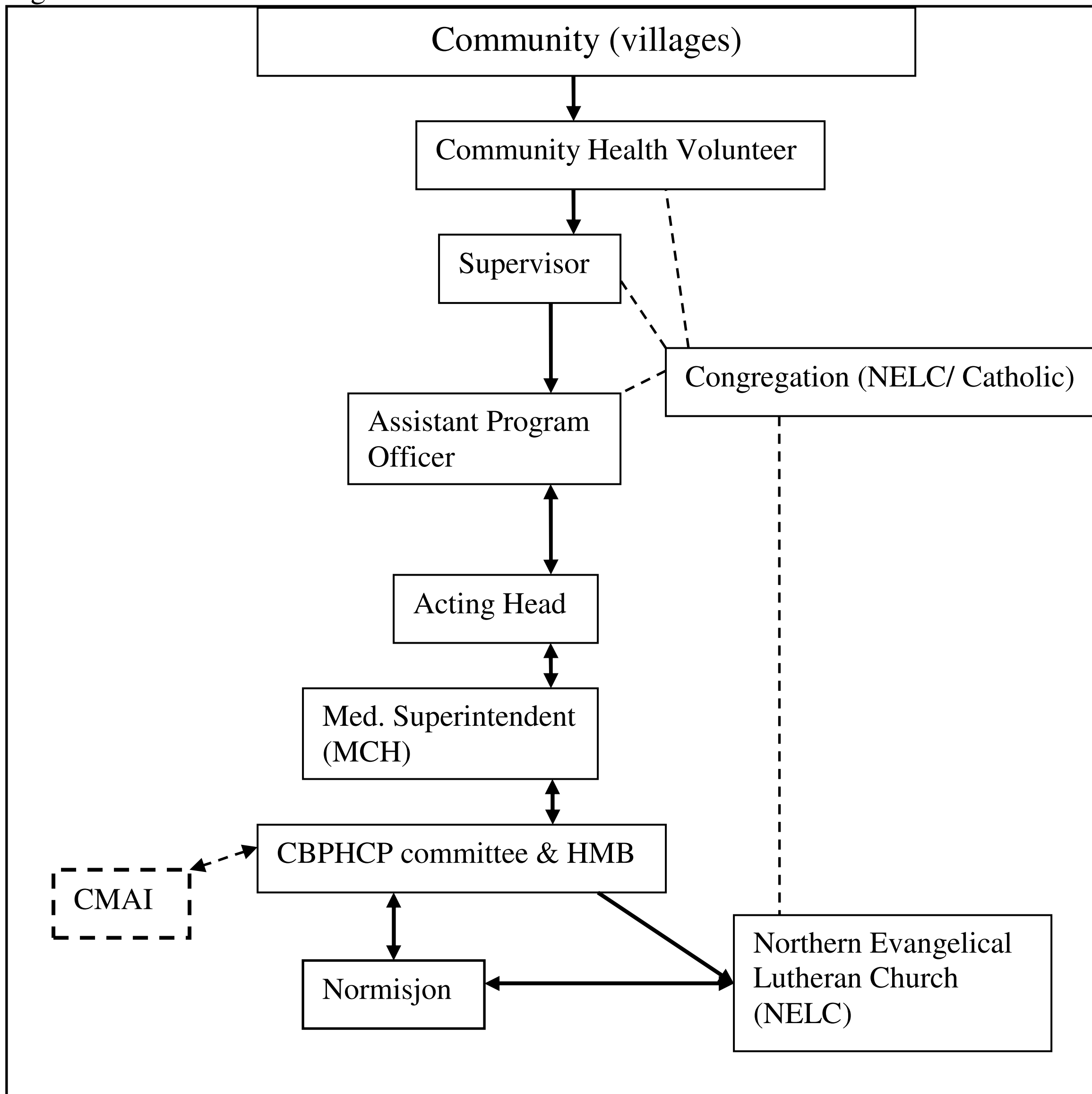
The planned organizational model within MCH is described as DCBI. However, due to rapid changes in staffing, the following exists now:

Figure 1.




This is the structure within MCH and project. However, the complete existing organizational model is represented in the following ***project model***. The directions of arrows indicate information flow.

Figure 2.




In many areas, the full village is not part of the project. In some villages only Santhal dominated areas are included while in others many parts or the whole village may be included. This creates confusion in terms of services and health indicators. At the same time this maybe perceived as discrimination. Though the project document clearly spells that the project is for Santhal communities, there is no clear policy and therefore differing implementation strategies.

The project document describes Health Supervisors as those providing direct supervision and support to the CHVs and is at a different level than currently existing Supervisors. They are Program Associate Trainees as described in the proposal. This is very evident in the program as the missing link, which needs strengthening.

The project model has a lot of strengths with many options for internal monitoring, support and participation of stakeholders at various levels. However, some of the links and roles are not well understood and internalized by the stakeholders. This has resulted in weak links (represented by dashed lines). Lack of clarity in communication and inadequate communication between groups has also resulted in weakening the links.

### *4.2 Role of partners*

Role of various partners are well defined in the MCHDP and subsequently in CBPHCP proposals. Normisjon, apart from being the funding partner was involved in discussions through the period of evolution of the project. All modifications and addition to the original project plan were in line with the vision of the institution and the project, and with assent from the funding partner. Normisjon's knowledge and experience in this region and especially work among Santhal people has been instrumental in the flexibility provided to the project to grow over time.

CMAI has been instrumental in challenging MCH as an institution to respond to the needs of the local people and provided the technical help to rise up to the challenge. The combined efforts of MCH family including the Church, CMAI and other consultants have led to a remarkable change in the systems and organization within the hospital and in developing human resource. This was not limited to the institution, but through the CBPHCP is gone beyond the boundaries of religion, people groups and areas of need.

The role of CMAI changed over time and with change in leadership positions in CMAI. A field staff of CMAI based in Ranchi continued to support and provide technical input on monitoring processes until 2007, but technical guidance reduced with change in understanding of CMAI's role. A clear mandate from funding partner and appropriate financial commitments is considered necessary for continuing input from CMAI.

### *4.3 Collaboration with other agencies*

**Development-**
There has been commendable effort in collaborating with local Catholic congregations that has resulted in a few active and inclusive Mahila Mandals among Santhals and other backward peoples groups.

Two thirds of the Mahila Mandals are linked to a nationalized bank since they are considered credit worthy. These are not linked to the block level Self Help Group (SHG) federation. One of the trainers for government's Income Generation Programs (IGP) is actively involved in the training of the Mahila Mandal members.

Two other NGOs are working in the same area with women, organizing SHGs and working towards income generation activities. PRADAAN (Professional Assistance for Development Action) is an independent NGO and Social Development Center (SDC) is a Catholic institution. There is no formal collaborative work done with these NGOs.

However, members of the SHGs work closely with the CHVs and actively participate in programs organized by them.

**Health-**

The Civil Surgeon of Dumka district, the person-in-charge of all medical and public health activities in the district is a member of Hospital Management Board. However, he has rarely participated in the meetings.

CHVs and project staff work closely with Auxiliary Nurse Midwife (ANM) at community level and have good relationship.

Both ***Block Medical Officers*** (BMO) were unaware of a community level health & development program of MCH. CEDPA (Center for Development & Population Activities) and CARE are other collaborating NGOs with the public health care system at Primary Health Center (PHC) and district level. Training of ANMs for CEDPA was done by MCH many years ago. Though the project leaders confirm that BMOs were informed at the start of project, the communication channels between the project staff and public health system are not active at present.

Janani Suraksha Yojna (JSY) a special program under the National Rural Health Mission (NRHM) recognizes MCH deliveries for financial support to women, but there no other active collaborative program with the hospital or the project at present. The hospital has worked in the past on specially funded Government projects for Paharia tribe, Kala-azar etc. but there have been financial difficulties with delay in fund transfers. This has been difficult for an institution with poor reserves.

The BMOs see the possibility of working more closely with the project to compliment the grass-root activities and help in involving local people in planning.

## 4.4 Relevance –

CBPHCP started at a time in Indian health scenario when there was a need for community based programs to support the public health care system in areas with poor health access indicators. The new Jharkhand state had some of the poorest health indicators and rural public health system had few personnel in place at the time of bifurcation from Bihar (2001). There have been remarkable changes over the last few years with special inputs in Malaria control, DOTS for Tuberculosis and most recently NRHM. Public health system in Jharkhand also got a boost after becoming a state in 2001.

Despite changes in personnel and improvements in health indicators, Jharkhand state still has some of the poorest health indicators in the country. Dumka district is one of the poorest in terms of appointment of personnel at public health centers. Fertility is one of the highest and most of the deliveries are unsafe (http://mohfw.nic.in/dlhs/Jharkhand-20/Dumka.pdf).

Mission hospitals in the past have provided the specialized medical care in remote and economically disadvantaged areas. Many like MCH have responded to the need of the community around them to make Primary Health Care available to the most vulnerable. The role for MCH does not end because NRHM and other programs have started. There is a wider role to play; in empowering the communities to claim health as a fundamental human right, bridge the gaps in existing government programs and collaborate with them to ensure that maximum benefit reaches the most vulnerable.

**4.5 Sustainability –**

The project design is very suitable for long term sustainability. The congregations are to be actively involved in all aspects of project activity implementation and monitoring. The project activities are expected to build community awareness of rights, health and development issues. This in turn is expected to empower women and other community member to participate in village governance and lead to accessing all programs in the area of health and development. Capacity building through the project is expected to lead to advocacy for the rights of people.

The changes at the community level will lead to functional sustainability of the objectives. These activities do not require special financial input however; the activities at the MCH will need some funds for administrative work.

Findings:
Mahila Mandals and their activities will continue since they can independently fulfill their objectives. This is a step towards capacity building that needs consolidation and multiplicative action. However, CHVs do not see themselves continuing the health related activities without any monetary benefit from project.

The activities at MCH will continue since there is a symbiotic relationship with the community. The hospital is an asset to the region and must continue to meet the health needs of the local community. To do this, subsidy will be needed for hospital based treatment. MCH can not be expected to subsidize the treatment cost from its income since the clientele is from poor socio-economic background. A strategy is needed involving all stakeholders to meet this very specific need for the sustainability of this component of the project. Some other processes and services e.g. staff development, Information and Guidance Center, part salary of some staffs etc. are from project funding. These will need to be supported either by MCH income or by another source of funding to continue the activities.

There is lack of clarity in the congregations about their role and ownership of the project. The MMs and other groups that are formed through the CBPHCP initiatives do not see themselves as owners of the project but are perceived as an activity or the outcome. There is a need for all community stakeholders to participate in the project activities from planning onwards, in order for them to take ownership of the program.

MCH will be able to support some activities of the project, but large scale funding support will not be possible.

# 5. Implementation, performance, effects and impact

### *5.1 Capacity building for health and development activities (general)-*

*5.1. a Community health volunteers*–

Description- 72 volunteers identified by the participating congregations, usually a member of the congregation have been trained on health issues. Inductive trainings were of several days duration followed by theme based one day training programs. Hospital and project staffs were the resource people. No specific curriculum or module was used. CHVs were trained specifically in MM management along with other members of MM.

Findings- 62 CHVs in place are not providing direct curative or preventive care hence their skills were not assessed. The level of knowledge regarding common diseases and pregnancy is inadequate. There was no specific training on health education or IEC (Information Education Communication) which can explain the lack of formal community education effort by the CHVs to share the knowledge gained.

Clarity on project objectives, implementation methods and role of health related data collection is lacking, leading to less importance given by CHVs to activities related to health. They have been trained on SHG concept and management and like this role.
*(Attendance in many training programs and accompanying community members leads to CHVs spending many days a month on project activities indirectly. The travel to the project office for the programs is also a burden)*

*5.1. b. Congregations*-
Finding -All eleven congregations have undergone training on the CBPHCP objectives, locally prevalent health issues, leadership development etc. Majority of the training programs have been conducted in the MCH premises. This has resulted in inadequate representation and participation from the ordinary congregation members and potential leaders. Therefore there is poor awareness about the project and their role among the congregation members and leaders.

CBPHCP Sunday celebration in the congregations is also expected to inform the members of the activities. There is involvement of a large number of MCH and CBPHCP staff in these programs who conduct a special worship service. The current program is expensive and needs large man-power resulting in very few programs. Many congregations could not recall when such a program took place.

*5.1. c. Mahila Mandals*-

Description -An activity of MMs is to learn about health related issues and specific diseases. This is done on a regular basis as documented in the minutes of the meetings

held. CHV is the main resource person. MM members are especially trained on management of MM, accounting, book-keeping and income generating activities. Workshops on self-awareness and leadership are aimed towards empowering the women.

Findings- This is the most important social capital built through the CBPHCP initiative. There are over 1000 women in 90 MMs who are in the process of empowerment at various levels. The MMs are of different growth and capabilities. Some are very much empowered, motivated and able to dream of a different future, while others need input for a longer time and hand-holding by the project or similar resource group. MMs are in place for different duration and some have received less input and support than others. There is a perception among members of some MM, as being left behind in terms of capacity building. Illiteracy was stated as a major factor in deciding the level of participation by a member in MM activities. All CHVs hold some office in MM usually secretary or treasurer and in some ways MMs are dependent on them.

*(Venue for trainings i.e. project office, was not convenient for many MM members and CHVs as they needed to travel long distance through difficult roads and had loss of wages in the process)*

***5.1d. Recommendations:***

1. Documentation- Most of the training documentation is in the form of short reports, attendance of participants and occasionally schedule for training. Uniform reporting format for all training and other capacity building programs will give more appropriate information.
2. Curriculum and modules for training for all groups are necessary. Pre-existing modules if used must be kept with the project documents.
3. Venue for the trainings should be convenient for the participants. This would encourage a much larger and diverse group of people to participate and benefit. Project personnel and NELC leadership need to utilize the Sundays for reaching a larger audience in the congregations.
4. Congregation leaders and representatives of women and youth need special program to encourage deeper participation in project activities. Basic concepts in health, development and program management must be covered followed by action based strategic planning.
5. Resource persons for trainings should be from within the MCH for most for the trainings as there is expertise available especially within *Nursing School* in training of health workers. All other staff, e.g. doctors, laboratory technician, project staff must develop expertise in the areas such as Malaria, TB, HIV/AIDS and development issues.
6. Trainings should be organized professionally in order to provide maximum benefit from it and for assessment of impact. For this purpose, the group of professional at MCH must develop appropriate expertise. The institution has the potential to become a training resource in all relevant health issues for the district, which was envisaged as one of the outcome of the project.

The input in terms of time and funds has been substantial on capacity building activities. There must be focus and planning for all training activities based on the objectives to capitalize on the effort. Further, there is a need to plan on how to consolidate the effects of this input.

### *5.2 Health related services for project population*

*5.2 a. Community awareness and improved utilization of health services-*

**Description of various components-**

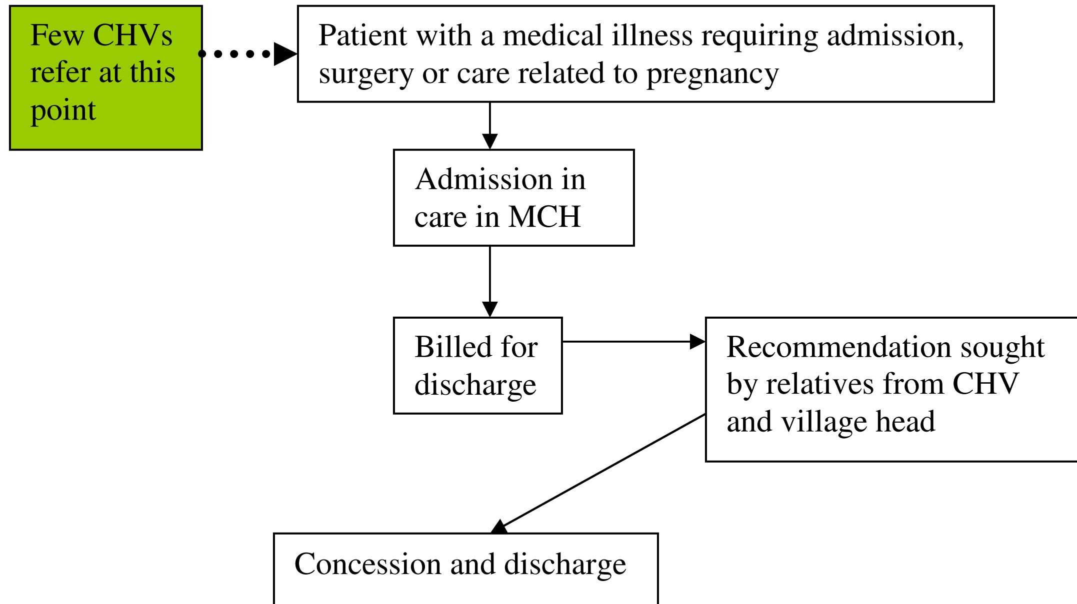
5.2 a.i. Community awareness building-
Community education and awareness building effort is largely through individual effort of the local CHV. Special programs for HIV/AIDS are conducted in the community by a group of animators previously trained through another project. Few community programs on other health issues are organized with the help of project staff with support from doctors and nursing school. Health education is also part of the Mobile Clinic which visits one village at a time. Health related topics are regularly discussed in the MM meeting which means the members (10-14) and their families have high input.

5.2 a.ii. Health Care delivery-
CHVs do not provide curative care in the village. There role is limited to advising the patient to seek care. A mobile clinic is planned to go out once a month to one village in the project area. Patient's consultation, investigations and drugs are provided from the project, though some pay a token amount. The mobile clinics are expected to provide treatment for all types of illnesses, screening for specific diseases (e.g. STI), antenatal care and referral. Patients seek care in MCH voluntarily and if they need subsidy on treatment cost, some part of their inpatient treatment is subsidized. This is done after recommendation from CHV and village head. MCH runs a **FREE consultation Out Patient Day** every week on Fridays which the patients from project area can avail. One special camp for EYE was organized in MCH premises in 2008.

5.2 a.iii. Referral system-

The referral system established by the project can be considered a passive system. A schematic representation is given below-

Figure 3.




The referral slip indicates that the person belongs to the village and has certain condition. There is recommendation for concession etc. on the slip.

**Findings- (refer Annex 8, Section I)**

The evaluation does not bring out the changes if any over the project period since the information for comparison is not available. The current status in terms of community level awareness of diseases and utilization of existing health services was assessed in an exploratory manner from the villagers, MM members and congregation members.

5.2 a. iv. Health Seeking practices and Community based health care-

Community is aware of common serious infectious diseases like malaria and TB. They are able to name hospitals with TB treatment facilities and sources of immunization and antenatal care. The knowledge about the availability of different types of health facilities is present; however, the practice depends on time of the day, cost, ease of transport and the suspected disease. For minor conditions like fever (not suspecting sever malaria), most people would utilize the local unqualified practitioner. This is done for both adults and children. Antenatal care and immunization is usually availed from the ANM at the sub-center or PHC. Some go to MCH, Catholic dispensary and private hospitals. For difficult deliveries people go to two nearby towns in West Bengal, MCH or Dumka. NRHM and JSY encourage women to deliver at hospitals and financial incentive is provided to women coming to MCH also. The cost of care is the major deterrent to people accessing MCH even though it is usually less than other private hospitals. People

also perceive some change in the care provided and therefore there is lack of confidence in the institution.

The active preventive health services (ANC and Vaccination) at the community level are largely provided by the government health system which has improved remarkably in the last few years with NRHM with the help of a community worker called ***Sahiya***. The Anganwadi workers were active community based links to health services earlier and they continue to be trusted by the community.

5.2 a. v. Mobile clinics/camps-

The mobile clinics can reach a maximum of 12 villages in a year. There were 16 mobile camps/ clinics in the years 2006 and 2007. The total number of patients seen was 711. All clinics were general clinics with lab facility. Among the 11 villages surveyed, villagers in 7 remembered a medical camp. The benefits of these clinics/camps were perceived differently by people as shown in table. 45% respondents see the medical camp as an activity to teach prevention on different diseases. Though many activities are carried out during the medical camp, prevention is perceived as the major activity. The effectiveness and impact of this activity is dependent on the frequency, purpose and site where the camp is organized. One special eye camp was organized at MCH by the project but other disease specific camps have not been organized so far.

5.2 a. vi. MCH based health care – (refer Annex 8, Section III)

Subsidized inpatient care is another way the project provides appropriate health care to patients from project area. About 40% of outpatients and inpatients come from project area. No direct subsidy is available for OP care however, free consultation is provided on Fridays as an incentive. Majority of these patients come from villages within five KM from the hospital. The common reasons are antenatal care, immunizations and infections. The referral system at present caters only to the admitted patients. The analysis of one month in the year showed that 25% of all inpatients from project area availed concession on the final bill. The total amount subsidized was 9% of the total billed amount for all patients.

This is commendable for the institution; however the subsidy is only on the hospital bills. In addition to this bill, patients need to buy medicines and some disposables. The discussions with the villagers had brought out cost of care as one of the reasons for not accessing MCH. The subsidy makes some difference, but not enough for any patient to readily seek care at MCH.

Physical access is difficult for many villages. There is no active ambulance service available in the project area.

5.2 a. vii. Referrals-

All the CHVs interviewed had different ideas about referral. Some referred for certain conditions, some for all. Few referred actively. Referral to OP is always verbal. The discussions with community members described the system same as in figure 3. The villagers found it useful that some concession was given if the referral was given.

The project staff at MCH based office keep a record of all patients referred when they receive the information by the patient's relatives. The feedback to CHV is only through the relatives.

***5.2 b. Health Information System (HIS)-***

**Description-**

HIS is expected to monitor activities and give overall indicators for change in the status of the population under project. Vital events, Maternal and Child Health related services and few diseases form the HIS for CBPHCP. Cause of death for a few important diseases is also collected. HIS for CBPHCP was modified following mid-term evaluation in 2002 and a user friendly, simple HIS was put in place. The population denominator at the start of the project was 56, 816.

**Findings-**

The reports compiled over the years do not reflect information from the total denominator. Data collection at the community level is totally dependent on the CHV with no supervision or checks. Many of the registers were not complete. This raises the question of quality and validity of the information at the project level. At present the data collected through HIS is not used for calculating indicators or planning and monitoring of the activities and outputs.

The understanding of the relevance of data collection and use for planning and monitoring is lacking among the CHVs and project staff. This has resulted in poor maintenance of registers. No inference can be drawn from the available consolidated information. The current project staffs have received varying level of training in health information system, but are not able to translate it for project management.

The project plan expected to use the following indicators to assess the change:

| Indicator | Expected level of change in 5 years (by 2009) | Reported by Govt. (2008) |
|---|---|---|
| Antenatal and Postnatal Care | 60% eligible women use | 25.1% 3 AN visit (DLHS 3) |
| Vaccination | 80% children completely vaccinated | 51.4% (DLHS 3) |
| Malaria | Reduction in morbidity and mortality by 40% | NA for district |
| TB | Reduction in morbidity and mortality by 30% | (Inadequate data*) |

http://mohfw.nic.in/dlhs/Jharkhand-20/Dumka.pdf

* http://209.61.208.136/pdfs/TB%20India-2005-Page%2055%20-72.pdf

***5.2 c. Recommendations (section 6.2.a and 6.2.b)-***

1. Information, education and communication (IEC) or community awareness building needs better organization and planning. The potentials of CHVs, MM members and interested congregation members are currently under-utilized. Congregations can function as units for planning and executing programs in the villages with the technical help from project staff, nursing school and MCH staff. The resources at nursing school can be utilized more for all training and educational activities. Animators trained for AIDS education are good resources for expanding this activity. Government resources (e.g. material, posters and films) should be used.
2. Allowing CHVs to treat minor ailments may change the current unethical practices of unqualified local practitioners. This should be considered seriously since this change in practice will build relationships and improve access of villagers to a better health practice. They will need more understanding of diseases and must have protocols for management for this activity. CHVs also should collaborate effectively with the Govt. staff to improve care provided in the villages.
3. The need for mobile clinics should be assessed with community based information. If needed in certain areas, these clinics need to be planned well to meet specific needs, be conducted regularly and efficiently. From the project and MCH side, there should be a team that will conduct these clinics or periodic camps. The mobile clinics/camps maybe needed to meet the need of an especially vulnerable group and therefore may not be cost-effective, however appropriate organization, planning and accounting is required to justify this activity.
4. Documentation of patients from project area in the outpatient services and inpatient record at MCH is necessary to look at trends and assess effectiveness of project level inputs to improve utilization of health services.
5. Special clinics at MCH for high risk antenatal women and patients with diseases like diabetes referred by CHVs and MM members, held on specific days may help referral, and confidence building.
6. Hospital data should be collected and analyzed on a regular basis to understand the client base, numbers from projects area and look at effectiveness of referral system. Sustainability of a costly service of *subsidized care for needy patients* is an area the hospital needs to plan for. This information can be used for fund raising activities.
7. Low cost of care is very much needed in this area. The hospital needs to cost all services carefully, introduce practices to reduce cost to the patient and introduce packages for standard procedures in order to make the services affordable to the local population.
8. Ambulance services can be extended to all patients for a charge, now that the telecommunication is widely available to make transportation easier.
9. Referral system needs to be reorganized and clearly understood by all, MCH staff, project Staff and the community. Register should be maintained to keep track of project patients coming to MCH for outpatient and inpatient services. CHVs should refer patients actively. The present system is meeting the needs of some

people; however the needy maybe left out of this system. The concession criteria should be clearly defined and understood clearly by all. Both MCH and community need each other and CBPHCP acts as a bridge between them.

10. Feedback system to the project from MCH should be developed. This should further disseminate to congregation and community level.
11. The project should be more actively involved with activities of the Government health system (PHC and Sub Center level). The project personnel need to explore areas for working in collaboration. Some possible areas are TB DOTS providers, referral directly to PHC and District level centers, support in National Immunization Days (NID) for Polio, Bed nets for malaria etc. The project should work for formal collaboration on some of these activities.

***5.3 Development Activities-*** (refer Annex 9)

*Description-*

The positive change in Santhal communities is envisaged through bringing about change in social status of women by transforming them into a group capable of living their lives in the changing society. The project has continued the work of forming Mahila Mandals with the objectives similar to Self Help Groups, which was started by MCHDP and CHDP. These groups have been through processes of leadership and team building, managing money, group saving and training on income generation schemes. There are 90 active MMs with over 1000 members. The details about MMs and their achievements are listed in the annex. Each MM has a president, secretary and a treasurer to manage the activities, accounts and loan recovery process. There are 12-14 members in each MM. The most important activity is group saving and loan procurement from a nationalized bank. The group saving is used as a revolving fund among the members. It is used for various purposes and repaid. The group's credit worthiness is assessed by a standard grading system followed by the banks and prescribed by the SGSY (Swarnjayanti Gram Swarozgar Yojna). Depending on the repayment history and utilization of loan taken from the banks; the group becomes eligible for larger loan and higher subsidy. The groups usually meet twice a month.

Learning about health issues and preventive and promotive health activities are an important component of the MMs started by various community projects of MCH. MMs have worked as the entry points into the community. Dissemination of information, collective knowledge gain and building of strength as a group are some of the outcomes envisaged by the project.

A *MELA* (gathering) of all MMs with CBPHCP takes place once a year where all MMs can meet and exchange information informally. They are able to display their talents through dance and songs and listen to speakers who encourage them.

*5.3 a. Findings*-

There are totally 90 MMs with CBPHCP. Some of them are as old as 5 years. They are at varying levels of growth. All are linked to banks and many have crossed Grade II credit level and are ready for Grade III. The income generating programs are agro based or

animal rearing. The group's savings are used mainly for agriculture related expenses. Some of the groups use the bank loans also for this purpose. The main function of MMs has been saving so far. The MM formation though initiated by project personnel, now relies more on the local CHVs initiatives and interests. Some CHVs have identified needy women in the neighboring villages and started groups. Most CHVs hold an office in the local MM.

*5.3 b. Direct benefits as perceived by the members*- Women unanimously declare that by being a part of the MM, they are out of the clutches of the money lenders, one group estimated this to be about ¼ less than what they owed to money lenders. Savings and loans from the bank have helped to make money available for farming, for sudden expenditure in times of sickness and also added income through small scale piggery and goat rearing. Some women have used loans for small businesses. Being able to add to family earning has reduced the burden of migration for some families. Women feel supported by each other, share knowledge and feel stronger as a group. Increased awareness about health conditions, their rights, how to access various programs and the confidence to venture out into a world largely unknown to most are some of the changes women attribute to joining MM.

*5.3 c. Other benefits*- Collective strength of MM is evident when talking to the women. They are vocal, take a lot of interest and pride in working in the group, and in showcasing their talents as a group for which they had little opportunity earlier. Non-Santhal MM members though few are helping the community to become cohesive. Some groups have started looking outwards beyond the monetary needs and are thinking of other issues like education and social evils like alcoholism. Some members have started participating in village administration.

Some MMs give small loans to non-members in times of need, thereby preventing indebtedness to an outsider (money lender). Most charge an interest which is viewed as development of asset for the group.

*5.3 d. Challenges*-
All MMs are not equally developed in managing the activities. Some need close supervision and direct help in interpersonal issues from the project staff. Trainings for team building and leadership development need focus with plans for long term sustainability.

Mahila Mandals and their membership is the biggest asset for CBPHCP. They are informed, aware and motivated group of women who are nurturing the next generation of citizens for the region. They form a vital and live link between the implementing group and general population. They have a great potential in taking the project objectives forward and making the activities sustainable. They can translate the project objectives into real action with the community participation which at present is at a low level.

The challenge for the project is to utilize the energies of the well established MMs into areas other than savings. Though some of them are thinking and some have worked in

small ways, there should be more training in the issues related to development now. The health activities are not optimum in Dumka district and the public health systems lacks many facilities and personnel, therefore MMs and CHVs still have a role to play in preventing diseases and promoting health.

***5. 3 e. Recommendations-***

1. Use strong MMs to support others in managing the MM activities.
2. Collaborate with other NGOs working with SHGs to share training resources and experiences.
3. Use more resource from the Government programs for SHGs. So far only one type of IGP training and one resource person has been invited.
4. Involve resource persons from local congregations and NELC to develop these groups since a large resource base exists within the Church. However, this activity is largely secular and should retain this flavor in order to be inclusive.
5. Use Mahila Mandal Mela as a platform to disseminate information about work of MMs, their annual achievements in all fields relevant to the project. This time can also be used for stock taking, planning or dreaming, target setting, and giving feed back to the groups.
6. Start need based programs e.g. quality education at primary level, career guidance etc.

***5.4 Role of CHVs-***

CHVs were expected to play a pivotal role in the project by becoming a grass-root worker bringing health awareness, good health practices, link to specialized care and also be a leader for social change especially among women. With the SHGs, CHVs were to involve in health and development issues at the community. They were expected to provide treatment for minor ailments and carry out preventive work for locally endemic diseases like TB and Malaria.

CHVs were to link with the congregations and work with their guidance. They were to be supervised and supported by Health Supervisors in all their activities.

*Findings-*
*5.4 a. Project's expectation of CHVs role-*
-Educate the target community regarding health and socio economic issues
-Form and nurture the female MMs as women's empowerment program
-Refer the patients to the Mohulpahari Christian Hospital
-Keep track of births, deaths and immunization of her target population
-Attend monthly review meeting and submit the report for consolidation at the project level

CHVs view their role as

1. managing Mahila Mandals
2. advice on ANC, Immunization and sickness on a one-to-one basis, as and when needed

3. referral of sick to MCH only for specific conditions
4. reporting births and deaths during the monthly meetings in MCH

They do not play any community level awareness building and community organization role. Supporting health related work of government staff is also not viewed as a possible role.

CHVs have done commendable work in organizing and leading Mahila Mandals. Many noteworthy initiatives have been taken by CHVs to develop new groups and especially vulnerable women.

*5.4 b. Training and Knowledge about diseases*– Multiple training sessions have been conducted over the years. These are mainly classroom sessions (no visits to PHCs, DTC etc.). CHVs use knowledge of diseases/conditions to advice woman and sick about accessing care at different places. Guidance on where to access care is not uniform by all CHVs. They seem to use their own knowledge and perceptions to do this. Some mentioned cost of care at MCH as being a reason for liberal referral to MCH. Some mentioned local unqualified practitioner as an appropriate health care provider. Individual perceptions about the quality of care lead to recommendations not inline with RNTCP (Revised National TB Control Program). Some chose private providers over MCH.

There are many gaps in knowledge. Most had good grasp of HIV/AIDS, but practical knowledge about the local killer disease TB was lacking. Only one CHV (also a teacher) has undergone training on TB. Special knowledge related to maternal health was poor uniformly among all CHVs interviewed.

*5.4 c. Community Survey-* (Annex 8, Section I):
38/77 respondent knew the CHV by name. Of the 35 respondent to the question about her role 7 said that she did not do anything in the village or they did not know. The roles mentioned were advice, help with immunization, organizing MM meetings and drug distribution for Filariasis and Malaria.

In terms of source of health information, CHVs are less significant. Govt. Health workers and Anganwadi Workers have played more prominent role in providing health information to the people.

One significant finding was that most of the births were at home conducted by untrained midwives. This was one of the areas for provision of health care planned by the project which still is relevant.

***5.4 d. Recommendations:***

1. Need to define and decide on the roles of CHVs as envisaged by the project objectives and based on current needs.

2. Health role is undermined by the lack of curative component at primary level. There is a need in the current health care scenario for a community level volunteer who would identify needs, inform and educate people and document health events. CHVs being literate are a great asset in this regard.
3. The roles CHVs play in MM should be consolidated with Training of trainers (TOT). They should be able to fulfill this role.
4. Regular training in health related issues is highly recommended, but this should be need based.

### *5.5 Congregational transformation*

The project envisaged development of the congregations into an active group responding to the needs of the community around them and using their capacity for supporting the objectives set out by CBPHCP. The process of developing interest and identifying skills were through a series of workshops and capacity building trainings. One specific health issue presented to the congregations was HIV/AIDS. Participation as individuals and as committee supporting and monitoring the CHV and Health Supervisor was the expected role of the congregations.

*5.5 a. Findings:*

There are changes in the community in terms of awareness about health issues and diseases. People are aware about safe delivery and immunization and access these services. The change is attributed to presence of CHVs and CBPHCP. Community health education programs on Malaria and HIV/AIDS were found to be useful. There are changes also in the educational status of the villagers due to schools, less dependence on “quacks” (unqualified local medical practitioner) and freedom from the clutches of money lender due to economic empowerment of women though MMs.

The most important contribution of CBPHCP is formation of Mahila Mandals.

The problems in the communities are of alcoholism, family disharmony, poor quality education in public schools and other infra structure issues. Congregations and community meetings had one common need or dream, better education for all.

Congregation members and leaders see their role as building awareness about health in the community. The reports do not go through the committee in general. Committee and leaders do not actively participate in any project monitoring or planning. They see CBPHCP as means to access care at MCH at a more affordable rate.

Few among those in the groups met had attended special training programs. Some leaders had attended meetings and trainings but due to the changes in congregational committees, all congregational leaders are not oriented to the concept of CBPHCP. Congregations do not have a clear concept of the “Healing Ministry of the Church”, therefore finding it difficult to internalize their role in CBPHCP.

*There is a concern by some stakeholders in the project on the name "**Congregation Based**". There is a possibility of misunderstanding and religious interpretation. This may hinder acceptance by persons of other faiths.*

***5.5 b. Recommendations-***

1. The church leaders and the Pradhans of the villages should be oriented properly on the concept of the project.
2. They should be trained
   -to see vision and dream for their village and congregation
   -to identify their felt needs and its possible solutions
   -on leadership and communication
   -on various health and socio-economic issues
   -on community governance
3. As far as empowerment of the community is concerned, all the age-groups and gender should be considered.
4. Congregation level committee could be formed for smooth functioning of the program.
5. There should be participatory processes put in place to encourage participation of all groups from congregations, for taking ownership of the project and long term sustainability.
6. NELC leadership should be actively involved in the education and orientation of the congregations and pastors in the healing ministry of the Church.

***5.6 Institutional development for Care of HIV/AIDS***

*5.6 a. Development of protocols for management of HIV/AIDS* –
No protocols are in place in service areas. The opinion of the staff and doctors was that they have not needed it since there have been no patients. Staffs are aware of practice of universal precaution however, no observation was done to assess practice.

Comment: Based on the information from Integrated Counseling and Testing Center (ICTC) Dumka, the prevalence of HIV infection among antenatal women is approximately 1%. This necessitates that all health care facilities providing obstetric and surgical care develop capacity to identify and manage patients. MCH does not have a policy of pre-op screening for blood borne infections and HIV testing is dependent on the treating physicians at present. This can place health care workers at higher risk especially with limited resources for ideal universal precaution.

*5.6 b. Establishment of Information and Guidance Center at MCH*
Information and guidance center functions from the CBPHCP project office. Some of the activities carried out through this center are
a. Awareness of women in Law and ethics
b. Updates for staff on quality improvement in mother and child care (Normal delivery, partograph etc.), infection control, universal precautions, HIV/AIDS awareness.
c. Refresher training of CHVs, women groups and village leaders.

***Comment:*** The function of the Information and Guidance Center has expanded from what was planned which is commendable. However, there is no sign indicating the existing of such a facility in the hospital premises. The organization of this facility is unclear. The originally intended Voluntary Counseling and Testing Center (VCTC) do not exist in a specific place. This may prevent development of HIV/AIDS prevention and care activities in the hospital. Not having dedicated personnel is another problem, since motivation and skill level of people defer and without appropriate training this specialized program component can not be taken forward.

*5.6 c. Capacity building of MCH staff to respond to challenge of HIV/AIDS-*

Description – In-service training on HIV/AIDS stigma and discrimination has been conducted for many categories of MCH staff and nursing students. The objective of this exercise was to develop environment for quality and compassionate care of patients with HIV/AIDS. No specific module was used for the purpose of training. Topics taught in the training program were only available in the descriptive report or schedule for training.

Finding- Practical experience is lacking among the staff about managing patients with HIV/AIDS and dealing with issues related to it. There is no hospital policy for pre-operative or antenatal screening. Knowledge of universal precaution is present but some attitudes suggest possibility of different practice with a person with HIV/AIDS. ***Annex 8, Section 4*** gives the details of survey among the staff. Since there is no known experience of caring for a person with HIV/AIDS, the answers for practice questions are largely hypothetical and may not reflect the actual behavior. Fear among staff for caring for HIV infected and shame with infection is low, but most of those surveyed expected to have the knowledge about a patient's HIV status. This indicates some gaps in knowledge even among health professionals and may lead to discriminatory behavior based on suspicion. Though all categories of staff have received training, all staffs are not trained. Class IV and office staffs are less likely to receive training. Despite having many programs in the hospital, only 50% of those surveyed considered in-service training the most reliable source of information on HIV/AIDS.

### *5.7 Special programs-*

#### *5.7 a. HIV / AIDS Education program*

Main groups (1) School students
(2) School drop-out adolescents
(3) Congregation members and leaders
(4) Mahila Mandal members & CHVs
(5) Hospital staff and student nurses (discussed under 6.5)

Brief description of the program-

- Program in community is conducted by a group of animators (all males). The program consists of a film on HIV/AIDS and talk.

- School program is called ***Life Skill*** program and the resource person is usually one of the animators (male). Some school health programs are conducted by school of nursing students and staff, and project staff.
- All other programs are conducted in project facility at Mohulpahari. The resource persons for these are project staff, doctors and occasionally nurses.

**Comments**

(1) All programs are organized by project staff. The request is not from the congregations or community.
(2) Poor utilization of available resource persons within the institution and project for community based programs.
(3) No standard module for life skill education for students and school drop-out adolescents.
(4) ***Facing aids module*** planned for use in congregational programs is not available
(5) All programs lack gender sensitivity. There is a male majority among project personnel, animators involved in community programs and resource persons for programs conducted in CBPHCP center at Mohulpahari. Participation of nursing personnel along with well prepared modules will help in making all programs and trainings gender sensitive.

Direct evaluation was done for school based program only. Boys appeared to have learnt more than girls about HIV/AIDS. Other topics covered were hygiene and common diseases. Students lacked understanding in other areas expected to be part of life skill education. Both schools visited had project staff and nursing students as resource persons.

***5.7 b. Radio program on HIV/AIDS awareness-***

Background-

NELC Recording studio has been broadcasting a Santhali Language Christian Radio program for 25 years through Trans World Radio.

The audience for this program is spread over all Santhali speaking regions in India and in the neighboring countries. The estimated population reached through the existing program over the years is approximately 10 million Santhals, Malpaharias, Mahale and Dom communities.

As a response for holistic development of the tribe, the HIV/AIDS radio program in Santhali was deemed appropriate.

***Brief description-***

Two professional groups involved in development of the programs are
(1) Doctors from MCH/CBPHCP in developing the content of the program.
(2) Team from NELC recording studio for recording and broad costing.

A third group is involved in composing / organizing music & songs. This includes musically talented persons connected to NELC Recording studio.

<u>Broad Cast</u> started in 2007. So far 38 programs have been developed and recorded, and 52 programs aired in 2007.

***Issues identified in planning & implementation of the HIV/AIDS radio program–***
Both technical groups have limited knowledge/experience in use of media for health awareness, resulting in the following –

(1) No inbuilt process to ensure quality of content, and acceptability of this program as an ***edutainment*** program.
(2) Lack of plans for dissemination of information about the program resulting in poor ***Reach*** among local non-Christians and Christians who are not regular TWR listeners. (Only 1 person among 13 radio listener had ever heard the program- Annex 8, Section I, Table 11, 11a)
(3) Dependence on a small group of professionals for content planning and development.
(4) Inadequate plan for follow-up and non-availability of printed materials with the radio ministry group to respond to the needs identified through ***queries***.

***<u>Evaluation of content & quality of randomly selected aired programs -</u>***
The recoded audio CDs were assessed by Santhali speaking persons from different backgrounds. Translated script was assessed by medical professionals.

Positive points

(2) Very good music, especially traditional music
(3) Dialogue / dramatization style
(4) Detailed information on the topic
(5) Language of common Santhals

Negative points

(1) Use of technical English terms
(2) Some programs are long monologues
(3) Repetition of points in the same program

**<u>Comments</u>**- The overall quality of the program was considered "very good". The persons working with communities were very appreciative of the effort and feel this program has good potential for HIV/AIDS awareness. The doctors and music team's effort is commendable.

***Recommendations for Radio Program***-

1. Develop teams of professionals (medical and technical) for planning and writing the scripts. Recording studio personnel, who have expertise in dramatization can aid in the development of the final program. Develop plan for quality assurance of the program.
2. Queries management and feedback system should be put in place. Regular consolidation of data from this will help in assessing the effectiveness of the program. This may need another group of professionals. Retired medical professional among NELC membership will be a good resource for this.

3. A strategy for improving REACH is the immediate need. A good program is currently not reaching people due to lack of information.
4. This program can be used by the project as a tool for HIV/AIDS awareness building. In which case, the project might consider providing some radios to groups in the project area, who then are encouraged to listen to the program. This is important since only 20% of persons surveyed in project villages listened to the radio.

***5.7 c. Comment on CBPHCP for Paharia Villages-***

Three villages inhabited by Mal-Paharia tribe are identified to expand the CBPHCP. These come under different congregations and have poor access. The needs are similar to other villages but the isolation from other population groups is likely to be more. The needs maybe different from those of Santhal communities, therefore special micro-plan will be needed for these villages. The observations based on one village visit suggest that strong community participation is possible. However, the distance from MCH is not feasible for an intensive program using the current implementation strategy. The project document lays emphasis on education for children. This will require exclusive time, special plan and involvement of civil societies. Feasibility of this new venture should be analyzed carefully before starting a full fledged program.

***5.8 Note on Community Based Health Insurance-***

CBHI was expected to lead to equitable access to quality health care by all people, irrespective of their economic status. The concept of risk sharing is the basis for health insurance and still a difficult concept to internalize for common rural folks. The plan was to introduce the concept in select villages and then expand. Many meetings and workshops were conducted for the congregations and community members, with no positive response. The activities were stopped from 2008 for CBHI.

**Comment:** There is no prepared document on CBHI and guideline for starting the program. The reports of the meetings/workshop are not sufficient to assess the efforts and outcome.

## 6. Organization and management

**Findings:**

*6.1 The Team-*

The project team at the central level consists of four members who work under the guidance of the acting head of CBPCP. All are based at Mohulpahari Hospital. They have been in place for varying duration and come with varying level of training and experience. All four staff together implement, monitor and supervise the programs. There is no geographic division of the project area among the staff, but there is some functional division. At present, the assistant program officer has overall responsibility for project management.

Field team consists of the CHV and supportive congregation members if any. The health supervisors at field level are not present. Animators working with AIDS education are not linked to CHVs. In effect, CHVs work alone.

*6.2 Monitoring and supervision-*

Field level- Most of the supervisory work is done by a team of staff together in one geographic area in a given day. Training and capacity building activities are done mostly in the project office. This has resulted in few community/congregation visits by the staff. On an average, only one field visit is done by them in a week to one village and respective Mahila Mandal. A lot of time is spent in guiding MMs, developing bank linkage and their follow up. Data collection for HIS is not checked on a regular basis at the community level and there no system for verification. Staffs are unsure of data collection and management processes. Congregation committees are not involved in monitoring or supervision.

Project level- Role of project management committee is unclear in active monitoring of the activities, planning and guiding staff. Reports are presented to HMB but feedback system is unclear.

*6.3 Review meetings-*

Review meeting is held once a month at project office. Staffs of CBPHCP conduct the meeting. CHVs submit the monthly consolidated report for the village and collect their honorarium. They are informed about the visit plan by staff for the month. There is no discussion or planning for activities.

*6.4 Project Committee-*

This is part of HMB which is expected meets to review all activities of the hospital and specifically provide technical input to the project. The board minutes do not indicate any specific input by the members for project work. The committee needs to be actively monitoring performance and giving inputs on management issues.

*6.5 Documentation and Accounting-*

Apart from HIS, all other program reports are in text form. Consolidated reports by project activity along with relevant documents will help in following the progress of activities and help in output assessment. There are no training modules or workshop details available with the project. Training modules should be developed or existing modules adapted for use in the project training.

Accounting is done by one of the project staff. There are many ways this process can be made simpler and streamlined to the system of MCH. Experienced persons with MCH can be requested to help with this work. Actual costing of some activities like mobile clinic will help to understand the financial input for an area with special constraints. Budgets are prepared according to the project plan and all deviations in the past years were after discussion from the funding partner. An audited statement of accounts is

prepared every year separately for CBPHCP. All budgets and annual reports, and audited statement for one year were reviewed.
The points to note are-

1. The most expensive activity is capacity building if all programs are put together. There is a need for detailed records and documentation of the process and build in assessment tools for quality and outcome. At present the assessment is possible through numbers trained only and do not reflect the gain for the community.
2. Mobile clinics need to be carefully evaluated for efficiency and cost effectiveness.
3. A large amount is paid to the hospital for treatment of patients. This is not sustainable without special funding and the hospital needs to look at ways of reducing the cost of care to increase the number of beneficiaries.
4. The travel cost needed for such a program for monitoring and supervision does not reflect in the accounts.
5. Radio program is costly and needs further assessment and justification for the funds used.
6. Special program for Mal-Paharia groups has incurred large expenses. There is very little organization and program development so far to justify this.

### *6.6 Other Comments*

The leader of the project team left the job and at the same time one senior lady staff passed away. Absence of the leader and a senior staff weakened the team and this adversely affected the program.
The present staff should be commended for their efforts in running the project with their existing knowledge and experience. However, a better organized program will be more efficient and improved documentation system will help in monitoring. Staffs need support and guidance from leaders. Regular input from the project committee along with regular review of activities is necessary.

### *6.7 Challenges*

i. Project staff and CHVs need to build relationship with the congregations, pastors and village Pradhans.

ii. To develop conceptual clarity among MCH staff and CBPHCP staff about CBPHCP and their roles.

iii. To achieve the objectives in the present context, the project staff should get special training on

- The understanding of community health
- Leadership and Communication skills
- Health information system
- Planning, Monitoring, Supervision

iv. Project staffs need to get to know the villages, the problems, activities etc. through regular village visit

v. The project and project personnel should become an active link, and liaison between the village people and Mohulpahari Christian Hospital

vi. Widen the focus to local non-health issues like pollution, alcoholism, early marriage, adding quality to primary education etc.

vii. To help the congregations and leaders to generate demands.

## 7. Human Resource Development-

Project staff and MCH staff have had the opportunity for special training in their own field as well as on community health. Project staffs received training on various aspects of program management and were able to share experiences in workshops and conferences.

MCH staffs have received special training on community health and development. They are well informed and interested in the growth of the project activities. However, many are not sure how they can participate in this initiative of the hospital.

There is a need for community health specialist in the staff of MCH if community based initiatives is to be a continued focus in future. The institution should consider appointing a trained middle level staff (nurse, doctor or social/development worker) for this.

## 8. Infra–structure development for project –

Good infra-structure is developed for project office purposes and activities. The office space and computer facilities are adequate for personnel and documentation processes. The proximity to the hospital office helps in getting support from experienced personnel for documentation and accounting. The conference hall is used for multiple purposes for trainings, meetings, and counseling. Vehicles are essential for mobility and reaching inaccessible areas. The assets need better and planned utilization by the project and MCH.

## 9. Summary of main findings, conclusions and recommendations-

*9.1 Organization and management of the project –*
Mohulpahari Christian hospital has taken the challenge to respond to a need for development of the local Santhal community and other vulnerable groups in the area. Local congregations have been involved in this venture both by learning about health and development issues and participating in various capacities to support the process of developing the community.

110 communities around Mohulpahari connected to 11 congregations and spread in three community development blocks have developed varying level of capacity. 72 volunteers from the villages have been trained in health and development issues. 62 are currently

based in the community, have the acceptance and the possibility of working formally and informally with existing government programs and health system. The project's strength is in organization and management of women's groups through whom it is able to reach, educate and motivate families towards a better future.

There is a need for geographic reorganization of the project area for better accountability, monitoring and supervision.

*9.2 Capacity building-*

The Mahila Mandals are the biggest asset for the project and the local communities. Together they have financial strength, self awareness, strength of unity and definitely some leaders in the making. They need to be supported by CBPHCP, other like minded NGOs and Government programs to develop further into a group with vision for themselves and their communities.

The congregations have the potential to be excellent partners for the growth of the community beyond religious line. Effective communication among NELC, congregations, MCH and project staff needs to take place and all stakeholders should participate in planning and monitoring.

Young people need building up with quality formal education, life-skills and capacity to develop their own communities. The project is working with them in small but effective ways. This needs formalization, and planning to systematically reach this very important group. Development of young people is one of the special needs of the area where the available programs and systems lack capacity and strategy to meet the need. CBPHCP could consider focusing on this group and be instrumental in effective transformation of the communities.

*9.3 Health Services-*

There is potential for community based health services to meet the needs in some components of Primary Health Care. Utilization of MCH services though improving, are still poor. Home deliveries by trained personnel, nurses or trained birth attendants are still an area that needs input from NGOs. NRHM is encouraging institutional deliveries which mean as a policy there will be no input to train and provide safe delivery at home by the public health system. High risk approach is needed for this region, especially since women tend to deliver at home due to problems of physical accessibility and poverty. IEC is another area of need in order to change the level of health services utilization. Other areas of need for health services are control of communicable diseases, minor ailment treatment and referral, and emerging non-communicable diseases. CHVs and members of MMs can be trained and motivated to provide these services with guidance and supervision, and collaborate with public PHC system wherever possible. TB and malaria are two diseases that need special strategies for control in this area.

MCH may consider special health projects in the villages around stone quarry and crushing units.

*9.4 Development initiatives-*

Formation of Mahila Mandals and few men's self help groups have led to improved economic security among the member households. This results in better nutrition, retention of children at school and better access to health care. Many of the positive changes in the villages are attributed to the MMs by community and congregations. People are more aware of health issues, health services and Government programs. There are efforts by other NGOs and many Government programs, with CBPHCP as one of the players in the field. The challenge for CBPHCP is to identify areas of need and formulate responses with the community and MMs, utilizing all the available resources.

One of the felt needs in the community and among young people is guidance for formal and non-formal education. Due to poor infra-structure development, the information dissemination is poor. The project could work as a catalyst to address the needs identified by the community members and groups.

*9.6 Transforming Congregations to respond to community needs*

Congregations are not partners as yet in this venture, though the potential exists. This is an opportunity to involve them in individual capacity and as a group towards building of a healthy and empowered community. The project staff, MCH and NELC leaders must commit themselves to educate, empower and support congregations to help local communities. This can be effectively done by developing links with NGOs, and by social response and advocacy for the rights of people going beyond spiritual nurture.

*9.7 Institutional development for HIV/AIDS care-*

The institution is not ready to deal with persons with HIV/AIDS. There is a possibility that patient who are HIV affected are getting treated in MCH. The opportunity to develop protocols, guidelines and to train personnel has not been utilized adequately. There is a lack of institutional commitment for capacity and systems development for this due to perceived lack of HIV infection in the local population.

Awareness of HIV/AIDS and is high among staff, but they are not conscious of the need for care. MCH has an opportunity to become only non-governmental general hospital providing VCTC, screening of pregnant women in Dumka District and become a HIV/AIDS care center. This could be considered an important service to the region.

9.8 *Role of partners*

Lack of clarity in the role of various partners has led to poor accountability and ownership. All stakeholders need to accept their roles, participate actively in respective aspects of project management and view each other as partners. There is a need for an external consultant or a group of experts to support the project personnel and MCH in project management. Periodic review by experts may help in fine tuning activities to the stated objectives in the present context.

A strong influence of CMAI in visioning, planning and initial implementation of the project has probably led to the other stakeholders not taking up ownership of the project. This needs to be acted on immediately. NELC, along with MCH and Normisjon needs to define the role of CMAI. NELC also needs a strategy to communicate with congregations, to ensure their participation and to take ownership along with the community.

***9.9 Conclusions and recommendations-***

The role of MCH is changing with time as public health system and other private providers become active. Mission hospitals have always responded to the needs of the vulnerable population and here again, MCH has attempted to do so. A lot has been achieved with much more to do. With a vision, participation of stakeholder and with appropriate technical guidance, there are possibilities of making a lasting change in the lives of common people.

The ownership of the project lies with major stakeholders; the congregations, MCH and the NELC church. There is lack of clarity on this important issue, probably due to compromise in community organization activities in order to keep time line of activities. Special community based projects in areas with difficult terrain and scattered population need a lot of time and effort and this deficiency needs to be corrected for communities to benefit from the project efforts.

Appropriate monitoring system at project level and at community level is necessary for planning, reviewing strategies and finding new avenues for bringing changes in the communities. Some of these activities will need special skill and support from experts. Organizational structure needs strengthening with skilled personnel and visionary leader to carry this forward.

Needs at the community level are enormous, despite commendable progress made by the public health system and other development initiatives. There is a role for NGOs and especially for MCH which has the trust of local people. Some of these require that the project plays a non-traditional role. The congregations are enthusiastic and have resources to share. Building on past experiences of community based projects; MCH and CBPHCP need to focus on specific needs and with the help of the Church and congregations, and build the program further.

Collaboration with NRHM and other special health programs such as DOTS are important for MCH for program sustainability and to ensure quality health care. Development programs are a new venture for a medical institution, therefore collaboration with other NGOs and government departments are necessary for success.

## 10. Lessons learnt

1. A community based project in a challenging terrain needs special motivation, special provisions in work timings and work conditions to enable staff to perform.

2. Involving congregations in community health and development activities is a novel idea which needs to be translated practically into a mandate for the congregations. The process will not be simple since rural congregations are not thus empowered.
3. A special project design may evolve with the participation of women's groups. They are definitely empowered to start looking at needs around them.
4. Mahila Mandals on their own are small units trying for their economic improvement. However, as a large group they can become a powerful advocacy group.
5. A group of persons with experience in community based health and development programs are needed to support MCH with their efforts in responding to the needs of the local community. This is especially needed since experienced and qualified staff is difficult to find and retain in such demanding work.
6. Community health and development work by a hospital, primarily involved in health care delivery is a special challenge. A community health program attached to a hospital can change the character of the hospital due to specific community needs. The group needs to share the vision with all stakeholders and accept the challenge.
7. Development work is new to medical institutions involved in health and development programs. Special skills are needed for it and suitable personnel needed to manage the programs. Personnel working in such programs should be able to define their role and delegate.
8. Collaboration with GOs and other NGOs often carry risks and ethical concerns for Christian institutions.

# PART B

# FOLLOW-UP OF RECOMMNEDATIONS OF FINAL EVALUATION OF MCHDP (2005)

## 1. Background-

The final evaluation of MCHDP in 2005 made certain recommendations to MCH in different functional areas. This evaluation team was requested to assess the implementation of those recommendations and identify special constraints in implementation. The special support from CMAI was slowly withdrawn over time. Special appointees to implement the project also left the project. The responsibility for implementing the recommendations was fully with MCH, with some technical support by consultants from CMAI and under the guidance of NELC leadership.

## 2. Scope & Methodology – Refer TOR (Annex 1)

Methodology followed included group discussion with staff, interviews with various members of the staff and administrators, and observation of facilities and few processes.

## 3. Limitations-

*3.1 Time*- This was done along with CBPHCP evaluation and dedicated time for MCH during the working hours became less than planned. Observation in all functional departments could not be done due to unavailability of the staff, special programs and the time of the day available. It is important to note that the evaluation team was able to spend very limited time on this and the report therefore reflects only the areas that could be observed and assessed.

*3.2 Sensitivity of topics*- Many of the points for discussion are sensitive e.g. inequitable salary structure, promotions, non-uniform human resource development (HRD) plans. Individual perceptions on this may affect the findings.

*3.3* Financial analysis was done based on 2007-2008 budget and statement of expenditure.

## 4. Main findings-

### *4.1 Infrastructure and equipment*-

**4.1a. Buildings**- The renovated medical ward is not in use because the needed furniture has not arrived. This has resulted in old Pediatrics ward still being used for male medical patients. Cottages are used more than Special wards (ICU) but overall bed occupancy is still very low at around 50%. The older building, earlier used as EYE and KALA- AZAR ward is used very rarely now. It has many unused areas but most of them are in good condition and usable. Few areas are redundant which could be demolished to improve the whole environment. The newer (and renovated) section has many parts needing repairs and it is evident that this building will constantly require high maintenance and is a liability.

The signs outside and in the hospital are adequate but not striking. Some of the signs need to be painted again.

**4.1b. Maintenance**- There is one person in charge of looking at maintenance issues, but he does not have *one* line manager to report. The manholes etc. are not in the best condition (many were open) indicating inadequate preventive maintenance plan. The current system still requires requests be sent for maintenance need of an area, to the persons for action.

**4.1c. Equipment maintenance and replacement/ up gradation** – This is again managed by individual departments or functional area, and lacks a system. Most equipments need replacement according to the staff, however are not done due to lack of funds. Laboratory personnel believe the need for a new machine exists for more tests and will be able to recover its cost. However, due to limited planning for expansion and dependence on centralized decision making, this has not been taken forward.

**4.1d. Electricity-** There is no change in power supply and unless the upcoming sub-station becomes functional soon, it may be worthwhile considering alternate source of energy for the hospital. At this time the power use is still very expensive for the hospital and the expenditure is managed by support from CBPHCP. There is positive effort to reduce expenditure by decreasing supply to residential areas; however other source of electricity like Solar Power is definitely something to be considered as a long term investment.

***4.2. Systems-***

**4.2a. Administration and managerial systems-**

Many of the systems put in place during MCHDP are functional though all are not at the same level. All systems could not be looked into however; there is a generic problem of lack of supervision from an administrative functionary. This leads to slackness in keeping all systems active and efficient. Involvement of functional departments in planning and managerial discussion may help in changing the current level of output. Staffs are appreciative of the phase soon after MCHDP project completion when participatory management was practiced. Reasons for change in this could not be explored adequately.

There is a need for developing line of controls for various departments and activities, so that staff is clear about reporting and there is accountability at every level. With diversification in the programs and activities, it is becoming necessary to maintain accounts for projects and activities. Financial management personnel need to be involved with all accounting procedures and should be able to guide project personnel and suggest accounting processes.

Medical records information is currently not utilized for planning and monitoring. Simple statistics can be generated with present recording system that will aid in the process. This can be used by HMB and at regular reviews for monitoring and planning. This will also help with prioritizing of hospital activities, infra-structure planning etc.

Job descriptions of staff though developed are not in place and not communicated to the staff. None of these could be physically reviewed.

**4.2b. Care to patients –**
Overall bed occupancy remains low with some wards not being used at all most of the time. At the time of evaluation three wards were not in use. We did not look at the numbers, but the impression was that the remaining four wards had fair occupancy. The question of special ward use remains, since the returns for the investment is not visible. There may be need to reassess the utility of special wards and make policy changes for more efficient use of this area to generate more income.

Cost to the inpatient is reasonable when analyzed for a month with a mean final bill of approximately Rs. 1200.00 and 50% of the patients paying less than Rs.1000.00. However, this does not include drugs and disposables which can vary. The total cost to the patient and perceived quality of care determines utilization of the services. About 12% of all inpatients received some concession in the month of analysis. But the total amount subsidized in the month was only 4.2% of total billed amount. (Annex 8, Section III, tables 4-7) Some of the specific recommendations to optimize patient cost have not been implemented namely, packaged cost for standard procedures and low cost medicines. Issues in implementing these were discussed with concerned staff. Reasons identified were, inadequate participation of smaller departments in planning and centralized decision making. The management may need skills to cost various treatments and services.

The waiting time for patients is still long especially in the mornings resulting in other OP services like lab, X-ray, pharmacy beginning their work late. Ultra-sound service is under utilized and special services like diabetic clinic and HIV counseling and testing that can attract special group of patients are not active. The lab can be more productive and an income generating venture.

***4.3 Financial Sustainability-***
**4.3a. Specialist Doctors-**
Recruitment of specialist doctors has been the most difficult task. Alternative plan for employing part time consultants was also not successful. There is a need to rethink this strategy since sustainability of this hospital depends to a large extent on provision of comparable level of specialized care in the region. Possibilities of collaboration with other Christian institutions should be explored.

**4.3b. Out Clinics-**
Objectives of OUT clinics at different locations are different. While it may certainly be useful to have a full time doctor at Benagaria, the facilities will need upgrading. This will be costly due to non-availability of electricity, poor road access and addition of new services. Out clinic income and expenditure need separate analysis to make a decision on this activity. At present separate accounting is not done.

**4.3c. Drug procurement –**

Pharmacy needs to start procuring low cost drugs at the earliest to reduce further debt on drug costs from medicine suppliers. This will also help in reducing cost to the patient and improving patient numbers.

**4.3d. Health Insurance-**

Hospital card system for nursing students for a very low charge has been stopped. They will be paying substantial amount towards the medical care from current academic year.

The other health insurance schemes are still in place. There was a loss on the health insurance in the last financial year. With a change in nursing student's scheme, this will remedy itself. 40% concession on MCH dependents still exists. The recommendation to make it better has not been implemented. A financial analysis of the last few years income and expenditure in dependents' health care is needed to inform new policy.

Most of the patients in Dumka Out clinic are Church workers and dependents. This needs careful analysis to determine the cost. A system of less frequent clinic may fulfill the needs of this group, making it more efficient.

**4.3e. Poor Patients Fund-**

At present CBPHCP is subsidizing the cost of care for patients coming from project area and out-patient consultancy fee on Friday. The plan to build up the fund by regular credit into the account has not happened due to other debt management. MCH needs to have a special strategy to generate funds from multiple sources. This is going to be a constant need of the hospital and must be a priority for action.

***4.4 Decreasing Expenditure***

**4.4 a. Staff recruitment and multi-tasking**

New recruitments are few though few retired staffs are retained in the areas of need. There is still a delay in action for second generation leadership in specific areas. The Nurse-Bed ratio is very much less than the recommended though support staff are little more than recommended (Indian Public Health Standards, GOI, MOHFW). Budget analysis of the hospital shows salary expenses within the recommended proportions and the salary proportions for various categories of staffs is also optimal.

Though the hospital is managing to keep the expenses low on salaries, there areas of concern remain. They are-

- Difference in salaries of doctors and other categories
- Large number of retired staff in nursing and administrative positions
- Relatively large number of support staff

Few support staff are multitasking but there are many more that can. Lack of job description prevents any objective analysis of the work load for individuals and therefore, is difficult to comment on.

**4.4 b. Debts repayment-**

The hospital is making constant effort to repay the debt with new investment plans and other support. However, substantial debt still remains and MCH should work on cost reduction and other supports in kind for hospital needs to prevent further debt.

**4.4 c. Discontinuation of Dietary service-**

Dietary service is continuing since there is a need for providing hot water for patients that is met by this kitchen. Other activities can be taken over by other kitchens in the campus or out-sourced. No other alternative is explored for hot water supply and solar energy is a definite option.

***4.5 Human Resource Sustainability-***

**4.5 a. Salaries/ Compensation issues-**

Staff felt that there is inequity in salaries and compensations available to doctors and others. It is possible that this decision of the board is justified, and this perception maybe due to lack of participatory management, and communication between administration and staff. Adequate salary and appropriate benefits are needed for professionals to work in challenging areas. Children's education is a felt need which must be considered. The other benefits can be sponsoring staff children for professional programs with the help of NELC. The hospital sponsorship for nursing education in MCH nursing school can also be considered.

**4.5 b Human Resource Development-**

Team building activities have not continued after MCHDP. There are many retreats conducted under CBPHCP, which were not identified as team building activities by staff. The structure and resource persons from other organization/other NELC institutions can help in this process without much added cost. Prayer and Fellowship groups were considered useful and a similar activity may be needed for team building and community fellowship among all staff.

Plan for HRD should be made at institutional and departmental level. Senior staff should identify potential leaders among students and junior staff and mentor them. MCH and School of Nursing must have a long term plan for graduate and specialization training for all professional staff. They must consider skills, motivation and long term prospects for MCH. There also a need to consider HRD for the region, for NELC and Santhal population. MCH should consider mentoring students in school and provide opportunities to understand health care professions. Involvement of few doctors in nurture of medical students with CMAI support should continue actively.

Promotion policy is not clear. HMB minutes suggest ad-hoc decisions on promotion. A system needs to be in place for staff evaluation by self and the superior which will help in promotions based on performance and duration of service.

### *4.6 Translation of Vision and Mission Statement-*

Vision and mission orientation takes place for all staff. There is Morning Prayer to bring all staff together to reflect on the challenges of health care and the work of MCH. This is poorly attended now, and may reflect on perceptions on belongingness, morale and team spirit.

### *4.7 Governance-*

Hospital Management Board meets regularly. There is one representative from staff in this meeting. Occasionally external members attend the meeting. This forum, if discussing the reports and programs in details, is not documenting them in details to explain decisions that follow. Few professionals other than staff are attending the meetings, hence technical input is lacking. There is no other mechanism for staff to contribute towards management issues.

Administrative assistant is appointed but may not stay long term. There is a need for a trained administrative staff to oversee and organize all activities.

### *4.8. Nursing School*

#### 4.8 a. Resources-

Staff strength has improved with seven full time tutors. The nursing school is better equipped with faculty now to train; however, other school facilities e.g. building, library, equipments need upgrading.

#### 4.8 b Finance and Fee structure-

Financial support from MCH continues. All graduates of nursing school have a service obligation to work in MCH for one year. They are paid small stipend during this period. This was justified with previous subsidized education.

The fee structure is changed from current academic year. It will make the school self sufficient if all seats are filled. It is important to note that the current fee structure may not be affordable by economically disadvantaged students from the region. NELC, MCH and School of Nursing need to make an extra effort to publicize the scholarships available and consider sponsoring policy. Some of the seats are unfilled this year. The school needs to follow this up carefully to assess if this is the impact of fee change.

## 5. Constraints identified

*At the level of Administration and management-*

**5.1 Burden on administrative team-**

The administrative team essentially consists of the medical superintendent, the deputy medical superintendent and the nursing superintendent. The day to day activities of the hospital, staff duty schedules and paper-work; is the responsibility of nursing superintendent. All other planning and decision making are done by the other two administrators. They also have clinical responsibilities and being the senior most, have more clinical load. These persons practically do not have enough time to involve themselves in strategic planning and implementation of those plans. The solutions could be to delegate activities to different groups, make inter-departmental groups to manage certain activities and delegate specific roles to individuals.

**5.2 Capacity-**

Some activities e.g. financial management, costing of services need some specialized skill that can be learned by most people. All administrators and some key staff should be trained in these. For some other special areas, it may be helpful to engage a consultant for or a volunteer short term to prepare the plan or write-up new proposals.

External resource persons are recommended for areas such as team building, participatory management and spiritual nurture.

**5.3 Poor involvement of other staff in implementation of recommendation-**

All staffs are not aware of the recommendations of MCHDP final evaluation. Departmental staffs are not involved in strategic planning of their area even though many of them have ideas. As a result they do not identify with the plan and may not be motivated to continue the new efficient system put in place during MCHDP.

**5.4 Monitoring of systems –**

Single administrative head also means poor monitoring of systems as evident in maintenance, stores etc.

*At the level of MCH Staff*

**5.5 Lack of Team Spirit-**

Some of the impact of MCHDP efforts has worn off. Poor team spirit leads to low morale and poor participation in the growth of the institution.

**5.6 Unclear vision for future of MCH-**

Many staffs are unclear of the future of MCH in the current competitive Health Care market. Therefore they may consider many efforts towards change as a futile exercise. Lack of participation in planning and management hinders innovative ideas and challenges for individuals which can develop MCH.

*Other*
**5.7 Specialist Doctors/ Specialization by MCH doctors**
MCH has not been successful in attracting specialists full time or part-time. There is a need to rethink the previous strategy and explore others e.g. collaboration with another Christian Organization, camp approaches etc.

The existing staff should be encouraged to develop skills if formal specialization is not possible. NELC should make an effort to identify and encourage young people for careers in health care.

# 6. Learning and Specific Recommendation-

MCH has been through a difficult phase of economic challenge. There are efforts to overcome this and some changes are seen. MCHDP brought in changes in systems and the team which have been difficult to sustain overtime. Inputs by new personnel during MCHDP were short-lived. It is evident now that some of the outputs during the project period were person dependent without change in working style and work ethics of all staff.

Many staffs of MCH are motivated but working in a limiting environment. Full potential of individuals and groups are not realized due to lack of shared vision by staff, administration and governing council. There is an urgent need to develop the team within the hospital, develop second line leadership and work together towards the mission of MCH.

**6.1. Recommendations-**

1. Team building efforts should be continuous with the help of external resource persons from NELC, CMAI or other institutions.
2. Delegation of administrative responsibilities is the need of the hour to develop and maintain efficient systems. This will also help in increased accountability.
3. Planned management training for senior and middle level staff on a regular basis.
4. NELC should take immediate steps to establish sponsorship program for health care professional training at undergraduate and post-graduate level at Christian Medical Colleges, Vellore and Ludhiana for not only training of staff for NELC hospitals but with a wider vision to develop human resource for the region. Funding for training in CMC, Ludhiana is needed; therefore, NELC may need to work on generating special funds for this purpose.
5. MCH should develop a plan for HRD that is justified for growth of the institution and is equitable.
6. A staff forum for communication between administration and staff, or more representation of different levels of staff in HMB is necessary for increasing transparency and building trust.

7. A monthly review of activities of the hospital by staff (middle and senior level) is important for monitoring and strategic planning. Active participation of all staff should be encouraged at this forum. External experts could be invited to this meeting periodically for inputs in specific areas.
8. Cost saving strategies and introduction of packages for standard procedures are immediately needed to increase patients and increase income. Utility of wards, special ward and redundant spaces should be evaluated for continuing service in these areas.
9. Nursing school needs a proactive plan to encourage economically disadvantaged students joining the school. They must carefully monitor the changes if any in the student profile over next few years and review fee structure if needed.