Third

Common Review Mission

State Report

Meghalaya

Report of the 3rd Common Review Mission

Meghalaya

4th to 11th November 2009

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The CRM team consisting of 3 members each visited the Jantia Hills district and West Garo
Hills districts. The facilities visited by the teams are detailed below. The team met Shri D.P. Wahlang, Mission director, NRHM and also had a debriefing meeting with Shri. A.K.Srivastava, Principal Secretary (Health).

List of Facilities Visited by the Teams

Facility	State Headquarter /Others	Jantia Hills district	West Khasi District
Sub-Centers		1. Wahiajer 2. Mowtyrshiah 3. Primary School Myusngat	1. Damlalgre 2. Balzek
Urban Health Centers	Demisieming (Shillong-East Khasi	1. Jowai	

	Hills District)		
Primary Health Centers (PHC)		1. Nartiang 2. Shangpung	1. Bapadam 2. Asanag 3. Garobadha 4. Betasing 5. Tikrikalia 6. Jeldupara
Community Health Centers(CHC)	Sohra (East Khasi Hills)	1. Khliehriat 2. Lasken 3. Ummulong	1. Ampati
District Hospital		1. Civil Hospital Jowai	1. Civil hospital Tura
Other Institutions (state/ District level)	1. Gopal Das Hospital, Shillong. 2. Regional Blood Bank 3. Pasteur Institute 4. State Warehouse 5. ANM Training Centre Shillong 6. EMRI- Central Office 7. North East Indira Gandhi Regional Institute of Health & Medical Sciences (NEIGRIHMS)	2.	2.

Meghalaya one of the eight North east States is located at an altitude of 1496 meters above sea level and is bounded by Assam on the north & east and Bangla Desh on the south & west. The state has an area of 22429 square kilometers, is inhabited by 2.32 million people (2001 census) living in seven districts, 39 blocks and 6026 villages. Meghalaya is a predominantly rural state as 80% of the population resides here.

The population consists of 3 regions, Khasi region in the north& east consisting of 3 districts of East Khasi Hills, West Khasi Hills and Ri Bhoi is mainly inhabited by Khasi people; the Garo region also consists of 3 districts of East Garo Hills, West Garo Hills and South Garo Hills and is inhabited by the Garo people. The third region consists of one district, the Jantia Hills district and is inhabited by Jantias. The state has comparatively better all weather roads, some of the areas are remote and difficult to access, and The Garo hills districts are located at a considerable distance from the State capital. The West Khasi Hills and West Garo Hills districts are identified difficult districts of Meghalaya.

The State of Meghalaya has always had a higher TFR than the rest of India, the last TFR of 3.8 being much higher than the national average of 2.7. Another area of concern is the rising trend of IMR from 47 (SRS 2006), through 53(SRS 2007) to 58 in a SRS 2008. The number of institutional deliveries has remained static at about 24,000 are for the years 2007-08 and 2008-09, with 13,174 deliveries conducted up to the year

2009-10. The number of JSY beneficiaries, has increased from 63 in 2005-06 to 13,373 in 2008-09, with 6390 beneficiaries in the current year (upto August 2009).

Demographic, Socio-economic and Health profile of Meghalaya State as compared to India figures

S. No.	Item	Meghalaya	India
1	Total population (Census 2001) (in millions)	2.32	1028.61
2	Decadal Growth (Census 2001) (%)	30.65	21.54
3	Crude Birth Rate (SRS 2008)	25.2	22.8
4	Crude Death Rate (SRS 2008)	7.9	7.4
5	Total Fertility Rate (SRS 2007)	NA	2.7
6	Infant Mortality Rate (SRS 2008) (SRS 2005)	58 49	53 58
7	Maternal Mortality Ratio (SRS 2004 - 2006)	NA	254
8	Sex Ratio (Census 2001)	972	933
9	Population below Poverty line (%)	33.87	26.10
10	Schedule Caste population (in millions)	0.01(0.43%)	166.64(16.2%)
11	Schedule Tribe population (in millions)	1.99 (85.8%)	84.33(8.2%)
12	Female Literacy Rate (Census 2001) (%)	59.6	53.7

The State has a considerably higher decadal growth rate, Crude Birth Rate, Infant mortality rate and population below poverty line compared to the national averages. Increase in infant maternity, from 49 as per SRS 2005 to 58 (SRS 2008) is a cause of immediate concern.

3.1 Infrastructure Up gradation

3.1.1 Base Line Resource Mapping

Table: Rural Health Infrastructure in Meghalaya

	Sub Centers (Norm 1:3000)	Pry Health Centers (Norm 1:20000)	Comm. Health Centers (Norm 1:80000)
Reqd. as per Population Norms (Rural Pop)	621	91	23
Sanctioned	460	141	39

Existing	401	104	28
GAP			
Bet Sanctioned & reqd.	-161	+48	+16
Bet. Existing & reqd.	-221	+23	+5

The situation of hospitals and **urban health facilities** is as below:

District Hospitals	:	6 (1200 beds).	Of the total of 1637 beds in the state, 1167
Other Hospitals (including			exist in Shillong City, East Khasi Hills
Medical college & TB Hosp	:	3 (437 beds)	district. 2 districts (West Khasi Hills &
Sub Divisional Hosp	:	1	South Garo Hills (do not have any district
Urban Family Welfare Centers	:	1	hospital.
Dispensary	:	13	

The state is a hilly tribal state. Based on the population norms for hilly/ tribal areas, the state needs to establish more sub centers to meet the need of rural population based on census 2001. While the sanction of new sub centers may take some time, the state can perhaps make immediate efforts to fill the gap between sanctioned and existing sub centers.

There is a need for rationalizing the nomenclature and the numbers of existing sub centers. In Jantia Hills district, they claim to have 78 sub centers and in addition 21 Attached sub centers. The state PIP on the other hand mentions the number of sanctioned and existing subentries as 86 & 72 respectively. While correcting the anomalies in Jantia and other districts is important, an obvious fall out is that the districts may not be indenting drug kits for the attached sub centers under the RCH-2 Programme.

The State is surplus in Primary Health centers and Community Health centers.

The state has proposed to upgrade all district hospitals and 9 CHCs to First Referral Units. At present only 2 district hospitals, one at Shillong and one at Jowai in Jantia Hills districts are fully functional.

For 24x 7 Primary Health centers, the state has a target of 26, of which 14 have already been made functional.

Most of the sub centers, PHCs and CHCs are in good Pacca structures and good functional state. Labour rooms, laboratories and beds exist in most facilities and are being utilized to varying degree.

Where ever required, renovation and up gradation of facilities including provision of water supply and electricity on 24 hr basis is being undertaken. Among the 2 districts visited, the facilities in West Garo district had provision of electric generators while this not visible anywhere in Jantia Hills district.

Most health facilities including sub centers are located in Government owned buildings. Provision of residential accommodation also exists and is being further strengthened.

20% of population lives in urban areas. Shillong, the state capital houses 71% of the 1637 beds available in the public sector hospitals. 2 districts still do not have a district hospital.

Shillong & Jowai (Jantia Hills district) have a large migrant labour population engaged in construction and coal sectors respectively. Only 2 urban Health centres exist in these cities in rented buildings.

Regional Blood Bank Shillong

The Blood Bank is a recent addition to the health infrastructure and is located in the existing building of Pasteur Institute, Shillong. It is a fully equipped functional bank and is outsourcing blood to the district hospital cum FRU at Jowai, Jantia Hills district located about 80 kms away. It has been fitted out with component separators, training for this purpose including use of components has been done and the functioning of this aspect is scheduled to begin shortly.

ANM Training Centre

State has 2 ANMTCs, one at Shillong and one at Tura, the district headquarter of West Garo district. Both of these were visited. Together these have an intake of 20 & 30 ANMs per batch. Both of these are located in good buildings and are adequately staffed and equipped.

The training is 18 months. They have not yet initiated the new curriculum which includes training of students at SBAs also. It is an important issue needing immediate attention as additional manikins have been supplied to them from GOI.

ANM training is skill based training. The students at Tura have to be transported to civil for which POL should be provided by the state.

Scarcity of hostel accommodation at both places.

In Shillong the students complained of non provision of stipend to them for over 2 years.

3.1.2 Infrastructure Up gradation

State has a dedicated Health Engineering Wing headed by an Executive Engineer taking care of the new constructions and renovations of the buildings.

Along with renovation and up gradation of existing structures, new construction of sub centres buildings, residential quarters for nurses and doctors, ware houses etc are being undertaken in a planned way. A detailed plan was shared with the teams.

Extension to labour rooms and making newborn corners is an important item being taken up. However, the design which was shared with the team is old and needs to be updated keeping all functional requirements for improving asepsis and waste management etc in view.

Perhaps Government of India could issue guidelines for construction of new labour rooms and newborn corners.

State Warehouse

The warehouse has been put up as a new structure. It was being fully utilized, however, only drugs procured by state government were being serviced from the warehouse. The drugs from national disease control programmes including RCH and Family Planning supplies and vaccines are socked elsewhere. This was not perhaps envisaged at the planning stage and now that the building has come up there is no scope for expanding the present structure.

Similar warehouse are being put up in most districts. There is a scope for having enhanced capacity in the districts where construction has not yet started so that drugs, vaccines, equipment and reagents from all programmes could be catered to from one place.

The state also needs to plan for training its staff in logistic and supply management for ensuring the warehouse becomes part of the overall supply chain management of the health department.

EMRI- Central Office

The state has an excellent EMRI catering to 3 functions, ambulance service, police and fire. The teams could visit the central office and see the functioning. In the field also the team at Jantia Hills could see a child with pneumonia being brought to the

CHC and from there being referred in the same ambulance to the district hospital after providing initial management. The child was tracked by the team and is better.

30 ambulances are functional now. Because of the distances & terrain more need to be added. Maintenance of the service, however is quite high costing about 1.6 lakhs each ambulance per month.

3.2 Human Resources Planning

3.2.1 Availability of HR& Gap analysis

Health Infrastructure (Manpower) of Meghalaya				
Sl. No.	**Category of Post**	**Requirement**	**In Position**	**Short Fall**
1	Medical & Health Officer	498	517	19 (Surplus)
2	Surgeon	34	6	28
3	Physician	34	0	34
4	Gynecologist	34	10	24
5	Anesthetist	34	11	23
6	Pediatrician	34	9	25
7	Ophthalmologist	29	0	29
8	Orthopedic Surgeon	11	6	5
9	Psychiatric	9	7	2
10	ENT Specialist	9	4	5
11	Eye Specialist	9	8	1
12	Dermatologist	9	0	9
13	Pathologist	11	5	6
14	Radiologist	9	3	6
15	Biochemist	7	4	3
16	General Medicine (Spl/Sr Spl)	9	7	2
17	Cardiology (Spl/ Sr Spl)	2	0	2
18	General Surgery (Spl/Sr Spl)	6	0	6
19	Oncology (Spl/ Sr Spl)	1	1	0

20	Pharmacist	220	208	12
21	Staff Nurse	546	525	21
22	ANM	967	753	214
23	LHV	80	80	0
24	Lab. Technician	163	141	22
25	X- Ray Technician	39	16	23
26	Dental Technician	34	0	34
27	Radiographer	39	24	15

Infrastructure Upgradation:

The State has 6 district hospitals, one sub-district hospitals, 29 CHCs, 107 PHCs and 404 sub-centres. The village district of East Khasi Hills has no district hospital as the Civil Hospital (Gauest Das Hospital) is located here. There are Tribal Village Darbars, who interact with Block Development Officers and than the District Management. The state has built and made functional the State Medical Warehouse. On visiting this warehouse, the scientific use of the logistics principles was not being adhered to. The officer in charge is a BA in Economics and had his training at NIHFW in 1989 for 15 days. The details of progress of physical infrastructure is at Annexure I.

Human Resources Planning:

With the facility under NRHM, the State has been able to appoint contractual Doctors and Nurses, so that there is currently no PHCs without a Doctor or ANM. Maintenance arrangement for the health facilities is still with the department. 29 difficult CHCs/PHSs have been selected for handing over to NGOs under the PPP mode. Till date 20 of these have

been handed over to 7 NGOs in various districts. There is resistance being faced from the local community to the handing over process. A copy of the status of implementation of PPP Management model is enclosed.

The State has no medical college. NGREIMS has recently started functioning and the second batch of students is currently being traced. Of the reported 2 ANMTCs to be set up by the states, work has yet to be initiated. The ANMTCs at Shillong was visited. With a yearly in take of 80 students, the availability of just 2 Lecture Halls would need rapid upgradation. The physical structure is old and dates back to the British times. The teachers were unaware of the new ANM Training syllabus which incorporates the SBA Guidelines and the books being prescribed have been last upgraded in the year 1985. In addition, the students have not received any stipend for the past two years.

The State has not yet created any new posts except the PMU. Filling up the gap between the existing vacant posts and the availability of personnel is still taking up the energies of the State. The Programme Management Units are in place and other than

this there are no incentives/Cadre Management Initiative in place. The short term plan of recruiting health personnel from the rest of the country for the contractual posts is ongoing. The state is still facing a handicap of salary limit of Rs.26,000 for the doctors and Specialists. However , the CRM team informed the state that this ceiling has since been removed and the state can set it's own recommendations for salaries, keeping in mind the difficulties of terrain and field conditions in mind. The long term planning of setting up 2 ANM Training Schools has not been acted on yet.

The skills of human resource in place in the health facility visited was found to be poor. Although, they are aware of the theoretical background, the necessary skills for provision of care are missing. Equipment was not available at about 50% of health facility visited, but at other time it was found that equipments have not been used.

Trend and IPD Services

The trend of OPD progress provided in the state is as follows:

	2007-2008	**2008-2009**	**2009-2010(September 2009)**
OPD	790,571	1000,454	967,626
IPD	34,238	49,584	33,715

Home deliveries are still the non-Meghalaya as last year the number of institutional deliveries remained statics at 24,000 while the number of home deliveries went from 37,921 (2007-08) to 41,981 (2008-09) as per NRHM 3, the percentage of fully vaccinated children in the state was 32.8%. The reported coverage of fully vaccinated children in the year 2008-09 is 90.57% with the drop out rate between BCG and measles to 30.22%. The reported coverage for the current year till September 2009 is 38.21% with a drop out between BCG and measles of 17.97%.

Preparedness of facilities for patient care services

As reported by the states, 5 health institutes are functional as First Referral Units (FRUs) (of these three are district hospitals and two are sub-district hospitals). This is shortfall from the target of 8 health facility to upgrade as FRUs by the year 2007. None of the CHCs is a functional FRUs as per the three criteria laid down by the Government of India. As the target of 26 Primary Health Centers (PHCs) to function 24x7, 14 have been made functional till date. There are fully functional FRUs with specialists and blood storage is Jowai, Nongpoh, Ganesh Das, and Tura Civil Hospitals, which are

district hospitals. Sterilization over the period of Family Planning has decreased to 14%, but the number of ICDS insertion has increased by 38%. The proportion of women discharge within the 48 hours deliveries is 59%.

Status of Training

Training of MOs	Planned 2009-10	Achievement	Remarks
EmOC LSAS	2 MOs 4 MOs	1 NIL	Already 2 trained and posted One MO undergoing training at GMC
MTP	14 MOs	NIL	Approved proposal in process
IMNCI	5 Pediatricians 70 MOs in 3 district	4 are on training NIL	Master training ongoing
Minilap	3 MOs	NIL	Districts have not deputed

Training of Mos/ANMs/SNs	Planned 2009-10	Achievement	Remarks
IUD insertion - MO	21 MOs	21	Accomplished
IUD insertion – SNs/ANMs	21 SN, 21 LHVs, 52 ANMs	21, 21 and ANM started	ANMs on going
RTI/STI - MOs	34 MOs	NIL	Not initiated by RHFWTC
RTI/STI – SNs/ANMs	514	NIL	Not received report from districts
ARSH – MO	34 MOs	NIL	Not received report from districts
ARSH – ANMs	757	NIL	Not received report from districts

Training of ANMs/SNs	Planned 2009-10	Achievement	Remarks
SBA	124	28	Ongoing

Outreach activities of Sub-centre

The Village health and Nutrition Days are being held as Health Education Days and not in the spirit of provision of integrated services as has been envisaged. Cross linkages with ICDS are in evident for service deliveries IEC/BCC activities were evident as the only activity being focused on in the VHNDs.

The state has 4 model Mobile Medical Units and 30 Ambulances under the system of EMIR functional. 2 districts have been left out completely from the system of EMIR and there is almost no connectivity with mobile telecom in those districts. As the Secretary(NRHM) is also In-charge of the IT Department, assurance was received that telecom would be achieved over the entire state by 2010. It has been found that each Ambulance is able to response only two calls per day on an average due to difficult terrain and the cost of maintaining each Ambulance, at the rate of Rs.1,70,000/- per month, is the highest in the country. It is also been found that Ambulance are used to transport cases of labour to health facilities in about 23 deliveries have already been taken place in the Ambulance. In fact two babies who are delivered here who have named EMIR.

Thrust on difficult areas and vulnerable social groups

As 85% of the population of the states is STs, there is an automatic focus on the vulnerable and underserved group. However, focus on reaching out of the under educated and economical weak section is missing.

Quality of services provided

The report on training has been provided in the preceding pages. Although, the availability of medical personnel has improved since the launch of NRHM, the status of training is grossly is inadequate. By and large the hospital facility are clean but impatient control measure including segregation of waste is completely missing. Clean toilets with water are available, but partitions and screens for privacy, and grievance redressal system are missing.

Diagnostics

Availability of diagnostic services as per IPHS is missing. However, basic lab services are being provided at health facilities, with Automated Health Care Facilities available only at district hospitals.

Logistics and Supply chain management

Drugs and Medicines appeared to be available adequate quantities as they have supplied in response to the intend sent by the districts. It appears that there is no adequate stock of vaccine/drugs/medicines at the health facilities.

Decentralized Planning

As per interaction with the States, Districts and Block Programme Managers, the District Health Action Plan where amalgamation of the block plan. Display of services available, the rights of partents and the details of Rogi Kalyan Samiti (RKS) are permanently display at all health facilities. All RKS societies are in place. Funds for infrastructure upgradation, untied funds are in place and are being utilized to improve the physical infrastructure.

Decentralised Local Health Action

The village health and sanitation committees has been informed along with Rogi Kalyan Samiti meeting of these institutes are being held and the funds have been received and utilized in a better way, right up to the Panchayati Raj levels and are being utilized for the procurement of basic facilities like buckets, turtle repair of roofs.

IEC

IEC activities have been initiated in the state only recently in the months of September 2009. The first thrust was on increasing the awareness about the NRHM brand and the current focus in maternal health including JSY. The continuum of awareness is scheduled to move on to child care next. Travelling bands have been involved in the IEC activity in a big way.

ASHA

ASHA has been recruited NRHM in place the vast majority of them have been trained on all the four modules and have received the ASHAs kits. However, they are getting payment only from institute deliveries. Communities are gradually becoming aware of the NRHM by the process of empowerment is yet to set in.

3.15 Reproductive & Child Health

A comparison of important RCH indicators available from District Level Health Facility surveys is given in the Table. The status of RCH Goals is as below:

Goal	Meghalaya		India	
	Goal(2010)	**Current Status**	**Goal (2010)**	**Current Status**
Maternal Mortality Rate	100	400 (estimated)	100	254 (SRS-2004-06)
Infant Mortality Rate	<40	58(SRS-2008)	<30	52(SRS-2008)
Total Fertility Rate	3.5	3.8(NFHS-3-2005-06)	2.1	2.7

i. Maternal Health

The Goal of the State is to bring it down to 100 by 2010. This is an ambitious goal. Data for MMR is not available from RGI. However data available from the district surveys indicate that there has been a considerable fall in coverage for all major maternal health indicators like institutional deliveries, safe deliveries, mothers who had 3 ante natal checkups as also in the numbers of mothers who were registered during first trimester during the period from 2002-04 (DLHS-2) to 2007-08(DLHS-3),

Emergency Obstetric Care (Em.OC)

The State has planned for up grading 26 PHCs into 24x7 operational PHCs by 2009-10. At present 14 are fully functional.

Against the target for setting up 9 FRUs by 2009-10, 4 (Shillong, Jowai, Tura & Nongpoh) are located at district hospitals and fulfill the three critical criteria of functionality i.e. doing Cesarean section, providing newborn care and having a blood storage unit. These are also manned by gynecologists, anesthetists and pediatricians and adequate numbers of support staff. 2 more FRUs are to be made functional soon.

Labour rooms at most facilities visited were found to be adequately staffed, had equipment but were lacking in provision of running water supply and attached toilet. In most places in West Garo hills provision of generator had been made but this was not so in Jantia Hills district where most facilities were without generator. As an immediate measure perhaps provision of inverter could be considered.

While routine drugs like antibiotics and oxytocin and were available in most health facilities including labor rooms, Misoprostol and Inj. Magnesium sulphate were not available anywhere. The practice of keeping emergency drugs in treys ready for use was found missing.

Phototherapy units, radiant warmer and ambu bags were found at nearly all facilities visited, however, none of the facilities including district hospital was following the practice of having newborn corners in labor rooms for resuscitation of newborns. Ambu bag and face mask and mucus suction were not available and the staff.

The State has a policy of posting at least 1-2 doctors at each upgraded PHC including the AYUSH doctors. They are to be supported by at least 2-3 staff nurses and an adequate number of ANMs. The facilities visited by the teams had at least 2 doctors including the Ayush doctor. At least at two CHC (not yet FRUs) a gynecologist and a pediatrician were also available. Each facility had 2-3 staff nurses who besides other things, were attending to the labor room work.

The State is short of specialists like gynecologists and anesthetists. They have already trained 2 MOs in Em.OC and posted them at district hospital FRUs. One MO is undergoing training in anesthesia at Guwahati Medical College. State plans to send MBBS doctors for training in Em.OC. Against the target for training 2 MOs in Em.OC and 4 in anesthesia, State has been able to achieve only 1 in Em.OC and none in anesthesia. Since they don't

have a medical college this training depends nominations by Government of India to other States.

While this training is important, the State must undertake an exercise for ***rationalizing the placement of the available specialists*** *and assess the need for training after placing the available* specialists at the FRUs.

Utilization

The team visited the district hospital, Jowai(Jantia Hills district). This is a 100 bed hospital providing 24 hours delivery services and catering to both elective & emergency cesarean sections. They have put up a small blood storage area being supervised by the anesthetist who has been trained for this along with a laboratory technician. The labor room and the OT are being fully utilized. The State has plans to increase the number of beds in this hospital.

At the Gopal Das Hospital, Shillong which is also an FRU, caters to emergency cases and a large number of deliveries. The hospital with 100 beds is overcrowded with more than one patient on each bed. *As a result, the immediate rooming in of newborns with their mothers and proper initiation of breastfeeding is not taking place*. This is a cause of concern particularly looking at the fact the IMR of the State is showing a rising trend and needs immediate attention. The state government needs to look into the possibility of increasing bed allocation to department of gynecology by transferring some surgical and other beds to the civil hospital Shillong which has 400 beds.

In both hospitals, there is adequate availability of support staff, laboratory investigations and availability of drugs. The state government has permitted transport of all pregnant cases with the EMRI ambulance service and this has led to a large number of women availing the services.

Institutional Delivery and Janani Suraksha Yojana

DLHS-3 showed a drop in institutional delivery rate from 32.5% in DLHS-2 to 24.4%. The number of institutional deliveries during 2007-08 and 2008-09 has also remained virtually static at 24486 & 24053 respectively despite JSY scheme.

Janani Suraksha Yojana (JSY) scheme is being implemented in all districts of the State since 2005-06. Compared to 2363 beneficiaries of the scheme in 2006-07, 13373 beneficiaries availed of the scheme in 2008-09. Despite this, no appreciable increase in overall number of institutional deliveries has taken place.

The State have permitted transport of pregnant women in labor through the EMRI ambulance service which they hope will help get more women to institutions for delivery. Indications are that this has led to larger number of deliveries in institutions during this year. According to reports the number of deliveries in public facilities has increased by 5.4% till 2nd Quarter. It was also heartening to see boards giving details of JSY at each facility. However, extra efforts may be required in the form of IEC etc to improve utilization of upgraded PHCs/CHCs.

The payment for JSY is, however, being made promptly to the beneficiaries. There is no system however for grievance redressal

Essential Obstetric Care and Village Health Nutrition Days

Proportion of pregnant women who had an antenatal check up during first trimester and the proportion of those who completed 3 checkups have also showed a decline from DLHS-2(2002—04) to DLHS-3(2007-08).

State is giving a lot of focus to holding 'Village Health and Nutrition day (VHND)'. 25154 VHNDs were held in the state during 2007-08 and 27797 were held in 2008-09. 14826 VHNDs have been held till September 2009.

The team at Jantia Hills district was taken to a 'Village Health and Nutrition day (VHND)' at one village. This session was being held at a school. It was good to see large number of women some pregnant and some with their children gather at the school. Anganwadi Worker, ASHAs and village headman were present and thus the team could speak o them. The focus of services, it was evident was on immunization and mid day meal and ANC and family planning services were lacking. The ANM did not have a written down plan for holding the VHNDs.

The Jantia Hills district could not show to the team any evidence of regularly holding the **Village Health and Nutrition days.** In most PHCs/CHCs visited, neither a regular plan for holding the VHNDs could be seen nor the staff were aware of the guidelines,

Medical Termination of Pregnancy (MTP)

24x7 health facilities are required to provide RTI/STI services and also medical termination of pregnancy using at least the Manual Vacuum Aspiration technique. However, at none of the facilities these 2 services are being provided. MTPs are available only in district hospital where gynecologists are available. MVA which is a very simple method and is advocated for use at 24x7 PHCs/CHCs has not even been initiated.

Referral Services

The state is running an EMRI ambulance service. The State has a policy of providing free transport to emergency obstetric cases free of cost from home to institutions as well as from field institution to FRU/district hospital. During the visit the teams could cases referred from a CHC with a referral slip containing detailed case notes.

The service is operating very well, the only cause of concern being ling term sustainability.

Infection prevention and waste management:

There is need for greater awareness and sensitivity amongst the health officers regarding the need for improving quality of care including even the basics like maintenance of general cleanliness not only in functional areas like labor rooms but also in and around health facilities.

Health care waste management and infection prevention practices and knowledge are extremely poor at all facilities with no segregation of waste, poor storage and disposal of sharps and placenta and body parts. Even the colour coded bins as advised in the guidelines have not been provided.

The systems/mechanisms for final disposal are also not there and need proper planning and orientation of facility staff.

The hub cutters available with the ANMs are being used but they have no idea on what to do after that. There is urgent need for training/orienting the ANMs as also the district staff.

Equipment and drugs

Availability of drugs is generally adequate at the district hospitals, CHCs and 24x7 PHCs except that SBA drugs like Misoprostol, Magnesium sulphate etc were not available.

Drug kits A& B have now become available in the sub centers. The kits supplied this year contain **new items** like Tablet Zinc Sulphate and liquid iron for children.

No information is provided in the kits on their use and as result no one knows what to do. AT one sub centre, the annual supply of iron liquid had been distributed within the first 2 months while at another sub centre this item was lying or want of instructions on how to use. For Tab zinc sulphate which is meant for diarrhea in children, one doctor thought pregnancy as the indication.

Skill Training is a weak area in maternal health.

In the background of the increased demand for institutional deliveries in the State and the States efforts to put in place the physical facilities and manpower, it is important that the staff is trained in the required skills for providing Emergency obstetric care.

The State has trained only 28 SBAs till date against a target of 124 for 2009-10. The training is done in district hospitals in view of the requirement of adequate case load at training sites. The Jantia hills team had the opportunity of talking to one staff nurse trained for 21 days at the district hospital under guidance of a gynecologist. Unfortunately the whole effort seemed to a waste as she had no idea of either the concept of SBA or the names of the drugs etc she can use after training. **SBA is skill training and quality of training needs immediate improvement and serious attention.**

The State has not as yet initiated the training of medical officers in basic emergency obstetric care (EmOC). With a large number of PHCs being made operational as 24x7 facilities, it becomes important for the State to take up training of medical officers urgently. This is particularly important because the Ayush MOs who are attending to women in labor need to be trained on priority. Government of India ,perhaps need to issue suitable guidelines to the states like Meghalaya which do not have medical colleges but still need to train their doctors manning 24x7 facilities.

For the training on Comprehensive EmOC and anesthesia, Government of India needs to help the state by getting slots in medical colleges of other states for meeting their immediate Training of doctors in anesthesia and EmOC (basic and comprehensive) needs to be carefully planned and related to the needs for Operationalisation of FRUs and 24x7 PHCs. The State could not share with the teams any detailed training plans based on need assessment or priority setting. In the 2 districts visited by the team, even the senior State/district health officers are not clear on what SBA or basic/comprehensive Em OC means?

Most district health staff were not aware of the Guidelines for operationalising 24x7 facilities, setting up FRUs, Blood storage units, MVA Guidelines, detailed VHND guidelines. IMEP guidelines and RTI/STI guidelines. Most of these guidelines have been issued by GOI within the last 2-3 years and some even recently. The fact that these are not available in the health facilities which are being upgraded is a cause for concern.

3.15.2 CHILD HEALTH

During the 5 years 2003-2008, IMR of the State has not shown any decline from 57/1000 live births in 2003 (RGI-SRS). The latest data for 2008, rather shows an increase to 58 in 2008. This should be a cause of serious concern to the state but no serious analysis of the reasons for this seems to have been taken up by the state. For achieving the State's Goal of reducing IMR to <40 by year 2010 this needs to be done urgently.

While DLHS-3 data shows some improvement in immunization coverage from 13.5 %(DLHS-2) to 31.7%, the number of children with **no immunization** has also gone up from 17.6% (DLHS-2) to 20.2% (DLHS-3). This is an unacceptable situation needing serious look.

Another cause of concern is the fall in number of children with diarrhea being taken for treatment(from 81.4% in DLHS-2 to 63.3% in DLHS-3). Diarrhea accounts for a large number of inpatient admission in the district of Jantia Hills and thus calls for serious preventive efforts by State Government.

Newborn care

There are significant gaps in the provision of newborn care at both health facility and community levels. In both districts visited by the teams newborn care at facilities was not found up to the mark. While ambu bags and some other items were available at most places but no one anywhere was aware of how to use them.

Post natal care however does not get enough attention.

Awareness about essential newborn care is low among most health professionals.

IMNCI is still to be taken up with any seriousness. Training of master trainers is going on now. As against a target of training 5 pediatricians and 70 MOs in 3 districts in 2009-10, training of only 4 is going on at present.

While items like radiant warmers and phototherapy units were available at most 24x7 PHCs, CHCs, FRUs, and Civil hospitals, these were not being adequately utilized. Adequate laboratory back up like serum bilirubin measurement –essential with phototherapy units, was not available. Health personnel, especially gynecologists and pediatricians, didn't appear to be very much involved in newborn care and in most secondary level health facilities, sick newborn, infants and children were apparently not a priority.

Breastfeeding: The one universally good thing seen by the teams was initiation of breastfeeding within one hour of birth at most facilities. Awareness about breastfeeding initiation within an hour of birth and exclusive breastfeeding for 6 months seemed to be high among basic health workers and mothers who were interviewed. Resistance to early breastfeeding is overwhelmingly reported as having gone down in the last few years.

ORT corners for treatment of diarrhea: There has been a fall in use of ORS for treatment of diarrhea from 81.4% to 63.3% from DLHS-2(2002-04) to DLHS-3(2007-08). Health care workers in general seemed to be well aware of ORS treatment for diarrhea; ORT corners existed at CHCs and civil hospital, but were not much in use. It may be appropriate to issue guidelines for establishing and use of ORT corners as also making efforts to improve community awareness.

Stock-outs: Drugs and vaccines were generally available. Guidelines on utilization of new drugs in the kits need to be sent urgently.

Immunisation: While coverage is showing improvement, proportion of children without any vaccination has also gone up. Expected level of achievement (ELA) is not calculated making it impossible for health facilities to plan for outreach sessions that would lead to improvement in coverage. No plans for outreach sessions or holding VHNDs existed anywhere.

There is a need to go into detailed reasons for low immunization coverage. May be community action, involvement of ASHAs and other measures will also need to be put in place urgently.

District vaccination coverage data, disaggregated by block, aren't very useful as no one even at district level was sure about the denominators. It seems this is provided by the State. A bottom-up approach, based on the household data generated by ASHAs and ANMs would evidently be more useful.

Monitoring charts were found almost everywhere, ticklers were used, the cold chain was adequate, AD syringes used, vitamin A given.

Injection safety is not optimum, used AD syringes are thrown away mostly with the waste. There were no safety boxes anywhere, only adhoc opened containers.

Immunisation is going on in isolation from VHNDs.

3.15.3 FAMILY PLANNING

Family Planning Status: Meghalaya's CPR is 22.9% which is much less than the national average of 54.1%. Unmet need has come down but at 32.7% it is still way above the national average of 21.5%. In 5 of the 7 districts in the state, however, the need for limiting

has gone up in recent years. There is thus a huge demand without any corresponding supply side initiative from the state.

Overall Performance: Sterilizations (both male & female) conducted at public & private facilities have decreased by 14% (108 cases less compared to last year period). On the other hand the numbers of IUCD insertion have increased substantially in both public and private facilities by 38.1%.

Leadership: A focus on FP is lacking at the State, as well as, the district level. Direction from the central level to the districts on various initiatives and interventions for the promotion of family planning in the State lacks clarity and focus. While family planning is one of three pillars of RCH II, the State's focus on this issue is lacking.

Demand Creation: Meghalaya is a State where it is perhaps necessary to go into various dimensions of Family Planning and chart a state specific action plan.

Planning for Results: Expected level of achievement (ELA) of the State and the districts are not calculated and hence facilities are not aware of their expected level of achievement, making it impossible for them to prepare detailed plans that would lead to achievement of positive outcomes for FP service delivery.

Monitoring: FP is rarely discussed in monthly block and district meetings, resulting in an overall lack of monitoring of FP service delivery, as well as, key indicators and outputs. This also contributes to an overall lack of focus at the district and block level on FP as provider's performance is not measured at all by their performance in FP.

Male participation: The focus on male participation is absent. Appointment of the male worker is also an issue as the State has not filled up the vacant posts of MPW. Very few NSV's have been conducted in 2009.

Human Resources: Human resource development in FP has been neglected as no training has been conducted on mini-lap, laparoscopy and NSV,IUDs and ECPs in the last few years. The only trainings which has been initiated now in some districts is on training of health workers on IUCD

Manpower (Doctors). Training on mini-lap and NSV. These clinical services can be provided by MBBS doctors without post-graduate qualifications, greatly augmenting the pool of providers and reducing the inherent barriers to service provision in providing laparoscopic tubectomy.

Missed Opportunity: The performance in JSY has been increasing steadily in the State with more and more women delivering in institutions. Yet this opportunity has not been capitalized upon for delivering post partum sterilization or IUCD insertion to women at a time when the motivation as well as demand for contraception is maximum.

Quality of service including maintenance, Waste/infection Management and adherence to standard treatment protocols.

A general lack of awareness/apathy towards quality issues was observed among staff across the board from district to PHC level. Primary reasons for this were

Lack of Technical/operational Guidelines: While the CMOs office and the Medical Officers in charge of facilities are required to operationalize the facilities – Technical/operational guidelines for operationalisation of FRUs and 24x7 PHCs were not available even with the CMO office. The only document available with facilities is the budget details which mention the head of expenditure but no detail on how to do things. In the absence of detailed guidelines, there is a lack of awareness of even critical determinants of functionality for FRUs and 24x7 PHCs among CMOs/MOs/ District Programme Managers. Apathy/lack of motivation of district officers contributes to this situation. Even at state level most technical officers were not aware of standards/protocols/guidelines.

No standard/treatment protocols except the SBA guidelines are available. In the case of SBAs, though the protocols are available, these are not being followed in practice for

conducting labor, keeping partograph or active management of third stage of labor (AMTSL).

Lack of Design/details on construction & maintenance of OTs/labor rooms

With availability of funds from NRHM, a large investment is being made in constructing/renovating OTs and labor rooms. It was observed that the existing designs of labor rooms continue to have wash basins in the e patient area, surface wiring and lack in attached toilet for use of patient.

A modern labor room should have running water supply toilet and should conform to other critical needs of infection prevention. OTs & Labour rooms are also resource intensive areas and the need of following the modern concepts for getting maximum benefit from the investments being made cannot be over emphasized. There is thus a case for immediately **consultants in hospital design who should finalize the designs with help of technical experts.** This should be done immediately as a number of buildings under renovations need these inputs immediately. Where construction is complete but use of the facility has not begun, possible necessary changes may be carried out.

Infection prevention and waste management:

Waste disposal No attention is presently being paid to this aspect. Health care waste management and infection prevention practices and knowledge are poor at all facilities with no segregation of waste, poor storage and disposal of sharps and placenta and body parts. The hub cutters available with the ANMs are rusted and nonfunctional and need urgent replacement with better quality equipment.

Training is an important issue in quality management. A detailed training plan needs to be made at State level and shared with districts as the ownership by districts is lacking. No detailed training plans for SBA / LSAS / EmOC/MTP/New Born care/SBA was available at the Jantia Hills district health office.

Grievance redressal; The team did not come across any efforts being made in this area.

2009-10	
Period	Expenditure
Quarter 1 (Apr-June)	Rs. 74.42 Lakhs
Quarter 2 (Jul-Sep)	Rs. 151.52 Lakhs
Combined	Rs. 225.94 Lakhs

NVBDCP

RNTCP - ORGANIZATIONAL STRUCTURE OF THE STATE OF MEGHALAYA

Sl.No	Name of the district	Projected Population (in Lakhs)	No. Of TUs		No. of DMCs		
			Govt.	NGO	Public Sector*	NGO	Private Sector^
1.	East Khasi Hills	736072	3	0	12	2	0
2.	West Khasi Hills	372522	2	0	8	0	0
3.	Jaintia Hills	329278	1	0	6	0	0
4.	RiBhoi District	214693	1	0	6	0	0
5.	West Garo Hills	574401	2	0	10	1	0
6.	East Garo Hills	275673	2	0	5	0	0
7.	South Garo Hills	110362	1	0	3	0	0
	Total	2568000	12	0	50	3	0

*Public Sector includes Medical Colleges, Govt. health dept and PSU,i.e,as defined in PMR report,^similarly, private sector includes Private Medical colleges, PP,Private clinics/nursing Homes and corporate sector

Comparative Performance Indicators	1Q08	1q09	2q08	2q09
Suspects examined per lakh population	144	158	156	204
Total patients registered for treatment	1138	988	1251	1215
Total NSP registered for treatment	359	359	439	486
Annualized Total Case Detection Rate	182	158	200	189
NSP Case Detection Rate	57 (77%)	57 (77%)	70 (94%)	78 (104%)
NSP Sputum Conversion Rate	298/334 (89%)	265/311 (85%)	294/359 (82%)	320/377 (85%)
NSP Cure Rate	310/365 (85%)	282/359 (79%)	329/392 (84%)	354/439 (81%)
NSP Success Rate	310/365 (85%)	285/359 (79%)	332/392 (85%)	358/439 (82%)
NSP Default Rate	23/365 (6%)	20/359 (5%)	18/392 (5%)	26/439 (6%)

Financial Status w.e.f.06-07 to 09-10 Sept-09

Financial Years	Budget proposed	Opening balance	Amount received	Bank Interest	Total fund available	Amount utilised	Closing balance
2006-07	1,41,23,310	25,60,438.63	74,00,000	96,479.63	1,00,56,918.28	78,95,418	21,61,500.26
2007-08	1,70,23,203	21,61,500.26	1,05,00,000	89,899.36	1,27,51,399.62	1,01,37,373.26	26,14,026.36
2008-09	1,91,66,554	26,14,026.36	1,11,00,000	70,827	1,37,84,853.36	1,28,28,352	9,56,501.36
2009-10	2,34,50,017	9,56,501.36	45,00,000	22,734	54,79,235.36	49,23,193.00	5,56,042.36

Note: In 09-10 Rs.45,00,000/- received in July 09

National Blindness Control Programme:

Physical Performance Report For The Year 2006-07,2007-08,2008-09 & 2009-10

CATARACT PERFORMANCE:

Years	Target	No. of I.O.L Implanted	Conventional	Total No. of Cataract Operated	Percentage of Achievement
2006-07	2000	725	22	747	37.35%
2007-08	2000	1011	53	1064	53.2%
2008-09	2000	1273	22	1295	64.75%
2009-10 (Till Sept)	2000	598	15	613	30.65%

Till date, out of a target of 90,000 children, 73,731 have been screened, 8217 have been detected with refractive errors and 1694 children have been provided with corrective glasses.1234 teachers, 46 MOs, 342 health workers and 1005 ASHAs/AWWs have been trained in the current year(to date).

Bottlenecks being faced currently in implementation of the Programme.

- Lack of Operating Ophthalmic Surgeons, Ophthalmic Assistants, Nursing staffs
- Difficult geographical terrains – some areas are accessible only during the winter months
- Lack of Optical shops in the remote areas for SES programme, people cannot afford to come upto the District HQ. for correction of R.E etc.
- Target set for Cataract by G.O.I. is too high.
- Fear of Patients for Cataract surgery.
- Apathy of the patients and relatives as the patients are of elderly age group and dependent.

IDSP:

- **THE PROJECT STRUCTURE**
- At the **State Level** there is the **State Surveillance Committee** headed by the Principal Secretary, Health & FW Dept. and **the State Surveillance Unit (SSU)** consisting of the State Surveillance Officer(SSO) with supporting staff.
- At the **District Level** there is the **District Surveillance Committee** headed by the Deputy Commissioner and the **District Surveillance Unit (DSU)** consisting of District Surveillance Officer (DSO) with supporting staff.
- **Rapid Response Teams (RRTs)** constituted at the State level and at all Districts.

All the 33 state and district level officials and 17 lab technicians have been trained.

Training Load		***138***	***546***	***119***
Sl. No.	***District***	***MOs trained***	***Health Workers Trained***	***Lab. Assistants***
1.	*South Garo Hills*	*10*	*40*	*8*
2.	*West Garo Hills*	*16*	*94*	*20*
3.	*East Khasi Hills*	*32*	*97*	*21*
4.	*West Khasi Hills*	*19*	*63*	*12*
5.	*Ri-Bhoi*	*12*	*54*	*12*
6.	*Jaintia Hills*	*18*	*100*	*17*
7.	*East Garo Hills*	*16*	*67*	*12*
	Total	**123**	**515**	**102**

26 RRT members have been trained in August 2009

Civil work

Completed for all the 7 districts for District Surveillance Unit Level

Laboratory renovation work not done as yet for East and West Khasi Hills and Garo Hills.

- Laboratory Network is being strengthened at the State level& all the Districts in terms of infrastructure, materials/supply, equipments and manpower to enable to detect outbreak at the earliest for early response.All laboratory materials and equipments have been procured. All the Districts HQs.(except Baghmara)are connected to the State by Internet and there is also Video-Conference facility for connecting the Districts and the State with the Central Surveillance Unit, Delhi**.** Reports are being collected from Sub-Centres and PHCs/CHCs in hard copy and sent to the District. The Districts sent reports to the State either by Fax or internet. The State sends report to the Central Surveillance Unit, Delhi, by internet.

  As of now the reports are being received and sent regularly on weekly basis and on daily basis when there is outbreak of any disease.

Constraint/Problems

1. Edusat at the State level and at the Districts (except South Garo) stopped functioning for almost a year now due to faulty UPS, etc.CSU informed but till now function is not restored. South Garo – Irregular connectivity.
2. Data Managers and Data Entry Operators are not fully trained and this hampers their function in Data Analysis, handling of EDUSAT equipments etc.
3. Poor Reporting coverage and late reporting from some of the Districts.

Outbreaks responded to:

Swine flu: there have been 8 cases of swine flu out of 37 suspected cases for which samoples were collected.

JE: 10 CASES

Meningococcal meningitis/coccaemia

REPORTING PERCENTAGE OF UNITS UNDER IDSP

STATE : MEGHALAYA					WEEK NO.	FROM : 01.01.09 TO:20.09.09			
No of Reporting units and nos. actually reporting.									
Districts	Form P			Form S			Form L		
	No Units	No Reporting	Percentage	No Units	No Reporting	Percentage	No Units	No Reporting	Percentage
East Khasi Hills	46	27	58.70	65	44	67.69	29	15	51.72
West Khasi Hills	22	3	13.64	62	4	6.45	22	1	4.55
Jaintia Hills	25	22	88.00	94	84	89.36	27	24	88.89
Ri Bhoi District	14	7	50.00	25	11	44.00	14	7	50.00
East Garo Hills	20	10	50.00	72	23	31.94	19	7	36.84
West Garo Hills	31	29	93.55	30	28	93.33	28	25	89.29
South Garo Hills	8	8	100.00	20	16	80.00	1	1	100.00

Issues & Recommendations

In most areas in the state public health facilities are perhaps the only source of health care for people, even private drug shops are not available. The state is seeing a surge in demand for both Outpatient services and indoor admissions with the improved availability of manpower and drugs at health facilities. A significant improvement is visible in the new infrastructure being put in place and old existing structures being renovated under NRHM. Besides this the Government has taken a number of initiatives in PPP and handing over facilities to NGOs. This coupled with increasing awareness and posting of contractual doctors and other staff has resulted in improved availability. The need now is to improve utilization of services in critical areas like immunization, care of pregnant women, institutional deliveries and other disease control programmes.

Facility & District Level

There is lack of **ownership** of the health facilities or the Programmes by the health staff at all levels. This stems from lack of knowledge and the absence of any systematic effort to orient them on **the pla**ns and Programmes and their responsibilities.

Technical Protocols for most interventions not available. There is lack of awareness among MOs in charge of PHCs and superintendent of District Hospitals on availability or need of standards/protocols. This is a key issue with the district health staff also.

In case of skilled attendance at birth the guidelines/ **protocols are available but not being followed** for conducting labor, Partograph, AMTSL.

Equipment for care of newborn at birth generally available but the facility staff are not clear on their use, training on use of equipment and establishing newborn corners within the labor rooms needed.

District hospitals providing obstetric care are overcrowded and need more beds as also more newborn care area. In some cases there is a need for rationalizing beds within the facility by reallocation between specialties.

ASHAs have been trained up to module 4, however they lack knowledge and need follow up on job supervision. Her placement as of now does not seem to have resulted in increased coverage either in immunization or even in utilization of JSY, so her role in motivation is also poor.

Cold chain equipment generally available. At some places like Sahora CHC there seems to be oversupply of equipment. Repair system also does not appear to be adequate to deal with complaints.

The districts /hospitals lack in facilities for training in areas requiring skill transfer like training in skilled attendance at birth. There is a case for providing facilities at district hospitals for training in essential newborn care & treatment/ stabilization of Sick Newborns; MTP, IUD insertion and /Minilaps as these are the only facilities with adequate case load for hands on training.

While **a training plan** has been prepared at State level it needs to be shared with districts, districts are still not aware of their involvement in the plan. Whatever training is going on is thus adhoc. A systematic needs based implementable training plan has to be put in place.

Drugs are available in adequate quantities but facilities lacked essential SBA drugs. Health workers and even MOs not aware of use of some new drugs in RCH Kits.

There is a total lack of the need for and understanding of monitoring and supportive supervision.

State Level

At State and district level officers have been designated as “State/district RCH Officers”. They are overseeing the implementation technical interventions like improving labor rooms, operationalising 24 hour delivery services at PHCs and operationalising FRUs. There is, however, a need particularly in districts, to orient them in the clear understanding of their roles and responsibilities and details of RCH technical interventions.

A clear policy option is to start ‘Induction Training’ for all categories of staff at recruitment or whenever they are given a new responsibility.

There is no clear policy on requirement (need), posting, training & deployment of staff particularly specialists. At places specialists who could be useful in FRU settings are working at PHCs/CHCs.

At the sub centre/village level, there is multiplicity of activities like immunization sessions and, VHNDs being implemented by ANM, ASHA and AWW. The integrated approach where in immunization is part of VHNDs is missing. There is an urgent need for having a relook on policy options for outreach services, issue appropriate guidelines and ensure their implementation for improving immunization coverage, provide ante natal care and reduce unmet need for FP services.

While HMIS is in place, systematic analysis and understanding of data & feed back to facilities or its use for planning or effecting corrections was not visible.

The IDSP is in position but their activities are limited to only 2-3 diseases. The records in health facilities reveal large numbers of cases with diarrheas and pneumonia seeking acre. There is a case for enlarging the scope of surveillance by IDSP.

Monitoring and Supervision is visibly absent. A well defined and implementable system for monitoring and supervision is needed urgently.

Many facilities are being handed over to NGOs. Clear guidelines on monitoring these services need to be issued to district officials for strict enforcement of standards. As at present some of the services are not being offered by the outsourced facilities.

Recommendations

The recommendations for JRM 5 are still valid for the 3rd CRM held in November 2009.

The services at all levels need strengthening for improving patient care and quality of service. Services particularly technical interventions need to be standardized and inputs like physical facilities, equipments and other requirements put in place based on these standards. Clear guidelines/protocols not only have to be drawn up by the state, these needs to be effectively shared with districts. There is also a need for expert involvement in the building of specialized areas like OTs /labor rooms etc.

Since public facilities are the main/only provider in many areas, it is imperative that providers are adequately trained and provided with all essential drugs and equipment. A clear policy option is to start ‘Induction Training’ for all categories of staff at recruitment or whenever they are given a new responsibility

There is a need to streamline state’s internal policy on fund usage and dissemination of clear guidelines for clarity of staff. There is also a need to monitor the usage and accounting of untied funds on routine activities.

Outreach services need strengthening. There is an urgent need to integrate and streamline service delivery of immunization with other child health interventions and maternal health and family planning particularly at the sub-centre, Anganwadi and community level.

There is…

Excellent knowledge about NRHM and the financial channels throughout the system and funds are available

In place the requisite infrastructure in terms of Committees and societies and notices displayed at health facilities

However…
Awareness among the health personnel as well as among the population about the services to be delivered has yet to be created.
Technical awareness about the medical guidelines, logistics, planning, training and monitoring procedures is very low.
There is an overall inertia about the system.

As a result…
The NRHM infrastructure is yet to begin to translate into a functioning system for delivery of health care services.

Annexure I

States of physical upgradation

Total Number of Sub-Centre	-	49 Nos.
No. of Sub-Centre Completed	-	22 Nos.
No. of sub-Centre in Progress	-	16 Nos.
No. of Sub-Centre not yet started	-	11 Nos.
Total No. of State Medical Ware House	-	01 No.
Total No. of State Medical Ware House Completed	-	01 No.
Total No. of A.N.M. Quarter	-	43 Nos.
Total No. of A.N.M. Quarter completed	-	20 Nos.
Total No. of A.N.M. Quarter in Progress	-	23 Nos.
Total No. of District Medical Ware House	-	03 Nos.
Total No. of District Medical Ware House Completed		03 Nos.
Total No. of G.N.M. Quarter	-	03 Nos.
Total No. of G.N.M. Quarter Completed	-	02 Nos.
Total No. of G.N.M. Quarter in Progress	-	01 No.
Total No. of Labour Room & Baby Corner	-	04 Nos.
Total No. of Labour Room & Baby Corner completed		Nil
Total No. of Labour Room & Baby Corner in Progress	-	04 Nos.

Important RCH Indicators

	India	State	Jantia Hills	W. Garo Hills	E. Garo Hills	S. Garo Hills	W. Khasi Hills	E. Khasi Hills	Ri Bhoi
MH Indicators (DLHS-3,DLHS-2 in brackets)									
Mothers who received any antenatal check up	75.4(73.6)	55.4(53.9)	na	na	na	na	na	na	na
Mothers who had ANC in first trimester	45.0(40.4)	24.8(27.5)	22.6(na)	26.6(na)	23.6(na)	23.5(na)	14.4(na)	43.0(na)	26.4(na)
Mothers who had 3 or more ANC	51.0(50.4)	39.4(42.8)	46.1(46.0)	29.2(na)	29.4(na)	26.3(16.1)	27.3(17.8)	64.7(75.6)	48.7(40.1)
Mothers who consumed 100 IFA Tabs	46.8(20.5)	24.0(13.9)	na	na	na	na	na	na	na
Institutional Delivery	47.0(40.9)	24.4(32.5)	25.1(22.8)	17.6(14.4)	10.6(12.3)	26.9(27.2)	21.6(14.4)	94.7(67.4)	27.3(13.5)
Safe Delivery	52.6(48.0)	28.8(36.7)	na	na	na	na	na	na	na
Mothers received PNC during 2 weeks of delivery.	49.9(na)	32.5(na)	29.8(na)	15.3(na)	8.3(na)	20(na)	28.3(na)	45.8(na)	27.8(na)
Child Health NFHS-3 &DLHS-3(DLHS-2 in brackets)									
Initiated within 1 hr of Birth(DLHS-3)	40.2(27.8)	75.0(66.5)	69.8(na)	76.1(na)	80.1(na)	89.4(na)	81.8(na)	64.3(na)	66.3(na)
Ch. 0-5M9age 6M & above) exclusively B, Fed	46.4(na)	47.5(na)	25.8(na)	34.0(na)	42.6(na)	18.0(na)	36.5(na)	36.0(na)	37.8(na)
Children 12-23 M Fully Immunized DLHS-3(2)	54.1(45.9)	33.7(13.5)	38.4(41.8)	22.6(1.2)	16.1(.8)	11.8(6.3)	14.6(32.1)	50.1(1.7)	53.1(12.0)
Children 12-23 M with no Immunisation,**DLHS-3(2)**	11.3(19.8)	20.2(17.6)	na	na	na	na	na	na	na
Children with Diarrhea given ORS,DLHS-3(2)	33.6(43.9)	45.2(44.3)	60.8(13.8)	52.1(0)	18.4(56.4)	74.9(45.3)	38.3(0)	45.2(47.9)	55.0(46.8)
Ch.with Diarr in last 2 weeks given treatment DLHS-3(2)	70.6(73.2)	63.3(81.4)	60.8(54.6)	30.4(89)	27.7(54.9)	40.4(41.6)	60.3(89.0)	88.2(93.0)	82.9(79.4)
Ch. with ARI/Fever in last 2 weeks given treatment-DLHS 3(2)	71.6(73.9)	80.5(77.3)	97.1(na)	73(na)	65.5	69.5(na)	75.9(na)	91.3(na)	88.7(na)
Family Planning (DLHS-3,DLHS-2 in brackets)									
Current Use of Any Modern Method	16.8()	16.8(13.8)	11.4(15.7)	24.1(16.1)	21.7(8.4)	19.4(11.1)	6.8(16.1)	24.1(8.9)	14.9(13.7)
Female sterilization	16.8()	8.3(6.7)	10.9(13.0)	7.4(8.0)	8.1(1.9)	7.7(3.4)	4.8(6.1)	14.6(5.9)	10.2(6.0)
Male Sterilization	16.8()	0.1(0.10	'-(0)	0.1(0.1)	.2(0)	.1(0)	-(0.1)	0	0.1(0)
Spacing Methods(Pill+IUD+Condom)	16.8()	8.3(7.0)	0.3(2.7)	16.2(9.9)	13.0(6.6)	11.6(7.1)	1.8(9.8)	8.8(3.0)	4.1(7.8)
Using spacing methods more than 6 Months	16.8()	5.3(na)	na	na	na	na	na	na	na
Unmet Need Total	16.8()	32.7(55.3)	37.0(42.7)	33.1(64.8)	33.6(64.2)	33.0(47.9)	49.3(36.7)	35.8(56.8)	39.5(57.6)
Spacing	16.8()	14.8(37.0)	21.0(40.1)	10.7(43.7)	8.8(33.0)	5.0(31.9)	35.3(33.1)	20.8(31.5)	25.9(39.6)
Limiting	16.8()	17.9(19.3)	16.0(2.6)	22.4(21.3)	24.8(31.3)	28.0(16.0)	14.0(3.6)	25.3(15.0)	13.6(17.9)
Other Indicators(DLHS-3)									
PHCs functioning on 24 hr basis	53.1	62.7	na	na	na	na	na	na	na
PHCs conducted at least 10 deliveries PM (*of 24 hr PHCs)*	38.5	16.2	na	na	na	na	na	na	na
CHCs designated as FRUs	52	46.2	na	na	na	na	na	na	na
CHCs designated as FRUs providing C. Sec (of designated FRUs)	18.8	8.0	na	na	na	na	na	na	na
(Data in brackets is for DLHS-2 where available)									

Expenditure on RCH:

2009-10	
Period	**Expenditure**
Quarter 1 (Apr-June)	**Rs. 74.42 Lakhs**
Quarter 2 (Jul-Sep)	**Rs. 151.52 Lakhs**
Combined	**Rs. 225.94 Lakhs**

AYUSH (Ayurveda, Yoga, Unani, Siddha, Homoeopathy)

Sl.No	2007-2008				Update number, whether AYUSH utilised, medicines available. Status of procurement of AYUSH drugs
78	No. of PHC where AYUSH practitioners have been co-located		Exp	14	1. The Facilities for AYUSH Services is full utilised in the PHC and CHC. 2. Medicines is available in all the PHC and CHC mentioned 3. AYUSH Medicines are procured from IMPCL Uttarkhand HOMCO, Kerela. Both the above Firms belong to Government of India and Government of Kerela
			Ach	14	
79	No. of PHC where AYUSH practitioners are being co-located				
80	Whether AYUSH Officer included in (Y/N)	Health Society		Yes	
		State Mission		Yes	
		Rogi Kalyan Samities		Yes	
		ASHA Training		Yes	
81	No. of AYUSH Doctors posted on Contractual appointment		CHCs	4	
			PHCs	14	
82	No. of AYUSH Paramedics posted on contractual appointment		CHCs	Nil	
			PHCs	Nil	
83	No. where AYUSH facilities is co-located		DH	7	
			PHCs	14	
			CHCs	4	
84	AYUSH components included in NRHM PIP		Salaries of the AYUSH Doctors and Multi-Purpose Workers.		
85	Funds sanctioned for AYUSH schemes during (In Lakhs) (as reported by DO AYUSH)		Salaries of the AYUSH Doctors – Rs.32,40,000/- (Rupees Thirty two lakhs forty thousand) only.		

AYUSH (Ayurveda, Yoga, Unani, Siddha, Homoeopathy)

Sl.No	2008-2009			To be reported by the State	Update number, whether AYUSH utilised, medicines available. Status of procurement of AYUSH drugs
78	No. of PHC where AYUSH practitioners have been co-located		Exp	14	1. The Facilities for AYUSH Services is full utilised in the PHC and CHC. 2. Medicines is available in all the PHC and CHC mentioned 3. AYUSH Medicines are procured from IMPCL Uttarkhand HOMCO, Kerela. Both the above Firms belong to Government of India and Government of Kerela
			Ach	14	
79	No. of PHC where AYUSH practitioners are being co-located				
80	Whether AYUSH Officer included in (Y/N)	Health Society		Yes	
		State Mission		Yes	
		Rogi Kalyan Samities		Yes	
		ASHA Training		Yes	
81	No. of AYUSH Doctors posted on Contractual appointment		CHCs	5	
			PHCs	10	
82	No. of AYUSH Paramedics posted on contractual appointment		CHCs	9	
			PHCs	24	
83	No. where AYUSH facilities is co-located		DH	Nil	
			PHCs	24	
			CHCs	13	
84	AYUSH components included in NRHM PIP		Salaries of the AYUSH Doctors and Multi-Purpose Health Workers.		

85	Funds sanctioned for AYUSH schemes during (In Lakhs) (as reported by DO AYUSH)	Salaries – Rs.79,20,000/- (Rupees Seventy nine lakhs twenty thousand) only.

AYUSH (Ayurveda, Yoga, Unani, Siddha, Homoeopathy)

Sl.No	2009-2010			To be reported by the State	Update number, whether AYUSH utilised, medicines available. Status of procurement of AYUSH drugs
78	No. of PHC where AYUSH practitioners have been co-located		Exp	24	1. The Facilities for AYUSH Services is full utilised in the PHC and CHC. 2. Medicines is available in all the PHC and CHC mentioned 3. AYUSH Medicines are procured from IMPCL Uttarkhand HOMCO, Kerela. Both the above Firms belong to Government of India and Government of Kerela
			Ach	24	
79	No. of PHC where AYUSH practitioners are being co-located.				
80	Whether AYUSH Officer included in (Y/N)	Health Society		Yes	
		State Mission		Yes	
		Rogi Kalyan Samities		Yes	
		ASHA Training		Yes	
81	No. of AYUSH Doctors posted on Contractual appointment		CHCs	4	
			PHCs	10	
82	No. of AYUSH Paramedics posted on contractual appointment		CHCs	4	
			PHCs	10	

83	No. where AYUSH facilities is co-located	DH	1	
		PHCs	34	
		CHCs	17	
84	AYUSH components included in NRHM PIP	Salaries of AYUSH Doctors and Multi-Purpose Health Workers		
85	Funds sanctioned for AYUSH schemes during (In Lakhs) (as reported by DO AYUSH)	Rs.1,49,76,000/- (Rupees One crore forty nine lakhs seventy six thousand) only.		