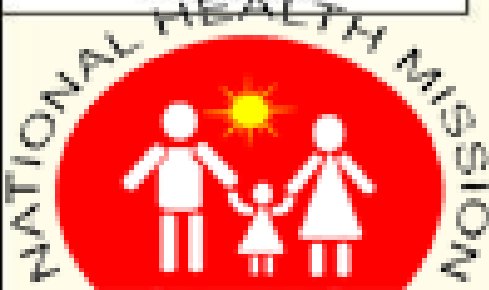


ARUNACHAL PRADESH

DISTRICT MAP



राष्ट्रीय स्वास्थ्य मिशन



BHUTAN

Map not to Scale

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(Updated on 29th May, 2013)

LEGEND

- Intl. Boundary
- State Boundary
- District Boundary
- State Capital
- District HQ

ARUNACHAL PRADESH

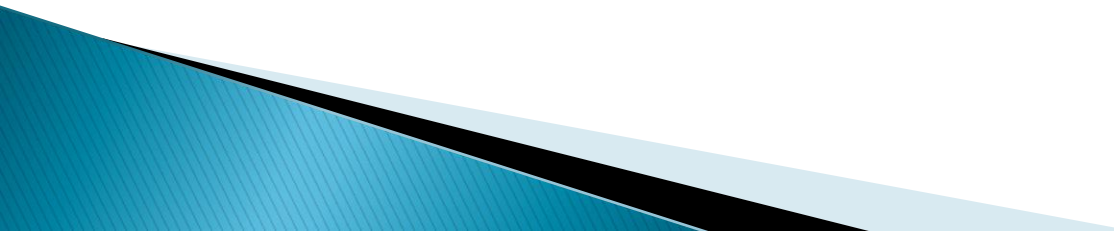
Team Members

District –I: Upper Subansiri (US) (HPD)	District –II: West Kameng (WK)
Sh. Shiv Singh Meena, Director, Planning Commission	Ms. Preeti Pant, Director(NRHM-III), MoH&FW
Sh. Kedar Nath Verma, DD (NRHM), MoH&FW	Dr. Kalpana Baruah, Joint Director, NVBDCP
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Dr. Ashish Chakraborty, Consultant NRU	Dr. Rajeev Gera, Senior, Advisor, PHFI
Dr. Asmita Jyoti Singh, Senior Consultant, NRHM MoH&FW	Sh. Sanjeev Rathore, FMG, MoH&FW
Dr Madhusudan Yadav ,Consultant, NHSRC	Dr. Ashalata Pati, Consultant, MoH&FW
Dr. Deka Dhrubjyoti, Consultant, WHO-RNTCP	Ms. Sonal Dhingra, Young Professional, Planning Commission





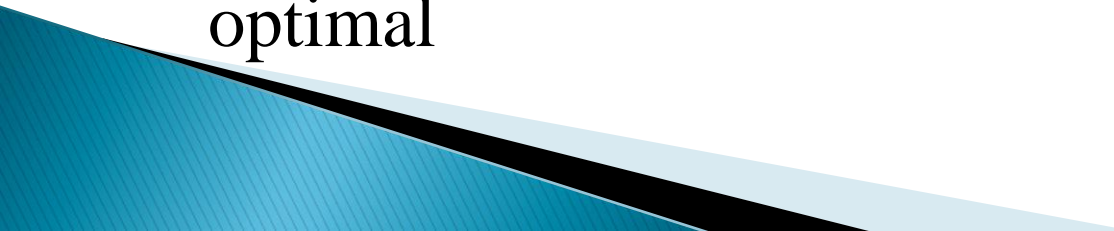
Positives

- ▶ Patient friendly attitude of health providers
 - ▶ ANMs are doing home deliveries, by and large
 - ▶ The AYUSH facilities co-located at CHCs and DHs
 - ▶ Staff quarters for ANMs were found at some SCs in WK
- 

Some Observations–TOR wise



1. Infrastructure & Service Delivery

- ▶ Full range of services available only at DHs.
 - ▶ Nomenclature of health facility not commensurate with staff, range of services available.
 - ▶ Utilization of health facilities - Sub-optimal
 - ▶ No Comprehensive planning for infrastructure development
 - ▶ Outreach services through ASHAs and ANMs is sub optimal
- 

HEALTH SUB-CENTRE
LIGU
INAUGURATED BY:-
Dr. J.M. BOJE
HON'BLE DISTRICT MEDICAL OFFICER
DAPORIJO
ON 26th FEB. 2007



2. Quality of Services

- ▶ Standard Treatment Protocol not found to be followed; eg Partograph,
- ▶ No preparedness for dealing with emergencies with stock of life saving drugs, oxygen etc
- ▶ Poor Bio-medical waste management; staff not trained, open pit dumping and incineration is the most common method.
- ▶ Supportive services (housekeeping, security etc) require urgent attention
- ▶ Display of signage, citizen charter absent at all facility in US
- ▶ Privacy and human dignity is compromised in US; Non-availability of trolleys, stretchers, curtains etc.
- ▶ Poor hygiene, especially in the toilet, wards etc.
- ▶ **No grievance redressal** mechanism

3. Mobile Medical Units (MMUs) and Referral Services

MMUs:

- ▶ MMU used more as a multipurpose mobility vehicle
- ▶ No route chart available, staffs not earmarked and records shows that only a few health camps conducted.

Ambulances and Referral Services:


- ▶ Use of existing ambulances- sub optimal
- ▶ Ambulances are not available to the patients in periphery
- ▶ **Only drop back** from facility provided but that too **not always** assured & free; referral transport service to higher facility is not available
- ▶ No display of phone numbers (Unique number absent, even driver's mobile numbers are not known to the nurses)

Tukmi Dulong -ASHA

Akme Dakge-RFW (Malaria)



4.Human Resource

- ▶ No data available on the facility wise sanctioned post
 - ▶ No sanctioned posts of MS, SN, Matron etc at dist hospital
 - ▶ Irrational deployment of staff e.g ANMs headquartered at PHC/CHC/DH leaving the SCs unmanned
 - ▶ This affects the outreach service mechanism, mentoring of ASHA etc
 - ▶ Requisite specialist cadre not created despite qualified PG doctors available in the periphery
- 

5.RCH (RMNCH+A)

- ▶ Functional FRUs operating only in DHs
- ▶ Non functional Blood Storage Unit; important equipments are found missing. e.g. Boyles apparatus for general anesthesia not available in district hospital US
- ▶ BEmOC and EmOC services not available at PHC/CHC

JSSK and JSY:

- ▶ **JSSK not implemented in US**
- ▶ JSY payments were found to be irregular
- ▶ Poor registration of ANC; improper recording of data. Home deliveries by ANM being reported as institutional deliveries
- ▶ Delivery registers were not as per GOI protocols; other registers found missing
- ▶ Safe abortion Services not available; non-availability of drugs and equipment
- ▶ No line listing of high risk cases

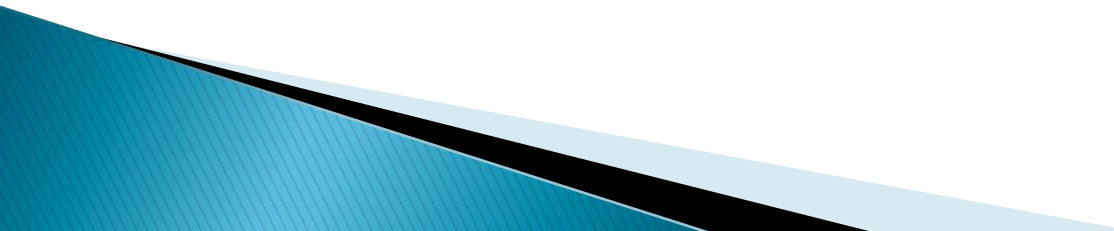


6. Child Health and Immunisation

NBCC and SNCUs:

- ▶ New Born Care Corners were used in WK whereas not in US

Immunisation:

- ▶ No due list for immunization being maintained
 - ▶ Immunization sessions are conducted only in the CHC, PHC and few Sub Centers that too only once a month
 - ▶ Few outreach session for immunization (WK)
 - ▶ NO Alternate vaccine delivery system in the districts in US
 - ▶ Measles vaccine is out of stock
 - ▶ Cold Chain equipment maintenance is highly compromised
- 

Service at China border




Dr.Hano Loder



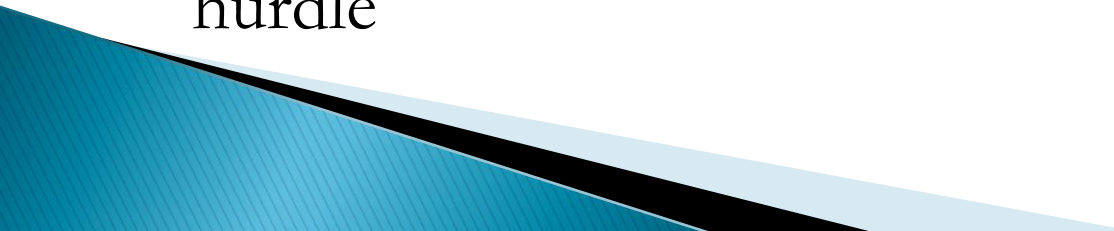
They got Immunized
only because of him

7.Rastriya Bal Swasthya Karyakram (RBSK)

One School health team constituted at district level per district

- ▶ Out of the identified defects among the screened children, only 53 % were referred to the health facilities
 - ▶ It was informed that the mobility allowance of Rs 1000 for visit per school is inadequate
- 

8. Integrated Disease Surveillance Programme (IDSP)

- Adequate man-power available and Weekly reporting status satisfactory
 - An outbreak of Scrub Typhus was reported timely in 2013 from Kalaktang CHC and investigated by District RRT and preventive measures taken to contain the outbreak. RMRC was involved for diagnosis and prevention of Scrub Typhus.
 - Poor Connectivity and communication is the biggest hurdle
- 

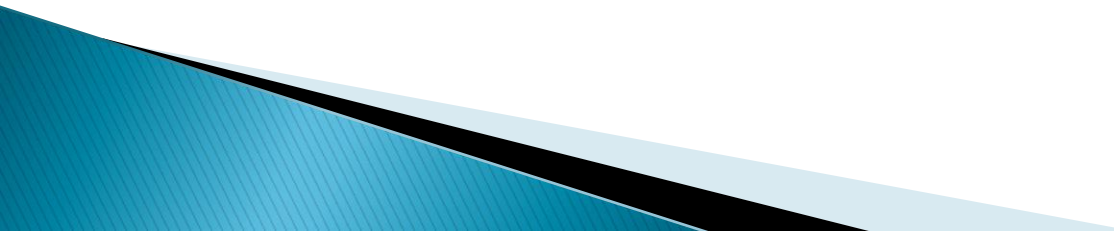
9.National Vector Borne Disease Control Programme...1

Malaria endemic State

- RDT kit and ACT was not available
- LLIN distribution is erratic and there is no plan for distribution of LLIN (GOI supplied 1lakh LLIN in 2011-12).
- IEC/BCC activity was not visible in the districts
- Irrational and ineffective deployment of staffs observed at all level in both the districts including staff under GFATM project.
- Only Passive collection observed. Involvement of ASHA in malaria programme is practically nil.
- ABER is declining over the yrs; <3% in West Kameng and <5% in Upper Subansiri district against national norm of 10%



National Vector Borne Disease Control Programme...2

- No **Dengue** outbreak after 2013
 - No case reporting of Chikungunya and Kala-azar.
 - 3 sentinel surveillance hospitals are identified and diagnostic kits were provided for Dengue detection
 - One case each of **Japanese Encephalitis** and **filariasis** reported.
- 


10. Revised National TB Control Programme

- Case detection, treatment success rate and determination of HIV status of TB patients are good in the state.
- The Intermediate Ref Lab (IRL) for diagnosis and follow-up of drug resistant TB is functional
- 2 Drug resistant TB Centres for treatment are fully functional with 220 MDR-TB patients under treatment

Considering the terrains, establishing more designated microscopy centres is needed for better coverage.

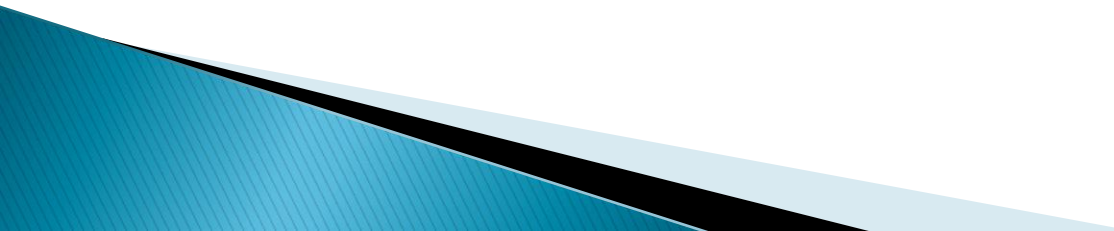


11.National Leprosy Eradication Programme (NLEP)


- Both the district are in Elimination Status ($PR < 1$)
 - Treatment completion rate need improvement
 - MDT drug stock available in the districts
 - No Training of Health Staff in DPMR in both the district
 - Deformity Grade –II are referred to a Pvt Hospital at Tezpur.
 - No Reconstructive Surgery done during the year
- 



12. Training

- ▶ Inadequate in-service training of staff- MO, SN, ANM, ASHA , Community mobilizer etc
 - ▶ Centralized nominations of trainees and not need based facility wise selection.
 - ▶ Recall of the training contents and skill demonstration inadequate.
 - ▶ Irrational Post training deployment (The first EmOC training Medical Officer is the State NUHM Nodal officer).
 - ▶ ASHA training material and registers not found at site.
- 

13.Community Process & Convergence

- ▶ Citizen Charter-did not cover the entire range of services & entitlements.
 - ▶ Display of Health messages and entitlements are conspicuous by its absence in Subanseri.
 - ▶ Involvement of PRI members not reflected.
 - ▶ VHSNC formation are not complete
 - ▶ Knowledge about conducting VHSNC and its components is not uniform.
 - ▶ Joint account of ASHA & PRI found, however the knowledge about use of grant was absent
 - ▶ Minutes of meetings and key decision taken not documented in US unlike in WK.
- 

14.HMIS/MCTS

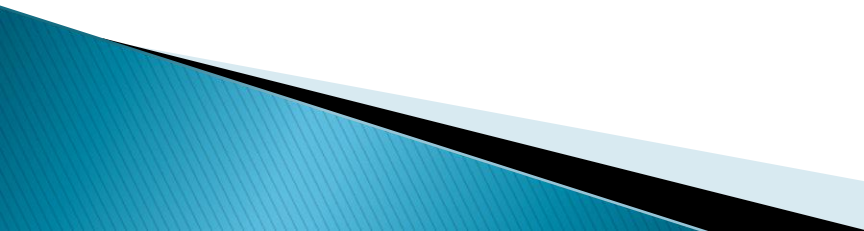
- ▶ Limited Internet connectivity in districts leading to delay in data uploading
- ▶ Poor knowledge of data elements across various levels
- ▶ Non-availability of proper/uniform formats at periphery

MCTS:


Incomplete registration, No due list, incomplete tracking.

- ▶ The technical agencies to be more actively involved in training and monitoring.

15. Health Care Financing

- ▶ Considerable time lag between releases of funds, consolidation of expenditures made by districts and submission of FMR.
 - ▶ Low expenditure both in core and in non-negotiable activities.
 - ▶ Physical progress not projected in FMR
 - ▶ Unspent balance not reconciled at all levels, even stale cheques. Release under AMG and Untied Fund has been treated as expenditure at few PHCs
 - ▶ CPSMS registration is in process, should be expedited
- 

16. Medicine and Technology

- ▶ Huge out of pocket expenditures for drugs
 - ▶ Life saving medicines found to be absent in the facilities. IFA, Zinc, MgSO₄, Oxytocin etc. are also absent
 - ▶ None of the facilities visited were found to have EDL.
 - ▶ Diagnostic facilities not assured; in both the districts due to non-availability of trained HR
 - ▶ It was observed that equipments were unused due to non-installation by the provider.
 - ▶ Lack of coordination between multiple supply channels
 - ▶ ASHA drug kit replenishment mechanism absent
- 

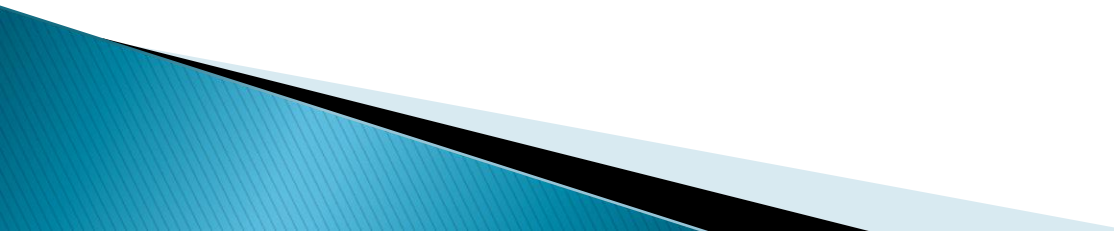
17. Program Management

- ▶ Total absence of coordination between NRHM and directorate of Health services;
- ▶ During state briefing meeting, no information was shared by SPOs about the vertical programmes
- ▶ Co-ordination between SPMU and different state program officers lacking – results in poor planning and monitoring all program components.
- ▶ Inadequate staffing at SPMU and DPMU (WK)
- ▶ Lack of communication between SPMU and DPMUs
- ▶ Total absence of supportive supervision at all levels
- ▶ Capacity building/ Program orientation of state and district level officers is poor leading to poor planning and implementation
- ▶ Record maintenance is poor at all the facilities.

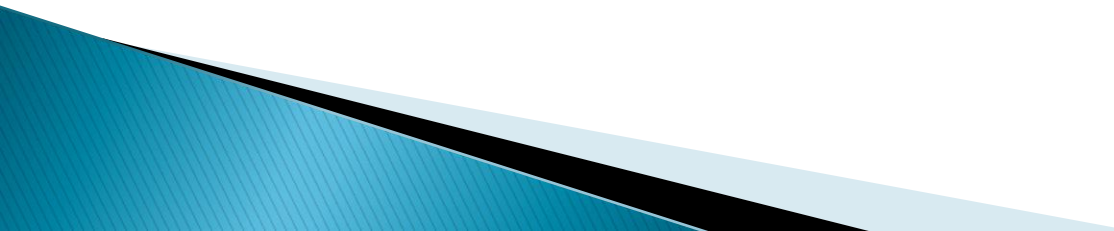
Compliance to previous CRM (Fourth CRM) Report

Sl. No.	Recommendations made in 4th CRM Report	Compliance Status
1	Special drive for recruiting specialists with high salary/incentive	Not undertaken. In state 61 specialists were posted as GDMOs at PHCs in absence of sanctioned posts of specialists at CHCs.
2	Higher salaries/Hard to reach area incentive along with performance incentives can be given to people working in difficult terrain	Incentive mechanism not institutionalized by the State.
3	ANMs working at District hospital should be posted back to the Sub-Centres	It was observed that ANMs were still functioning in the DH and SCs were functioning without ANMs

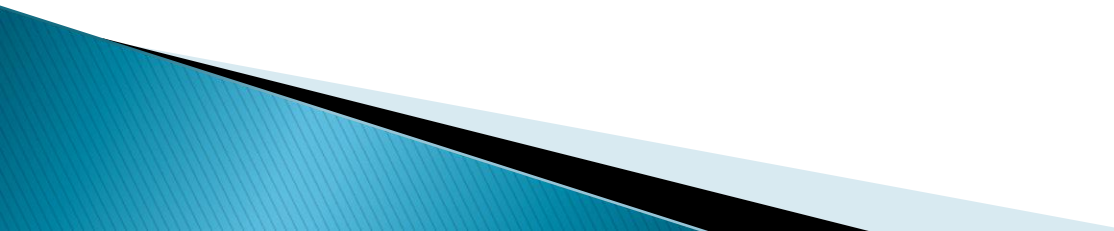
Suggestions

- ▶ State should identify and prioritize facilities where sufficient infrastructure exists and ensure availability of entire range of services
 - ▶ Assured referral services through sourcing in of local vehicles and empanelment could be considered.
 - ▶ Link up-gradation with case load and range of services provided
- 

Suggestions cont..

- ▶ More ANM/SN training centres needed along with pool of master trainers
 - ▶ State to have a comprehensive and sustainable plan for procurements
 - ▶ Last payment to the supplier to be linked with installation report
 - ▶ IEC/BCC materials should be displayed/available at all facilities
 - ▶ Meetings of DHS, QA committee, RKS etc needs to be conducted regularly and recorded
- 

Suggestions cont..

- ▶ State to timely deposit its state share in State Health society account
 - ▶ Budget Vs expenditure must be analyzed to know the exact variance of budget and expenditure so that proper, timely steps can be taken to improve the utilization of funds
 - ▶ Block level Financial Training is required.
- 



Thank You



DO THY BROTHERHOOD IS NOT THY CONCERN