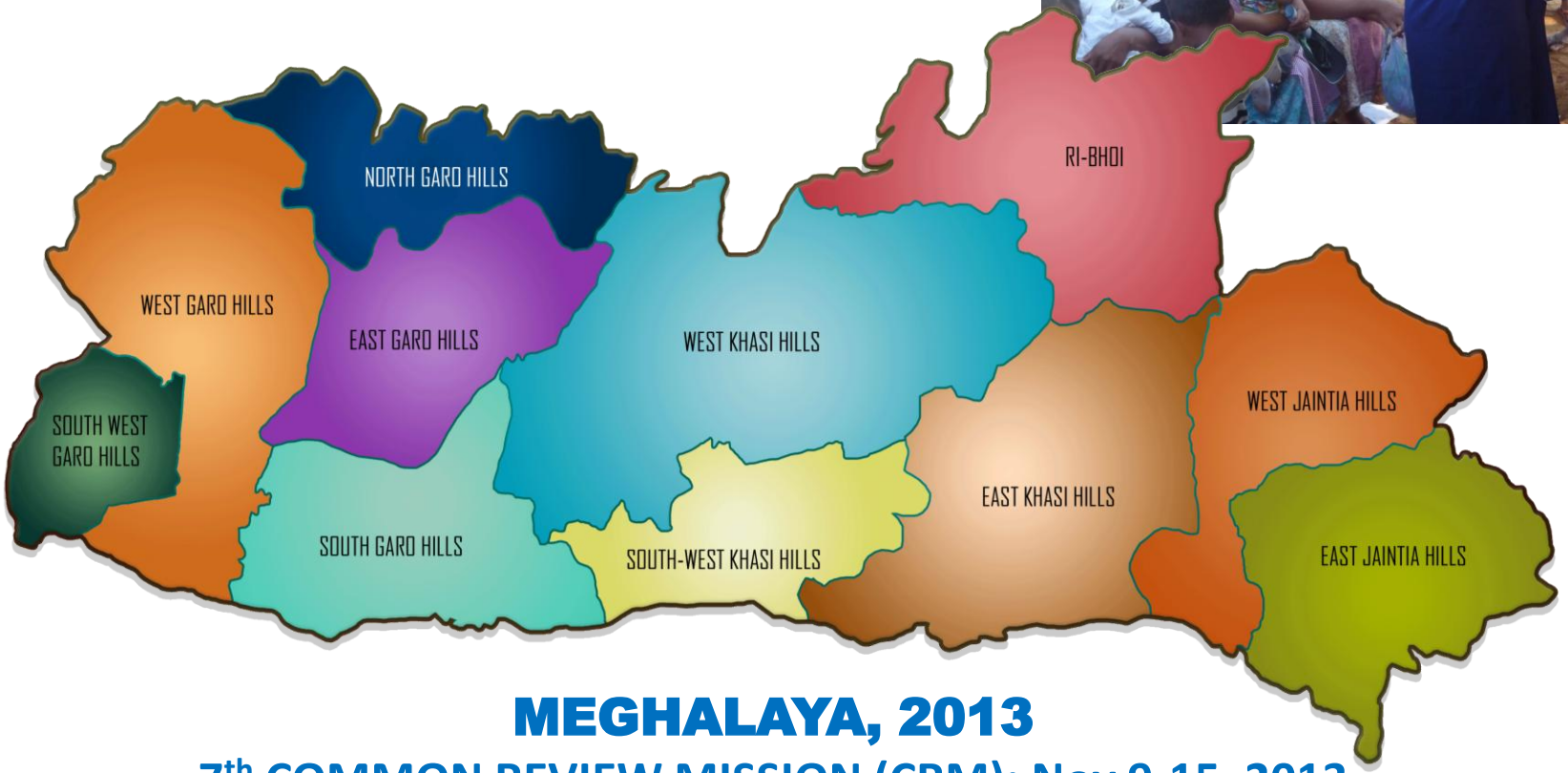


MEGHALAYA, 2013

7th COMMON REVIEW MISSION (CRM): Nov 9-15, 2013

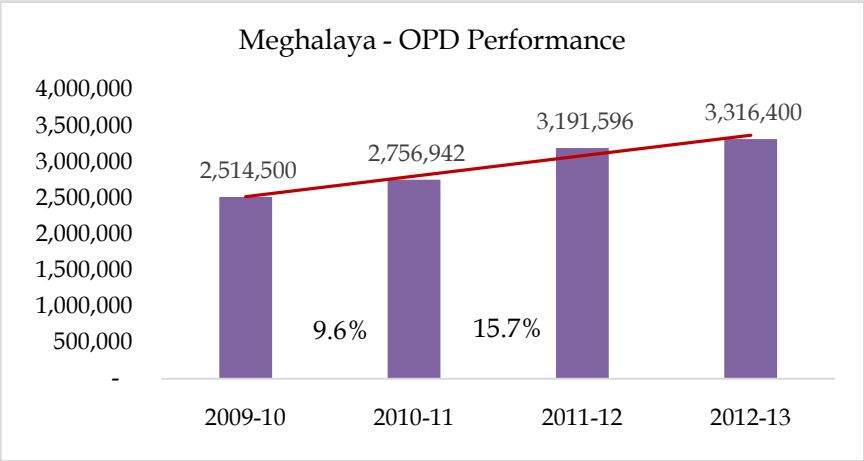
CRM Meghalaya: Nov 9-15, 2013

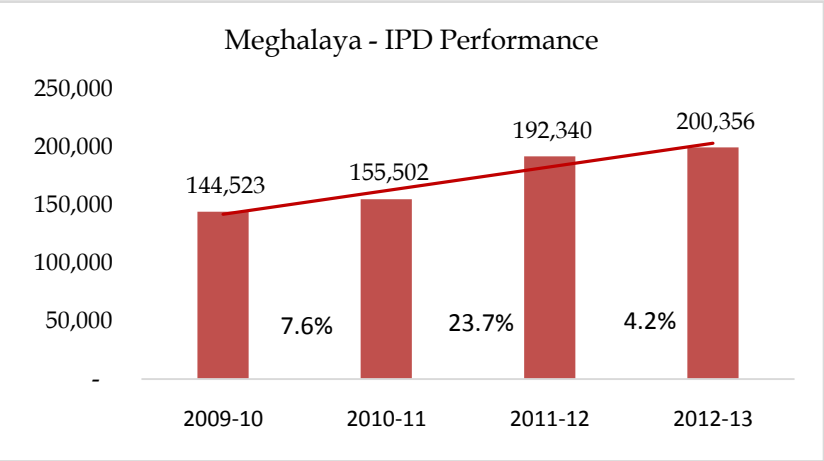
Ri Bhoi District	West Garo Hills District
Dr. Sher Singh Kashotia, Asst. Dir, NVBDCP	Dr. Sudha Balakrishnan, UNICEF
Dr. L. Ramakrishnan, SAATHII	Dr. Adarsh Kumar, Asst. Dir, AYUSH
Ms. Pallabhi B Gohain, VBD	Dr. Shahab Ali Siddiqui, Consultant, MoHFW
Dr. Vipin, RO AYUSH	Mr. P L Verma, DS M/o Tribal Affairs
Dr. Ruchika Arora, Consultant, MoHFW	Dr. Gautam B, Consultant, RNTCP
Dr. Alok K Mathur, IIHMR Jaipur	Dr. Pooja Passi, TMSA
Mr. Dharmendra Kumar, FMG Consultant, MoHFW	Mr. Nikhil Herur, Consultant, MH Div., MOHFW
Mr. Venkatesh Roddawar, NSHRC	

Ri Bhoi: 12 facilities and 6 villages visited for CRM

West Garo Hills: 13 facilities and 1 village visited for CRM

Service Delivery (1)





Performance of OPD increased by 30% and IPD by 36% over a period of 4 years from 2009-10 to 2012-13

	Meghalaya			Ri Bhoi			West Garo Hills		
	Required	Existing	SF	Required	Existing	SF	Required	Existing	SF
DH	11	11	0	1	1	0	1	2	0
CHC	65	28	37	6	3	3	15	7	8
PHC	256	108	148	21	8	13	50	18	32
HSC	1410	422	988	113	27	86	306	92	214
Total	**1742**	**569**	**1173**	**141**	**39**	**102**	**372**	**119**	**254**

-

Service Delivery (2)

- No mechanism to ensure adherence to standard treatment protocol or treatment guidelines in the state.
- Infection Management and Environment Plan (IMEP) committees are non-functional even at district level.
- Low utilization of MMU services observed and not well equipped to provide diagnostic services.
  No GPS system installed.

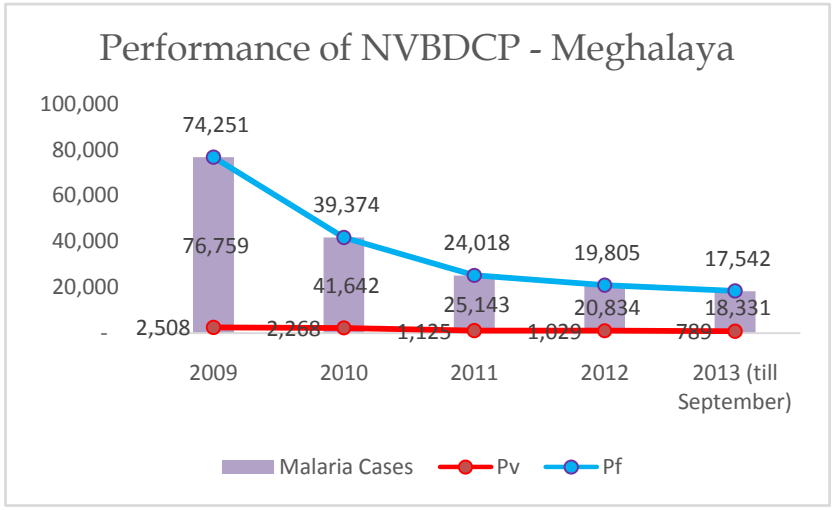
Reproductive and Child Health (1)

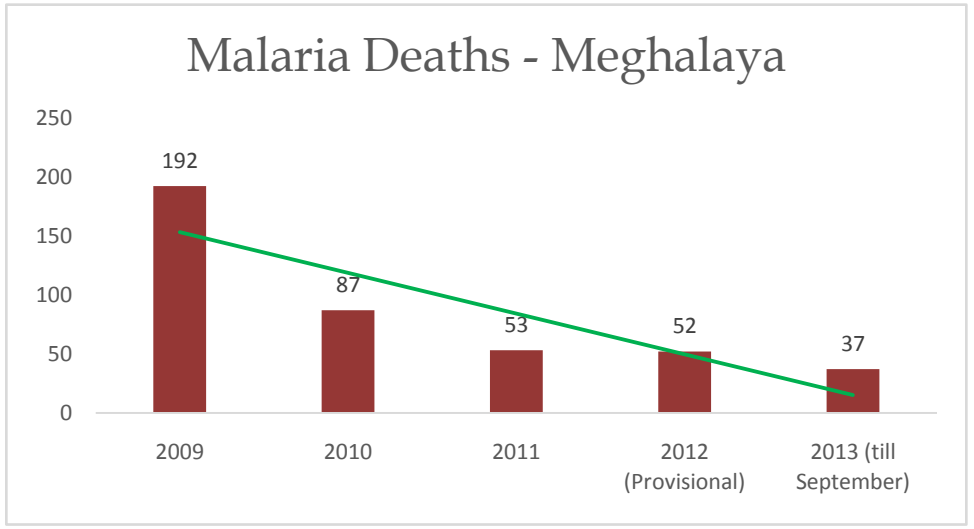
- High fertility pattern, high infant deaths, religious/cultural challenges in achieving family planning.
- Low density of delivery points, partially functional in terms of SBA and EmOC. Most PHC and CHCs provide only Level 1 service delivery care. Incomplete line listing of high risk pregnant women, eligible couple and no follow up were maintained.
- Level 3 facility in Ri Bhoi District not operational yet despite presence of Specialists (due to non functional equipment, Blood Storage Unit/Blood Bank, shortage of trained technician)
- Both districts have more than 70% home deliveries (with less than 5% assisted by SBA) and around 30% institutional deliveries. However, only 2% of reported maternal deaths are reviewed
- New Born Care Corners (NBCC) were up and functional but in 50 % facilities ANM/SN was unable to operate the radiant warmer. NBSU and SNCU functional in MCH Hospital but with staff shortage.

Reproductive and Child Health (2)

- No blood storage facility in MCH hospital and district hospitals (Tura and Ri Bhoi). Vital drugs viz. Mag. Sulphate and Misoprostol not available at 90% of facilities across districts.
- Meghalaya Maternal Benefit Scheme (MMBS) has given an additional thrust to JSY in the state, which provides additional Rs.4000 up to 2 children. However, home delivery incentive disbursement was negligible.
- Routine Immunization sessions executed during VHNDs and fixed health days in the villages. Most ANMs at sub centers aware and delivering services as per guidelines viz. noting down time of reconstitution, ice packs availability, aware of correct administration site. Counseling part observed to be missing.
- HIV-ANC linkages need strengthening
- No ARSH clinics seen at the PHC and CHC in West Garo Hills, (functional in RiBhoi).

Disease Control Programmes (1)





- National drug policy for treatment of malaria was not observed displayed at any health facility.
- ASHAs are not aware, nor having RDT kit for diagnosis of malaria cases, Artemisinin Combination Treatments (ACT) for Pf cases, chloroquine-primaquine (CQ-PQ) for treatment of Pv cases
- 1075 IDSP Toll Free number not available in the state

Disease Control Programmes (2)

RNTCP:

–Around 1674 new smear positive case put on treatment and annualized new smear positive case detection rate is 72% per lakh in 2012-13. A total of 220 drug resistance (MDR) TB cases registered for treatment, which include 191 MDR at Shillong DRT and 29 at Tura DRT center.

–Overall shortage of Anti TB medicine in the State. As per directions from Central TB Division (CTD), some of the drugs are being **managed locally by state level** procurement.

Leprosy

–Annual New Case Detection Rate (ANCDR), Released from Treatment (RFT), Child cases and Grade-II cases of leprosy have shown reduction in 2013 from 2011.

–Registered cases and newly detected cases have decreased in 2013 by 16 from 61 in 2011. Leprosy cases are likely under reported as ASHAs incentives are not paid on case detection.

AYUSH

- Most AYUSH clinics co-located within health facilities with consultation and dispensing rooms at CHCs and DHs level.
- One room available for AYUSH at PHC level and treatment rooms are available only at DH level but nonfunctional (RB).
- Doctors are placed, but after the year 2009, no paramedic, pharmacist and helper recruited in the state.
- Essential equipments, instruments and furniture are available, but medicines have not been supplied since 2009.
- Some of the doctors have received training in NSSK/ RCH/ NVBDCP/ RNTCP/ School Health programme and are involved.
- AYUSH related performance is monitored at state level and recording and reporting AYUSH related information maintained at facility level.
- 20-30 patients attend OPD per day. OPD services at Nongpo civil hospital, Ri Bhoi at first floor without any lift facilities, difficult for arthritis patients access the clinic
- IPD services for AYUSH clinics are not functional in the state and no separate IEC wing available for AYUSH programme.

Human Resources for Health

- Recruitment of contractual staff under NRHM increased by 1142 personnel in 2013 from 120 in 2005
- Differences between DHS and NRHM on HR issues viz. recruitment, training and deployment observed.
- Lack of adequate training infrastructure both in terms of HR (Master trainers) and facilities observed in the state. The State only has 2 GNM schools and 1 ANMTC.

Community Processes and Convergence

- Poor engagement of PRI members in VHSNC and RKS and for addressing low institutional deliveries and high prevalence of communicable diseases observed in both districts.
- Components such as HB%, urine examination, and physical examination are not being done at VHND sites.
- Challenges in rolling out training for ASHAs due to lack of fully equipped residential training sites
- ASHAs' grievance related to irregular payment of disease control programme incentives like NLEP, NVBDCP.
- Around 69 ASHA dropped out during 2012-13 and 286 villages yet to have ASHAs that include 88 new villages. Around 198 villages where ASHA cover more than 1500 population in the state.

INFORMATION SYSTEMS

- HMIS: Facility data in registers at CHCs and PHCs were found to tally fully with the HMIS data. Discrepancies were identified in the Sub Centre- level data - monthly ANC totals in registers did not tally with the reports downloaded from the HMIS.
- MCTS: high prevalence of home deliveries leads to some mothers and children not being included in MCTS. FY 2012, only 23% ANC were registered in MCTS. Delays in MCTS report and work plan generation => limited use of data by frontline health workers

MEDICINES AND TECHNOLOGY

- Warehouses: WGH -> not yet functional whereas in Ri Bhoi -> operational but lacked power supply. Drugs requiring refrigeration were housed in another room at the Civil Hospital.
- EDLs were displayed, but some essential drugs IFA, Zinc, Vit –A, Vit-K, Misoprostol and supplies like gloves were absent in the state and both districts. Availability of ORS, Paracetamol and condoms varied across facilities and were mostly absent in Ri-Bhoi, as per the ASHAs.
- Free Drug policy not implemented and out of pocket expenditure found to the amount of Rs.100 observed for many patients..
- ProMIS not implemented and no new rate contracts between state and suppliers for past three years.

Finance and Accounts

- Cash books are not closed on daily basis. It is observed that in Nangpoh DH, daily cash book balance were not maintained and not even in chronological order.
- Most of facilities do not preparing Bank Reconciliation Statement (BRS) on monthly basis, and/or do not separate BRS for each account
- Appointment of concurrent auditor is not made timely. Concurrent auditor submit report very late as concurrent report of the 1st and 2nd Quarter of 2013-14 is yet to be submitted.
- Low frequency of reporting of expenditure: HSC found to submit their expenditure report once in a year. PHC/CHC submit their expenditure report on monthly basis but there is no proper format whereby one can find out monthly expenditure as well as cumulative expenditure of the year.

Recommendations (1)

FINANCE AND ACCOUNTS

- Key post of finance director, which is vacant in the state needs to be filled-up on priority basis. Release of AMG and untied funds to the sub-center and VHSNC should be streamlined.
- State should monitor monthly both fund release and utilization under the selected activities like untied funds, AMG and RKS funds.
- Training to finance staff should be provided at the state level: Tally ERP.9, Operation Guidelines and Model Accounting Hand Book
- Concurrent audit system needs to be strengthened. Report submitted by the auditor should be analyzed and corrective measure should be ensured by the state officials.
- Funds of all programmes (including NDCPs) should be routed through the state and tracked programme-wise
- Awareness programme for staff as well as PRIs members should be organised to disseminate how and for what purposes funds like RKS can be utilised.
- Implement the Central Plan Scheme Monitoring System (CPSMS) on priority and make payment of ASHA incentives and JSY payment through DBT (Direct Benefit Transfer) Scheme.

DRUGS

- Operationalize the drug ware house (WGH) and ensure power supply (RB) at earliest
- Computerize and ensure timely and rational distribution of drugs, diagnostics and equipment to all the facilities (ensure ProMIS implemented immediately).
- Integrate state and NRHM (central) drug supply system and warehousing

Recommendations (2)

RMNCH+A

- Consider BIRTH WAITING HOMES near PHCs and CHCs wherein High risk ANC can be brought 2 days prior to their EDD.
- Operationalize Level 3 facilities ASAP
- State needs to take immediate and strong efforts to train all SN/ANM at delivery points in SBA, RI, IUCD, IYCF,IMNCI and Newborn Care (NSSK)
- Better planning of ARSH counsellor activity in terms of RMNCHA counsellor can be explored and better convergence with SABLA scheme to be undertaken.

HMIS

- Staff at facilities needed to be enabled to enter data at their own facilities on spreadsheets and have them verified before submission to the next level. To make this happen, basic computer literacy for facility staff is essential.
- Training of staff in data verification prior to submission of compiled sheets, and in use of data for planning and gap analysis

Recommendations (3)

AYUSH

•Provide training to AYUSH doctors and ensure availability of AYUSH Drugs and facilities. All vacant AYUSH posts should be filled up at earliest. Place dedicated AYUSH nodal officer at State level.

COMMUNITY PROCESSES

•Organize re-orientation programme on NRHM activities to PRI and VHSNC members in the state. Ensure diversification of VHSNC fund at village level for optimal utilization.

•Ensure ANC check-up and profiling of high risk pregnant women during VHNDS.

•Develop supportive supervision mechanism at all levels – state, district and blocks to strengthen community process.

•Directorate of Health should resolve disease control programme incentives for ASHAs.

•Selection of ASHAs for remaining 286 villages in the state and maintain ASHA population ratio as per guidelines

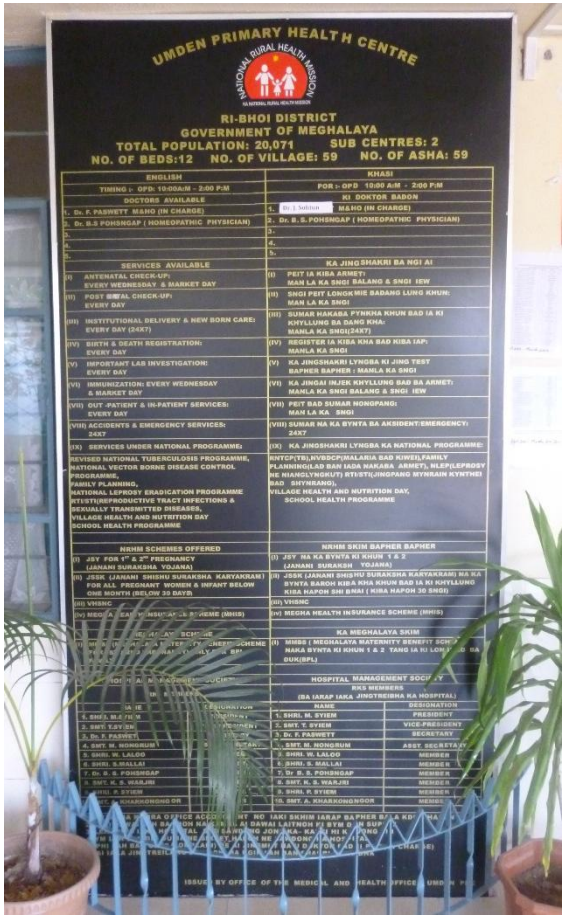
•Emphasize, train for proper record maintenance during the VHNDs with line listing of high risk pregnancies and SAM children. Special attention on orientation and training of ASHA facilitators particularly those who have not been selected from within the existing ASHAs

Recommendations (4) Disease Control Programmes

- National Drug Policy 2010 for treatment of Malaria to be displayed at all delivery points and implemented in entire state, with test reports and start of treatment of malaria within 24 hours
- Repair microscopes and condemn if non-repairable. Ensure availability of RDT kits for diagnosis, ACT, CQ and PQ for treatment of Malaria with all ASHAs.
- Ensure source reduction by quality spray through intensive supervision activities, use of bed nets/ LLIN, and use of Larvivorous fishes
- Timely referrals to be ensured to reduce morbidity
- Cross referral in TB-HIV patients needs strengthening. PPD vials for diagnosis of pediatric TB should be properly utilized.
- Reporting of leprosy cases needs strengthening by timely payment of incentives to ASHAs on detection of cases and completion of treatment
- Reconstructive surgery can be started by providing instruments and training to eligible officials.
- All vacant posts should be filled up immediately.

Recommendations (5): Governance and Management

- State level experience sharing forums should be provided every six months to all employees
- Supportive supervision and handholding from state level needs to be provided on a regular basis in a systematic way.
- Systematic and continuous field visits to CHC and PHC from district level officials will be of great help in boosting the morale of the officials who otherwise do not get any chance to interact with the senior doctors/officials.
- Grievance redressal mechanisms, social audit, and vigilance committees are recommended.



Thanks to Meghalaya NRHM teams and all health facilities for support during CRM visit