



7th Common Review Mission To Arunachal Pradesh

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Executive Summary

The Seventh Common Review Mission to Arunachal Pradesh visited the districts of West Kameng and Upper Subansiri, from 9th to 16th November 2013. While a comparatively better program implementation was observed in West Kameng district, there were serious concerns in Upper Subansiri. Some of the key observations made during the field visits are as follows:

Service Delivery –

- In spite of the presence of adequate number of health facilities in the State, the concern, however, is non-functionality of many of these health institutions at all levels.
- Substantive progress has been made by the State in improving its health infrastructure during the NRHM period. A lack of comprehensive infrastructure development plan and namesake up-gradation of its health facilities was observed. Some concerns for the State also relate to absence of coordination between the different implementing agencies.
- Most of the health facilities were neat and clean, however having low utilization of services. Majorly out of pocket expenditure (OOPE) was observed on account of transport, drugs and diagnostics.
- There are 44 Ayurveda, Yoga, Unani, Siddhi and Homoeopathy (AYUSH) co-located facilities in the state and case load was found to be adequate in these co-located AYUSH clinics.
- However adequate biomedical waste disposal mechanism was not found operative in the districts. Also the Biomedical waste management training has not been institutionalized though some awareness was observed in the staff interacted in the health facilities.
- The state has 94 ambulances and they were observed to be stationed at District Hospital (DH) and Community Health Centers (CHC) level facilities. At present these ambulances are not GPS enabled and not linked to call center. However in ROP 2013-14 approval for setting up of these have been given to State.
- Ambulances were largely observed to be used as inter-facility transfer (mostly from sub-district level to district level) vehicles.
- Concept of Medical Mobile Units (MMU) has not been well understood, as it was observed that there was no route chart, and no dedicated staff for MMUs. Overall utilization of MMUs is sub-optimal in the State and value addition to service provision is minimal.

RMNCH+A

- There is lack of understanding regarding Village Health and Nutrition Day (VHND) and Immunization sessions.
- Most labour rooms and toilets attached were found to be neat and clean.

- Adequate supply of IV Fluids were available in all the health facilities. However, non-availability of essential drugs such as injection Oxytocin and Injection Magnesium Sulphate in the labour rooms, is a serious concern.
- Integration of lab services was absent in Upper Subansiri, and all the ANC cases have to be referred to the district hospital for any laboratory procedures. However in West Kameng such services were available at Primary Health Centers (PHCs) and CHCs.
- Though Blood Bank is functional only at State capital; the State has potential to develop 2 blood banks, in Upper Subansiri and West Kameng, as both the districts have blood bank infrastructure.
- Across districts SNCUs are not functional. However all delivery points had Radiant Warmers installed and were being used, though this was not the case in Upper Subansiri.
- All vaccines under Extended Program on Immunization (EPI) except measles were available.
- Though all CHCs, PHCs visited and DH are conducting regular sessions on fix days in a month it was observed that vaccination of new-borns was irregular and incomplete. Across the districts it was observed that there is no system for provision of zero dose of OPV, HepB, and BCG (even in the district hospitals).
- Immunization registers were found to be well maintained and corroborates with MCTS and HMIS reporting.
- This is the first year of Rashtriya Bal Swasthya Karyakaram (RBSK) roll out in the State and thirty four dedicated teams have been constituted for implementation of RBSK in the state.
- Only in West Kameng, fixed day services were being provided for IUCD insertion. OCP distribution is being done at all facilities. Across districts PPICUD is not being performed.
- JSY incentives are being given in cash across the state
- Poor implementation of JSSK is noted in both the districts visited. Free blood and assured diagnostics is not being provided. Referral transport provided includes drop back to home and referral to higher facilities yet pick up from home is not provided. Provision of diet under JSSK ranges from 'no diet' to 'cash payment for diet' to 'actually providing diet'.
- Though facility level MDR communities have been formed, however, community based maternal death review has not been initiated.

Disease Control Program -

- Overall implementation of various disease control programs is satisfactory, however, infrequent monitoring is a cause of concern.

Human Resources –

- Since inception of NRHM state has recruited 4 Specialists, 85 Medical Officers (including AYUSH Medical Officers), 15 Dental Surgeons, 194 Staff Nurses, 62 Laboratory Technicians, 20 Male Health Workers, 4 Refrigerator Mechanics, and 2 Statistical Investigators.
- State's efforts to increase strength of its Medical Officer cadre is commendable but at the same time Specialists recruitment is a cause of concern. The 4th CRM also had made this observation and recommended a drive for Specialists recruitment, which seems to not have been undertaken.
- It was observed across the State that exact number of sanctioned posts against a facility was not available.
- State contends that its existing sanctioned positions are filled up and do not have vacant posts. However the State must consider increasing the sanctioned posts at each level of health facilities, so as to meet its demand of service provision.
- It is evident from field observations that desired level of rational deployment of its existing HR has not been undertaken rigorously by the State.
- Across districts it was observed that while SHCs were unmanned (being managed by pharmacists, MPWs, HAs), the ANMs were attached at the level of DH, CHCs and PHCs. While there may be a requirement of posting of ANMs at high level facilities, however, the service provision at SHCs should not get neglected in the process.
- State has not institutionalized any incentives for its staff working in the difficult areas. This is leading to demotivation of staff posted in difficult areas.
- While annual training plans are being prepared by the State, the centralized nature of planning with practically no need assessment and participation from district level is an area of concern which needs to be addressed.

Community Process & Convergence

- In the State 3772 villages have constituted VHSNCs out of 5589 villages. While VHNDs are being conducted the exact role envisaged for VHND was not observed. The concept of VHNDs and its role in provision of community level preventive and promotive care has not percolated and been understood at the district and sub-district level.
- The institutional mechanisms available were not being leveraged for engagement of PRI members. It was observed that involvement of PRIs was more dependent on initiatives of ASHAs.
- Out of 3862 selected ASHAs, 3682 ASHAs have been trained up to 1st module, 3606 ASHAs trained up to 4th Module, 3643 ASHAs are trained up to 5th Module and 3135 ASHA has been trained in 2nd round of 6th & 7th Modules.
- Across districts ASHAs informed that trainings on modules 6&7 have been completed and all the ASHAs had uniform.
- However the ASHAs interacted with, though generally were aware about the trainings given to them they were not able to recall the messages received in the trainings. They were not able to produce the training material supplied to them.

- It was observed that ASHAs incentives range from 600 to 1200 per month. Though all the ASHAs had bank accounts they preferred receiving the incentives in cash. It was also observed that ASHAs have poor control over their joint account with PRI members.
- A regular mechanism for refill of ASHA drug kits was absent across the districts. ASHA drug kit refill was not on the basis of the needs and requirement of ASHA but was rather dependent on the supplies available at the PHC/CHC.

Information and Knowledge

- Out of 17 districts of Arunachal Pradesh, 16 districts follow facility based reporting of HMIS data. Out of total 591 facilities in the state 514 (87%) facilities are actively reporting HMIS data.
- It was observed that while HMIS data is available at state and district level but the utilization of HMIS data is sub-optimal. Consolidation of data on a regular basis, generating information and using that information for improving service delivery of the facility was not adequately understood at facility, block and district level.
- Progress of MCTS implementation in the State needs wide improvement in terms of registration, timely service delivery and updating the service delivery status.
- Data reported on MCTS Portal depicts that during 2013-14, only **36.27%** pregnant women and **29.78%** children have been registered on the system so far (status as on 4th November, 2013)

Health Care Financing

- There is considerable time lag between - a) releases of funds b) consolidation of expenditures made by districts and c) submission of FMR by SPMU.
- State has not been projecting physical progress in the FMR.
- CPSMS registration is in process, but it should be expedited.

Medicine and Technology

- Gaps were observed in drug supply management across both the districts. There are three sources of drugs supply in the State: State supply, NRHM supply and procurement of drugs through untied funds (provided by state) by a district level committee. However, no coordination observed between these multiple supply chains.
- At State level Essential Drug List (EDL) is available. Facility wise differential EDL was observed to be absent. This manifested in terms of high generation antibiotics being available at SHCs and PHCs that were visited.
- Shortage of essential medicines observed as universal phenomenon in all most all facilities visited (e.g. IFA, Vit A etc.).

- Procurements at State level is not coordinated with the demands and needs of the district. In cases where the district is unaware of the supplier, issues relating to installation of the equipment, adherence to AMC etc. is affected adversely.

NUHM

- Urban Local bodies are not involved in delivery of primary Health Care.
- PIP for state capital has been prepared and has been submitted.
- Slum Mapping in the State has been done by Department of Urban Development and Housing.

Program Management

- Total absence of coordination was observed between the NRHM and Directorate of Health Services. This in turns affects program implementation and also the program outputs.
- At State level co-ordination between different State Program Officers and SPMU was observed to be lacking. This affects the planning and monitoring of program components at district level.
- Supportive supervision at all levels was not of the desired level. At State level no supportive supervision plan was found. This is leading to inadequate capacities and program orientation at State and District level.
- The quality of record maintenance at facility level was not uniform and at a few facilities the records did not match with the HMIS data.
- Overall program management requires more attention by the State.

Arunachal Pradesh - The 'Land of Dawn-Lit Mountains'

The Land –

Situated in North Eastern region of the country Arunachal Pradesh is a predominantly a tribal state. Known as North-East frontier Agency till 1972, it became a State on February 20, 1987. While area-wise it is the largest state of North-East but has a very sparse population density. The land is mostly mountainous with Himalayan ranges along the northern borders criss-crossed with mountain ranges running north-south. These ranges divide the State into five river valleys: the Kameng, the Subansiri, the Siang, the Lohit and the Tirap.

Siang, called Tsangpo in Tibet, is largest amongst the rivers and it becomes Brahmaputra after it is joined by Dibang and Lohit in the plains of Assam. State has its international boundaries with Peoples Republic of China in North and North-East; Bhutan in West and Myanmar in East. It also shares inter-state borders with Assam (South) and Nagaland (East and South-East).

The People –

There are 26 major tribes and as high as 100 sub-tribes in the state. Difficult terrain has led to geographical isolation of various tribes from each other and thus each of these tribes have a different dialect. The major tribes in the state are:

1. The Monpas, Mijis, Akas, Khowas, Sherdukepens and Bangnis in Tawang, West Kameng and East Kameng districts.
2. The Adis, Galos, Membas and Khambas in West, East and Upper Siang districts.
3. The Mishmis, Khamptis and Singhphos in Lohit, Dibang Valley and Lower Dibang Valley districts.
4. The Noctes, Wanchos and Tangsas in Tirap and Changlang districts.
5. The Apatanis, Nyishis, Tagins and Hills Miris in Lower and Upper Subansiri districts

Today most of the tribes have agriculture as their main source of income, with wet-rice cultivation being the most common. Among the tribes, Apathanis are known for practicing paddy-cum-pisciculture, and fishes are harvested along with every crop of paddy.

On basis of socio-religious beliefs and practices the people inhabiting the State are divided in following cultural groups –

1. Followers of Lamaistic tradition of Mahayana - Monpas and Sheredukpens of Tawang and West Kameng districts
2. Followers of Hinayana sect of Buddhism - Khamptis and Singhphos of Lohit and Changlang districts
3. Worshippers of Sun and Moon God - Adis, Galos, Akas, Apatanis, Nyishis, Mishmis, Mijis, Tangsas etc.
4. Vaishnavism - Noctes and Wanchos of Tirap district

Table 1 Socio-demographic Profile of Arunachal Pradesh

Population (Census – 2011)	Person	1,382,611
	Male	720,232
	Female	662,379
Sex Ratio (No. of Females per1000 males)	Census - 2011	920
Sex Ratio 0 - 6 years	Census - 2011	960
MMR (per 100,000 live births)	SRS - 2011	-
CBR (per 1000 population)		21
CDR (per 1000 population)		6
IMR		31
Neo- natal Mortality Rate		
Under Five Mortality Rate		-
Literacy Rate - Census - 2011	Person	66.95
	Male	73.69
	Female	59.57
% Decadal Growth Rate	Census - 2011	26
Population Density per Sq.K.m	Census - 2011	17

Source - NHSRC

Where Do the Sick Go - Availability of Health Resources

Overall availability (in terms of numbers) of health facilities is adequate in the State. A bigger concern for the State is to classify its existing health infrastructure as per central norms (IPHS/MCH L1, L2, L3) so that it can be in a position to identify the level of services being made available to its populations, especially after the infrastructure up-gradation of its

health facilities. As demonstrated in Table 2 there mismatch in the number of various health facilities as per Rural Health Statistics vis-à-vis that perceived by the State.

Table 2 Health Infrastructure in Arunachal Pradesh

Health Infrastructure	Required as Per Population Norms	Available as Per RHS 2012	State's Figures on its Health Infrastructure (As Informed during State Debriefing)	
			Total	Functional
District Hospitals	-	14	13	13
General Hospitals	-	-	2	2
Community Health Centres	13	48	54	49
Primary Health Centres	53	97	129	117
Number of Sub Centres	356	286	468	286

Source – RHS/ State Debriefing Presentation

Where Did We Go –

Seventh Common Review Mission visited a High Priority District (Upper Subansiri) and a better performing district (West Kameng). Figure 1 shows a very brief comparison of two districts. As seen in Figure 1, the boundaries between a 'Better Performing' and 'High Priority District' very fluid. If Upper Subansiri performs better than West Kameng on ANC registrations, it fails miserably on immunization; while common problems such as those of non-functional health facilities face both of them.

A total of 19 health facilities were visited across both the districts and in addition interactions were taken up with ASHAs, community members, beneficiaries, and programme staff at State and district level. Table 3 details the number and level of health facilities that were visited by CRM team.

Table 3 Details of Health Facilities Visited –

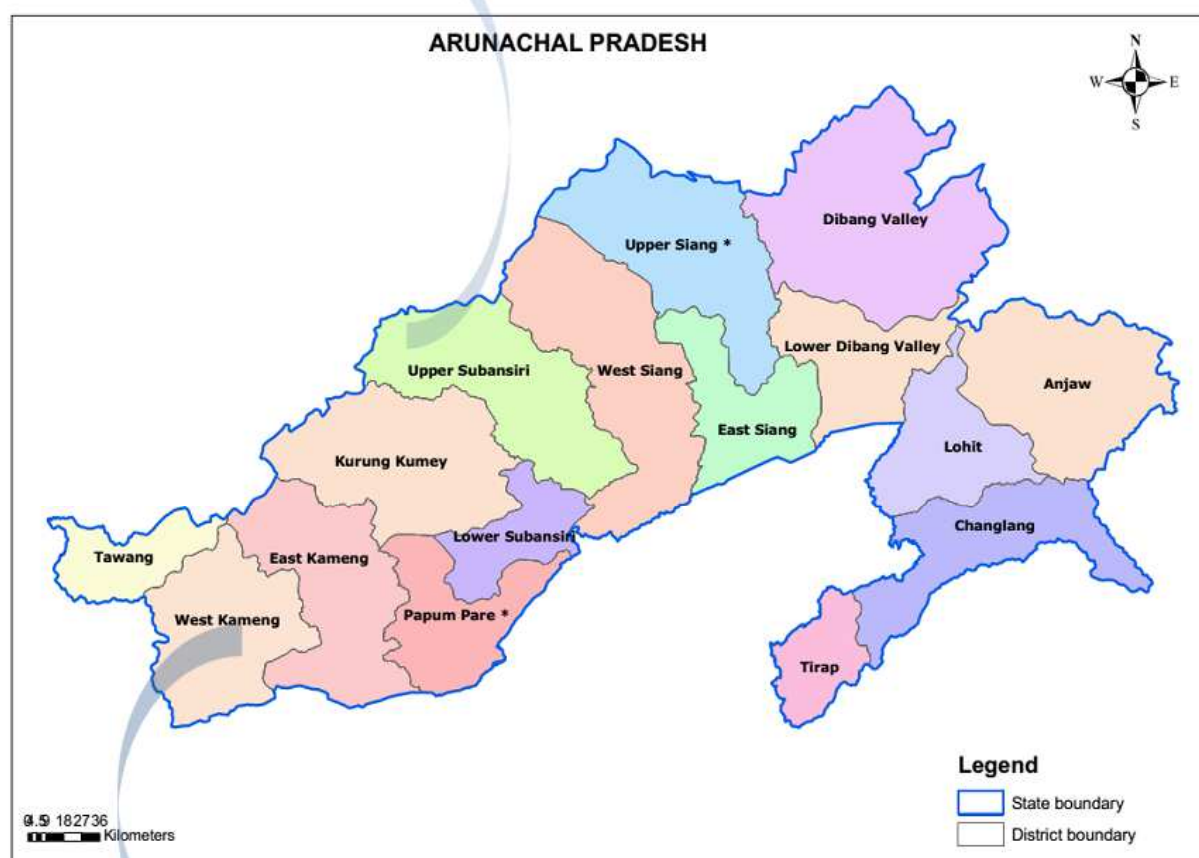
Name of The District	DH	CHC	PHC	SC
West Kameng	1	2	2	3
Upper Subansiri	1	3	2	5
Total	2	5	4	8

Figure 1 West Kameng and Upper Subansiri – A brief Comparison

Population (Census 2011)	83,205
Health Facilities	DH – 1, CHC – 5, PHC – 4*, SHC – 14**
ANC Registration against Expected Pregnancies	99%
Institutional Deliveries against Estimated Deliveries	55.30%
Newborns weighed against Reported Live Births	87%
Fully Immunized Children against Expected Live Births	34%

*Total PHCs 13 but only 4 functional

** Total SHCs 46 but only 14 functional



Population (2011 Census)	87,103
Health Infrastructure	DH - 1, CHC - 4, PHC - 6, SHC – 9***
ANC Registration against Expected Pregnancies	87%
Institutional Deliveries against Estimated Deliveries	37.50%
Newborns weighed against Reported Live Births	99%
Fully Immunized Children against Expected Live Births	88%

*** Total SHCs 25, but only 9 functional

Observations Made by 4th CRM in Past- A Follow Up

Recommendations made in 4 th CRM Report	Observations/Compliance
Establishing Regional Monitoring Units for close supervision and quality implementation of the activities	Not in place
Creation of Infrastructure & office set up for DPMU & NRHM Staff	The DPMU and NRHM staff are housed in DMO Office with functional set up
Re-orientation of DPM, Data Manager, Finance Manager & Other Program Managers on Monitoring with a checklist	No Action taken
Clear targets and accountability to be given to program officers and DPMUs	No such targets were available with the Program Officers or the DPMUs.
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. It was informed by Secretary Health during the de-briefing that due to resource crunch in the health budget sanction of new posts have not been taken up.
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.
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.
Family planning services, ANC, PNC and Nutritional activities needs a special focus	It was observed that 48.5% mothers had ANC in 1 st trimester in West Kameng however only 27.8 % had ANC check-up in Upper Subansiri. Thus, while regular action is been taken; the need for focussed attention is still required to improve the RCH services.
Provision of diet below district hospitals for facilitating 48 hour stay	Partial compliance observed in the facilities in West Kameng while it was lacking in Upper Subansiri.
NRC can be created along with strengthening of micro-nutrient supplementation Plan	The entire State has one NRC. The state may plan for establishment of NRC as per

Recommendations made in 4 th CRM Report	Observations/Compliance
	requirement at-least at regional levels. Also, much focussed attention is needed for strengthening the micro-nutrient supplementation plan.
Innovations like Palki scheme, birth waiting home, incentive etc. can be thought for linking service delivery with assured transport	GOI has launched Janani Shishu Suraksha Karyakram. The state is providing cash for drop back to the Pregnant woman.
Comprehensive IEC/BCC plan to be prepared involving all program for optimal and best utilization of IEC funds available under different programs	A very weak IEC observed across both districts. Across all the facility levels both the display & written material was found deficient.
IEC need to be focussed particularly in blocks and villages	
PRI's, public leaders, opinion farmers to be oriented at regular interval on RCH and NRHM key issues	No mechanism for training of PRIs, public leaders on RCH & NRHM issues was found to be present.
Targeting married couple required for FP services	No institutional arrangement for targeting the married couples for family planning services was observed. However, this was being provided by ASHAs & ANMs on demand basis and through informal counselling.
Presence of doctors at the facility with assured services delivery should be ensured at DH during emergency hours	Doctors were available on call at DH level in both the districts
Key skill based trainings like SBA, IMNCI, NSSK, Minilap needs augmentation	Regular training calendar was not found. Training was centralized and need-based training plan is not been drawn up. The new training institute in Upper Subansiri district needs to be operationalized at the earliest. Once operationalized it should be fully utilized to cater to training requirements.
More training centres need to be created along with pool of master trainers	
Need to give induction training to fresh recruits	State has made efforts towards providing induction training. For the newly recruited 84 HMIS data operators induction training has been planned. However, it was observed that school health teams have been posted to district

Recommendations made in 4 th CRM Report	Observations/Compliance
	without being provided any orientation.
Assured referral transport with innovations like Palki Scheme, Birth Waiting Homes can be established	The State is implementing the Janani Shishu Suraksha Karyakram. Under the scheme free referral is being provided, though gaps were observed.
MCH Centre Plan for all districts with more focus on creation of level I facility, catering to the needs of scattered population.	No separate plan for level I facility, catering to the needs of scattered population has been made by the State.
Disease surveillance and reporting needs improvements	There is need for coordination between NVBDCP and IDSP for compilation and submission of reports.
Reorientation of Paramedical workers and doctors for special focus on timely detection & treatment of Malaria cases particularly in endemic zones	Only Passive collection observed. Active collection is nil as the field level workers (MPWs, DHV, RFWs) not involved for collection blood slide. Involvement of ASHA in malaria programme is practically nil.
Anti-malaria drugs and RD kits to be made available on priority	ACT and RD kits are not available in the health institutions.

Observations of Seventh CRM –

TOR 1. Service Delivery

Adequacy of facilities:

- Overall availability (in terms of numbers) of health facilities is adequate in the State.
- The concern for the State is non-functionality of many of its health institutions across all the levels. For instance in Upper Subansiri district there are a total of 65 government hospitals (1 DH, 5CHC, 13 PHCs and 46 SHCs) but only 24 (1 DH, 5 CHC, 4 PHCs and 14 SHCs) of them are functional. There are also instances where none of the available health facilities in the block are functional. For e.g. in Nacho block of Upper Subansiri (population – 5203), there are no PHCs and out of 3 SHCs available, none are functional.
- Further it is also noted that accessibility to many of these facilities may be limited due to - a) very difficult terrain and b) lack of assured transport services. Table 4 details the status of functional health infrastructure available in the State.

Table 4 Status of Functional Health Infrastructure in Arunachal Pradesh and in Districts visited by CRM

FACILITIES	Arunachal Pradesh		West Kameng		Upper Subansiri (HPD)	
	Number	Functional	Total	Functional	Total	Functional
General Hospitals	2	2	-	-	-	-
Mental Hospital	1	1	-	-	-	-
District Hospital	13	12	1	1	1	1
Community Health Centre	54	49	4	4	5	5
Primary Health Centre	129	117	6	6	13	4
Sub Centre	472	286	25	9	46	14

Source – State Debriefing Presentation

Infrastructure:

Substantive progress has been made by the State in improving health infrastructure during the NRHM period. Some key progress made by the State is as follows:

- 159 new facilities have been sanctioned under NRHM (14 DHs, 2 PHCs, 1 CHC, 139 SHCs, and 3 DEICs under RBSK programme)
- 272 health facilities have been taken up for Renovation and Up-gradation (42 CHCs, 100 PHCs and 130 SHCs)
- 44 AYUSH facilities have been co-located across all levels of health facilities (excluding SHCs)

In spite of such large extent of works undertaken, the following concerns were observed:

1. Coordination between various implementers –

- Apart from NRHM, other sources of funding were available and being utilized for construction of health facilities in the State (such as Additional Central Assistance, MLA Funds). Also there are multiple agencies involved in health infrastructure development in the state, such as, RWD and PWD. Due to poor coordination amongst these agencies it was observed that a) there are irrational civil works being done at many facilities. For instance, a new construction of DH building is being done at Upper Subansiri district in spite of existing infrastructure and b) at district level the DMOs were not part of the committee looking into the construction of health facilities resulting in poor monitoring of the pace of work; and inability to address the design issues (e.g. location of labor rooms and wards) For e.g. at Dirang CHC the labor room was constructed on first floor with no provision of ramp.

2. Infrastructure Development Plan –

- A need based and implementable plan for health infrastructure development is not followed by the State. As a result the State has upgraded its health facilities without need assessment of demands, human resources availability and gap analysis.
- During interactions, it emerged that a few of these ‘up-gradation’ of the health facilities were politically motivated too. Such up-gradations also hamper district’s ability to determine the criteria for assessing functionality of these facilities. This further leads to discrepancies in HMIS data. For e.g.

Puchigeko and Baririjo are reported as PHCs by district but in HMIS reporting it is mentioned as a CHC.

- Lack of planning of new constructions and up-gradation affects the reach of services to difficult areas.

3. Infrastructure Up-gradation vis-a-vis Service Delivery

- Many of facilities visited were under- utilized and was observed that the infrastructure development does not commensurate with either the case load or range of services provided at the facility.
- Instead of working on demand generation within the existing population, and focusing more on relevant human resources availability, State has diverted its attention towards creating new buildings with no value addition to service provision.

4. Involvement of Health Staff in Planning –

- As discussed in earlier part of the report as a regular drafting in of doctors with regard to the construction of health facility is absent. It depends on the contractor's initiative to involve doctors or other health staff in planning and implementation of new construction. Thus at West Kameng district none of the medical staff were not involved in planning of facility whereas at Upper Subansiri such participation was contractor's initiative and medical/paramedical staff were consulted during the construction of DH Daporijo.

5. Maintenance of Existing facilities –

- Most of the existing health facilities were maintained well, though there are few sub-centres that operate out of non-pucca structures. Patient amenities (like beddings, mattresses, curtains, toilets) were not up-to satisfactory levels. Figure 3 and 4 demonstrate some concerns that were observed.

Figure 2 Lack of Approach Road – PHC Baririjo



Figure 3 Open Sewage Area Behind Wards – PHC Baririjo

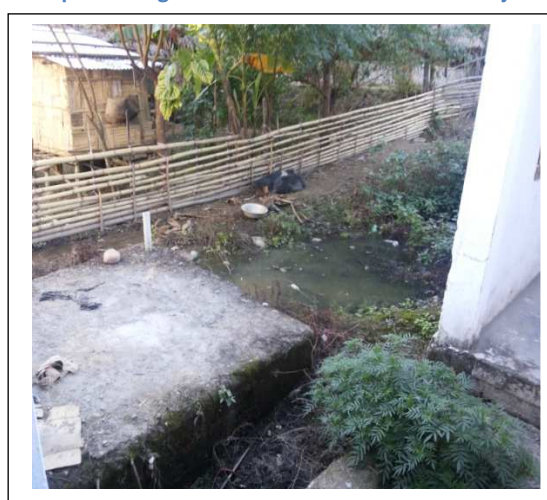


Figure 4 Ligu SHC – Upper Subansiri District (Operational Out of Non-pucca Structure)



Suggested Measures -

- a. For any new infrastructure built the prime concern should be making available the adequate human resources i.e. doctors, SNs, LTs and other paramedical staff.
- b. Minimum service provision must be also be ensured at all new constructions and up-gradations.
- c. DMO and MO I/C should compulsorily be made part of both the planning and execution processes.
- d. Newly constructed infrastructure should be made functional as early as possible. While it was absent in West Kameng district (at Dirang CHC) in Upper Subansiri the OPD wing of newly constructed DH building was being utilized.
- e. Infrastructure should commensurate with service delivery package.
- f. Need assessments should carried out before sanctioning of new constructions/ up-gradations.

Utilization of Facility Based Services:

1. Wide Variation in Range of Services Available –

- At SHCs – a) OPD, b) immunization and c) family planning, excluding IUCD.
- At PHC a) OPD and IPD, b) ANC, normal delivery and PNC c) family planning services (including IUCD) d) laboratory services – In West Kameng availability of basic lab services was observed but in Upper Subansiri , which is an HPD lab services were mostly not available at most PHCs.
- CHC - Minor surgeries (I&D, foreign body removal etc.) were performed though not all CHCs. Major surgeries were being performed only at the district hospital since specialists are only available at DHs.

- Poor attention to development of allied services like laboratories has led to a situation where referrals are made even for simple tests (esp. in HPDs) and leading to out of pocket expenditure.
2. Service Utilization –
- In most of the facilities visited, low utilization of services was observed. Footfall at PHCs and CHCs were very low possibly as the patients were aware of unavailability of the whole package of services. Firstly the catchment population is small; and even these population groups are sparingly utilizing services.
3. Out of Pocket Expenditure –
- Major OOPE was observed on account of transport, drugs and diagnostics. For instance, in the entire Upper Subansiri district ultrasound facility is not available at any of the public health facility and the only option is to either avail the service in private or travel to Itanagar (with an average travelling time of 14 hours) to access the service at government health facility.
 - Similarly due to lack of integration of lab technicians the patients have to travel to DH from various blocks for basic blood/sputum investigations.
4. Availability and Utilization of AYUSH –
- There are 44 AYUSH co-located facilities in the state (at 14 DHs, 15 CHCs and 14 PHCs) across the state. AYUSH case load was found satisfactory in the co-located AYUSH clinics.
 - As compared to Upper Subansiri it was noticed in West Kameng district that due to non-availability of Ayurvedic drugs in the AYUSH clinic the doctors were prescribing allopathic medicines.

Quality of care:

1. Bio –medical waste Disposal
- Across the districts adequate biomedical waste disposal mechanism was not found operative. While colour coded bins were placed at the facilities in West Kameng district, no such protocol was observed in Upper Subansiri. The Biomedical waste management training has not been institutionalized.
 - It was informed that as per the local practice the placenta is carried back to home by relatives. And for other biomedical waste, most common method of BMW disposal was burying and burning. Some facilities did have sharp pits, though

knowledge and practice of handling sharp waste (e.g. needles) was not as per the desired protocols.

Figure 5 Waste Material Burnt At SC Sipi, Upper Subansiri, The Half Burnt Drugs Visible Had Expiry Of 2009



2. Standard Treatment Protocols –

- No adherence to STPs was observed at any facility across the districts. For instance at DH Daporijo HMIS data of the financial year 12-13 shows that no case of treatment of obstetric complication using IV antibiotics, Oxytocics, Inj. Magnesium Sulphate and Blood Transfusion. This indicates the quality of obstetric care available at DH level facility

Supportive services:

1. Citizen Charter - In Upper Subansiri none of the facilities displayed citizen charter. However, in West Kameng district citizen charter were displayed at almost all facilities that were visited. However they were lacking in service package information. Across facilities very poor display of IEC material- program component, various entitlement information- was observed.
2. Power backup – In both the districts power backup was not present at sub-district level facilities. Though generator backup was available at District Hospital level, the response time (in case of power failure) was found to be delayed.
3. Diet - In Upper Subansiri district none of the facilities were providing diet to in-patients (including pregnant women); whereas in West Kameng district facilities) were providing diet.

4. Privacy of Patients – The privacy of patients varied across the districts. It was observed to be highly compromised in Upper Subansiri, but was comparatively better in West Kameng district. Special mention is made with regard to DH Daporijo (Distt. Upper Subansiri) where the labour room had transparent glass windows and the door opened directly into corridor with direct access to waiting patients and relatives.
5. The toilet maintenance was found to be poor at most of the facilities in Upper Subansiri district. However, adequate water supply and clean bed-sheets were observed at most of the facilities.
6. Grievance Redressal – In Upper Subansiri no mechanism to capture patient satisfaction levels or to address patient grievances was seen at any of the facilities that were visited. Whereas in West Kameng, though grievance redressal boxes were present, the mechanisms for follow up actions on grievances was not in place.

Figure 6 Complaint Box at DH Daporijo (Upper Subansiri District)



Ambulance & Referral services:

- The state has 94 ambulances and they were observed to be stationed at DH and CHC level facilities. At present these ambulances are not GPS enabled and not linked to call center. However in ROP 2013-14 approval for setting up of these have been given to State.
- Ambulances were observed largely observed to be used for inter-facility transfer (mostly from sub-district level to district level).
- There was no display of ambulance numbers at the facilities visited. It also emerged from patient interactions that free drop back under JSSK is not occurring and patients

are being charged for diesel. Alternatively they were being paid in cash at fixed rates for the expenditure in the transportation.

- Upon referral of a patient to next level facility, it is the responsibility of relatives to search for the number of ambulance driver or arrange for a private vehicle.
- High degree of OOPE is being incurred due to such lack of assured ambulance availability.
- One of the concerns voiced by district officials was regarding long breakdown period of existing ambulances due to rough terrain and long inter-facility distances that these vehicles travel. In absence of backup ambulance/vehicle the service to the patient is suboptimal.

National Ambulance Service –

- State briefing presentation mentioned that all the ambulances are fitted with GPS. But during the field visit it was found that none of the ambulances were GPS fitted.
- Though NAS logo was displayed, but they were not compliant to NAS guidelines.

Figure 7 Ambulances under NAS



Suggestive Measures -

1. For increasing availability of ambulances/ patient transport vehicles –
 - In hilly terrains the system of assured transport for patients need to consider not only the distances but also the fact that even in case of a call center being operational the ambulance positioned at a farther distance may not be able to timely reach the patient. Perhaps the State should explore that local vehicles could be empanelled for provision of patient transport services.

- State should perform a situation analysis of its existing ambulances and ensure that planning of ambulance services should be based on average distance covered by these vehicles and average break-down period, apart from population covered by them.
 - Maintenance mechanisms for all the existing vehicles should be put in place.
2. For addressing transport need at facility level –
- Contact numbers of the ambulance drivers must be prominently displayed at various points in the hospital
 - It should also be displayed at the doctors and SNs duty room.
3. NAS – It must be ensured that all ambulances are compliant to NAS guidelines.

Medical mobile units (MMUs):

- State has 16 MMUs (Source - NRHM MIS Bulletin, as on 30.6.2013)
- Concept of MMU has not been well understood, as it was observed that no route chart had been prepared, and no dedicated staff has been put in place. Also it was used more as a multipurpose mobility vehicle, for instance in Upper Subansiri, the district has 2 MMUs and they have been re-named as ‘Rashtriya Medical Mobile Unit’ that are used for monitoring visits.
- Overall utilization of MMUs is sub-optimal in the State and value addition to service provision is minimal. For instance in West Kameng one MMU is operational (but has no dedicated HR) and it conducted only one camp in the current financial year.

IEC/BCC:

1. IEC –
- Across the districts it was observed that overall visibility of various health programs (including NRHM) and health messages was inadequate. There was hardly any display of measures for prevention of various communicable and non-communicable disease.
 - While hospitals in West Kameng had health messages painted on walls, they were conspicuous by their absence in Upper Subansiri district.
2. BCC -
- None of the districts have tried to assess behaviour indicators and plan strategies to address these behaviours thus BCC activities are not need based.

- Neither the State nor the district had conducted any communication need assessment. As of now the practice is the district undertaking activities as approved in the ROP.
3. A general lack in capacity to develop district specific communication and BCC strategy based on program needs was observed. Even at State level no plan to enhance capacities of the relevant staff was found.

TOR 2. Reproductive and Child Health

Planning

- There is lack of understanding regarding VHND and Immunisation session. The state is following its own pattern for planning the field based RCH services. Across districts it was observed that one VHND session per SHC per month is being conducted, while the norm is to hold 2 VHND session per week. There are hardly any outreach sessions being undertaken.
- The use of MCTS for planning the VHND sessions were found missing and MCTS due list is not being generated.
- In Upper Subansiri, it was observed that the district is following a 'Date' based VHND planning. All the SHC conduct VHND only once a month, and the date is planned in advance and all the ASHA and ANMs are aware of the date. The minutes of the meetings were kept by the ANMs. Whereas none of this was observed in West Kameng.

Care of Mother and Child

1. Signage
 - There is lack of prominent display of signage in the hospitals.
 - The signages were found only for the JSY program, even then the display of entitlements was wrongly mentioned.
2. Help Desk
 - JSSK help desk was not present in any of the facilities of both the districts.
3. ANC OPD:
 - Space for ANC OPD is not present in the hospitals. In Upper Subansiri ANC checkup was being done mainly in the labour rooms. However, in West Kameng ANC is being done in the general OPDs of the PHC and CHC.

Figure 8 - Arrangements to maintain privacy of the patient during ANC, General OPD Dirang CHC.



- Privacy of patients during ANC was observed to be absent in most of the health facilities in Upper Subansiri. For instance, in CHC Taliha, there was no examination table and no privacy for the patient.
- Essential equipment such as functional BP apparatus, stethoscope, fetoscope along with the ANC register was also not available in delivery points of Upper Subansiri. However, in WK the health facilities offer better quality ANC service in terms of privacy and availability of other essential equipment. ANC records found to be maintained in almost all health facilities visited.
- Non availability of essential supplements such as IFA and Folic acid was observed as a universal phenomenon across the health facilities visited in the state.

4. Labour Room

- All the labour rooms were found to be neat and clean. Mostly the toilets of the labour room were also found to be neat and clean.
- In both the district hospitals there was one generator each, however, no health facility at sub district had any power back-up. Long power cuts were observed in both the districts which created hindrance in the management of emergency cases.
- Essential equipment, (such as delivery sets, blood pressure equipment, stethoscope, cord clamp and foetal ambu bag) were available in labour rooms of Delivery Points. The trays for the labour room were missing.
- Adequate supply of IV Fluids was available in all the health facilities. However, non-availability of essential drugs such as injection Oxytocin and injection Magnesium sulphate in the labour rooms, is a serious concern.
- Across the districts labour rooms were well –maintained. The labor tables were neat and clean. Kelly’s Pad was missing in all the labour rooms across all facilities visited in Upper Subansiri.
- Absence of standard treatment protocols:
 - The standard treatment protocols were not displayed in any of the labour room.

- Partograph not found in all labour rooms except in DH Bomdilla and the nurses working in the labour room did not know the importance of Partograph.
- On duty staff present in all the labour rooms were not aware of any infection prevention protocol e.g. the delivery instruments were reused after washing with plain water. Bleaching powder solution, colour coded waste disposal buckets, needle destroyer were not in use in any labour room of Upper Subansiri. Autoclave and sterilizers were not found in any of the labour rooms visited.

Laboratory Services

1. Lack of integration of lab technicians has led to a situation where all the laboratory technicians recruited under NVBCP program, perform only malarial parasite examination. As a result of this in Upper Subansiri, there was no provision of laboratory services below DH level health facility. All the ANC cases have to be referred to the district hospital for any laboratory procedures. However in West Kameng such services were available at PHCs and CHCs.
2. Laboratory records were also found to be well- maintained in most facilities visited.

Blood Bank

1. Blood Bank is functional only at State capital i.e. Itanagar (DH Naharlagun) The state also has two private blood banks.
2. State has potential to develop blood banks both in Upper Subansiri and West Kameng. It was observed that in both the district blood bank infrastructure was present, though nonfunctional due to lack of adequate human resources in Upper Subansiri, and on account of lack of blood bank license in West Kameng district.

Maternal Health Training

1. There are only two SBA training sites (GH Pasighat and GH Naharlagun) and only one BEMOC training site (GH Naharlagun) in the state. No SBA training conducted at district level.
2. The district has no say in nomination for the trainees. Nominations are centralized at the State level and results in inappropriate nominations. This was evident by the lack of SBA trained staff nurse/ANMs in most of the delivery points.

Record Keeping:

1. In all health facilities though ANC and delivery registers were being maintained but the accuracy of the records was not proper.
2. Across districts the system of admission notes and delivery notes (which would record the process of labour and its outcome) were absent.
3. Other important registers such as the referral in, referral out register and the referral slips are not in use.

Child Health

- Across districts it was noted that none of the on-duty staffs of the delivery points were trained in NSSK. Also none could properly enumerate the correct procedure of neonatal resuscitation.
- NRC is not present in both the districts.
- SNCUs are not functional across both districts.

Immunization Services

- Status of Cold Chain equipment – While across both districts Cold Chain equipment were available in most facilities (such as Ice Lined Refrigerator and Deep Freezer), however all equipment need maintenance and repair.
- Vaccine stocks availability, supplies and stock recording -
 - All vaccines under Extended Program on Immunization (EPI) except measles were available. Across districts measles vaccine is out of stock.
 - Vitamin A is also out of stock at all the health facilities that were visited.
 - Vaccines from district headquarter are supplied based on the indent from the PHCs and CHCs. But it was observed that there was no criteria for calculating the requirements and no schedule for indenting and delivery.
 - Vaccine stock register were available at all the stores visited but recording is not correct except at district headquarters. The knowledge of ANMs about maintaining the stock register is inadequate and field staffs have not been trained since many years.
- Vaccination of newborns were irregular and incomplete. Across the districts it was observed that there is no system for provision of zero dose of OPV, HepB, and BCG

(even in the district hospitals). The interaction with on duty staff of all the delivery points revealed that the vaccination of the newborns is being done only in the field during VHND. This leads to a one month gap in initiation of vaccination for the new born.

- Regular Immunization sessions at Health Facilities

- All CHCs, PHCs visited and DH are conducting regular sessions on fix days in a month.
- For sub-centers there is no fix schedule and ANM/HA visit from CHC/PHC following a circular from the MO in-charge. Not all villages are being visited as no micro-plans are being made.
- Due list was not observed at any facility that were visited thus across districts total number of immunized children is much lower than the expected.
- Immunization monitoring chart was not available at any of the facility visited.

- Recording and Reporting

- Immunization registers were found to be well maintained and corroborates with MCTS and HMIS reporting. But due list were not being generated and line listing of all beneficiaries was also not maintained.

- Program Management, Review And Monitoring

- There is no provision of regular program review with staff at all levels. At the district and PHC/CHC level poor use of data was observed for monitoring of the program performance.
- Monitoring visits plan was not available across districts and on-job skill support was also not observed.

- Delivery Of Outreach Services:

- Health system has a very passive approach to the immunization services in the district with regular sessions being conducted only at PHCs, CHCs and few sub centers.
- There was no plan to reach all the beneficiaries in the catchment areas on regular basis through a systematic approach.

- Staff Capacity And Supportive Supervision

- Training status of immunization staff was not uniform and there were gaps in the knowledge levels.

Suggestive Measures –

- It is critical that due lists are generated and line listing of beneficiaries is maintained. This must be linked with regular VHNDs so that missed children are provided service.
- Availability of all vaccines under EPI must be ensured, and stock outs must be avoided.
- There is a critical need of capacity building of field staff.

RBSK

- This is the first year of RBSK roll out in the State.
- Thirty four dedicated teams have been constituted for implementation of RBSK in the state. The general structure of team is 1 MO (AYUSH/ Dental), 1 ANM, 1 (HA/ Ophthalmic Assistant). State has also got approval for 3 zonal DEICs.
- The referral mechanisms under RBSK is as follows: (i) in case of any acute complain, the vehicle carrying RBSK team carries the student to the nearest health facilities, (ii) in case of chronic disease the school teachers given instruction to talk to the student' s parents regarding complaint concerned.

Family Planning

- Only in West Kameng, fixed day services were being provided for IUCD insertion. OCP distribution is being done at all facilities.
- Across districts PPICUD is not being performed.
- Very few MOs were found to be trained in IUCD, RTI and STI (especially in Upper Subansiri).
- In Upper Subansiri the staff at the CHCs informed that they perform IUCD insertion. However on verification of the registers it was found that no IUCD insertions have been done.
- Condoms were found to be in short supply across districts.

JSY

- JSY incentives are being given in cash across the state. Interaction with the hospital staffs revealed that JSY incentives are being given to the mother after discharge.

JSSK

- Poor implementation of JSSK is noted in both the districts visited. State level officials informed that IEC material for JSSK, along with a clear instruction to display JSSK entitlement at all health facilities have been issued to all districts. However, visit to both the districts revealed that JSSK displays in all the health facilities were inadequate.
- Free referral transport and free blood are not being provided. Referral transport provided includes drop back to home and referral to higher facilities but pick up from home is not provided as yet. Provision of diet under JSSK ranges from 'no diet' to 'cash payment for diet' to 'actually providing diet'. Basic diagnostic facilities were observed to be highly inadequate in the districts that were visited.

Maternal and Infant Death review

- 4 maternal deaths have been reported in the state in this financial year.
- Facility level MDR communities have been formed and are evaluating the facility level deaths.
- But Community level reporting of Female deaths in the age group of 15-45 and Community based maternal death review is not happening.

TOR 3. Disease Control Programs

Integrated Disease Surveillance Programme

- At present the weekly reporting status of District Surveillance Unit (DSU) is around 80% (for P-form), 65% (for L-Form) and 45% (for S-Form). Time lag observed in S Form is 3 to 4 weeks. This may be due to inadequate communication facility.
- Out-break reports are being generated.
- Connectivity and communication is appraised to be biggest hurdle for effective implementation of IDSP program in the state

National Vector Borne Disease Control Programme

Malaria and Dengue are most prominent public health issues and concern of the state. Recently few JE cases have been reported from the State.

Malaria

1. Programme implementation

- Action Plan for Malaria was available both at State and District level.
 - Irrational and in effective deployment of Malaria staffs are observed at all level health institution in the Districts.
 - Reorientation training of all level staff is essential.
 - IEC /BCC activity was not visible at any level in the districts
2. Passive Collection observed at DH, PHC and CHC. Sub Centres are not carrying out any malaria activity including Blood slide Collection.
 3. ASHAs are not at all involved in malaria activity nor are RDTs/anti-malarial etc. provided to them. Active collection is nil as the DHV (Domiciliary Health Visitors), RFW(Regular Field worker) including MSI(Malaria Surveillance Inspector) are not at all involved for collection blood slide in the community and they were observed to be involved in office /hospital activities.
 4. The Annual Blood Slide Examination (ABER) of State is >10% and it is declining over the years.
 5. RDT was not available in any health facility including ASHA kit in both the districts.

6. IRS Planning at PHC, CHC at District was not available. DMO (District Medical officer) informed that all IRS plan are prepared at State level and such plan are being communicated to the District. It was observed during the visit that Malaria matric indices (ABER/API) are not being considered while preparing IRS micro planning.
7. Both Upper Subansiri and West Kameng District has adequate manpower but it was observed that they are not utilized optimally.
8. Logistics:
 - DDT and Spraying pumps are available. Staff informed about the availability of PPE but failed to produce. In Upper Subansiri, staffs complained of non-functioning of some HC pumps.
 - Across districts Artesunate Combination Therapy (ACT) was not available in any of the health institutions.
 - RDT was not available at all the institutions where the team visited. Although the DH in West Kameng has procured some RDTs for their routine use from their RKS fund.
 - Micro slide was not available and lab tech informed that they used same micro slide by repeated washing.
 - Long lasting Insecticidal Net (LLIN) distribution is erratic and officials failed to produce plan for distribution of LLIN.
 - Inter-sectoral coordination not visible at any level for implementation of VBDCP.
- Due to non-availability of adequate diagnostic facility as well as drugs like ACT for Pf positive cases, malaria patient has to bear out of pocket expense amounting from Rs700-800 which is against the national policy.
- Though 96 LTs (regular & contractual) are in position, diagnosis is done at private labs in maximum facilities.
- Supportive supervision was observed to be lacking across all levels and it is a concern for the State as it is malaria endemic.

DENGUE

- The State has reported Dengue outbreak in 2012. In 2013, till date no case is reported. Out of the 3 sentinel surveillance Hospitals, DH Naharlagun is functioning. The other two are yet to be operational. Test kits are provided by Govt. of India.

National Leprosy Elimination Programme

1. State

- New Case detection rate 2009-10(1.78), 2010-11(2.32), 2011-2012(1.90) 2012-13(0.23).
- Treatment completion rate 2009-10(34.48), 2010-11(46.66), 2011-12(59.21), 2012-13(38).
- Budget (2013-14) - Allocation 47.89 Lacs; Expenditure - 16.04 lakhs

2. Disability Prevention and Medical Rehabilitation (DPMR) Status

- Across districts training of health staff in DPMR was lacking.
- Referral system for leprosy at District is available but case load was observed to be very low.
- Deformity Grade –II are referred to Private Hospital at Tezpur.
- No reconstructive surgery (RCS) has been conducted during the year.
- IEC plan available at State and District for implementation and visibility and implementation was observed to be very poor.
- MDT Stock is available in all level of health institution

Revised National TB Control Programme

- New Sputum Positive (NSP) case detection rate in the state is 87% in 2013 September' 13. It is 82% in West Kameng and 60% in Upper Subansiri district.
- Treatment Success rate in the state is 85%. Success rate in West Kameng and Upper Subansiri is 98% and 93% respectively in 2013.
- Default rate is below the expected rate of 5%.

- All key RNTCP human resource are in place and trained at both state and district level. But a Designated Microscopy Centre (DMC) should be established at Taliha CHC for better diagnostic coverage in Upper Subansiri.
- Proportion of registered TB patients with known HIV status is 75% in the state. It is 93% and 52% respectively in Upper Subansiri and West Kameng districts.
- Proportion of paediatric TB cases out of total new cases is 11% and 10% in Upper Subansiri and West Kameng district respectively.
- NIKSHAY registration status in the state is above 90% in the districts.
- The Intermediate Reference Laboratory (IRL) for diagnosis and follow-up of drug resistant TB is functional with dedicated and trained staffs at State hospital Naharlagun.
- 1 GeneXpert machine has recently been installed at IRL which will be catering to not only to all the districts of the state but also the neighbouring districts of Assam.

TOR 4. Human Resources and Training

Generation of Health Human Resources

1. Doctors and Specialists - As of now the State does not have a medical college and thus there are challenges in securing doctors and specialists.
2. Staff Nurses and ANMs - For nursing education there is one ANM training institute at District Hospital Pasighat and one private GNM training institute at Ram Krishna Mission Hospital in Itanagar. At District Hospital Daporijo (Distt. Upper Subansiri) a new ANM/GNM training institute has been constructed and new batch is proposed to start from next financial year.

Availability:

- Since inception of NRHM state has recruited 4 Specialists, 85 Medical Officers (including AYUSH Medical Officers), 15 Dental Surgeons, 194 Staff Nurses, 62 Laboratory Technicians, 20 Male Health Workers, 4 Refrigerator Mechanics, and 2 Statistical Investigators.
- State's efforts to increase strength of its Medical Officer cadre is commendable but at the same time Specialists recruitment is a cause of concern. The 4th CRM also had made this observation and recommended a drive for Specialists recruitment, which seems to not have been undertaken.
- In addition to medical personnel State has also recruited program management staff (6 at SPMU level, 56 at DPMU level including DPMs, DAMs, DDMs, and 168 Staff at BPMU level including BAMs, BDMs). It appears that many of these recruitments were not need based and rather dependent on sanctions provided by Govt. of India.
- For improving availability of Specialists there is an opportunity for State; as there are 60 specialists who are working as General Duty Medical Officers (GDMOs) at various PHCs and CHCs, who could be posted at First Referral Units and District Hospitals.
- One of the reasons for poor availability of HR, put forth by the State, was the budget crunch that State is facing post recommendations of 6th Pay Commission.
- Given its tight fiscal position and high expenditure on non-plan components it is very important that State undertakes rationalization of its existing Human resources as a

priority activity. Some of the measures that State could undertake in this regard are following:

- Map out all specialists available with State and post them at District Hospitals and First referral Units.
- Ensure that as a policy measure State actively discourages posting of ANMs at various District Hospitals and monitors the presence of ANMs at sub-centers.
- Ensure that all lab technicians perform the basic blood examinations across all the facilities (irrespective of the program under which they have been recruited).

Sanctioned Posts

- It was observed across the State that exact number of sanctioned posts against a facility was not available.
- Even during the State briefing for CRM, it was informed that there are no vacancies in the State against sanctioned positions. State could provide neither facility wise nor cadre-wise breakup of sanctioned positions.
- State contends that its existing sanctioned positions are filled up and do not have vacant posts. However the State must consider increasing the sanctioned posts at each level of health facilities, so as to meet its demand of service provision.
- Table below details the existing HR and requirement as per IPHS.

Table 5 Availability of Health Human Resources in Arunachal Pradesh

Discipline	Arunachal Pradesh	
	Existing	Shortfall
Medicine	7	78
Surgery	8	77
Obs. & Gynae	11	76
Paediatric	7	80
Anaesthesiology	7	78
Ophthalmology	12	58
Orthopaedic	5	11
Pathology	5	13

Discipline	Arunachal Pradesh	
	Existing	Shortfall
ENT	3	13
Psychiatric	2	13
Dermatology	1	14
Forensic	1	14
Microbiology	1	14
Epidemiologist	1	16
GDMO (Allo)	419	334
MO (AYUSH)	67	130
Dental Surgeon	39	31
Staff Nurse/ GNM	233	2367
Lab. Tech	94	167
Radiographer	28	114
Ophthal. Asstt.	26	44
ECG. Tech.	5	13
OT Tech.	2	247
Pharmacist	201	63
Blood Bank Tech.	0	15
ANM	419	365

Source – NRHM Arunachal Pradesh

Deployment

- It is evident from field observations that desired level of rational deployment of its existing HR has not been undertaken rigorously by the State.
- A glaring example of such mismanagement was observed in Upper Subansiri where one LSAS trained medical officer posted at District Hospital has now been made the DRCHO. Given the fact that DH is the only facility where EMOC is available and next referral facility is 14 hours away; deployment of a practicing clinician to program management should be reconsidered.

- Across districts it was observed that while SHCs were unmanned (being managed by pharmacists, MPWs, HAs), the ANMS were attached at the level of DH, CHCs and PHCs.
- While there may be a requirement of posting of ANMs at high level facilities, however, the service provision at SHCs should not get neglected in the process.
- Also such non-availability of ANMs usually affects the mentoring and support to ASHAs at village level.

Workforce Management:

1. Human Resources Policy – While there is a policy for its regular cadre, the State lacks a clearly defined HR policy for its contractual staff. As a result contractual recruitments are usually done as per the emerging needs of the program. Continuation of all such posts are more dependent upon the funds sanctioned in PIP rather than on the value addition that these posts bring in to the program implementation.
2. Incentives - State has not institutionalized any incentives for its staff working in the difficult areas. This is leading to demotivation of staff posted in difficult areas. Such incentives also gain significance in view of the disparities that exist in the salaries between regular and contractual workers. For instance among staff nurses, a contractual SN earns 16,000/-whereas regulars draw a salary of around 42,000/-.¹
3. An opportunity for State is to ensure that incentives allowed by Govt. of India is provided to its staff. For instance, State could consider incentivizing staff nurses and ANMs who assist in conducting safe home deliveries as it has been allowed by Govt. of India (but has not been planned in the DHAP by the district).
4. Appraisals - Performance appraisal for contractual as well as regular staff is not in place as of now and as a result blanket increments are given. It is important that such appraisals are based on fixed output criteria and transparent, so that better productivity and retention could be ensured.
5. There are few positive steps being taken by the State. It has finalized the HR handbook for the contractual staff and intends to adopt it in current financial year. Also, for assessing the competency levels of its paramedical staff the State is undertaking an assessment for ANMs and it would be used to further improving their skills.

¹ Report on 'Arunachal Pradesh Public Health Workforce – Issues and Challenges', by RRC-NE and NHSRC (Oct 2012)

Training & Capacity Building:

- While annual training plans (ATPs) are being prepared by the State, the centralized nature of planning with practically no need assessment and participation from district level is an area of concern which needs to be addressed.
- For instance, nominations for LSAS, BEMOC, EMOC, SBA etc. are done at State level, and these do not take into account the requirements at the facility level. Further many times the trained manpower is not posted rationally thus leading to no improvement in the range of service delivery.
- It is important that districts be needs of the districts be assessed while preparing the ATPs AND State may also consider to decentralize trainings (such as SBA, IUCD etc.) at district level.

TOR 5. Community Processes and Convergence

Panchayati Raj Institutions (PRI)

- The institutional mechanisms available were not being leveraged for engagement of PRI members. It was observed that involvement of PRIs was more dependent on initiatives of ASHAs.
- Regular orientation program for PRI members was not in place and State does not seem to have a plan for the same.
- In West Kameng, some villages were observed to have ‘gaon boodhas’ who are elders respected in the community having more say in the village affairs, were involved in community initiatives.

VHSNCs

- Out of 5589 villages, 3772 have constituted VHSNCs.
- It was observed in Upper Subansiri district, that there are frequent creation of ‘segments’ within existing villages resulting in fragmentation of populations. Most of these segments then demand an ASHA for their population and this has led to multiple ASHAs within one VHSNC.
- It was also observed that ASHAs have poor control over their joint account with PRI members.
- A proxy measure to assess the functionality of VHSNCs is their fund utilization. Interaction with ASHAs revealed that for 2012-13 all ASHAs got only 5000/- as their VHSNC deposit as previous year expenditure was less and only Rs. 500/- per VHSNC has been sanctioned this year owing to poor utilization of last year’s money.
- ASHAs seem to be stuck in a vicious cycle of not being able to utilize the funds (due to non-cooperation of PRI members) leading to consequent reduction in fund allocation for the next year and poor availability of funds.

Suggested Measure -

- If ASHAs report a genuine difficulty in operating joint accounts with PRI then some alternate measure e.g. joint accounts between ASHAs and their respective facilitators could be considered.

VHNDs

- The concept of VHNDs and its role in provision of community level preventive and promotive care has not percolated and been understood at the district and sub-district level.
- While VHNDs are being conducted the exact role envisaged for VHND was not observed.
- The quality of VHNDs is not being monitored. Supportive monitoring of VHND sessions is not being carried out either at district level, or at sub-district level (by ASHA facilitators, and ANMs)
- At SHCs no micro-plans were being prepared for conducting VHNDs and it was up to ASHAs, AHSA facilitators and ANMs to organize VHND as per their convenience.
- ASHAs are AWWs to whom we met were also not very much clear about services to be provided during these sessions.

ASHA Training & Performance:

- Out of 3862 selected ASHAs, 3682 ASHAs have been trained up to 1st module, 3606 ASHAs trained up to 4th Module, 3643 ASHAs are trained up to 5th Module and 3135 ASHA has been trained in 2nd round of 6th & 7th Modules.
- Across districts ASHAs claimed that trainings on modules 6&7 have been completed. All the ASHAs had uniform.
- However the ASHAs interacted with, though generally were aware about the trainings given to them they were not able to recall the messages received in the trainings. They were not able to produce the training material supplied to them.
- It was observed that ASHAs were largely involved in RCH activities. However due to less dense population there were very few ANCs to follow up and escort, leading to meager incentive generation from this activity.
- Other major source of incentive was observed to be immunization sessions (during VHNDs), but none of the ASHAs reported that these sessions happen regularly or according to a fixed plan.
- In disease control programs ASHAs are acting as DOTS provider and are getting the incentives attached with it.
- Currently use of the ten indicator-based performance monitoring system to monitor ASHA performance has not been institutionalized. Although ASHA facilitators have been sensitized about it.

- A regular mechanism for refilling of ASHA drug kits was absent across the districts. Similarly the mentoring mechanism at SHC level was (through ANMs) was lacking.
- ASHA drug kit refill was not on the basis of the needs and requirement of ASHA and it was rather dependent on the supplies available at the PHC/CHC.
- It was also observed that ASHAs did not have proper drug 'kits'. They were using polyethylene bags/cardboard boxes as their kit.

ASHA Incentives & Support Systems:

- It was observed that ASHAs incentives range from 600 to 1200 per month.
- Some of ASHAs working more than three years are not aware about other incentives/entitlements other than RCH activities. In Upper Subansiri all incentives are paid in cash to ASHAs, and 'immunization sessions' are the main source of incentives.
- Though all the ASHAs had bank accounts they preferred receiving the incentives in cash. One reason for such preference is that most of these accounts are in banks at district headquarters and travelling costs are usually higher than the incentives which are deposited there.

Community Monitoring:

- State has not initiated efforts to put in place measures for social audit of facility or community based services and thus community monitoring is not visible at district or sub-district level.

Convergence:

- Across districts convergence between ASHAs and other field level functionaries was not observed. ASHAs in Upper Subansiri reported conducting monthly village cleanliness drives, though this could not be verified.

TOR 6. Information and Knowledge

Health Management Information System (HMIS):

1. Out of 17 districts of Arunachal Pradesh, 16 districts follow facility based reporting of HMIS data. However, out of total 591 facilities in the state 514 (87%) facilities are actively reporting HMIS data.
2. Utilization of data at State/ District/ Facility level: It was observed that while HMIS data is available at state and district level but the utilization of HMIS data is sub-optimal. Consolidation of data on a regular basis, generating information and using that information for improving service delivery of the facility was not adequately understood at facility, block and district level.
3. HMIS as planning tool: Though, program-wise performance targets have been fixed by district during preparation of its DHAP, facility-wise targets have not been set. The methodology for arriving at such targets has also not been spelled out by the district. Further the 'target setting' seems like one-time exercise taken up during PIP preparation and no mid-term or end-term reviews are performed by the district.
4. Availability of Registers etc.: Standardized registers are not being used at various health facilities. This results in inappropriate and incomplete record maintenance in the health facilities.

Mother and Child Tracking System (MCTS):

- Progress of MCTS implementation in the State needs wide improvement in terms of registration, timely service delivery and updating the service delivery status.
- Data reported on MCTS Portal depicts that during 2013-14, only **36.27%** pregnant women and **29.78%** children have been registered on the system so far (status as on 4th November, 2013).
- It was seen that while **856** pregnant women registered in MCTS with LMP in November, 2012, only **2.8%** of pregnant women have received all four ANC services.
- Similarly, it was seen that **403** children were registered on MCTS with date of birth (DoB) in September, 2012. Ideally all the vaccinations should have been received by the children's by now out of which **82.88%** received all doses of BCG whereas only **32.75%** received all doses of OPV, only **34.24%** received all doses of DPT and only **11.66%** received full immunization.

- Uploading of validated phone number of ANM and ASHA on MCTS portal is a major concern. For instance only **0.63%** of all the numbers that are registered for ASHAs have been validated.
- **Field Observation:** Field visit to the district revealed that, the filled in MCP cards are being sent to the district headquarter for entry in MCTS software. The MCTS numbers once generated are filled in the MCP card and the card are returned to the beneficiary. There is no process of generation of MCTS due list and sharing it regularly with the field staffs such as ANMs and ASHAs.

TOR 7. Health Care Financing

Finance and Administration:

1. Status of Human Resource:

- All the posts are in place at State level i.e. Director Finance, State Finance Manager, State Accounts Manager, District Accounts Manager and Block Data Accountant.
- Delegation of Financial Power from State Health Society to District Health Society and DHS to down the line has already been issued.

2. Status of Release, Utilization and Unspent Balance under RKS/AMG/Untied Funds:

- Status of Release, Utilization and Unspent Balance as on 2012-13 and 2013-14 under RKS, AMG and Untied Funds at DHS level. The year wise breakup is as under:

Table 6 Status of Release, Utilization and Unspent Balance under RKS/AMG/Untied Funds

Rs.in lakh								
Particulars	2012-13				2013-14 (Up to September, 2013)			
	Opening Balance	Release	Expenditure	Unspent Balance	Opening Balance	Release	Expenditure	Unspent Balance
Corpus Grant to RKS	1.99	8.03	8.93	1.09	1.09	1.88	0.77	2.2
AMG to PHC/CHC/SC	0.75	3.54	4.24	0.05	0.05	0.89	0.1	0.84
Untied Funds to PHC/CHC/SC	0.51	10	10.32	0.19	0.19	0.42	0.19	0.42
Total	3.25	21.57	23.49	1.33	1.33	3.19	1.06	3.46

3. Low/Nil Expenditure during 2013-14 up to August, 2013

SHS Level

- Out of the approved annual SPIP of Rs.1827.12 lakh, reported expenditure is only Rs.281.97 lac (up to August 2013) under RCH Flexi pool i.e. only 15.43%.
- Out of the approved SPIP of Rs. 2186.76 lakh, reported expenditure is Rs. 339.81 lakh up to August, 2013 under NRHM Additionalities i.e. only 15.54% of the approved PIP.

Area of Concern

- Low/Negligible expenditure has been reported by the state on core activities i.e. Maternal Health (0%), Family Planning Services (0.37%), JSSK (6.72%) and Sterilization & IUD Compensation and NSV Camp (3.12%) of the approved PIP.
- The State has reported low expenditure on nonnegotiable activities i.e. ASHA (7.20%), Untied funds (20%), Annual Maintenance Grants (4.10%), and Corpus Grants to HMS/RKS (12.91%) of the approved PIP.
- The State has reported low utilization of funds under Procurement (5.20%) and Hospital Strengthening (2.04%) of the approved PIP.
- The state has reported utilization of Rs. 188.17 lakh under New Construction /Renovation and Setting Up and Rs. 17.31 lakh where there is no provision in the approved PIP.

DHS Level

General Observation

- Out of the approved SPIP of Rs. 78.42 lakh, reported expenditure is Rs. 30.92 lakh up-to second quarter, 2013 under RCH Flexible Pool i.e. 39.43% of the approved PIP.
- Out of the approved SPIP of Rs. 33.79 lakh, reported expenditure is Rs. 64.26 lakh up-to second quarter, 2013 under Mission Flexible Pool i.e. 190% of the approved PIP.

RKS/HMD

- 185 out of 188 RKS has been registered in the State. There three new RKS which needs to be registered but fund has not been released to new one.
- Separate statutory audit of RKS has not been taken place since 2007-08. Auditors have been appointed for the same but audit has not yet started anywhere in the State.

Fund Flow:

- **Status of CPSMS**
 - The CPSMS implementation in the State is under process. Till 31st October, 2013 agencies registration has been completed 214 block level. The fund to the beneficiaries is yet to be transferred through DBT.
- The State is releasing funds to the Districts in a pool SPIP and Districts are releasing funds activity wise to blocks as per DHAP.

- Holding time of funds more than one month at State level and 10-15 days at district level.
- **Pending Utilization Certificates:**
 - There is pending Utilization Certificates of Rs 4.97 crore under Mission Flexible Pool as per Audit Report, 2012-13. The same pending Utilization Certificates would be submitting with Audit Report, 2013-14.
- Status of Advance: The advance detail as per Audit Report, 2012-13 is as under:

Table 7 Status of Advance

Name of programme	Advance as per AR, 2012-13 at State (Rs in lakh)	Unspent Balance as per AR, 2012-13 at DHS	Difference in Advances
RCH Flexible Pool	12.27	26.03	-13.76
Mission Flexible Pool	4.70	51.43	-46.73
Routine Immunization	1.11	2.06	-0.95
PPI	0.00	0.00	0.00

The above difference needs to be reconciled by the State Health Society with DHS.

State Share Contribution

There is a shortfall of Rs. 8.38 Crores under State share till date. Against the desired contribution of Rs. 51.37 Crore, the State has contributed Rs. 42.99 Crore as on date.

Table 8 State Share Contribution (Rs. In crore)

Year	Amounts required on basis of releases	Amount Credited	Short/ (Excess)
2007-08	6.45	0.00	6.45
2008-09	4.32	4.00	0.32
2009-10	7.8	4.00	3.8
2010-11	10.8	9.99	0.81
2011-12	9.79	15.00	-5.21
2012-13	6.12	10.00	-3.88
2013-14	6.1	0.00	6.1
Total	51.38	42.99	8.39

Accountability

1. Statutory Audit, Concurrent Audit, and AG Audit

The State is conducting audits i.e. Statutory Audit on regular basis, Concurrent Audit on time on monthly basis but audit report is being submitted to the State on quarterly basis.

- **Statutory Audit**

Statutory Audit, 2012-13 is already completed on time as per GoI guidelines but statutory audit report has not been presented in GB meeting. The State has not yet sent audit compliances for 2011-12 to GoI. Major observation as per audit report, 2012-13 as is under:

- **RNTCP**

As per audit report, 2012-13, there is over expenditure reported against approved PIP under RNTCP. Details are under:

Table 9 Expenditure under RNTCP (Rs. In lac)

Name of Activity	Approved PIP, 2012-13	Actual expenditure incurred
IEC/BCC	25.00	43.28
Vehicle Maintenance	21.75	29.87
Misc. expenditure	65.60	70.58

- **Concurrent Audit**

The Concurrent Auditors have been appointed for 2013-14 by the SHS and DHS. First quarter concurrent audit is completed at SHS and DHS and report submitted by the auditor but action taken yet be taken. The executive summary of concurrent audit of 2013-14 has not been sent to GoI by the State.

- **AG Audit**

AG Audit has been completed in the State up to 2007-08 and action taken report submitted by the State.

2. Statutory Compliances

As reported District and State Health Societies is not registered u/s 12A of the Income Tax Act, 1961 for claiming exemption under the relevant. The State Health Society has also filed income tax return since incorporation as they are not registered u/s 12A, they are liable to be

taxed at basic 30% of the receipt from all sources. The SHS is deducting TDS and depositing on time and also filing TDS return on time. District West Kameng is not deducting TDS on salary. The detail is as under:

Table 10 West Kameng – Status of TDS Deduction

Contractual Employees	Amount for the year, 2012-13	TDS not deducted @ 10%
DHS/CHC/PHC	1252870.00	125290.00
RNTCP	336300.00	33630.00

- There is utilization of earned interest Rs. 4.95 lakh under Programme Management during the year, 2012-13. In current year, we have not observed any utilization out of earned interest.

3. Diversion of Funds

State has diverted funds Rs. 45 lac Mission Flexible Pool to NVBDCP at State Health Society during the year. Rs. 3.20 lakh has been diverted during the year from Mission Flexible Pool to Routine Immunization at the District Health Society, West Kameng.

Financial Management

1. Status of Maintenance of Books of Accounts:

Books of Accounts are properly maintained as per Finance and Accounts Manual at SHS/DHS Level as they are maintaining books of account on Customized Tally ERP9 software and books of accounts has been maintained manually till 10th November, 2013. Hence, observations related to the maintenance of books of accounts are based on manual accounts as well as tally ERP9:-

2. Type of books of accounts maintained by the State Health Society/DHSs is as follows:

- Cash/Bank Book
- Ledger
- Grant Receipt Register
- Cheque Issue Register
- Fixed Assets Register
- Advance Register has not been maintained by the State.

3. Cash/Bank Book

- It was seen that cash books were updated on tally ERP9 but manual cash book were updated till 30th June, 2013 by the SHS.
- It was seen that cash books were updated on tally ERP9 but manual cash book were not maintained by the DHS.
- It was seen that cash books were updated by the CHCs/PHCs.
- Single cash book had been prepared for RKS, RCH and Mission Flexible Pool by the CHC and PHCs.

4. Bank Reconciliation

- Bank reconciliation has not been prepared by the State Health Society, the details are given below:

Table 11 Bank Reconciliation – Arunachal Pradesh

Programme	Balance as per Cash Book as on 30.09.2013	Balance as per Pass Book as on 30.09.2013	Difference in Rupee (Rs. In crore)
RCH	39.13	35.35	3.78
MFP			
RI			

- Bank reconciliation has not been prepared for the period April to October, 2013 by the NVBDCP and RNTCP at State Health Society.
- Bank reconciliation has not been prepared for the April to September, 2013 by the NVBDCP at District.
- Bank reconciliation has not been prepared by PHC Bhalokpong for April to September, 2013
- Single bank account has been maintained by the PHC- Bhalokpong for RKS, RCH, Mission Flexible Pool.

5. Vouchers

The vouchers of cash/bank are properly maintained at State and, District but vouchers are not serially numbered at SHS and DHS, DH, CHC and PHC.

6. Journal

Manual Journal has not been maintained by the SHS and District. Journal has neither been maintained by CHC-Dirang, PHC Bhalokpong and Singsung nor have journal entries been passed in the books of accounts.

7. Status of e-transfer

The e-transfer has been implemented in the State up to block level. The State is sending funds to Districts and Districts are sending funds through electronic transfer.

8. Status of customized Tally ERP9

The customized Tally ERP9 has already been implemented in the State as well as in the District. The State and Districts are maintaining books of accounts on tally which are updated till 10th November, 2013. Tally ERP9 is yet to be implemented at the block level.

9. Procurements Procedures

- State and Districts are followed GFR 2005 for procurement. There is limited tender is applicable for procurement less than 25 lakh and more than 25 lakh will be applicable open tender as per GFR 2005. In the State, procurement is decentralised.
- At all level joint signatory is required for funds disbursement as the delegation of financial power.
- One contract worth of Rs.200 core for construction of hospital has been given to agency called HSSC.
- One contract has been given to Rural Development which is State Govt. organization for construction of sub centre.
- Procedure for payment to beneficiaries: At all level beneficiaries are being paid in cash.

10. Block Health Action Plan

Copy of DHAP has not been provided to Block CHC and PHCs by the District Health Society.

11. Treatment of Release as Expenditure

Release under AMG and Untied Fund has been treated as expenditure at PHC Bhalokpong and PHC Singsung

12. High Cash Balance

Cash balance Rs. 19,300.00, at PHC Bhalokpong, Rs. 11500.00 at PHC Shingsung and Rs. 45000.00 at CHC Dirang has been found for making payment to JSY beneficiaries where the limit is Rs. 5000.00 as per the guidelines.

13. Stale Cheques

Stale cheques of Rs. 50,491.00 have been found as on 31.03.2013 as per bank reconciliation of NVBDCP at SHS. Detail is as follows:

Table 12 Status of Stale Cheques

Cheque No.	Date	Amount in Rs.
185974	30.07.2012	11254.00
185967	2.07.2012	4862.00
185944	31.03.2012	3090.00
185968	31.03.2012	11285.00
510062	30.06.2010	10000.00
393184	18.12.2012	10000.00
Total -		50491.00

14. Group Bank Accounts

Group bank account has not been implemented at State Health Society and District. The SHS has one bank account where they are receiving funds from Govt. of India for RCH Flexible Pool, Mission Flexible Pool, Routine Immunization and PPI. The State should have one group bank account where state will receive the fund for NRHM including NDCPs and should have sub group bank account for each programme after than fund will be transferred the sub group bank accounts of the concern programme. In the same manner group bank accounts should be implemented at the District level.

15. Utilization of State Share

We have observed that the State has utilized funds Rs. 5.82 crore during 2012-13 for RCH Flexible Pool, PPI and NDCP in approved activities.

16. Monitoring and Evaluation Methodologies adopted by the State to improve management

The State Health Society had conducted training on financial management and monitoring in 2012 and State and DHS analysis their FMR if any low/high utilization is reported against the

approve SPIP or DHAP then sends reminder to the District or district to block level and District-West Kameng also visits the block check expenditure of block on quarterly basis.

17. Training on Finance and Accounts Professional

There was conducted one training by the State on 6th October, 2012 during the financial year, 2012-13 at District level. No training has been conducted by the State during this year as there is no approval in the PIP, 2013-14.

18. Unspent Balance under RCH-I

There was unspent balance under RCH-I which is already in 2010-11, so there is no pending against RCH-I.

Key Recommendations

1. Advance Register should be maintained for all kind of advances block level. Further, State is required to reconcile the advances between State and DHS.
2. Bank Reconciliation should be prepared on monthly basis at SHS, PHC and CHC.
3. Journal Entries must be passed in manually in the books of accounts at Block level for bills and SOE.
4. Budget Vs. expenditure must be analyzed to know the exact variance of budget and expenditure so that proper steps can be taken to improve the utilization of funds.
5. Financial Monitoring is required by the DHS to block level in the case of high utilization against DHAP.
6. Income Tax provision for deduction of TDS must be followed by the DHS for statutory requirements.
7. State Health Societies and District Health Society should be registered u/s 12A of the Income Tax Act, 1961 for claiming exemption under the relevant.
8. FMR/SoE should be analysed by the DHS on time so that corrective steps could be taken to increase the expenditure in the case of low utilization.
9. Bank account should be separate for each programme. Funds of State Health Programme should not be mixed with funds of NRHM, therefore, State and District is required to group bank accounts and sub bank account.
10. Diversion of funds is not allowed from one programme to another programme as per the GoI.

11. RKS should be registered
12. State is required to deposit matching state share in bank account of SHS.
13. Stale cheque should be reversed from the books of accounts.
14. Maximum cash in hand is allowed Rs.5000 at block level.
15. Cash payment to JSY beneficiary should be avoided.
16. Copy of DHAP should be provided to block by DHS.

TOR 8. Medicine and Technology

Drugs, Equipment and Diagnostics:

- State budget for drugs in 2013-14 is Rs 10 Cr. Under NRHM Rs 8.40 Cr. has been approved in the year 2013-14. This amount approved under NRHM is for JSSK drugs and IFA.
- Status of EDL in the state: At State level Essential Drug List (EDL) is available. However, facility specific EDLs are yet to be developed.
- Drug availability in the Health Facilities:
 - Gaps were observed in Supply chain management of drugs from State to District and further to Health Facility level.
 - Shortage of essential medicines was observed in most of the facilities visited.
 - In West Kameng district Ayurvedic drugs were in short supply at most of the co-located facilities. Though homoeopathic drugs were available in DH Bomdilla (West Kameng district) the whole range of essential homoeopathic medicines was not present.
 - High out of pocket expenditure was being incurred by patients on drugs and diagnostics.
- Diagnostic Facilities:
 - Diagnostics facility in the health facilities visited found to be highly inadequate. Especially in Upper Subansiri district a very limited range of diagnostic facilities was available. For instance at DH Daporijo, X-ray facility was not available due to lack of technician; USG was not being done and only basic blood investigations were available.
 - Also it was observed in Upper Subansiri that, at sub-district level none of the facilities provided blood or sputum investigations and interaction with patients revealed that as high as Rs.1000/- was being spent on travelling to District headquarters for basic lab investigations. However, in West Kameng district hospitals were providing all basic diagnostic facilities except USG.

Procurement

- At State level procurements are being done through open tendering (i.e. financial bid and technical bid) process.

- Procurement at State level is not coordinated with the demands and needs of the district. Many a times districts are not aware about the supplier and this affects follow up issues arising at district level. There were instances reported by districts where equipment was supplied to hospitals and no one turned up to install them.

Suggested Measure

- At State level, the final payment to be made to the supplier upon receipt of the certificate of completion from the district.
- At facility level, a log book of all major equipment to be maintained to enable understanding the utilization pattern and breakdown period.

Storage & Supply

- There are three sources of drugs supply available in the state - State supply, NRHM supply and procurement of drugs through untied funds (provided by state) by a district level committee.
- However, no coordination observed between multiple supply channels for drugs.
- At State level no effort has been made to assess the utilization pattern of drugs/supplies in facilities/ districts which could ensure rational procurement. Thus supply of drugs at facility level was not as per the needs of the facility. Even in the DH West Kameng IFA was found to be in short supply.
- In Upper Subansiri it was observed that drugs/utilities that supplied to the facilities are very close to expiry. Almost every health facilities that were visited had expired medicines in their stock.
- District Medical Store in West Kameng had separate storage for supplies of NRHM and State drugs.

TOR 9. National Urban Health Mission

Urban Slums

- Primary Health Care in urban slums managed through District Hospitals and General Hospitals, managed by state Govt. However, there are only two urban PHCs located in Papum Pare district and East Siang District. No urban PHCs are present in any of the other 15 District Head Quarters.
- Implementations of key national programmes such as JSY, JSSK, DCP, NCDs are being covered under NRHM till now.
- Urban Local bodies are not involved in delivery of primary Health Care. There is no effective involvement and coordination between different government agencies.
- No targeted activities being carried out for urban slums. There are hardly any slum areas in the State. There may be pockets where low income group population reside. There are only two community based organizations (CBOs) existing in urban slums for health care service delivery.

Implementation of National Urban Health Mission in the State

- Only PIP for state capital has been prepared and has been submitted.
- Slum Mapping in the State has been done by Department of Urban Development and Housing, Govt. of Arunachal Pradesh.
- NUHM office (SPMU) has been set up in one of the vaccine cold chain room as there is no other vacant room available and the present room for cold chain is not used for any cold chain activity. Two staff have been earmarked for implementing NUHM at state level.

TOR 10. Governance and Management

Program Management:

- Coordination between NRHM and State Directorate – Poor coordination observed between State Health Directorate and NRHM. This was evident during the State briefing to CRM team wherein the NRHM nodal officer presented the level of program implementation and no details for other program components were not presented.
- There is a need for coordination between various programs, including the disease control programs. This will boost not only program implementation but also cross learnings.
- Structure and Functioning of SPMU: The state level PMU is under staffed. The State Nodal Officer for NRHM also functions as State Programme Officer for multiple programme components (such as Maternal health, Child Health, Family Planning, MMU, Referral transport, Infrastructure and Civil works and Procurement) and this has resulted in inadequate programme management support to districts. A weak SPMU has effect on functioning of DPMUs and overall program implementation output.
- Structure and Functioning of DPMUs – The DPMUs were well staffed and were found working in tandem with other program officers at district level. However, the DPMU staff have not received any training/orientation; this was evident with the lack of program knowledge.

Institutional Mechanism:

- District Health Society (DHS) – DHS have been constituted and meetings are held under the chairmanship of district collector. However in Upper Subansiri, frequency of these meetings were infrequent and decisions arrived at were not available (minutes of the meeting). This was not the case in West Kameng.
- Overall impression is that these meetings were ad hoc and instead of assessing the existing systems holistically, they decide upon pressing issues.
- District Planning Process – District Health Action Plans have been prepared by the districts. Districts have also used HMIS data to assess its performance. But the whole effort of such district planning becomes futile when it is not linked with the financial

sanctions from state or when it fails to feed in to state PIP, which seems to be the case.

- Rogi Kalyan Samitis (RKS) – The concept of RKS seemed to be not clearly understood by the district officials as well as the facility in-charges. During field visits to various health institutions it was noticed that regular RKS meetings to plan and execute patient welfare activities were not being taken up.
- Overall impression – Institutional support mechanisms have been put in place however, there is much desired for their improvement in order to bring about improved delivery of patient friendly services.

Supervision & Monitoring:

- Supervision And Monitoring – An efficient mechanism of supervision and monitoring is critical in ensuring that provision of existing services are maintained and timely intervention can be taken up to mitigate any emerging challenges.
- Practically this can happen by rigorous visits to health institutions (at-least to health facilities having higher case load) and hands-on training to existing staff.
- A severe lack of such monitoring and supervision was noted and this has resulted not only in poor program implementation but also disorientation esp. amongst the field staff regarding activities undertaken under NRHM.
- It is possible that local realities could alter implementation of various interventions but such deviations need to be monitored and must be ensured that they do not hamper the envisaged goals. For e.g. ASHAs are being paid incentives in cash (and ASHAs are preferring such mode of payment), but such payments are not being monitored closely by the districts and thus it cannot be ensured that pilferages are not occurring.
- Lack of regular monitoring has also led to a non-uniformity in the understanding of NRHM components and latest clinical protocols at field level.
- Therefore an inadequate level of clinical care is not being provided by field level staff. For e.g. at none of the health facilities AMTSL protocols is being followed.
- Inadequate frequency and lack of a fixed monitoring plan has also led poor handholding of block level functionaries.
- Further geographical constraints, poor communication facilities, lack of steady internet at block and sub-block level, poor road conditions and minimal attempts at innovative measures alienates the sub-district functionaries.

Key Recommendations

Immediate

1. A fully functional and robust coordination mechanism be put in place between the State Health Directorate and the SPMU.
2. At all levels in the State an adequate monitoring and supportive supervision mechanism, not only for programme management but also for disease control programs, must be ensured.
3. State may ensure availability of entire range of services and human resources, at those identified health facilities, which are having sufficient infrastructure.
4. The infrastructure up-gradation of the health facility must be as far as possible need-based and compulsorily with the involvement of the DMO.
5. Across State assured referral services must be provided and local vehicles could be sourced-in and empanelled for this purpose.
6. ASHA training mechanism should be energised, ensuring not only proper training but also supplies (drug kits, training material, uniform etc.) to both existing and newly recruited ASHAs.

Short Term

1. State must ensure that state share is timely deposited in State Health Society account.
2. Meetings of DHS, RKS etc. to be conducted at regular intervals and minutes be drawn.
3. Community level outreach services through ASHAs and ANMs should be ensured across all Sub-centers.
4. Incentives should be provided to all personnel serving in difficult areas.
5. Program orientation and induction training of SMPUs, DPMUs and other Program Officers should be ensured.
6. There should be adequate display of IEC/BCC materials at all facilities.

7. Proper utilization of funds must be ensured and budget versus expenditure pattern must be analyzed for the purpose.
8. Bank Reconciliation should be carried out on a monthly basis at SHS, PHC and CHC.
9. State should ensure timely submission of the FMR along with physical progress.

Long Term -

1. State needs to increase the sanctioned number of posts at all levels.
2. Special drive for recruitment of specialists needs to be carried out.
3. A comprehensive drug supply chain management should be put in place by the State.
4. A comprehensive and need based procurement plan should be drawn up by the State, which addresses the facility based requirements and also ensures the accountability of the suppliers.
5. More ANM/SN training centres are needed in the State. Also a pool of master trainers must be created to address the training needs of the State.
6. Disease surveillance and reporting must be improved upon.

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