The report is based on 7th CRM visit carried out in Ri Bhoi and West Garo Hills of Meghalaya from 9th to 15th November 2013.

7th COMMON REVIEW MISSION
MEGHALAYA
9th to 15th November 2013
NRHM, MoHFW
GOVERNMENT OF INDIA
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7th Common Review Mission Report for Meghalaya
Summary of Findings

1. Service Delivery

- In terms of required facilities, there is a deficit of 57%, 58% and 70% of CHCs, PHCs and health sub-centers in the state. The state of health infrastructure shows poor level of coverage, which is one of the essential factors for improving public health outcomes in the state.

- Performance of OPD over a period of 4 years increased from 2.5 million in 2009-10 to 3.3 million in 2012-13 with an increment of 30% in the state. Similarly, IPD increased from 1.44 lakhs to 2 lakhs with an increment of 36% over a period of 4 years from 2009-10 to 2012-13 in the state.

- There is no mechanism to ensure adherence to standard treatment protocols or treatment guidelines in the state. IMEP committees are non-functional even at district level. No policy for provision of free generic drugs in the state.

- Given the situation of the state in terms of scant spread of the villages, transit time due to hilly area number of 108 ambulance are inadequate in the state.

- Low utilization of MMU services observed and these MMUs are not well equipped to provide diagnostic services and no GPS system installed. No system in place for monitoring the performance of MMU in Ri Bhoi district however, DPMU and BPMU structures available in the district.

2. Reproductive and Child Health

- The density of delivery points thinly spread and partially functional in terms of SBA and EmOC. All PHCs and CHCs are providing only Level 1 service delivery care.

- No line listing of high-risk pregnant women, eligible couple and no follow up were maintained. By and large the situation remains the same across the state.

- NBCC were up and functional but in 50% facilities ANM/SN was unable to operate the baby warmer. NBSU and SNCU Functional in MCH Hospital but with staff shortage.

- No blood storage facility in MCH hospital and district hospitals (Tura and Ri Bhoi). Vital drugs viz. Mag. Sulphate and Misoprostol not available at 90% of facilities across districts.

- USG facility not available although equipment available in Ri Bhoi district due to non-availability of radiologist/trained gynecologist. NRC has just been established in MCH and district hospital Ri Bhoi.

- No ARSH clinics seen at the PHC and CHC in WGH, however in Ri Bhoi dedicated AFHS center at district hospital and CHC levels are well staffed and equipped with and IEC tools and appropriate records are being maintained. Around 40 functional adolescent clinics established in all CHCs and DHs and a model ARSH clinic established in Ganesh Das hospital in Shillong.

- Home deliveries are not attended by SBA. It appears that adequate number of SBA not trained and also a trend is observed that selection preference is given to regular staff nurse and ANMs over the contractual ones for training.
The high fertility pattern is linked to the high infant deaths in the district. In addition, religious beliefs and social norms are major challenges in achieving family planning goal in the state. All staff members are trained in IUCD but still no PPS at the CHCs and no PPIUCD, except in CHC-Aampati.

Meghalaya Maternal Benefit Scheme (MMBS) has given an additional thrust to JSY in the state, which provides additional Rs.4000 up to 2 children. However, home delivery incentive disbursement was negligible as SBA attendance of home delivery is only 5% in the state.

No pickup facility available due to lack of centralized number, 108 not reachable due to network problem. The vehicle at the PHC is not used for drop back, instead beneficiary are given an estimated amount depending upon their home distance from the facility.

Both districts have more than 70% home deliveries (with less than 5% assisted by SBA) and around 30% institutional deliveries. However, only 2% of maternal deaths are reviewed as against to reported maternal deaths in the state.

RI outreach is good in terms of quantity such as VHNDs and fixed health days in the villages. Most ANMs at sub centers aware and delivering services as per guidelines viz. noting down time of reconstitution, ice packs availability, aware of correct administration site.

NIDCP programme has not been active in the state from last few years, the last survey was done in 2010-11 and there is urgent need to revive the programme in the State.

3. Disease Control Programme

No IT support for IDSP apparent in visited health center however, existing system of reporting and available infrastructure is enough for better reporting provided all required resources available and functional. 1075 IDSP Toll Free number not available in the state and need to establishment state alert center.

Downward trend observed in incidence of malaria cases, Plasmodium falciparum (Pf), Plasmodium vivax (Pv) and deaths due to malaria from 2009 to 2012 in the state and both the districts visited.

Deaths related to malaria shows downward trend, from 197 deaths in 2009 to 52 deaths in 2012 which 73% change in death rate. ASHAs are not aware, nor having RDT kit for diagnosis of malaria cases, ACT for treatment of Pf cases, CQ and PQ for treatment of Pv cases are not available with them.

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

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

ANCDR, RFT, Child cases and Grade-II cases of leprosy have shown reduction in 2013 from 2011. Prevalence Rate in 2013 is 0.09 and New Cases Detection Rate is 0.52. Registered cases and newly detected cases have decreased in 2013 by 16 from 61 in 2011. Leprosy cases are under reported as ASHAs incentives are not paid on case detection.
Only 927 cataracts operations were performed, 924 IOL were supplied and 5592 children were checked for refractive errors in entire state. However, eye surgeon not available in Ampati FRU CHC in WGH district. Four eye surgeon post are vacant out of 5 sanctioned posts in the state.

Almost all health facilities are co-located with AYUSH clinics with consultation and dispensing rooms at CHCs and DHs level. Essential equipment’s, instruments and furniture required for AYUSH are available, but medicines are not supplied since 2009.

4. Health Human Resource

Over NRHM period the HR situation improved tremendously in district and state level. The recruitment of contractual staff under NRHM increased by 1142 personnel in 2013 from 120 in 2005, which is manifold increase in the state.

There is no rational deployment of HR especially when State has more than the required number of staff. Differences between DHS and NRHM on HR issues viz. recruitment, training and deployment observed.

Lack of adequate training infrastructure both in terms of HR (Master trainers) and facilities observed in the state. The State only has 2 GNM schools and 1 ANMTC.

5. Community Processes and Convergences

Poor engagement of VHSNC and PRI members in NRHM activities for addressing low institutional deliveries and high prevalence of communicable diseases observed in both the districts.

Though the utilization of VHSNC funds is satisfactory but diversification in the activities for which the funds are being utilized is required. Poor involvement of PRIs members in activities of VHSNC and RKS observed in Ri Bhoi and West Garo Hills.

Components such as HB%, urine examination, and physical examination are not being done at VHND sites. No line listing of High risk pregnancies and VHND monitoring mechanisms rudimentary in the state.

State has many challenges in rolling out training for ASHAs due to lack of fully equipped residential training sites at district and block level. ASHAs grievance are generally related to irregular payment of disease control programme incentives like NLEP, NVBDCP.

Around 69 ASHA were dropped out during 2012-13 and 286 villages yet to have ASHAs that include 88 new villages. Around 198 villages where ASHA cover more than 1500 population in the state.

State has initiated piloting community based monitoring in 3 blocks each in three districts - East Khasi Hills, Jaintia Hills and west garo hills covering 9 blocks.
6. Information and Knowledge

- Facility data examined in registers at CHCs and PHCs were found to tally fully with the HMIS data for the – validation and verification at block and district levels appears to be strong.
- The team learned that the 2 MBPS line leased from NIC has frequent outages. These, combined with power disruptions make it difficult to submit data on time (District, Block, Facility level). This is particularly critical for MCTS as the data have to be entered directly on the online database, and have to be re-entered if there is Internet or power outage.
- In the area of HMIS, discrepancies were identified in the Sub Centre- level data, where the monthly ANC totals manually computed from the MCH registers did not tally with the reports downloaded from the HMIS.
- With respect to MCTS, the team learned that high prevalence of home deliveries leads to some mothers and children not being included in MCTS. For instance, in FY 2012, only 23% ANC were registered in MCTS. Further, delays in MCTS report and work plan generation, leads to limited use of data by frontline health workers for planning and gap identification.
- At facility level, there appears to be a lack of dedicated human resources for data entry (at one CHC, the work was taken up by a facility accountant), and this is an additional reason for data being entered at block level.

7. Health Care Financing

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

8. Medicines and Technology

- Warehouses existed in both districts West Garo Hills (WGH) and Ri Bhoi. The one in WGH was not yet functional whereas in Ri Bhoi it was operational but lacked power supply and drugs requiring refrigeration were housed in another room at the Civil Hospital.
- EDLs were displayed, but some essential drugs IFA, Zinc, Vit –A, Vit-K, Misoprostol and supplies like gloves were absent in the state and both districts. Availability of ORS, Paracetamol and condoms varied across facilities and were mostly absent in Ri-Bhoi, as per the ASHAs.
• Free Drug policy not implemented and out of pocket expenditure found to the amount of Rs.100 observed for many patients. Simple drugs like Diclofenac, Inj. Realgen, Syrup Quinine were being bought from outside.

• ProMIS not implemented and no new rate contracts between state and suppliers for past three years.

9. National Urban Health Mission

• The state runs 19 Urban Health centers to cater to the needs of the urban poor in terms of basic health care services. UHC includes Shillong (13), Jowai (2), Nonstoin (1), and Tura (3).

• UHCs are functional and required additional manpower, equipment and medicines to make it fully functional. 72% [454111] of total states urban population concentrate in two major cities – Shillong and Tura.

• Problems include lack of access to basic services like water supply, electricity, toilets, sewerage, health care facilities etc. Poor civic amenities and inadequate sanitation are widespread in slums.

• State proposed NUHM in three major towns – Shillong, Tura, and Jaintio Jo wai. Three towns cover 68 slums out of which 29 are notified slums. Urban RCH Service delivery indicators like ANC and PNC show poor performance (31% ANC, 19% PNC)

• State has prepared and submitted city and state level NUHM PIP. City level mapping of availability of health infrastructure, manpower and equipment in urban slum completed.

10 Governance and Management

• There is an optimal mix of experienced government staff with young, qualified, enthusiastic and energetic open market staff. However, level health delivery points are required to run the programme efficiently and effectively but somehow the government officials are not taking initiative in this direction.

• Regularity in Monitoring visit from State level to district and from district to lower facilities needs to be strengthened. A regular visit followed by feedback mechanism is surely going to improve the condition of the health facility.

• Although the State level officials know the importance of accountability but no formal systematic mechanisms for social audit and other accountability measures for health has been initiated in Meghalaya.
7th CRM Meghalaya

Introduction
The report is based on 7th CRM visit carried out in Ri Bhoi and West Garo Hills of Meghalaya from 10th to 13th November 2013. The monitoring visit included all levels of health facilities – Health Sub Centre (HSC), Primary Health Centre (PHC), Community Health Centre (CHC) and District Hospital (DH) and few villages. The 7th Common Review Mission was led by officials from the Ministry of Health and Family Welfare, members of civil society and development partners. The team was also joined by senior officers from state Directorate of Health Services, government of Meghalaya. The main objective of 7th CRM is to review progress of NRHM vis-à-vis its goals and objectives-identify the changes that have occurred in last eight years and make recommendations to improve programme implementation and design.

Dr. L.L. Sawian, DHS cum Joint Mission Director NRHM, government of Meghalaya chaired the state briefing on 9th November 2013, which was attended by officers and consultants of DHS. A detailed presentation was made by perspective programme heads including SPM highlighting the progress and status of main programmes under NRHM. The CRM team visited two districts, Ri Bhoi and West Garo Hills. The details of the facilities visited as follows.

<table>
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<tr>
<th>District/Block</th>
<th>Description</th>
<th>Facilities/villages visited</th>
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<tr>
<td><strong>Umsning</strong>&lt;br&gt;Dist: Ri Bhoi</td>
<td>Comprise of 2 Non FRU CHCs, 4 PHCs, 1 Dispensary, 17 HSC covering 1.43 lakh population</td>
<td>Umsning CHC, Bhoiyymbong CHC, Umtrai PHC, Mawlasnai HSC, HSC Sonidan, HSC Umroi, Villages: Yo Umroi, Bhoirymbong,</td>
</tr>
<tr>
<td><strong>Umling</strong>&lt;br&gt;Dist: Ri Bhoi</td>
<td>Comprise of 1 DH, 3 PHCs and 9 HSCs covering 98 thousand population</td>
<td>Nangpoh DH, Umden PHCs, Byrnihat PHC, HSC Mermain, HSC Iapngar, HSC Pynthor, Villages: Pynthor, Sonidan, Mawtneng, Thadnongyiaw</td>
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<tr>
<td><strong>Rongram</strong>&lt;br&gt;Dist: WGH</td>
<td>Comprise of 2 24X7 PHCs and 11 SCs covering a population of 54171</td>
<td>PHC-Asanang&lt;br&gt;PHC Babadam (PPP)&lt;br&gt;Village : Bhalupura&lt;br&gt;MCH Hospital Tura&lt;br&gt;Civil Hospital Tura</td>
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<tr>
<td><strong>Selsella</strong>&lt;br&gt;Dist: WGH</td>
<td>Comprise of 3 24X7 PHCs, 2 CHC and 26 SCs covering a population of 188539</td>
<td>SC-Aandharkona&lt;br&gt;CHC-Selsella&lt;br&gt;SC-Damalgre&lt;br&gt;PHC-Garobadha</td>
</tr>
<tr>
<td><strong>Betasing</strong>&lt;br&gt;Dist: WGH</td>
<td>Comprise of 1 24X7 PHCs, 2 PHC, 1 CHC and 9 SCs covering a population of 62449</td>
<td>CHC-Ampati</td>
</tr>
<tr>
<td><strong>Dalu</strong>&lt;br&gt;Dist: WGH</td>
<td>Comprise of 2 24X7 PHCs, 2 CHC and 10 SCs covering a population of 73594</td>
<td>CHC-Dalu&lt;br&gt;SC-Rimrangpara&lt;br&gt;PHC-Kherapara&lt;br&gt;CHC-Alagre</td>
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At the end of the CRM filed visits, a debriefing session held on 15th November 2013 chaired by Joint Mission Director, government of Meghalaya. The respective programme heads were present during debriefing meeting in the state (Annexure-I).

The mission visited two districts, Ri Bhoi and West Garo Hills and details of mission members are in Annexure-II.

The team would like to sincerely express appreciation and thank the officials of the Government of Meghalaya, SHS, Directorate and staff of the facilities visited by the CRM for facilitating the review, providing all the documents asked for, appropriately and very openly responding to various issues raised by the CRM members and excellent hospitality provided.

The structure of the report

Summary of findings and TOR wise descriptive report with recommendations is as follows

1. Service Delivery
2. Reproductive and Child Health
3. Disease Control Programme
4. Human Resources and Training
5. Community Processes and Convergence
6. Information and Knowledge
7. Health Care Financing
8. Medicine and Technology
9. National Urban Health Mission; and
10. Governance and Management
State Profile and Key Health and Service Delivery Indicators

Meghalaya, one of the eight North-East states, is located at an altitude of 1496 meters above sea level and is bounded by Assam on the Northeast and People’s Republic of Bangladesh on the Southwest. The state has an area of 22,429 square kilometers inhabited by 29.64 lakhs people (2011 census) living in eleven districts, 39 blocks and 6544 villages. Meghalaya has three regions – Khasi region in the North consist of four district, Jaintia Hill in East consist of two district, Garo region in the West consist of five districts. About one-third of the state is covered with forest and 80% of the population lives in rural areas. Meghalaya has recorded the highest decennial growth of 27.82% among all the seven Northeastern states as per the census 2011. The state literacy rate is 75.48% and density of population is 132/km². The major spoken languages include Khasi, Garo, Pnar and English.

Table 2 State and district profile

<table>
<thead>
<tr>
<th>State/District</th>
<th>Meghalaya</th>
<th>Ri Bhoi</th>
<th>West Garo Hills</th>
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<tbody>
<tr>
<td>State/Dist. HQ</td>
<td>Shillong</td>
<td>Nomgph</td>
<td>Tura</td>
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<tr>
<td>No. of Blocks</td>
<td>39</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>No. of Villages</td>
<td>6544</td>
<td>584</td>
<td>1617</td>
</tr>
<tr>
<td>No. of AWCs</td>
<td>4930</td>
<td>414</td>
<td>1291</td>
</tr>
<tr>
<td>No. of ASHAs</td>
<td>6258</td>
<td>534</td>
<td>1617</td>
</tr>
<tr>
<td>Population (2011)</td>
<td>29,64,007</td>
<td>2,71,915</td>
<td>6,81,314</td>
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<tr>
<td>Literacy</td>
<td>75.48</td>
<td>75.67%</td>
<td>68.38%</td>
</tr>
<tr>
<td>Sex Ratio</td>
<td>989</td>
<td>984</td>
<td>984</td>
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<tr>
<td>Density of POP</td>
<td>132/km²</td>
<td>106/km²</td>
<td>175/km²</td>
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<td>North</td>
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<td>West</td>
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Source: DHS, Meghalaya (Pop: CNNA annual survey)

The key health indicators of Meghalaya reflect poor performance in comparison with national level. Meghalaya recorded 288 Maternal Mortality Ratio (MMR) per 100,000 live births, which is 76 points higher in comparison with national average of, 212/100,000 live births. Maternal health is one of the important goals of NRHM that targets to reduce MMR by <100 per lakh live births by the end of 2017. India has substantially reduced the MMR from 523 in 1990 to 212 in 2007-09. Despite the progress, India tends to fall short to achieve NRHM maternal goal by 112 per 100,000
live births by the end of 2017. However, southern states like Tamil Nadu has already achieved success in arresting incidence, whereas Northeaster states like Assam, Manipur, Meghalaya etc. might fall behind the targets.

IMR for the country declined by nine points between 2008 and 2011 with IMR at national level being 42 in 2012. However, the set IMR target of NRHM is to reduce by <20 per 1000 by 2017. Meghalaya IMR is 49 per 1000 live births, which is 7 points higher than national average. Meghalaya is short of 29 points in achieving NRHM IMR goal by 2017.

Service delivery indicators like ANC, PNC, institutional deliveries, TFR and unmet needs for family planning indicate that Meghalaya’s performance is below national average. % of first ANC check-ups and institutional deliveries against estimated deliveries in Meghalaya is 26% and 54.4% reported by the end of September 2013-14, which is far below the national average. Meghalaya state unmet need for family planning is 32.4%, which is 19.6% higher than national unmet needs.

Table 3 Meghalaya key health and service delivery indicators

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<tr>
<th>Sl. No.</th>
<th>Health indicators</th>
<th>India</th>
<th>Meghalaya</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MMR (per 100,000 live births) 2011</td>
<td>212 (SRS '07-09)</td>
<td>288</td>
</tr>
<tr>
<td></td>
<td>CBR</td>
<td>21.8 (SRS 2011)</td>
<td>24.1</td>
</tr>
<tr>
<td>2</td>
<td>CBR (per 1000 population) 2011</td>
<td>7.1 (SRS 2011)</td>
<td>7.6</td>
</tr>
<tr>
<td>3</td>
<td>IMR (per 1000 population) 2011</td>
<td>42 (SRS 2012)</td>
<td>49</td>
</tr>
<tr>
<td>4</td>
<td>Neo-natal Mortality Rate</td>
<td>33 (SRS 2010)</td>
<td>..</td>
</tr>
<tr>
<td>5</td>
<td>Under Five Mortality Rate</td>
<td>59 (SRS 2010)</td>
<td>..</td>
</tr>
<tr>
<td>6</td>
<td>Antenatal Care (HMIS ’12-13)</td>
<td>..</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>a ANC Check-up in first trimester</td>
<td>69% (HMIS ‘12-13)</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>b 3 or more ANC Check-up</td>
<td>..</td>
<td>26%</td>
</tr>
<tr>
<td>7</td>
<td>Postnatal Care (HMIS ’12-13)</td>
<td>..</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>a Breastfed within 1 hour of birth</td>
<td>..</td>
<td>85%</td>
</tr>
<tr>
<td>9</td>
<td>Instit. Deli. Against Esti. Deliveries</td>
<td>62% (SRS 2010)</td>
<td>54.4%</td>
</tr>
<tr>
<td></td>
<td>Total Fertility Rate</td>
<td>2.5 (SRS 2010)</td>
<td>3.1</td>
</tr>
<tr>
<td>10</td>
<td>Full Immunisation</td>
<td>82 (HMIS ’11-12)</td>
<td>82</td>
</tr>
<tr>
<td>11</td>
<td>Unmet Need for FP</td>
<td>12.8 (DHS ’05-06)</td>
<td>32.4</td>
</tr>
<tr>
<td></td>
<td>a Spacing</td>
<td>6.2</td>
<td>13.4</td>
</tr>
<tr>
<td></td>
<td>b Limiting</td>
<td>6.6</td>
<td>19</td>
</tr>
</tbody>
</table>
TOR wise key findings

1. Service Delivery

A. Adequacy of facilities

Meghalaya has inadequate health infrastructure as per population norms. State has 11 districts including four districts that have been recently created. Out of 11 districts hospitals, 6 DHs are FRU (CEmOC) centers, 2 DHs are 24x7 (BEmOC) centers and 3 DHS are non FRU 24x7 facilities. However, directorate of health services reports only 7 district administration. In terms of required facilities, there is a deficit of 57%, 58% and 70% of CHCs, PHCs and health sub-centers in the state. The state of health infrastructure shows poor level of coverage, which is one of the essential factor for improving public health outcomes in the state. Similar picture reflects in Ri Bhoi and West Garo Hills (WGH) district. In terms of required facilities, there is deficit of 50% 62% and 76% of CHC, PHCs and health sub-centers in Ri Bhoi district and 53%, 64% and 70% of CHCs, PHCs and health sub-centers in WGH district, which is essential for delivering health services in the peripheral areas of the district.

Table 4 Health facility mapping – Meghalaya, Ri Bhoi and WGH

<table>
<thead>
<tr>
<th>District Hospital</th>
<th>Meghalaya</th>
<th>Ri Bhoi</th>
<th>West Garo Hills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required</td>
<td>Existing</td>
<td>SF</td>
<td>Required</td>
</tr>
<tr>
<td>District Hospital</td>
<td>11</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>CHC</td>
<td>65</td>
<td>28</td>
<td>37</td>
</tr>
<tr>
<td>PHC</td>
<td>256</td>
<td>108</td>
<td>148</td>
</tr>
<tr>
<td>HSC</td>
<td>1410</td>
<td>422</td>
<td>988</td>
</tr>
<tr>
<td>Total</td>
<td>1742</td>
<td>569</td>
<td>1173</td>
</tr>
</tbody>
</table>

Source: DHS, Meghalaya; SF=Shortfall

Meghalaya has 39 blocks in 7 districts with a population of 2.9 million population. District population range from minimum 1.42 lakhs in South Garo Hills to maximum 8.24 lakhs in East Khasi Hills. On an average every district has 4 CHCs, 15 PHCs and 60 health sub-centers in the state. However, the catchment area of health facilities are not as per the population norms. On an average every health sub-center covers more than seven (7) thousand population in the state whereas the norm for HSC in hilly areas is 3 thousand.

Table 5 District wise health facilities and peripheral structures available

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Districts</th>
<th>Population</th>
<th>Blocks</th>
<th>PHC</th>
<th>SC</th>
<th>AWC</th>
<th>ASHAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>East Garo Hills</td>
<td>317,618</td>
<td>5</td>
<td>16</td>
<td>73</td>
<td>699</td>
<td>952</td>
</tr>
<tr>
<td>2</td>
<td>East Khasi Hills</td>
<td>824,059</td>
<td>8</td>
<td>23</td>
<td>67</td>
<td>916</td>
<td>1033</td>
</tr>
<tr>
<td>3</td>
<td>Jaintia Hills</td>
<td>392,852</td>
<td>5</td>
<td>18</td>
<td>76</td>
<td>574</td>
<td>552</td>
</tr>
<tr>
<td>4</td>
<td>Ri Bhoi</td>
<td>258,380</td>
<td>3</td>
<td>8</td>
<td>27</td>
<td>414</td>
<td>534</td>
</tr>
<tr>
<td>5</td>
<td>South Garo Hills</td>
<td>142,574</td>
<td>4</td>
<td>6</td>
<td>21</td>
<td>321</td>
<td>542</td>
</tr>
<tr>
<td>6</td>
<td>West Garo Hills</td>
<td>642,923</td>
<td>8</td>
<td>18</td>
<td>92</td>
<td>1291</td>
<td>1617</td>
</tr>
<tr>
<td>7</td>
<td>West Khasi Hills</td>
<td>385,601</td>
<td>6</td>
<td>19</td>
<td>66</td>
<td>715</td>
<td>1028</td>
</tr>
</tbody>
</table>
State and district have mapped inaccessibility of health facilities in terms of difficult areas, most difficult areas and inaccessible areas. In Ri Bhoi district, 1 CHC Patharkhmah and 2 PHCs Warmawsaw and Umtrai and 3 HSC are located in difficult areas and 1 HSC in most difficult area. Umtrai PHC, which is located in difficult area is functioning under PPP mode under Karuna trust. In West Garo Hills, 1 CHC, 5 PHCs and 25 HSC are located in difficult area, whereas 6 HSC located in most difficult areas and 1 HSC inaccessible area in the district.

State has made efforts to reach marginalized sections thorough Village Health and Nutrition Days (VHNDs) and Village Health Sanitation and Nutrition Committees (VHSNC). VHSNC guidelines translated into local language and circulated to all VHSNC committees. Village headman presides VHSNC and ASHA acts as member secretary of VHSNC in the state. There are total 6250 VHSNC constituted in the state. Un-tied fund of Rs. 10,000 was maintained by ASHA along with bank passbook observed in Pynthor village. It is observed that VHSNC generally use untied fund for constructing village level garbage pits, purifying drinking water and conducting awareness programme in the local communities.

VHNDs are held monthly once at Anganwadi center or local school. It is observed that VHNDs are active in immunizations but unable to undertake ANC check-ups. VHND, School health and MMU clinic observed at one site but except medicine, did not find any equipment like BP/HB meter and pregnancy test kit on the site. However, there was a MO who was diagnosing school children and maintaining child health card. Around 17,492 VHNDs and 24,156 immunizations sessions held from April to September 2013 where ASHAs were present on the site.

B. Infrastructure
As per available information, the state has achieved considerable progress in the area of infrastructure development. Above 70% of sanctioned infrastructure projects have been completed over a period of three years and the quality and pace of the construction is satisfactory. One MCH hospital at Tura in West Garo Hills and another MCH wing at Jowai civil hospital under process.

In Ri Bhoi district, construction of new PHC at Byrnihat has been completed and functioning. Renovation of Umden PHC completed in October 2013 and renovation of Bhoirymbong CHC and construction of new 10 bedded AYUSH hospital almost completed by 90%. Four new HSC – Amjong, Pilangkata, Sohphoh and Raitong completed in 2012-13 in Ri Bhoi district.

Within the directorate of health services there is a civil engineering division who looks after the construction work from tendering, selection of contractors and completion of the works. Most of the health facilities are in good conditions and are located in government building. But the utilization pattern varies from facility to facility. Renovation and up-gradation of facilities have been taken-up wherever required and provision of residential accommodation for MOs and
GNMs exist but one needs to understand the utilization of these quarter. Most of the HSC are attached with staff quarter but it was occupied by security guard (chowkidar) instead of ANMs.

Table 6 progress of sanctioned infrastructure projects in Meghalaya

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of activity*</th>
<th>Sanctioned</th>
<th>Completion</th>
<th>work in progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td>construction HSC</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Construction of MO and GNM quarters</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>2007-08</td>
<td>construction of HSC</td>
<td>43</td>
<td>41</td>
<td>2</td>
</tr>
<tr>
<td>2008-09</td>
<td>Construction of GNM Qt</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>2009-10</td>
<td>Construction of HSC</td>
<td>30</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>2010-11</td>
<td>Construction of MO and GNM quarters</td>
<td>148</td>
<td>112</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Construction of PHCs</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Construction of specialist Qt.</td>
<td>14</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Up-gradation of PHCs and CHCs</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>2011-12</td>
<td>Up-gradation of HSC to level-1</td>
<td>53</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Construction of Qrts - MO and GNM</td>
<td>41</td>
<td>33</td>
<td>8</td>
</tr>
<tr>
<td>2012-13</td>
<td>Construction of Spe. and GNM Qt</td>
<td>39</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Construction of HSC</td>
<td>24</td>
<td>9</td>
<td>15</td>
</tr>
</tbody>
</table>

Source: DHS, Meghalaya (*selected projects)

C. Utilization of facility based services
Performance of OPD over a period of 4 years increased from 2.5 million in 2009-10 to 3.3 million in 2012-13 with an increment of 30% in the state. AYUSH OPD also increased with an increment of 22% over a period of four years.
Similarly, IPD increased from 1.44 lakhs to 2 lakhs with an increment of 36% over a period of 4 years from 2009-10 to 2012-13 in the state.
Graph 3 Year wise IPD performance of Meghalaya

Source: HMIS

Utilization pattern of IPD and OPD in 2012-13 is reasonable in the state however, it varies across levels of facilities and districts. Around 40% of total OPD and IPD services in the state utilized in Ganesh Das hospital alone, which is situated at Shillong in East Khasi Hills. The level of utilization of OPD and IPD services was least in South Garo hills district, which is 0.66 OPD per capita and 23 IPD per 1,000 population in the district. However, the state average remains 1.12 OPD per capita and 68 IPD per 1,000 population during 2012-13.

Graph 4 District wise OPD per Capita and IPD/1,000 population during 2012-13 - Meghalaya

Source: HMIS

Lab and diagnostics services are available at PHC to DH level in Ri Bhoi and WGH district but there is a shortage of drugs and consumables. Ri Bhoi district has one Blood Storage Unit but
non-functional and none of the complicated pregnancies treat with blood transfusion. However, West Garo Hills reported 342 blood transfusions over a period of six months (April to Sept 2013). HMIS data indicates only three districts, East Khasi Hills, Jaintia Hills, West Garo Hills are catering to the needs of complicated pregnancies that need blood transfusion.

Graph 5 Major Surgeries - Meghalaya

In Ri Bhoi district many of the complicated pregnancies were referred from PHC to CHC, CHC to DH, and DH to Shillong hospital. Given the difficult terrain and distance the referral transportation may futile for pregnancy complications.

D. Quality of Care and Subcontracting
There are no centralized sterile services available in Ri Bhoi district and the situation remains same across all facilities in the state. Biomedical waste management systems observed by color coding of bio-waste segregation in DH, CHC and PHC level in Ri Bhoi district. No third party agency collects bio-waste in the district and they dispose in deep pits within the hospital premises. However, it seems centralized bio-medical waste management system at Shillong is under process for selection of contracting agency.

There is no mechanism to ensure adherence to standard treatment protocol or treatment guidelines in the state. IMEP committees are non-functional even at district level. No policy for provision of free generic drugs in the state. Most of the supportive services like housekeeping, laundry, diet and security services are in-house available in Ri Bhoi district. However, across the state some services like diet and security were provided by third party. Citizen charter was observed in all facilities visited in Ri Bhoi and WGH district. There is no feedback mechanism available in the district and state to capture the patient satisfaction. Suggestion box available in some facilities but hardly receive any feedback from patients. No formal grievance redressal mechanism was observed in both districts nonetheless the facilities address grievance as and when they arises. There is no subcontracting system in place in the state.
E. Ambulance and Referral Services and MMUs

41 EMRI (108) ambulance, which include 31 BLS and 10 ALS with fully functional GPS system and centralized call center, are available in the state. Around 109 facility based ambulances are available in the state. These ambulances have not displayed their numbers neither in the facility nor on the ambulances and without centralized call center. However, Meghalaya state in the proposal stage for 102 model ambulance. National Ambulance Service guidelines are not strictly followed in the state. It is observed that facility based ambulances are primarily being used for administrative (staff) purpose rather than for patients. Except PW, facilities are charging money for referral transportation.

Graph 6 utilization of facility based ambulance services – Meghalaya

On an average each facility based ambulance cover 25,000 population and 108 ambulance cover 70,000 population in the state. Given the situation of state in terms of scant spread of the villages, transit time due to hilly area number of 108 ambulance are inadequate in the state. The average response time for 108 ambulance is 25 minutes and 40 trips per month handled whereas facility based ambulance handled 19 trips per month in the state.
F. Mobile Medical Units and IEC/BCC

Every district has 3 MMU, except Jaintia hills and West Khasi hills district. Ri Bhoi has 3 MMUs and each MMU covers an average 10 villages and 700 OPD per month with an operational cost of Rs.7200 per trip. Low utilization of MMU services observed and these MMUs are not well equipped to provide diagnostic services and no GPS system installed. Staff and supplies were inadequate and the space inside MMU was not utilized for patient diagnosis instead medicines and other materials dumped. MMUs in Ri Bhoi are partially aligned with national MMU and situation remains the same across the state. No system in place for monitoring the performance of MMU in Ri Bhoi district however, DPMU and BPMU structures available in the district.

IEC material was sparsely available across all health facilities in the district. IEC material include posters on various schemes under NRHM and wall paintings on disease control programme like leprosy etc. Meghalaya government has outsourced an agency for outreach communication, which focuses mainly on street plays and announcement through public address systems. The state experimented with SMS based IEC/BCC but the response was not encouraging hence discontinued with SMS based IEC/BCC communication.
UMTRAI PHC, A Public-Private Partnership  
Ri Bhoi, Meghalaya

On Nov 12, 2013, a team from the CRM team in Meghalaya visited Umtrai PHC in Ri-Bhoi district. Umtrai PHC is one of the PHCs operated by the Karuna Trust under the PPP model. Karuna Trust initiated its work in Karnataka in 1996, and currently manages 68 Primary Health Care Centers (PHCs) in eight states – including the northeastern states of Arunachal Pradesh, Manipur, and Meghalaya.

**Persons met:** Manager of Karuna Trust, GNM Nurse, Medical Officer, ASHA Facilitator and Pharmacist. The tenure of these staff ranged from five years (Manager) to on month (Medical Officer).

**Major points:** Karuna Trust took over the PHC from Government of Meghalaya in 2009. Previous to that, the PHC was dysfunctional and had no staff. Karuna adopted the practice of engaging young staff as doctors willing to work for the community, considering the general shortage of doctors in Meghalaya (deficit = 200, source: pers. Comm. Manager). The current medical officer is a homeopath from Assam, and was hired to replace another doctor who had stayed at Umtrai for four years. The latter, along with two of his colleagues had been kidnapped, and resigned after managing to escape.

**Public contribution:** The PPP was formalized by an MOU with the government. Drugs and supplies are provisioned from the government district warehouse. The government has also recently constructed two staff quarters. Doctors and all staff residential. It funds 90% of the cost of running the PHC, and additional drugs are purchased by RKS funds and by the Trust.

**Private contribution:** KT supplements the medicines and supplies with products not available through the government supply – such as Iron and Folic Acid. A generator and inverter are also supplied by KT. KT also organizes review meetings for medical officers from all the 11 facilities it operates in Meghalaya, and has trained theme with resource persons including those from the government.

**Functioning:** The PHC is operational 24/7. From 9am to 5 pm clients are treated as OPD cases, and those arriving before and after that as emergency cases. All services and lab investigations free. The facility has an ambulance and its own waste dumping station. The PHC conducts regular deliveries, and complicated deliveries referred to higher-level facilities. The closest hospital is Khetri CHC in Assam, 16 km away.

**Salient points:**
The staff met, in particular, the Medical Officer, GNM and ASHA facilitator, were highly motivated and appeared committed to the cause of public health.
Cont..

Challenges and Recommendations:

_Treatment:_
- As there is currently no allopathic doctor, the existing medical officer (homeopathic) supplements her knowledge by consulting colleagues at other facilities. While she is obviously capable and resourceful, it may be good to strengthen the facility’s human resources with an allopathic doctor.
- Functional neonatal, Paediatric and Adult Resuscitation kit is present but no one knows how to use it. All complicated deliveries are referred out.
- No referrals to HIV counselling and testing are taking place. This needs to be remedied immediately.

*PEP:* The facility lacks pre-exposure prophylaxis (PEP) kits, which are an essential response to occupational exposure to HIV-infected blood. This was also the case with many other facilities, and requires attention.

_Community practices:* As there is a high prevalence of home-deliveries, complications are difficult to address. Further tracking on mother and child is difficult. Outreach and motivating clients for institutional delivery is needed. The ASHA facilitator noted the poor health-seeking behaviour of villagers.

![Figure 1: Discussion with staff at Umtrai PHC](image)

**Recommendations for Service Delivery**

a. The state of the health infrastructure shows poor coverage, which is one of the essential factor for improving public health outcomes in the state. In terms of required facilities, there is a deficit of 24%, 27% and 57% of CHCs, PHCs and HSC in the state.

b. State needs to operationalize phase wise health sub-centers as delivery points based on available infrastructure and human resources. State needs to develop need based comprehensive health infrastructure plan in the state and in the district. State has to upgrade remain 5 district hospital as FRU.
c. Mapping of inaccessible facilities has been done in the state but needs to strategize for human resource deployment at these facilities. Other priorities are to ensure completion of remaining infrastructure projects including renovation/repair on time, and the need to understand the utilization of staff (MO and GNMs) quarters available at all levels of facilities.

d. HMIS data indicates that the utilization of health services varies across all districts and around 40% of all OPD and IPD in the state are utilized only in Ganesh Das hospital, which is a matter of concern.

e. State needs to take serious view on cross-referral of complicated pregnancy from one facility to another. Given the difficult terrain and distance the referral transportation may futile for pregnancy complications.

f. State should form a technical committee to ensure adherence to standard treatment protocol or treatment guidelines in the state. Establish and strengthen IMEP committees across all district and ensure effective functioning of district quality assurance teams.

g. Ensure that all ambulance and facilities display the ambulance phone number and adhere national ambulance guidelines. Utilization of facility based ambulance is questionable because most of them are used for administrative purpose.

h. Ensure no ambulance will charge any money from the patients. State and district needs to budget accordingly in NRHM PIP. Provide adequate drugs and consumables for MMUs and develop monitoring mechanism.

i. State needs to study the impact and effectiveness of IEC/BCC, which is outsourced to third party and its impact on health seeking behavior of the community in the district and state.
2. Reproductive and Child Health

A. Planning

Table 7 Level wise facilities available in Ri Bhoi and West Garo

<table>
<thead>
<tr>
<th>District</th>
<th>Level 3</th>
<th>Level 2</th>
<th>Level 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ri Bhoi</td>
<td>Functional FRU: Nil SNCU: Nil</td>
<td>FRU: Nil NBSU: Nil PPIUCD: Yes, No Minilap</td>
<td>24xDel: 3 CHC, 6 PHC NBCCs: All Delivery Points</td>
</tr>
<tr>
<td></td>
<td>Tubec/Minilap: Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Garo</td>
<td>only 1 with functional SNCU and NRC</td>
<td>25 but none performing C-section or other surgical procedures</td>
<td>49, none with 24X7 facilities</td>
</tr>
</tbody>
</table>

The density of delivery points thinly spread and partially functional in terms of SBA and EmOC. All PHC and CHCs are providing only Level 1 service delivery care. State itself is not clear on its number of SCs as delivery points (State mentions only 2 SC as delivery points in WGH, while districts mentions 49 SCs as delivery points). District plans do not reflect field implementation gaps such as low SBA home deliveries and low uptake of FP services.

Table 8 District wise indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Ri-Bhoi</th>
<th>West Garo Hills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>2,70,000</td>
<td>6,81,314</td>
</tr>
<tr>
<td>Live Birth</td>
<td>5512</td>
<td>18377 (infants)</td>
</tr>
<tr>
<td>Estimated Pregnant Women</td>
<td>8100</td>
<td>20899</td>
</tr>
<tr>
<td>Eligible couples</td>
<td>45,900</td>
<td>1,15,823</td>
</tr>
<tr>
<td>IMR</td>
<td>15 (dist. HMIS)</td>
<td>34 (Dist. HMIS)</td>
</tr>
<tr>
<td>MMR</td>
<td>309 (18 in number from 5815 live births; Dist. HMIS)</td>
<td>422 (71 in number from 16758 Live Births; Dist. HMIS)</td>
</tr>
<tr>
<td>TFR</td>
<td>..</td>
<td>5 (Dist. HMIS)</td>
</tr>
</tbody>
</table>

B. Mother and Child Services

Only normal deliveries are being performed at the facilities visited by the team. Only one C-section performing facility in each of the districts covered viz. CHC-Aampati (WGH) and Nongpoh district hospital, Ri-Bhoi. However, it was observed that the emergency protocols in some facilities were freshly displayed. In both the district, no line listing of high risk pregnant women, eligible couple and no follow up were maintained. By and large the situation remains the same across the state.

NBCC were up and functional but in 50% facilities ANM/SN was unable to operate the baby warmer. NBSU and SNCU Functional in MCH Hospital but with staff shortage. Availability of
infrastructure (Dist. hospitals and MCH hospital), Gynecologists, Anesthesics, round clock MOs, Staff Nurses along with necessary equipment in the Districts are big assets which needs to be capitalized by the District.

Table 9 Selected Maternal Indicators of Meghalaya from 2009-10 to 2012-13

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Key Indicators</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3 ANC Check-ups against ANC Registrations</td>
<td>41%</td>
<td>42%</td>
<td>46%</td>
<td>50.0%</td>
</tr>
<tr>
<td>2</td>
<td>Severe anemia (Hb&lt;7) treated against reported ANC registration</td>
<td>1.7%</td>
<td>2.1%</td>
<td>1.7%</td>
<td>2.3%</td>
</tr>
<tr>
<td>3</td>
<td>Hypertension in pregnancy- detected against ANC reported</td>
<td>2.2%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>3.1%</td>
</tr>
<tr>
<td>4</td>
<td>Institutional Deliveries against Estimated Deliveries</td>
<td>40.6%</td>
<td>42.8%</td>
<td>51.8%</td>
<td>54.4%</td>
</tr>
<tr>
<td>5</td>
<td>Home deliveries (SBA and Non SBA) against estimated deliveries</td>
<td>51.7%</td>
<td>52.8%</td>
<td>53.4%</td>
<td>52.0%</td>
</tr>
<tr>
<td>6</td>
<td>PNC visits within 48 hours and 14 days against total deliveries</td>
<td>34.0%</td>
<td>36.0%</td>
<td>37.0%</td>
<td>39.0%</td>
</tr>
</tbody>
</table>

Source: HIMS

No facility of USG in any facility in Ri Bhoi district (although equipment is available) due to non-availability of radiologist/trained gynecologist. A radiologist can be hired from Shillong/Assam on call basis twice a week. No blood storage facility in MCH hospital and district hospitals (Tura and Ri Bhoi). Vital drugs viz. Mag. Sulphate and Misoprostal not available at 90% of facilities across districts. 48 hr stay not ensured due to non-availability of beds (DH PNC ward beds: 10 which is the same number for CHC) and also due to patient refusal.

Despite high Neonatal death rates (11 in 2012-13, 2 in 13-14) no tertiary or secondary level neonatal care services available in the District. It is also observed that few inborn died of sepsis. State needs to strengthen sepsis control mechanism of labour rooms. Quality of care at these facilities also requires review as it was observed that there is no systematic follow up/assessment of seriousness of the case in district hospital. (Ri Bhoi district one child died during visit at 1.30 PM, admitted at 11.00, no vitals taken, only malaria test was being done). NRC has just been established in MCH and district hospital Ri Bhoi. Quality of care in terms of privacy, staff attention and cleanliness was good.

C. School Health, ARSH and Community Level Care Arrangement
No ARSH clinics seen at the PHC and CHC in WGH, however in Ri Bhoi dedicated AFHS center at district hospital and CHC levels are well staffed and equipped with and IEC tools and
appropriate records are being maintained. WGH, however, counselor was mentioned to be absent from the CHC-Selsera. A total of 2,79,266 number of students across 4,631 schools 22,387 out of school girls across 5,115 Anganwadi Centers (AWC) are covered in the state. Altogether 7,263 nodal teachers and 4491 Anganwadi Workers (AWW) are trained on WIFS. Around 40 functional adolescent clinics established in all CHCs and DHs and a model ARSH clinic established in Ganesh Das hospital in Shillong. ARSH activities were mentioned to be carried out by the health educator.

Screening of school children till class 5 was done under school health programme and referral register was maintained at both districts. However no linkage was seen at the civil hospital and need to improve coverage. Improving outside referrals, community awareness of available services through mass communication, convergence with education department, ICDS and NGOs on issues of drug abuse and teenage pregnancy and availability of counseling services is required.

Table 10 Type of Deliveries from 2009-10 to 2012-13 - Meghalaya

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Deliveries</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Expected deliveries</td>
<td>71,827</td>
<td>73,777</td>
<td>74,214</td>
<td>75,832</td>
</tr>
<tr>
<td>2</td>
<td>Institutional deliveries</td>
<td>29185</td>
<td>31564</td>
<td>38449</td>
<td>41266</td>
</tr>
<tr>
<td>3</td>
<td>Skill Birth Attendant (Home)</td>
<td>4053</td>
<td>3574</td>
<td>4143</td>
<td>3691</td>
</tr>
<tr>
<td>4</td>
<td>Non-Skill Birth Attendant (Home)</td>
<td>33049</td>
<td>35345</td>
<td>35509</td>
<td>35744</td>
</tr>
<tr>
<td>5</td>
<td>Unreported deliveries</td>
<td>5540</td>
<td>3294</td>
<td>..</td>
<td>..</td>
</tr>
</tbody>
</table>

Source: HMIS

Many of the home deliveries are not attended by SBA. However, ANM in Sonidan HSC had 27 years of service and had assisted many of the home deliveries but the situation not remain the same across all sub-centers. It appears that adequate number of SBA not trained and also a trend is observed that selection preference is given to regular staff nurse and ANMs over the contractual ones for training. From the above table it indicates that non SBA home deliveries are over reporting at the state level.

Hard to reach villages are allocated to Male Health workers (MHW) and RI component and Malaria services are rendered – ANC and MDR is visibly absent in areas catered to by the male health workers. HBNC just initiated in the state and outreach is very weak except for Immunization services, as focus is on immunization in the fixed health day services and VHND. No availability of IFA in the state for more than a year now- hence this intervention is completely missed out. Monitoring and Supervision of service delivery is literally absent in the districts and states.
D. Family Planning
TFR of Meghalaya is one of the highest in the country, 5.5 TRF reported in WGH. As observed in the VHND, families with 6, 8 and even 13 children are a reality in the district. The high fertility pattern is linked to the high infant deaths in the district. In addition, religious beliefs and social norms are major challenges in achieving family planning goal in the state.

Table 11 Family Planning Key Indicators from 2010-11 to 2012-13 - Meghalaya

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>FP Key Indicators</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Eligible Couples for unmet need - Calculated Using DLHSIII need</td>
<td>161425</td>
<td>165317</td>
<td>169167</td>
</tr>
<tr>
<td>2</td>
<td>Total reported FP Users against estimated eligible couples</td>
<td>15595 10%</td>
<td>18443 11%</td>
<td>17551 10%</td>
</tr>
<tr>
<td>3</td>
<td>Total IUDs reported against total reported FP users</td>
<td>3917 25%</td>
<td>4678 25%</td>
<td>4795 27%</td>
</tr>
<tr>
<td>4</td>
<td>Total OCP users against total reported FP users</td>
<td>5633 36%</td>
<td>6038 33%</td>
<td>5126 29%</td>
</tr>
<tr>
<td>5</td>
<td>Total sterilization (against Estimated Level of Achievement)</td>
<td>2030 13%</td>
<td>2997 16%</td>
<td>2783 16%</td>
</tr>
<tr>
<td>6</td>
<td>Postpartum sterilization out of total female sterilizations</td>
<td>1627 81%</td>
<td>1699 58%</td>
<td>1424 52%</td>
</tr>
<tr>
<td>7</td>
<td>Male sterilizations out of total sterilizations</td>
<td>14 1%</td>
<td>56 2%</td>
<td>18 1%</td>
</tr>
<tr>
<td>8</td>
<td>Female sterilizations out of total sterilizations</td>
<td>2016 99%</td>
<td>2941 98%</td>
<td>2765 99%</td>
</tr>
</tbody>
</table>

Source: HMIS

Uptake of FP services is very poor and there is absolute lack of BCC for contraceptives. All staff members are trained in IUCD but still no PPS at the CHCs and no PPIUCD, except in CHC-Aampil. PPIUCD being a new programme, only 6 MO were trained in the state. Regular services rather than fixed day IUCD service available at all facilities with sufficient stocks. ASHAs are aware of the incentive for IUCDs and also provided in the state. OCPs are popular but not available in Ri Bhoi however, uptake is very limited due to social norms. RMNCHA counselors not providing any family planning counseling. Abortion care is very restricted and MVA is not available at CHC/PHC. This is due to the religious and social cultural situation of the State. In such a scenario state may look for provision of EC pills to counter the rising number of teenage pregnancies.

E. JSY and JSSK
Meghalaya Maternal Benefit Scheme (MMBS) has given an additional thrust to JSY in the state, which provides additional Rs.4000 up to 2 children. The JSY payment is done through bank cheque the payment is done timely. State is providing incentive to ASHA even if not
accompanying pregnant women to facility but has provided ANC care and motivated for institutional delivery.

Table 12 JSY incentive performance - Meghalaya

<table>
<thead>
<tr>
<th>Year</th>
<th>Institutional Deliveries</th>
<th>JSY paid</th>
<th>Home Deliveries</th>
<th>JSY paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-10</td>
<td>29,185</td>
<td>9461 [32%]</td>
<td>37,102</td>
<td>5195 [14%]</td>
</tr>
<tr>
<td>2010-11</td>
<td>31,564</td>
<td>12618 [40%]</td>
<td>38,919</td>
<td>4482 [12%]</td>
</tr>
<tr>
<td>2011-12</td>
<td>38,449</td>
<td>16260 [42%]</td>
<td>39,652</td>
<td>5168 [13%]</td>
</tr>
<tr>
<td>2012-13</td>
<td>41,266</td>
<td>16471 [42%]</td>
<td>39,435</td>
<td>3883 [10%]</td>
</tr>
</tbody>
</table>

Source: HMIS

Home delivery incentive disbursement was negligible as SBA attendance of home delivery is only 5% in the state. JSY is better functioning than JSSK in terms of IEC and awareness. IEC display for JSY was available and appropriate in 80% of facilities. However, drugs and drop back is an issue in JSSK. Some of the JSSK concerns include expenditure on drugs and transportation. It was observed that patients were asked to buy drugs due to drug stock outs at the state level, patients are not even compensated for procuring drugs from outside. No pickup facility available due to lack of centralized number, 108 not reachable due to network problem. The vehicle at the PHC is not used for drop back, instead beneficiary are given an estimated amount depending upon their home distance from the facility. Public grievance cell was not in place at any of the facilities.

F. Maternal and Infant Deaths

Facility and community based maternal death review committees are in place in the district and reviewing maternal deaths. CBMDR are more than FBMDR, this is attributed to the fact that districts have more than 70% home deliveries (with less than 5% assisted by SBA) and around 30% institutional deliveries. However, only 2% of maternal deaths are reviewed as against to reported maternal deaths in the state. Maternal deaths review need to be linked to action. Corrective steps required for addressing the identified cause of maternal deaths. There is need to improve the line listing of high risk pregnant women and timely referral by ASHA in the community. Infant deaths review are yet to initiate in the state.

Table 13 Cause of Maternal Deaths – Meghalaya

<table>
<thead>
<tr>
<th>Reported Maternal Deaths</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Obstructed/prolonged labour</td>
<td>19</td>
<td>25</td>
<td>29</td>
</tr>
<tr>
<td>Severe hypertension/fits</td>
<td>10</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>Bleeding</td>
<td>38</td>
<td>43</td>
<td>47</td>
</tr>
<tr>
<td>High fever</td>
<td>3</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Other Causes (including causes not known)</td>
<td>87 [54%]</td>
<td>112 [49%]</td>
<td>120 [52%]</td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>229</td>
<td>232</td>
</tr>
</tbody>
</table>
However, the IMR trend in the state shows improvement in reduction of infant mortality rate, which is reduced by 11% [6 points] from 2010 to 2012.

Graph 7 IMR Trends - Meghalaya

![IMR Trends - Meghalaya](image)

**G. Immunization**

RI outreach is good in terms of quantity such as VHNDs and fixed health days in the villages with no AWCs. AVD functional and cold chain management is regular, backup generator observed in visited health facilities. Preventive maintenance and repair systems/ people available in the district. Tickler box available and ILRs maintained in the facilities. Zero dose OPV/Hep B being given at all facilities and sufficient stocks available. Most ANMs at sub centers aware and delivering services as per guidelines viz. noting down time of reconstitution, ice packs availability, aware of correct administration site.

Preparation of due list requires much strengthening as home delivered babies are not being captured in due lists. There are variety of registers capturing information- manual/MCTS/ Institutional delivery/HBNC registers being maintained and all of these need to be synchronized to capture the correct denominator. Routine Immunization refresher orientation need to be undertaken as some ANM especially second ANM could not tell correct site of administration, 4 key messages etc. Measles vaccine expires on Nov. 2013 stocks need to be taken care of.

**H. National Iodine Deficiency Control Programme**

Sale of non-iodated salt has been banned in the state following the notification by the state government with effect from 17th May 2006 under the prevention of food adulteration Act 1954. The state IDD monitoring laboratory is located in Pasteur institute. However, sample collection and dispatching by the districts to the state lab for testing is a constraint.
The programme has not been active in the State from last few years, the last survey was done in 2010-11. The findings of the survey do not match DLHS; Training for program officers at state and district levels is required to enable proper implementation and monitoring. There is urgent need to revive the programme in the State.

**Recommendations**

a. Referral is not a possibility in State due to the terrain and dilapidated roads in the State, hence State should consider BIRTH WAITING HOMES near PHCs and CHCs wherein High risk Ante Natal women can be brought 2 days prior to their EDD. Such has been done in State like Tamil Nadu and State should propose for same in the PIP.

b. Rationalization and operationalization of L1/L2/L3 facilities–HR, Infra, supplies.

c. State needs to take immediate and strong efforts to train all SN/ANM at delivery points in SBA, RI, IUCD, IYCF,IMNCI and NSSK

d. Need to improve focus on a spectrum of activities (IEC/ IPC) to improve community demand for quality RMNCH+A services

e. Strengthen monitoring and supervision through
   a. District monitoring and supervision plan: technical supervision
   b. Assess capacity gaps of supervisory cadre and enhance the same

f. Sort the drug SCM issues / Ensuring availability of drugs

g. Mechanism to track referred sick newborns to facilities needs to be linked with HBNC for better monitoring of outcomes and better technical handholding of ASHA by MOs

**3. Disease Control Programs**

**A. Integrated Disease Surveillance program (IDSP)**

Broadband connection available in state and five district except East and South Garo hills in the state. In West Garo, the broadband connection is disconnected due to nonpayment of bills. Data center facilities, training centers and VSAT facilities available in state unit and across all the district. In Ri Bhoi, UPS not working and the facility shifted to a new building similarly, CPU in both the districts are nonfunctional. It is not evident how far IDSP data is in use for district planning in the state.

Epidemiologist are not recruited in Ri Bhoi district, which is essential for analysis and feedback. Data manager and DEO are maintaining data from available records. Many of equipment’s are out of order and needs up-gradation. No IT support for IDSP apparent in visited health center. However, existing system of reporting and available infrastructure is enough for better reporting provided all required resources available and functional. One of the major challenge in the state
is stable internet connection and state has to explore alternative source for uninterrupted internet connection in all the IDSP facilities.

1075 IDSP Toll Free number not available in the state and need to establishment state alert center. It is mandatory to report all state and private health institutions to the state surveillance unit but how many public and private institutions are reporting is a question?

B. National Vector Borne Disease Control Program (NVBDCP)
The state and the districts report malaria, dengue Cehikungunya and Japanese Encephalitis (JE). The state is supported by IMCP-II of GFATM. All 5 sanctioned posts of state level consultants and district level DVBDCOs (Dual charge), DVBDCs, DEOs, LTs and MPWs and 6276 ASHAs are filled up. 1 out of 3 posts of MTS in Ri Bhoi and 3 out of 9 in WGH are vacant. One post of Contractual MPW (M) in WGH is also vacant. Delay in funds and inadequate IEC material on NVBDCP in the state.

Graph 8 Performance of Malaria – Meghalaya

Downward trend observed in incidence of malaria cases, Plasmodium falciparum (Pf), Plasmodium vivax (Pv) and deaths due to malaria from 2009 to 2012 in the state and both the district. However, in comparison with previous year till September, malaria cases have increased by 10% from 16,539 in September 2012 to 18331 cases in September 2013. Similarly, Pf and Pv cases increased by 10% and 12% in the same period. Deaths related to malaria shows downward trend, from 197 deaths in 2009 to 52 deaths in 2012 which 73% change in death rate.
In Ribhoi district, there is an increase in 2013 (till Sept.) as compared to corresponding period of 2012 in Malaria cases to 1178 from 564, in Pf cases to 806 from 364 and deaths due to malaria to 5 from 2. However in WGH, there is marginal decrease in malaria particularly Pf cases and marked decline in malaria deaths in 2013 as compared to 2012. ASHAs are not aware, nor having RDT kit for diagnosis of malaria cases, ACT for treatment of Pf cases, CQ and PQ for treatment of Pv cases are not available with them. Even Paracetamol tablet is not available with ASHAs. However, RDT, ACT, CQ and PQ are available at district, sub-district and sub-center level. Due to lack of integration with vertical programs in the state, ASHAs incentives are inordinately delayed.

Reports of slides prepared by MPWs/ASHAs is communicated in 3-7 days and about 60% microscopes are not working and need of minor repair. National drug policy for treatment of malaria is not displayed or implemented at any health facility. Malaria cases are not treated below PHC level. Service providers and doctors are advising medicines from market as not having trust in government supply. Only two Sentinel Site Hospital (SSH) for Malaria are established in the state. SSH in WGH at Tura Civil Hospital is functional, but no SSH is identified in district Ri Bhoi. Although, second round of IRS has completed in October 2013 in both the districts, however quality of DDT Spray was very poor and needs intensive supervision. Hatchery and larvivorous fishes are available in WGH district.

Although, 30,000 bed nets and 15000 LLIN in Ri Bhoi and 1, 97,400 LLINs in WGH were distributed, however in field it was observed that some bed nets/LLIN were torn and not in use. NMMIS is not operational; however state is planning to conduct training of DEOs in December 2013. Monitoring, supervision and reporting is not as per NVBDCP guidelines.
There is marked increase in dengue and JE cases in 2013 as compared to 2012. 3, 16 and 24 Dengue cases have been reported in 2010, 2012 and 2013 (till Oct.). 11 and 26 cases of Cehikungunya were reported in 2010 and 2011. Two deaths due to dengue in 2012 were reported from Ri Bhoi. Three Sentinel Site Hospital (SSH) for Dengue and Cehikungunya are identified in the state as per NVBDCP, Delhi. SSH in WGH was functional. The cases load of JE has increased in 2013 (till Oct) to 27 from 9 in 2012. However SSH could not be identified in the state for diagnosis and treatment of Japanese Encephalitis despite several requests from NVBDCP. Fogging is not done in the affected rural areas. The State could not provide complete information during state presentation and field visits and response during state debriefing.

C. Revised National Tuberculosis Control Programme (RNTCP)

The state TB performance indicates that 5177 TB cases put on treatment for the period of 2012-13 with annualized total case detection rate per lakh population is 1534.5. Around 1674 new smear positive case put on treatment and annualized new smear positive case detection rate is 72% per lakh. The success rate for NSP cases detected in the last corresponding quarter is 82.28%. Two (2) DOTS Plus sites available in the state. The Drug Resistance TB (DRT) center Shillong covers the following district East Khasi Hills, West Khasi Hills, Jaintia and Ri Bhoi District. Similarly, Tura DRT covers West Garo Hills, East Garo Hills, and South Garo Hills.

Graph 10 Performance of RNTCP – Meghalaya

A total of 220 drug resistance (MDR) TB cases registered for treatment, which include 191 MDR at Shillong DRT and 29 at Tura DRT center up to November 2013. Tura DR TB center is not functional due to manpower. Position of DR TB Counselor is vacant. STO, APO and DEO are trained in NIKSHAY at National Level and all DTOs, DEOs, of Districts are trained in the state in NIKSHAY. Number of TB Cases registered in NIKSHAY up to 6th June, 2013 is 5584. Constraint:
Poor internet connectivity and needs support from NRHM to speed up the process of NIKSHAY entry

Sensitization and CME of private providers has been held in East Khasi Hills, Jaintia Hills for TB notification. Others districts have notified TB cases to their respective nodal officer (DTO). It appears that only 40 cases have been notified in the state, which is minimal at state level. Frequent transfer of trained officials is a challenge for the district and state. However, achievement of targeted case detection rate and cure rate has improved in Meghalaya. NGOs are involved in TB programme through PPP model but cross referral of TB-HIV patients needs strengthening. Poor utilization of PPD vials for diagnosis of pediatric TB observed. Mantoux test in the State is not observed. ASHAs incentives are not paid timely though they are the main DOTS provider at peripheral level

There is an overall shortage of Anti TB medicine in the State. As per directions from Central TB Division (CTD), some of the drugs are being managed locally by state level procurement and some drugs are also being managed by inter-state/district transfer wherever stock is available. Following are the drugs of which there are no/nil stock at State drug store though there is some minimum quantity left at the district drug stores.

PC-13, PC-14, PC-15, PC-16 for pediatric TB
Cat. I drugs for new patients and Cat.II drugs for previously treated patients.
Tab. Ethionamide.
Inj. Kanamycin.

The shortage of anti TB drugs is reported to Central TB division and fresh supplies of drug is under process from Central level. In case no immediate fresh supply of anti TB drugs to the state of Meghalaya, there may be a situation of acute shortage or crisis of anti TB medicine in the State.

D. National Leprosy Eradication Programme (NLEP)
ANCDR, RFT, Child cases and Grade-II cases of leprosy have shown reduction in 2013 from 2011. Prevalence Rate in 2013 is 0.09 and New Cases Detection Rate is 0.52. Registered cases and newly detected cases have decreased in 2013 by 16 from 61 in 2011. Leprosy cases are under reported as ASHAs incentives are not paid on case detection. MOs needs proper prescribed training. Reconstructive surgery can be started by providing instruments and training to eligible Officials.

Table 14 Performance of NLEP programme – Meghalaya

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Indicators</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13 (up to Oct 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No. of new cases detected (ANCDR/100,000)</td>
<td>14 (0.50)</td>
<td>17 (0.60)</td>
<td>20 (0.68)</td>
<td>61 (2.05)</td>
<td>36 (1.34)</td>
<td>16 (0.52)</td>
</tr>
<tr>
<td>2</td>
<td>No. of cases on record at year end (PR/10,000)</td>
<td>43 (0.15)</td>
<td>20 (0.07)</td>
<td>33 (0.11)</td>
<td>71 (0.23)</td>
<td>88 (0.12)</td>
<td>57 (0.09)</td>
</tr>
<tr>
<td></td>
<td>No. of Grade II disability among new cases (%)</td>
<td>0%</td>
<td>1%</td>
<td>4%</td>
<td>85%</td>
<td>16%</td>
<td>Nil</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>3</td>
<td>Treatment Completion Rate</td>
<td>29%</td>
<td>45%</td>
<td>63%</td>
<td>23%</td>
<td>35%</td>
<td>N.A</td>
</tr>
<tr>
<td>4</td>
<td>Reconstructive Surgery conducted</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>12</td>
<td>11</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Source: DHS, Meghalaya

E. National Program for Control of Blindness (NPCB)
Three eye OTs have built in the state including 1 in Ri Bhoi and in addition this, 50% of Tura and Ialong eye OT completed in WGH district. Only 927 cataracts operations were performed, 924 IOL were supplied and 5592 children were checked for refractive errors in entire state. However, eye surgeon not available in Ampati FRU CHC in WGH district. Four eye surgeon post are vacant out of 5 sanctioned posts in the state.

F. Involvement of AYUSH in National Health Programmes
Almost all health facilities are co-located with AYUSH clinics with consultation and dispensing rooms at CHCs and Dhs level. One room available for AYUSH at PHC level and treatment rooms are available only at DH level but nonfunctional. Beds for AYUSH are not earmarked, however available beds can be utilized. No separate Staff Room is available.

Doctors are placed but after the year 2009, no paramedic, pharmacist and helper recruited in the state. Essential equipment’s, instruments and furniture are available, but medicines are not supplied since 2009. Some of the doctors have received training in NSSK/ RCH/ NVBDCP/ RNTCP/ School Health programme and involved in some of these programmes. However, most of AYUSH doctors need orientation in NHPs to manage emergencies. AYUSH related performance is monitored at state level and recording and reporting AYUSH related information maintained at facility level.

It was observed that around 20 to 30 patients attend OPD per day. OPD services at Nongpo civil hospitals, Ri Bhoi is at first floor without any lift facilities, which is difficult for arthritis patients access the clinic. However, Ayurveda OPD was closed due to non-availability of doctor. IPD services for AYUSH clinics are not functional in the state and no separate IEC wing available for AYUSH programme.

Recommendations
1. All vacant post of MTS and MPW in WGH district should be filled up immediately. DVBDCOs should be fulltime officers and not engaged with in-charge. Avoid frequent transfer of trained officials.
2. National Drug Policy 2010 for treatment of Malaria should be displayed at all delivery points and implemented in entire state. Lab confirmation and start of treatment of Malaria
is expected within 24 hours and completeness of treatment has to be ensured as per NDP 2010.

3. Repair microscopes to make functional and condemn if non-repairable. Ensure availability of RDT kits for diagnosis, ACT, CQ and PQ for treatment of Malaria with all ASHAs.

4. ASHAs, ANMs are required to be trained in malaria and Orientation of Health functionaries on surveillance and management of Malaria cases and other VBDs.

5. Ensure source reduction by quality spray through intensive supervision activities, use of bed nets/LLIN, and use of Larvivorous fishes.

6. Cross referral in TB-HIV patients needs strengthening. PPD vials for diagnosis of pediatric TB should be properly utilized.

7. Reporting of leprosy cases needs strengthening by timely payment of incentives to ASHAs on detection of cases and completion of treatment. Reconstructive surgery can be started by providing instruments and training to eligible Officials.

8. Bill should be paid and action to be taken for working Broadband, CPU and UPS in all the districts. All vacant posts of Epidemiologist should be filled up and most of equipment’s needs up gradation.

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

10. Eye OT needs early completion and vacant posts of eye surgeon need to be filled up. Other NCD programmes need to be implemented in the state viz. NPCDCS, NTCP and MNHP etc. Continuous supply of essential medicines should be ensured.
4. Human Resources and Training

A. Generation of Health Human Resources

Over NRHM period the HR situation improved tremendously in district and state level. The recruitment of contractual staff under NRHM increased by 1142 personnel in 2013 from 120 in 2005, which is manifold increase in the state.

Table 15 Increase in Human resources for Health over the NRHM period – Meghalaya

<table>
<thead>
<tr>
<th>Year</th>
<th>State</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regular*</td>
<td>Contractual</td>
</tr>
<tr>
<td>2005</td>
<td>..</td>
<td>12</td>
</tr>
<tr>
<td>2006</td>
<td>..</td>
<td>16</td>
</tr>
<tr>
<td>2007</td>
<td>..</td>
<td>22</td>
</tr>
<tr>
<td>2008</td>
<td>..</td>
<td>24</td>
</tr>
<tr>
<td>2009</td>
<td>5221</td>
<td>24</td>
</tr>
<tr>
<td>2010</td>
<td>5227</td>
<td>39</td>
</tr>
<tr>
<td>2011</td>
<td>5231</td>
<td>46</td>
</tr>
<tr>
<td>2012</td>
<td>5242</td>
<td>46</td>
</tr>
<tr>
<td>2013</td>
<td>5656</td>
<td>41</td>
</tr>
</tbody>
</table>

Source: DHS, Meghalaya (* Regular staff consist both state and district no bifurcation given by the state)

B. Availability, Deployment and Workforce Management

The current HR status of the State is as shown in table16, which depicts that there is no rational deployment of HR especially when State has more than the required number of staff1 (number of sanctioned posts more than the facility based requirement).

Table 16 Status of Health Human Resources – Meghalaya

<table>
<thead>
<tr>
<th>HR categories</th>
<th>HR Requirement</th>
<th>Current HR Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All facilities</td>
<td>Sanctioned Reg. posts</td>
</tr>
<tr>
<td>ANM</td>
<td>537</td>
<td>807</td>
</tr>
<tr>
<td>SN</td>
<td>974</td>
<td>1088</td>
</tr>
<tr>
<td>LT</td>
<td>214</td>
<td>160</td>
</tr>
<tr>
<td>MO</td>
<td>254</td>
<td>515</td>
</tr>
<tr>
<td>Specialist</td>
<td>159</td>
<td>193</td>
</tr>
</tbody>
</table>

It is evident that even though more number of sanctioned positions are available, state has not been able to hire and/or retain the HR. This clearly indicates that state needs to have an HR policy in place so that the entire HR hiring, training and deployment process can be streamlined.

1 HR sheet provided by State as part of 2013-14 PIP
Differences between DHS and NRHM on HR issues viz. recruitment, training and deployment observed. In course of discussion it was observed that the State Directorate of Health Services and NRHM were not able to work in harmony with each other.

The sole principle of NRHM funds i.e. providing flexibility to State towards hiring and deployment of contractual staff is not being practiced in the State. All postings, be it regular or contractual are controlled by the DHS and as a result even though sufficient number of HR is available in the state, they are not been appropriately deployed viz. 2 EmOC doctors posted at Aampati CHC-FRU and 1 EmOC doctor posted at CHC- Dalu, but no provision of blood is made and CS are being conducted and SNCU in Tura district hospital is working with a single Pediatrician and only 3 SNs

C Training and Capacity Building
Lack of adequate training infrastructure both in terms of HR (Master trainers) and facilities observed in the state. The State only has 2 GNM schools and 1 ANMTC. Clinical trainings viz. LSAS, CEmOC and BEmOC trainings etc are carried out only at Ganesh Das hospital and 2 District hospitals. As for the RIHFW, it caters majorly to the regular staff trainings only and does not carry out any clinical training.

Given the fact that state has 60% home deliveries, SBA trainings of all the ANMs is a must; but the existing number of trainings sites and absolute lack of skill labs are not sufficient to handle the training load. This implies that State needs to propose and develop more training infrastructure and same can be proposed in the PIP. It was also observed that while selecting candidates for clinical trainings, preference was given to regular ANMs and SNs. State needs to ensure that such does not happen as all ANMs, SNs and other service delivery staff needs to be trained.

Recommendations
1. Establish HR cell in coordination with the Directorate of Health Services
The NRHM staff as well the DHS staff needs to come together and develop an HR cell and subsequently the State HR policy. Currently all the senior staff positions are new to the program i.e. MD – NRHM has joined 4 months ago, SPM joining 2 months ago and the Director DHS has joined just a week back. This situation can be en-cashed and the program heads can start afresh, coordinate and develop flexible policies and solutions to handle the HR crunch in the State.

2. Propose for more incentives for MOs as well as ANMs in the difficult and very difficult areas
The current incentive are not sufficient, State should propose for more incentives both for MOs and ANMs on lines of what States like Uttarakhand, Assam, J and K and Himachal have proposed.
3. **Ensure equal preference to contractual staff for trainings**

The pressing need of the hour in the State is to SBA train all its ANMs. Given such a situation there is no space left for preferential treatment and State should thereby train all its HR irrespective of the hiring mode of the same.

4. **A stronger political will/support/push required for the entire State’s HR situation**

Provision of health services needs to be a priority of the political heads of the State, as it contributes to the greater good of people by cutting down the out of pocket expenditure on health. Also health now needs to be treated as a right of the people rather than just a service delivery item. To manage this, the political leaders of the State need to support the HR policy and need to ensure the rightful and appropriate hiring and deployment of service delivery human resource.
5. Community Processes and Convergence

A. Panchayati Raj Institutions (PRI), VHSNCs and VHNDs
Poor engagement of VHSNC and PRI members in NRHM activities for addressing low institutional deliveries and high prevalence of communicable diseases observed in both the districts. Though the utilization of VHSNC funds is satisfactory but diversification in the activities for which the funds are being utilized is required. Poor involvement of PRIs members in activities of VHSNC and RKS observed in Ri Bhoi and West Garo Hills. The village headman select ASHA but it is observed that when headman changes there is possibilities of change in ASHA.

ANC is being partially done during VHNDs. Components such as HB%, urine examination, physical examination are not being done at VHND sites. No line listing of High risk pregnancies is being done in Ri Bhoi and West Garo hills. VHND monitoring mechanisms rudimentary in RB and WGH. Emphasis is more on immunization ignoring other areas.

B. ASHAs
As per 2013-14, the state has a target of 6544 ASHAs and 96% [6258] of them are selected. 7 DCM and 39 BCM are positioned in the state. Out of 312, 97% [303] of ASHA Facilitator are placed in the state. State has many challenges in rolling out training for ASHAs due to lack of fully equipped residential training sites at district and block level. ASHAs training usually takes place in PHCs/community halls in the districts. Due to unavailability of training sites many ASHAs were travelling daily to attend the training.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>District</th>
<th>No. of ASHAs</th>
<th>No. of ASHA Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>East Khasi Hills</td>
<td>1033</td>
<td>55</td>
</tr>
<tr>
<td>2</td>
<td>West Khasi Hills</td>
<td>1028</td>
<td>50</td>
</tr>
<tr>
<td>3</td>
<td>Ri Bhoi</td>
<td>534</td>
<td>26</td>
</tr>
<tr>
<td>4</td>
<td>Jaintia Hills</td>
<td>552</td>
<td>27</td>
</tr>
<tr>
<td>5</td>
<td>West Garo Hills</td>
<td>1617</td>
<td>80</td>
</tr>
<tr>
<td>6</td>
<td>East Garo Hills</td>
<td>952</td>
<td>28</td>
</tr>
<tr>
<td>7</td>
<td>South Garo Hills</td>
<td>542</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6258</strong></td>
<td><strong>290</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: DHS, Meghalaya

To claim HBNC incentives, ASHA fills the following forms – pregnancy form, birth preparedness form, delivery form, first visit of newborn form and home visit form. However, Ri Bhoi district reported high number of non-SBA home deliveries. ASHAs grievance are generally related to
irregular payment of disease control programme incentives like NLEP, NVBDCP. Provisions for ASHAs in the state include ASHAs rest house, which we found in all health facilities. ASHA help desk placed in all PHC and CHCs, along with uniform, bags and raincoat has been provided in the state. While interacting with ASHA they expressed their desire to have torchlight, which is useful during night times. State is also in the process of providing mobile phones including recharge support.

Around 69 ASHA were dropped out during 2012-13 and 286 villages yet to have ASHAs that include 88 new villages. Around 198 villages where ASHA cover more than 1500 population in the state. Government of Meghalaya planning to introduce single window payment (quarterly ones) for ASHAs incentives. Government willing to pilot test in Ri Bhoi district and guidelines were issued by secretary, health and family welfare, government of Meghalaya.

No grievance redressal mechanism available at district and state level for ASHAs. In Ri Bhoi district total 539 ASHAs were positioned and around 85% of ASHAs were trained in module 6 and 7. ASHA facilitators are filled in both the districts – 26 AF in Ri Bhoi and 80 AF in West Garo Hills.

**C. Convergence and Community Monitoring**

Access to safe drinking water is abysmally low as evident in Ri Bhoi and WGH and a large number of household are without proper sanitation facility (> 30% households). Tracking of SAM children and referral for nutritional rehabilitation is virtually absent. However, good convergence of education department with school health programme observed.

State has initiated piloting community based monitoring in 3 blocks each in three districts - East Khasi Hills, Jaintia Hills and west garo hills covering 9 blocks. Nodal person for each district appointed by the state and voluntary health association of Meghalaya act as nodal agency for community monitoring. Community monitoring is apparently absent in Ri Bhoi district. However, Jan Sunwai held in the month of March 2013 in piloted three districts of the state. Advisory group of community action constituted under the chairmanship of the mission director. Members include officers from various department and civil society from state. Around 30 visioning workshop for community monitoring held so far in the state. Similarly, 8 completed at the district level and 100 at block level. No grievance redressal mechanism in place and no ombudsman appointed to address the grievances of the community in the state.

**Recommendations**

1. State needs to organize re-orientation programme on NRHM activities to PRI and VHSNC members in the state. Ensure diversification of VHSNC fund at village level for optimal utilization.
2. State should develop comprehensive work plan to strengthen VHNDs and provide on-site support to ASHAs. Ensure ANC check-up and profiling of high risk pregnant women during VHNDs.

3. Develop supportive supervision mechanism at all levels – state, district and blocks to strengthen community process. Given the constraints for fully equipped residential training site for ASHAs, the district hospital could be ideal place to develop as fully equipped training center.

4. Directorate of health should resolve the issues related to disease control programme incentives for ASHAs. State should ensure the selection of ASHAs for remaining 286 villages in the state and maintain ASHA population ratio as per guidelines

5. Government of Meghalaya has already issued guidelines related to single window payment (quarterly once) for ASHAs as a pilot in Ri Bhoi district the outcome of the same should share with the MoHFW.

6. ASHA help desks available but state should establish grievance redressal mechanism for ASHAs at state, district and block level. Convergence with ICDS, RWS and other line department should be strengthen in the districts.

7. Anganwadi workers, ASHAs and other par-medical workers should be trained in identifying SAM children and referring them to nutritional rehabilitation center

8. State has piloted community based monitoring in 9 blocks of three district, which should extend across all block and districts in the state. State should appoint ombudsman to address the community grievances in the state

9. State to emphasize on proper record maintenance during the VHNDs with line listing of high risk pregnancies and SAM children. Special attention on orientation and training of ASHA facilitators particularly those who have not been selected from within the existing ASHAs

10. State should enhance non-monetary incentives for ASHAs for increased motivation in bring pregnant women to institutions.
6. Information and Knowledge

Data pertaining to the performance of India’s National Health Mission are critical to assessing the performance of the public health system and facilitating planning and resource allocation. As part of the Seventh Common Review Mission, the CRM Meghalaya team was assigned the task of assessing the functionality, successes and challenges of information systems designed to capture health data.

Beginning 2009, the state of Meghalaya has been implementing the reporting formats for the Health Management Information System (HMIS) developed by the Ministry of Health and Family Welfare, Govt. of India. Data from the formats, entered offline in MS Excel™ spreadsheets from facilities (PHC, CHC, Sub-Centres, sub-district and district hospitals) are compiled and uploaded on the HMIS database, and monthly, quarterly and annual data shared with the Ministry. The HMIS is to be used for tracking progress across the state with respect to antenatal care (ANC), deliveries, immunization, disease and disease control measures, and other indicators.

I. HMIS Formats

A. Forms to be submitted by States/U.Ts to Government of India

<table>
<thead>
<tr>
<th>S.No</th>
<th>Form No.</th>
<th>Form Name</th>
<th>Periodicity</th>
<th>Version</th>
<th>Submission Date</th>
<th>Last Update Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NHM/HG/1/A</td>
<td>Annual Consolidated</td>
<td>Annual</td>
<td>1.1</td>
<td>30th April</td>
<td>27th April 2010</td>
</tr>
<tr>
<td>2.</td>
<td>NHM/HG/2/Q</td>
<td>Quarterly Consolidated</td>
<td>Quarterly</td>
<td>1.1</td>
<td>20th of Month following respective Quarter</td>
<td>27th April 2010</td>
</tr>
<tr>
<td>3.</td>
<td>NHM/HG/3/M</td>
<td>Monthly Consolidated</td>
<td>Monthly</td>
<td>2.0</td>
<td>20th of following Month</td>
<td>22nd Nov 2013</td>
</tr>
</tbody>
</table>

B. Forms for use within States for internal reporting (Not to be sent to GOI)

<table>
<thead>
<tr>
<th>S.No</th>
<th>Form No.</th>
<th>Form Name</th>
<th>Periodicity</th>
<th>Version</th>
<th>Submission Date</th>
<th>Last Update Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>NHM/GS/1/A</td>
<td>Annual format for State</td>
<td>Annual</td>
<td>1.1</td>
<td>15th April</td>
<td>27th April 2010</td>
</tr>
<tr>
<td>5.</td>
<td>NHM/GS/2/Q</td>
<td>Quarterly format for State HQ</td>
<td>Quarterly</td>
<td>1.1</td>
<td>20th of Month following respective Quarter</td>
<td>27th April 2010</td>
</tr>
<tr>
<td>6.</td>
<td>NHM/DH/1/A</td>
<td>Annual format for District</td>
<td>Annual</td>
<td>1.1</td>
<td>5th April</td>
<td>27th April 2010</td>
</tr>
<tr>
<td>7.</td>
<td>NHM/DH/2/Q</td>
<td>Quarterly format for District</td>
<td>Quarterly</td>
<td>1.1</td>
<td>10th of Month following respective Quarter</td>
<td>27th April 2010</td>
</tr>
<tr>
<td>8.</td>
<td>NHM/DH/3/M</td>
<td>Monthly format for District HQ</td>
<td>Monthly</td>
<td>2.0</td>
<td>10th of following Month</td>
<td>22nd Nov 2013</td>
</tr>
</tbody>
</table>

C. Facility Level Forms for internal reporting

<table>
<thead>
<tr>
<th>S.No</th>
<th>Form No.</th>
<th>Form Name</th>
<th>Periodicity</th>
<th>Version</th>
<th>Submission Date</th>
<th>Last Update Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>NHM/DH/3/M</td>
<td>Monthly format for District hospitals</td>
<td>Monthly</td>
<td>2.0</td>
<td>5th of following Month</td>
<td>22nd Nov 2013</td>
</tr>
<tr>
<td>10.</td>
<td>NHM/DH/2/H</td>
<td>Monthly format for Sub-District hospitals</td>
<td>Monthly</td>
<td>2.0</td>
<td>5th of following Month</td>
<td>22nd Nov 2013</td>
</tr>
<tr>
<td>11.</td>
<td>NHM/HC/3/M</td>
<td>Monthly format for CHCs and equivalent hospitals</td>
<td>Monthly</td>
<td>2.0</td>
<td>5th of following Month</td>
<td>22nd Nov 2013</td>
</tr>
<tr>
<td>12.</td>
<td>NHM/HC/3/M</td>
<td>Monthly format for PHCs and equivalent facilities</td>
<td>Monthly</td>
<td>2.0</td>
<td>5th of following Month</td>
<td>22nd Nov 2013</td>
</tr>
<tr>
<td>13.</td>
<td>NHM/HC/3/M</td>
<td>Monthly format for SCs and equivalent facilities</td>
<td>Monthly</td>
<td>2.0</td>
<td>5th of following Month</td>
<td>22nd Nov 2013</td>
</tr>
</tbody>
</table>

Figure 2: Some reporting Formats for HMIS

Additionally, case-wise data on pregnant women and newborns are entered in the Mother and Child Tracking System (MCTS) online database – a system designed to track individual trajectories of maternal and child health.
The previous review of Meghalaya (Third CRM, 2009) noted, “While HMIS [was] in place, systematic analysis and understanding of data and feedback to facilities or its use for planning or effecting corrections was not visible.”

Further, feedback from the MOHFW on the MCTS performance observed that only 48.28% pregnant women and 27.62% children have been registered on the system so far (status as on 4th November, 2013), and only 0.89% of registered pregnant women had received all four ANC services. MCTS data also indicated that of 4,640 children born in September 2012 and registered, 83.36% received all doses of BCG whereas only 24.72% received all doses of OPV, only 24.83% received all doses of DPT and only 3.81% received full immunization.²

**Study questions**
The CRM VII visiting Meghalaya was tasked with exploring answers to the following questions concerning information systems for health:

- What are the key processes of NRHM data consolidation, verification and transmission from facility to state levels in Meghalaya?
- What good practices and challenges exist in the above processes, training, infrastructure, and utilization of data for program monitoring, improvement and planning?
- How can we strengthen HMIS and MCTS information systems in Meghalaya?

**II. Methods**
The CRM VI team visited the state headquarters in Shillong, and 25 facilities and seven villages in the districts of Ri-Bhoi and West Garo Hills from Nov 9-14, 2013 (see Table 1).

The study pertaining to data and information systems was primarily qualitative, and relied on interviews with the following categories of staff:

- State: HMIS Consultant
- District: District Data Manager
- Block: Block Data Managers, Block Programme Manager
- Facility- and Field- levels: ANM-s, PHN-s, HE, DEO, GNM, LHV, Accountant

These were supplemented with observation of registers, summary sheets and manual verification against HMIS extracts for Q1 and Q2 of FY2013

**III. Results**
The team observed that most facilities are not capacitated to enter data into the HMIS spreadsheets - and this activity is primarily carried out at the block level and at certain CHCs.

The typical flow of data is as follows:

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² MOHFW, Nov 4, 2013: MCTS Key Concerns - Meghalaya
HMIS data from registers are compiled into monthly summary sheets by ANM-s (sometimes with the help of HE-s). Facility-wise summary sheets are verified by PHN-s and signed off by the Medical Superintendent. These are then taken to the block, where data are entered into Excel formats by the BDM, who also validates (see Annexure 3) and verifies them against compiled sheets and/or registers.

- In the Nomgphoh Civil Hospital, data are compiled by the PHN from the in-patient services and given to the DDM.
- Uploading into HMIS database is done at District Level with validation and verification by DDM. These data are received, consolidated and further validated at state-level by HMIS consultant.
- MCTS data are compiled from registers at facilities by ANM-s (separate forms for mother and child) and entered in the online MCTS database at CHC (by accountant) or district or state level, depending on availability of uninterrupted internet connection. This compilation tends to be sporadic.

Salient Features
Based on the CRM team’s observations at state level and in two districts and blocks, the Meghalaya health system has committed and knowledgeable HMIS staff (HMIS consultant and data managers). At the field level, ANM-s who compiled data, and the PHN-s and HE-s were supportive and competent, particularly in Ri-Bhoi facilities.

Facility data examined in registers at CHCs and PHCs were found to tally fully with the HMIS data for the – validation and verification at block and district levels appears to be strong.

Challenges
Challenges were observed in three principal areas: infrastructure and connectivity, data quality and utilization, and human resources.

Infrastructure and Connectivity: The team learned that the 2 MBPS line leased from NIC has frequent outages. These, combined with power disruptions make it difficult to submit data on time (District, Block, Facility level). This is particularly critical for MCTS as the data have to be entered directly on the online database, and have to be re-entered if there is Internet or power outage.

Data Quality and Utilization: In the area of HMIS, discrepancies were identified in the Sub Centre-level data, where the monthly ANC totals manually computed from the MCH registers did not tally with the reports downloaded from the HMIS.

With respect to MCTS, the team learned that high prevalence of home deliveries leads to some mothers and children not being included in MCTS. For instance, in FY 2012, only 23% ANC were registered in MCTS. Further, delays in MCTS report and work plan generation, leads to limited use of data by frontline health workers for planning and gap identification.
**Human Resources:** At facility level, there appears to be a lack of dedicated human resources for data entry (at one CHC, the work was taken up by a facility accountant), and this is an additional reason for data being entered at block level. Further, due to staff attrition and transfers, some of the staff at facilities are relatively new and have yet to be trained on the HMIS system.

PHN-s in one of the visited districts (West Garo Hills) had a poor understanding of the systems of data validation: however, this was not the case in Ri-Bhoi.

**Recommendations**

As compared to the state of Meghalaya’s HMIS during the last CRM review of 2009, it is evident that the system is functional and several systems of data consolidation, validation and verification are in place.

The team recognizes the challenges posed by unpredictable power availability and Internet connectivity, and difficulties of service delivery and mother-child tracking, which have implications for the completeness of HMIS data and their utilization.

(i) **Human Resources and Capacity Building**

Staff at facilities needed to be enabled to enter data at their own facilities on spreadsheets and have them verified before submission to the next level. To make this happen, basic computer literacy for facility staff is essential. If feasible, data entry operators may be recruited. Further, training of frontline health workers in data verification prior to submission of compiled sheets, and in use of data for planning and gap analysis is important.

Training of state, district and block DMs in basic statistical analysis would improve the use of data for monitoring and decision-making at all levels.

(ii) **Infrastructure and Connectivity**

Internet connectivity improvement is needed to enable rapid consolidation and analysis. The NRHM is urged to ensure availability of UPS, functional AMCs and rapid response to computer malfunctions at facilities.

(iii) **Service delivery and reporting**

Several components of service delivery (discussed in the other parts of the overall report) and reporting need to be strengthened to ensure availability of data for the HMIS and MCTS. For instance case-wise reporting of registered ANCs and their live births needs to ensure complete entry of all other components such as the full spectrum of antenatal and post-natal care, and of immunization data.

(iv) **Data-entry modules and data-entry**

- Of the hospital MIS (HOS-MIS) functioning at the Nomgphoh Civil Hospital, only two modules are currently functional. Complete development of the HOS-MIS is necessary.
- MCTS offline data entry prior to uploading must be enabled
- At facilities, register entry can start on a new page for every month with serial numbering commencing for each month, to reduce summation errors
7. Health Care Financing

A. Finance and Administration

Finance Personnel: At state level, key post of the finance (i.e. Director Finance) is vacant. State has planned to appoint a full time director finance/finance advisor, preferably retired finance officer of state finance services or central allied services and advertisement in this regard would be put up by December 2013. Status of other finance personnel is as below table.

Table 18 Status of Finance HR – Meghalaya

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of the post</th>
<th>Sanctioned</th>
<th>Positioned</th>
<th>Vacant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Director Finance</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2.</td>
<td>State Finance Manager</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3.</td>
<td>State Account Manager</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4.</td>
<td>District Account Manager</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>5.</td>
<td>Block Account Manager</td>
<td>39</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>6.</td>
<td>CHC/PHC Accountant</td>
<td>118</td>
<td>118</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: DHS, Meghalaya

Maintenance of Books of Accounts: At state level Tally is used for maintaining Books of Account but not customized version of Tally ERP. At District and block level manual books of accounts are maintained. Other observation on maintenance of books of accounts are as under-

Books of accounts are not updated and delay is ranging from 2 to 3 week like
(1) PHC Byrnihat books are up to 25th October, 2013.
(2) District Hospital Nagpoh- Book is updated up to 30th October, 2013.
(3) PHC Umtari - Books are updated up to 31/10/1013

Cash books are not closed on daily basis. It is observed that in Nagpoh DH, daily cash book balance were not maintained and not even in chronological order (i.e. April to July in a cashbook). After completion of cash books, the next cash books start with August leaving 15-20 pages, after completion of September they start October on left side of the pages. It indicates that the books of accounts are not maintained properly as per required norms.

Most of facilities do not preparing Bank Reconciliation Statement (BRS) on monthly basis. Facilities, which are preparing BRS is not in proper shape, instead of separate BRS for each account they prepare combined bank account BRS. Fixed assets register are not maintained by the facility and large amount of cash retained at DH Tura, WGH, ranging from 2 to 7 lakhs under RCH Flexi Pool in 2012-13.
Cheque issue register was not properly maintained as it does not record number, date of signing etc. Further, frequent cancellation of cheques (Cheque No. 202517, 21,33,35,39,53,57 and 59) at State level observed that shows week financial management.

B. Accountability
Auditing: State has mechanism of auditing like statutory audit and concurrent audit. Statutory auditor of the previous year was re-appointed as auditor of 2012-13. Auditor has submitted the audit report for the financial year 2012-13. Concurrent audit for the year 2013-14 has been done but report yet to submit for the 1st and 2nd Quarter of 2013-14. Major observation on the audit are as follows-

Appointment of concurrent auditor is not made timely. Concurrent auditor submit report very late as concurrent report of the 1st and 2nd Quarter of 2013-14 is yet to be submitted. Audit report is not analyzed as no action taken report was found at any level.


C. Fund Flow
Funds are transferred from state to district and district to block electronically through RTGS and NEFT. But below Block level funds are transferred through the cheques. It was observed that funds are released from state to district mostly pool wise funds like RCH Flexi Pool, additonalities, and Polio Immunization (PPI). From district to block, activity wise like JSY, ASHA training, untied fund, annual maintenance grant, IEC/BCC etc. However, in Re-Bhoi district, it was observed that funds released were not detailed break-up which create problem for accountant in identifying and recording of the funds.

AMG and untied fund to sub-center could not be released till the date of visit. Funds are released to the district as per the approved DHAP. It was observed that reporting of expenditure is very poor for example, sub-center submit their expenditure report once in a year. PHC/CHC submit their expenditure report on monthly basis but there is no proper format whereby one can find out monthly expenditure as well as cumulative expenditure of the year.

FMR does not reflect physical progress along with the financial progress. Funds regarding untied funds and RKS are not released on differential finance basis means considering the delivery load of the health facilities. Funds of RKS, AMG and untied funds was released on lump sum basis, without considering unspent balance at the beginning of the year. In Re-Bhoi district, at Umtari PHC, which is under PPP model with Karuna Trust does not submit any progress report to the NRHM.
Fund Utilization: Funds are utilized for the activities approved in the PIP. Utilization is reported to the state by district by way of submission of FMR on monthly basis. Utilization status for 6 months of 2013-14 (up to 30th September, 2013) under major heads exhibit in below graphs for respective districts.

Graph 11 Utilization status of fund (6 months) for Ri Bhoi District – Meghalaya

Graph 12 utilization status of fund (6 months) for West Garo Hills District – Meghalaya

From above graphs, it clearly indicates that the fund utilization under JSY, untied fund, AMG and RKS is very low.
Training for Finance and Account Professionals: Training of finance and account personnel was conducted in 2011. Considering the employee turnover under NRHM, status of training is not satisfactory. However, state has planned to organize four training session in 3rd and 4th quarter of 2013-14 (I- CPSMS, II- Basic Accounting, III- Audit observation and IV- Tally Implementation. During the interaction with the finance and account personnel, it is necessary that they need training on financial management at all level.

Tally ERP.9 Implementation: State has procured NRHM customized Tally ERP.9 version up to block level. However, the same is not being used due to various technical problem (data many times get omitted while generating reports, system crash etc.). Therefore, at state level normal version of Tally ERP.9 used. However, district and block level books of accounts are being maintained manually.

Diversion of Fund: Diversion of fund from one programme to other programme was found. In Re- Bhoi district diversion of fund from one programme was frequent without any approval.

Financial Integration under NRHM: Financial Integration under NRHM has been made and Main bank account as well as group account for the NDCPs has been opened at state level. However, no such arrangement at district level and funds are transferred directly to the bank account of the disease control programme. Further, disease control programme does not submit financial reports to the state/district health society. Therefore, state has to do more on integration of the National Disease Control Programmes.

Utilization of interest earned on NRHM programmes/not: Interest have been clubbed into the pool and utilized against the approved activities in the PIP.

Implementation of Model Accounting Handbooks: operational guidelines for financial management and model accounting handbooks for sub-district level finance staff has been not disseminated properly. It was observed that only accountant of few facilities like Bhoirymbong CHC has model accounting handbooks.

Recommendations
1. Key post of finance director, which is vacant in the state needs to be filled-up on priority basis. Release of AMG and untied funds to the sub-center and VHSNC should be streamlined.

2. Expenditure is not reported by the lower units on regular basis. Therefore, it is requested that the state should monitor the activities on a monthly basis both release of funds and their utilization under the selected activities like untied funds, AMG and RKS funds. It is recommended that a special monitoring cell should be established at the state as well as district level for regular monitoring of the progress of activities.

3. Training to finance staff should be provided at the state level, so that the opportunity of cross learning as well as exposure can be expected. It is recommended that 4 days training programme (2 days on Tally ERP.9 and 2 days on Operation Guidelines and Model Accounting Hand Book developed by the MoHFW) can be made and thereafter 1 day
refresher training at 6 months interval should be organized. As for as possible state concurrent auditor should also be involved in such training programme.

4. Concurrent audit system needs to be strengthened with a view to obtain hand holding support of the concurrent auditor. Report submitted by the auditor should be analyzed and corrective measure should be ensured by the state officials.

5. Financial Monitoring Reports (FMR/SoE) are prepared by the districts and blocks but it does not have a) Physical Progress along with the financial progress; b) Progress of the National Disease Control Programme and c) an office order should be issued to the district in this regards.

6. Integration of National Disease Control Programmes (NDCPs) should be smoothen since NDCPs does not submitted its expenditure report to the state/district health society. Funds of all programme should be routed through the state and no separate bank accounts are maintained for each programme at district level due to which programme wise tracking of fund cannot be made and there is always possibility of diversion of funds. Therefore, banking arrangement should be made as per the guidelines of the Ministry.

7. It was observed that the staff are not aware about the utilisation of untied fund and AMG, mainly at sub-centre level and VHSNC level. Therefore, an awareness programme for staff as well as PRIs members should be organised to disseminate that how and for what purposes that funds can be utilised. As RKS fund should be utilised with the decision of the Rogi Kalyan Samiti (RKS) but in very few cases meeting minutes was found and meeting of the RKS is not so regular.

8. It was observed that state has provided quarterly payment for ASHA incentive considering the difficulty in access of banking facility and quantum of the incentive. In this regards it should be noted that it should not be a long term solution and state should reconsider the decision in order to provide liquidity to ASHA. As a long term solution it is suggested that state should implement the CPSMS on priority and make payment of ASHA incentive and JSY payment through DBT (Direct Benefit Transfer) Scheme.
8. Medicine and Technology

Key Questions:
- What policies and systems are in place for ensuring free essential drugs, diagnostics and equipments?
- What is the degree of availability of facility wise Essential Drug Lists (EDLs), drugs, equipment, and assured diagnostics at facilities.
- What are the mechanisms of drug and equipment procurement, including tools and manuals? What is the availability of essential drugs?
- How is quality being ensured for drugs diagnostic services and equipment?

Findings:
- Warehouses existed in both districts West Garo Hills (WGH) and Ri Bhoi. The one in WGH was not yet functional whereas in Ri Bhoi it was operational but lacked power supply and drugs requiring refrigeration were housed in another room at the Civil Hospital.
- EDLs were displayed, but some essential drugs IFA, Zinc, Vit –A, Vit-K, Misoprostol and supplies like gloves were absent in the state and both districts.
- Availability of ORS, paracetamol and condoms varied across facilities and were mostly absent in Ri-Bhoi, as per the ASHAs.
- Demand based and rational supply of drugs, supplies and equipment was lacking. One CHC (Rimrongpara SC, WGH) had been conducting three deliveries a month had one labour table, two old radiant warmers and two cots without mattresses. Some facilities (SC-s) in RB that conducted deliveries did not have a bed or radiant warmer.
- Community members in one Ri Bhoi village (Thadnongyiaw, near Iapngar DC) said they did not seek public health services because they did not have any of the needed medicines/supplements.
- Free Drug policy not implemented and out of pocket expenditure found to the amount of Rs. 100 observed for many patients. Simple drugs like Diclofenac, Inj Realgen, Syrup Quinine were being bought from outside.
- ProMIS not implemented.
- No new rate contracts between state and suppliers for past three years.
- No cold-chain mechanics in Ri Bhoi but was available at WGH.

Challenges
Drug, Equipment and Supply Availability
a. Demand based and rational supply of drugs, supplies and equipment was lacking. One CHC (Rimrongpara SC, WGH) had been conducting three deliveries a month had one labour table, two old radiant warmers and two cots without mattresses. Some facilities (SC-s) in RB that conducted deliveries did not have a bed or radiant warmer.
b. Many needed drugs such as IFA, Zinc, Vit –A, Vit-K, Misoprostol and supplies like gloves were lacking. Community members in one Ri Bhoi village (Thadnongyiaw, near
Iapnar DC said they did not seek public health services because they did not have any of the needed medicines/supplements.

c. Free Drug policy not implemented and out of pocket expenditure found to the amount of Rs. 100 observed for many patients. Simple drugs like Diclofenac, Inj Realgen, Syrup Quinine were being bought from outside

d. ProMIS not implemented

e. No new rate contracts between state and suppliers for past three years

f. No EDLS in WGH

**Human Resource Capacity**

a. In one facility (Rimrongpara SC, WGH) the ANM, despite being trained in using the radiant warmer lacked knowledge to utilize the instrument.

b. No cold-chain mechanics in RB

**Recommendations**

1. Operationalize the drug warehouse (WGH) and ensure power supply (RB) at earliest

2. Computerize and ensure timely and rational distribution of drugs, diagnostics and equipment to all the facilities (ensure ProMIS implemented immediately).

3. Integrate state and NRHM (central) drug supply system and warehousing
9. National Urban Health Mission

1. Urban Slums

As per the provisions of Meghalaya Slum Areas (improvement and Clearance) Act, 1973, about forty five slums have been identified and notified in the state. The state runs 19 Urban Health centers to cater to the needs of the urban poor in terms of basic health care services. UHC includes Shillong (13), Jowai (2), Nonstoin (1), and Tura (3). These UHCs are functional and required additional manpower, equipment and medicines to make it fully functional. Mapping of Shillong UHC annexure-1

72% [454111] of the state’s total urban population is concentrated in two major cities – Shillong and Tura. Generally slum pockets in the state are located in low lying and water logged areas with poor sanitary conditions. Problems include lack of access to basic services like water supply, electricity, toilets, sewerage, health care facilities etc. Poor civic amenities and inadequate sanitation are widespread in slums.

Table 19 Details of cities/towns to be covered under NUHM

<table>
<thead>
<tr>
<th>Sl.no.</th>
<th>Name of the city/town</th>
<th>Type</th>
<th>Pop 2011 census</th>
<th>No. of Slums</th>
<th>Slum Pop</th>
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<tbody>
<tr>
<td>1</td>
<td>Shillong</td>
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<td>Tura</td>
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<td>3</td>
<td>Jowai</td>
<td>District HQ</td>
<td>28430</td>
<td>14</td>
<td>15882</td>
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</tbody>
</table>

(Source: Census 2011) Tura and Shillong proposed for NUHM 2013-14

State proposed NUHM in three major towns – Shillong, Tura, and Jaintio Jowai. Three towns cover 68 slums out of which 29 are notified slums. Urban RCH Service delivery indicators like ANC and PNC show poor performance (31% ANC, 19% PNC)

2. National Urban Health Mission (NUHM)

State has prepared and submitted city and state level NUHM PIP. City level mapping of availability of health infrastructure, manpower and equipment in urban slum completed.

Recommendations

1. Cities and state level mapping of community structures such as youth clubs, self-help groups, CBOs etc needs to be completed.
2. Inadequate outreach services in urban slum and need to plan outreach activities within available UHC facilities in the cities.
10. Governance and Management

1. Program Management
It was reported that the Principal Secretary, Government of Meghalaya has already taken an initiative and has issued an order to strengthen integrated NHM management structure. NRHM strategy of decentralization, integration of vertical programmes, Health system strengthening and inter-sectoral convergence will take some time to be fully functional. The ultimate goal of NRHM was that the delegation of powers to local health institutions will be done in a manner so that they can take the responsibility of health of people in their catchment area with the help of PRIs was neither seen nor reported.

The structure and functioning of MPMU is in place and it is well integrated with Department of Health and family Welfare. All the State level offices (Except HIV and AIDS, CD) are in same premises. This proximity also facilitate the integration and convergence. The well qualified and enthusiastic contractual staff hired from open market is assisting Government Officials in most of the component areas in a Mission Mode. The experienced Government officials have to provide systematic direction to the contractual staff this will accelerate the pace of each programme and the objectives will be achieved in stipulated time.

There is an optimal mix of experienced Government staff with young, qualified, enthusiastic and energetic open market staff. This is in a way helpful to move the NRHM in the desired direction. Although there are a few issues with regards to the quality of the output and satisfaction. It was seen that there is ample scope to improve the delegation and decentralization of powers at State level in decision making with regards to both financial and administrative matters. As per guideline they have the powers in administrative matters. Lower level health delivery points are required to run the programme efficiently and effectively but somehow the government officials are not taking initiative in this direction.

2. Institutional Mechanism
All the DHS and RKS are found to be functional. District officials reported that the additional fund through donations etc. was not generated in RKS. There is a provision of supervision and monitoring visits at a regular interval, but these are not taking place. It was reported that one coordination meeting every month at the district level is scheduled which result into higher coordination and cooperation among District hospital staff and District management unit. Indifference among hospital staff was noticed during the visit probably they were not mentally prepared.

3. Supervision and Monitoring
At CHC level Review and feedback mechanisms was reported to be in place. It was also reported that a team of two senior officials visit the facility every time once in six months. The records
show that there is a provision but last visit was made in December 2012 which means that frequency is not maintained.

A form 1C District Quality Assurance Group has been filled by the officials during the visit and accordingly instructions are provided. There are 8 sections regarding – Providers availability, Infrastructure, Protocols and job aids, Infection prevention practices, Equipment and supplies, Availability of family planning practices, Maternal health screening and counseling, and Newborn care and immunization. Feedback to the MO in charge is provided so that the improvements measures can take place.

Regularity in Monitoring visit from State level to district and from district to lower facilities needs to be strengthened. A regular visit followed by feedback mechanism is surely going to improve the condition of the health facility. It was reported that there has been a provision of Supportive Supervision which means that the higher officials visit and guide the CHC or PHC staff so that the Medical officers of lower facility should feel motivated. While examining the records it was found that there was no regularity of supportive supervision.

4. Accountability
Although the State level officials know the importance of accountability but no formal systematic mechanisms for social audit and other accountability measures for health has been initiated in Meghalaya. It was reported that there was no Vigilance system at the district level. Regarding grievance redressal there is no special provision although at one CHC it was reported that during the meeting they try to resolve almost all the issues which are basically interpersonal.

A drop box for complaints was also placed but it was reported that no complaints has been received. The inconsequential complaints were reported to be solved during the meetings and as such there were no serious complaints in last six months.

5. Regulations
The officers were aware about PCPNDT rules and Clinical Establishment (Registration and Regulation) Act, 2010 for Registration and Regulation of Clinical Establishments. It was told that the Director Medical Institution has to take initiative to have the regulatory system in place for all Private and Public Clinical establishments. There was an issue of up-gradation of PHC to CHC. The Doctors reported that their PHC was catering more villages and patients but still it was not upgraded to CHC where as other PHC which was catering to lesser villages was upgraded to CHC. This de-motivates their team.

Almost all doctors were of the opinion that they were capable of handling the diseases but when it comes to management and administration they were lacking these skills. They were already overworked as there was dearth of human resource. As in some of the health care facilities construction was going on so doctors were running from pillar to post to ensure the procurement
of raw material, payment, etc. to achieve quality of construction as well as performing their main duty i.e. to attend patients and ensure the proper treatment.

They told that such hectic schedule make them tense, they feel burdened and have a pressure to perform by the evening they are under heavy stress. They requested to arrange a training in stress management. There was a mixed reaction on the issue of creation of separate Public health cadre. Some of them told that the creation of public health cadre will improve the health delivery system. The patients as well as the doctors will also be relieved from additional pressures of management and administrative responsibilities. This group of skilled people will take on the responsibility of managing the health care facilities in more efficient and effective way. The others were of the opinion that the doctors if trained in management skills will be in a position to carryout both the things more efficiently and effectively.

6. SWOT Analysis
The strength was that the state level officials are very attentive and experienced. In addition to this they have a group of young qualified and enthusiastic group of people hired from open market. Thus there is a synergy in the efforts at state as well as district level. Another strength was of good adequate infrastructure at all the levels. Third strength was that they were open to suggestions and ready to change provided they get some guidance from center.

The weakness was that the staff at all levels was not trained in management skills. Thus management trainings on the issues like TQM, Stress management, Leadership, OB, Motivation etc. were required at all levels of health delivery system. Another weakness was that they were unable to optimize the use of existing infrastructure and equipment in the absence of guidance from experienced staff.

The opportunity is that in country there are specialized institutes which provide such training in health and hospital management. So the state training officer need to conduct a Training Need Assessment TNA at all the levels by themselves or hire a professional agency which will do TNA for them and on the basis of that they can organize a series of trainings of the staff.

The threat is that the individual who receives these trainings after building their skills in specific areas may join some other organization. Thus talent retention will be an issue after skill building of personnel. The state will have to offer good working conditions, salaries and use emotional intelligence to retain good performers on the basis of their appraisal.

Recommendations:
1. Looking at the geographical difficulties of the state special structures at different levels can be proposed to cater the needs of the people living in area which have difficult access.
2. State level sharing forums should be provided every six months to all the employees so that they can share their good as well as bad experiences on a common platform honestly. This will enrich the learning’s of the state and provide an opportunity of cross learning. Many other programmes in health and education field have proved this strategy to be very helpful in shaping the programme.

3. Supportive supervision from state level needs to be provided on a regular basis in a systematic way. This is going to help the lower level officials to share their difficulties and to State level officials for taking corrective measures at a fast pace.

4. Systematic and continuous field visits to CHC and PHC from district level officials will be of great help in boosting the moral of the officials who otherwise do not get any chance to interact with the senior doctors/officials.

5. Creating mechanism for handholding is necessary for any intervention to be successful. For this the frequency and duration of the visits matters. One night stay at the lower facility will drastically change the perception of the officials and they will get ample opportunity to understand the root causes of why the things are not moving in the desired way and what options/actions will work.

6. Systematic grievance redressal mechanism has to be in place. Different models of social audit may evolve in different districts. Initiative needs to be taken to set up vigilance committees at all the levels.

7. For having the regulatory system in place the director of medical Institution needs to take proactive roles.

8. Force field analysis needs to be carried out in Meghalaya in order to ensure the benefits of change in Governance and Management.
OFFICIALS PRESENT AT THE STATE DEBRIEFING MEETING HELD ON 15TH NOVEMBER 2013

1. Dr L L Sawain- Director MCH& FW cum Jt.MD NRHM
2. The Director of Health Services (Research) Shillong.
3. Dr Mawlong- The Dy. Director of Health Services (Malaria) Shillong
4. Dr D Nongkynrih- The Dy. Director of Health Services (MI) I/c SHEP, Shillong
5. Dr J V Shullai- The State TB Officer, Meghalaya, Shillong
6. Dr D.K. Raswai- The Nodal Officer, AYUSH, Directorate of Health Services (MI) Shillong. –
7. Dr T Nongkhlaw- The State Leprosy Officer, Shillong
8. Dr R Budnah- The Surveillance Officer, (IDSP), Directorate of Health Services (MI) Shillong
9. Dr P Nongrum- The Programme Officer, (IDD) Directorate of Health Services (MCH & FW) Shillong
10. Dr Chyne- The Programme Officer, (UIP) Directorate of Health Services (MCH & FW) Shillong
11. Dr M Nonghuloo- The State Program Officer NPCB
12. Mr M. Shylla- PHE,Executive Engineer
13. Dr William- Director Regional Training Institute
14. Dr. E. Chyne, Addl. DHS (MCH&FW), Directorate of Health Services, Shillong.
15. Dr. E.Shullai, Jt. DHS (MCH&FW), Directorate of Health Services, Shillong.
16. Dr. P. Dohtdong, Jt. DHS (MCH&FW), Directorate of Health Services, Shillong
17. Dr. K. Lyngdoh, Jt. DHS (MCH&FW), Directorate of Health Services, Shillong
18. Dr. B. Mawthoh, Jt. DHS (MCH&FW), Directorate of Health Services, Shillong
19. Dr. P. D. Chyne, Dy. Director (MCH&FW), Directorate of Health Services, Shillong
20. Dr. M. Kharshiing, Asst. DHS (MCH&FW), Directorate of Health Services, Shillong
21. Dr. P. Nongrum, Senior M&HO, Directorate of Health Services (MCH&FW),Shillong
22. Dr. S. Kharkongor
23. Dr. Larintuangi
24. Dr. C.B. Sangma
25. Mrs. Ibamonlang Nongbri
26. Mr. Malcolm S. Kharshiing
27. Mr. Nathaneal Dkhar
28. Mr. Joel E. Suchiang  
29. Mr. Banrilang Tallang  
30. Mrs. Juliesha Kshiar  
31. Mr. Ethel Mikel Wahlang  
32. Mr. Mac Gifferet L. Nongpiur

### Meghalaya – District wise CRM team composition

<table>
<thead>
<tr>
<th></th>
<th><strong>Ri Bhoi District</strong></th>
<th><strong>West Garo Hills District</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Sher Singh Kashotia</td>
<td>Asst. Dir, NVBDCP, MoHFW</td>
<td>Dr. Adarsh Kumar</td>
</tr>
<tr>
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<td>Asst. Dir, AYUSH, MoHFW</td>
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<tr>
<td>Dr. Vipin, RO, AYUSH, MoHFW</td>
<td>Mr. P L Verma</td>
<td>DS M/o Tribal Affairs</td>
</tr>
<tr>
<td>Dr. L. Ramakrishnan SAATHI</td>
<td>Dr. Sudha Balakrishnan</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Dr. Alok K Mathur Associate Prof, IIHMR Jaipur</td>
<td>Dr. Gautam B</td>
<td>WHO Consultant, RNTCP</td>
</tr>
<tr>
<td>Dr. Ruchika Arora Consultant, MoHFW</td>
<td>Dr. Shahab Ali Siddiqui</td>
<td>Consultant, NRHM-I, MoHFW</td>
</tr>
<tr>
<td>Ms. Pallabhi B Gohain Consultant VBD, MoHFW</td>
<td>Dr. Pooja Passi</td>
<td>TMSA</td>
</tr>
<tr>
<td>Mr. Venkatesh Roddawar NHSRC</td>
<td>Dr. Nikhil Herur, Consultant, MH Div., MoHFW</td>
<td></td>
</tr>
<tr>
<td>Mr. Dharmendra Kumar FMR Consultant, MoHFW</td>
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Annexure 3

Annexure 3 Photographs

![MCH register at a Sub-Centre in Ri-Bhoi district](image)

Figure 3: MCH register at a Sub-Centre in Ri-Bhoi district