MIZORAM
8TH COMMON REVIEW MISSION

CRM Dissemination Meeting
Feb 16th, 2015
CRM Team Members

<table>
<thead>
<tr>
<th>Team Members:</th>
<th>Aizawl West (Non HPD)</th>
<th>Lunglei (HPD)</th>
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<tbody>
<tr>
<td></td>
<td>Ms Renu Sobti, Jt Adv(HRD)-Planning Commission</td>
<td>Dr. Shahab Ali Siddiqui, NRHM-I</td>
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<td>Dr S N Sharma, Jt Director(NVBDCP)</td>
<td>Dr. Ravinder Kaur, MH Division</td>
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<td></td>
<td>Dr Pushpanjali Swain, NIHFW</td>
<td>Mr. Ajit Kumar Singh, NHSRC</td>
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<td>Ms Shalini Nair, TSA</td>
<td>Prof. Sandra Albert, PHFI</td>
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<td>Dr. Sheema Chowdhary, CH&amp;I Division</td>
<td>Shri Parijat Mishra, YP(SP)-Planning Commission</td>
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<td>Dr Singh, Regional Director</td>
<td>Ms Supriya Pattanayak, DFID</td>
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<td>Mr. Satyajit Sahoo, NHM-Finance</td>
<td>Dr Tulika Singh, SAATHI</td>
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<td>Ms Aastha, NHSRC</td>
<td>Dr. Gautam Borgohain, RNTCP</td>
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<td>Mr RLM Kima, RRC</td>
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Team Leaders:

- Dr. M.K. Aggarwal, MoHFW
- Dr. Shailendra Kumar, Dir.(Drugs)
# Facilities visited

<table>
<thead>
<tr>
<th>S.No</th>
<th>Facility</th>
<th>Aizwal- West</th>
<th>Lunglei</th>
<th>Total Number</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Anganwadi Centre</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Sub Centre</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>PHC</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>CHC</td>
<td>NA</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>District Hospital</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Sub district Hospital</td>
<td>1</td>
<td>NA</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Mobile Medical Unit</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Ambulance Call centre</td>
<td>1 (state level)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>10.</td>
<td>Others</td>
<td>Central Drugs Warehouse</td>
<td>TB Hospital</td>
<td>2</td>
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**Total Facilities Visited**: 26
## Innovations and Best Practices

- **DH Aizawl** is an ISO Certified hospital with Electronic Medical Record System, Functional Eye Bank and Cornea Transplantation facility, Tobacco cessation clinic, Cancer registry at pathology department.

- Well functional **psychiatry unit at SDH** (Kulikawn) which is also providing treatment for drug de-addictions.

- Concept of **“Sub Center Clinic”** based on time to care approach for scattered population.

- **Motorcycle Ambulance** for first aid in hilly terrain.

- Strong **community participation** in health activities, donations by NGOs and charitable organizations to health department.

- **Telemedicine** in 3 districts for eye care in collaboration with Sathi NGO.
Key Findings
Key Findings: Service Delivery

- Good range of services available in DH Aizawl including super specialty services such as cardiology and dialysis unit.

- DH Aizawl also runs a well functioning Eye Bank with mobile unit for collection of cornea (Achievement 500 cornea collected since 2008 and 30% transplanted at DH whereas rest distributed in adjoining State).

- RRC – NE has conducted a QA assessment of DH (Aizawl) and found that it is complying 62% of QA indicators.

- RSBY scheme has been implemented across the state since 2008.

- Availability of Male and Female Health Workers in all Health Centers visited.

- Underutilization of Ambulances & MMUs (2-5 visits per month) were observed. 102 was mostly engaged for drop-back through JSSK.

- High Out of Pocket Expenditure on drugs, diagnostics & transport despite schemes like JSSK and RSBY.
Key Findings: RMNCH+A & DCPs

- No line listing of severely anemic women & high risk pregnancies
- IUCD insertion services were available in most facility, but the removal rate was high.
- PPIUCD facility not available in the state
- MTP services not available below DH.
- Process of Maternal Death Audits (facility based and community based) satisfactory
- Vaccination at birth (OPV & Hepatitis birth dose, and BCG) is not being provided at any of the health facilities. Immunization micro-plans and due-lists also not being prepared.
- In DCPs, though contractual HR is in place, there are no nodal programme officers to head the programme in many of the districts
- LLINs as intervention tool for vector control under National Vector Borne Disease Control Program
- No computerization and delay in flow of information under Integrated Disease Surveillance Program
## Key Findings: HR, PM & Finance

- Differential salary for contractual staff is provided to HR posted in difficult and very difficult areas.
- Although there is adequate availability of staff, rational deployment of staff to higher case load facilities and delivery points remains an issue.
- No mechanism of supportive supervision and no clear cut supervision and monitoring plan at SPMU.
- State had clinical establishment act earlier which has been amended to adopt the features of central regulations.
- District Vigilance and Monitoring Committees formed and first meeting has been held.
- Data triangulation while preparation of PIP is not happening (HMIS, IDSP, FMR data is not used in PIP preparation).
- The funds from DHS to PHC/CHC are being released in cash for different programs and all payments to the beneficiaries/vendors are made through cash instead of PFMS, e-transfer or through cheque.
- State is not maintaining books of account on Tally software at any level.
Key Findings: Community processes, Medicine and technology

- VHNDs being conducted regularly.
- HBNC visits are being conducted by ASHAs.
- Community based organizations are actively involved in health and nutrition programs.
- ASHA incentives not being given on time. Payment mechanism not well defined.
- Biomedical Waste Management is poor at facilities below DH level.
- Availability of Central Drug Warehouse in the State.
- No Display of EDL or Standard Treatment Guidelines. No Free Drug Policy and Entitlements.
- User Fees across facilities for diagnostic services.
- Strong involvement of Urban Local Bodies (ULBs) and formation of MAS has been initiated under NUHM.
Recommendations

- ‘Medical Canteens’ need to be modified to provide only generic medicines to reduce OOPE and cost to the health system.
- Effective awareness generation strategy for optimal utilization of NAS.
- MMU could be under administrative control of district CMO instead of MS of DH/SDH for enhanced coverage and effective monitoring by nearby PHC/CHC.
- Call center based Public Grievance Redressal System.
- Supportive supervision plan for improving the quality of RMNCH+A services.
- JSSK entitlements not to be channeled through RSBY.
- Immunization Services need focused attention. Dire need for immunization at birth after institutional deliveries, vaccine storage policies, availability of micro plans.
- Adolescent health services need to be initiated across the state.
Recommendations

- Appoint dedicated/full time District program officers for each program under Disease Control Programs & state Entomologist
- Out reach services to be strengthened under DCPs
- State should initiate selection and training of Urban ASHAs
- Mechanism for payment of ASHA incentives at PHC only, at regular and timely intervals from single nearest facility.
- Approved District Action plan and Block level plan should be sent by the State to Districts/Blocks for implementation of the NHM activity.
- All payments should be made through e-transfer, PFMS, or through cheque. Cash withdrawal system should be avoided by all levels of the state.
- Separate audit should be conducted for RKS at District Hospitals.
Thank You