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# DRAFT EVALUATION REPORT ON PPP FOR HEALTH CARE DELIVERY IN MEGHALAYA

NATIONAL HEALTH SYSTEMS RESOURCE CENTER (NHSRC)  
NRHM, MINISTRY OF HEALTH & FAMILY WELFARE,  
GOVERNMENT OF INDIA



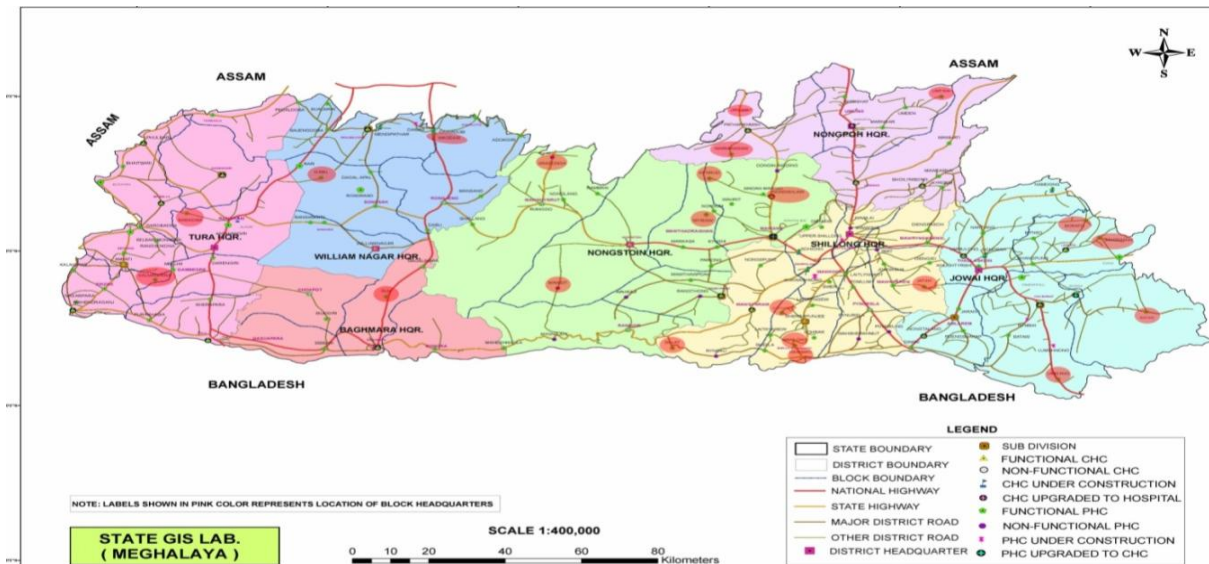
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## Executive Summary:

### I. Introduction:

Meghalaya "the abode of clouds" was inaugurated as an autonomous state on April 2, 1970 and declared a full-fledged State on January 21, 1972. The State is divided into seven administrative districts which are Jaintia Hills District, East Garo Hills District, West Garo Hills District, East Khasi Hills District, West Khasi Hills District, Bhoi District and South Garo Hills District. They are predominantly inhabited by the different tribal communities such as Khasis, the Jaintias and the Garos who are the descendents of very ancient people having distinctive traits and ethnic origins. Shillong is the capital town and also the district headquarters of East Khasi Hills District. The city has been the seat of Government since the consolidation of the British administration over a century ago and it is popularly known as "Scotland of the East". The population of Meghalaya is 2.32 according to 2001 census and is scattered over 7 districts 39 blocks and 6026 villages. The State has the density of 103 persons per sq. km. The sex ratio of Meghalaya at 972 females to 1000 males is higher than the national average of 933. The female literacy of the state rose to 60.41% from 44.85% in 1991. The Infant Mortality Rate is 58 and Maternal Mortality Ratio is NA (SRS 2004 - 2006) while the Crude Birth Rate and Crude Death Rate are 25.2 and 7.9 respectively. The female literacy rate is 59.6% as per 2011 census. The public health care services is provided through 5 district hospitals, 1 Ayurvedic hospitals, 22 CHCs, 103 PHCs and 401 HSC.



In the year 2008, the Government of Meghalaya (GoM) had adopted the PPP approach for providing health care delivery services in CHCs and PHCs/HSCs located in peripheral and difficult areas of the state through NGOs for management and operations of these facilities and services. As a result, 29 CHCs including PHCs/HSCs were handing over to NGOs/Voluntary agencies (copy of MoU is enclosed

as Annexure- I). Out of these 29 health care facilities, 22 has been handed over till date to 7 NGOs which are Bakdil, Karuna Trust, North East Society for Promotion of Youth and masses (NESPYM), Citizens' foundation, Voluntary Health Association Of Meghalaya (VHAM), Jaintia Hills Development Society (JHDS) and Akhil Bhartiya Kishan Kalyan Samiti (ABKKS) located in various districts. The GoM through these 7 NGOs has been successfully providing health care services in these difficult areas for almost three years till date since the signing of MoU.

With the request of the GoM, the National Health System Resource Center (NHSRC) in collaboration with North-East- Regional Resource Center (NE-RRC) conducted the evaluation of the PPP model for health care delivery system during the time period from November 2011 to January, 2012. The aim is to understand the effectiveness of the PPP model for health care service delivery in the state.

### **1. Study objectives:**

- i. Assess the service delivery outcomes in NGO run health facilities with respect to the Memorandum of Understanding.
- ii. Review the Management & Implementation Process under the PPP – this will include assessment of infrastructure (additions/renovations), human resources (recruitment & availability - over what is mandated), training, ongoing capacity building
- iii. Assess the performance of community level interventions, including the ASHA and VHSNC programs in the outsourced facility service area
- iv. Analyze the adequacy of financial arrangements between the state and the NGO, the quantum of in-kind and monetary contributions.

### **2. Methodology & Tools:**

Both qualitative and quantitative research approach is used in the evaluation of PPP.

- i. Review of government policies on health & PPP (if any), ToR of MoU signed between partners etc
- ii. Review of any baseline data/information about health indicators, human resources availability, infrastructure , service delivery and performance of facilities etc
- iii. Review of secondary data, HMIS/programme reports and relevant documentation at various levels of functioning such as headquarter facility, field levels with the beneficiaries/communities and NGO level.
- iv. In-depth Interviews with key informants such as government officials, beneficiaries, communities and FDGs with ASHA and RKS members

A total 6 teams comprising of two members in each team visited health facilities in 7 districts run by 7 different NGOs/voluntary agencies. The lists of team members and the tools/formats are enclosed as Annexure-II and III.

### 3. Review of MoU for PPP under NRHM:

#### 1. HEALTH FACILITY CONTRACTING-OUT (CHC/PHC/SHC)

Meghalaya had also contracted out 26 PHCs through 7 NGOs. This analysis does not cover the strengths of the program. The comments relate only to those aspects of the MOU, which could constrain successful implementation and replication of this model from the “design” point of view.

PROVISIONS (as per MOU)	IMPLICATIONS	SUGGESTIONS
<b>(a) Period of Engagement</b>		
3 years from the date of handover of facility.  Start-up time allowed 2 months from the date of signing the contract.	3 years seem reasonable as this is only “operations contract” and no capital investment is envisaged.  Ambiguity in case of handover takes longer than 2 months after signing of contract.	A 3-5 year maintenance contract is recommended with annual review and penalty/incentive clause.
<b>(b) Service Package</b>		
All “routine” services that is “normally delivered” (OPD, IPD, MCH and Delivery, surgical, etc.) at SHC/PHC/ CHC, including outreach services under RCH and national disease control programs.  Additional services may be offered by the private party.	Does not specifically talk about service guarantees as per IPHS. Scope of additional services also not defined (for example can they start giving specialist service in PHCs?)	Service guarantees should be as per IPHS. Additional services should be in line with the level of health facility i.e. paramedical services for SHC, GP level services for PHC and specialist level services for CHC.
<b>(c) Coverage</b>		
Entire population served by the contracted out facility (CHC/ PHC/ SHC)	Slight ambiguity regarding referral cases from outside the catchment area, especially in the case of CHCs	The present clause seems sufficient, and an exception for referred/emergency cases may be made for CHCs.
<b>(d) Asset Ownership</b>		
Physical assets (building, equipment, vehicle/ambulance) to be “handed over to the private party for operations”. Maintenance of these assets to be contracted party’s	It implies private party cannot charge depreciation of all movable and immovable assets and also cannot mortgage/hypothecate them for raising loans.	Government staff working with the private party may be treated on “deputation” and appropriate services conditions may apply.  A limit of 20-25% of the annual

PROVISIONS (as per MOU)	IMPLICATIONS	SUGGESTIONS
<p>responsibility.</p> <p>HR to be fully owned and managed by contracted party. However government staff for ophthalmology, dentistry, AYUSH may be retained.</p> <p>Any asset built by community or by government subsequent to handover to the contracted party will be maintained by the party and handed back to the government on cessation of the contract. Assets acquired/erected by the private party may be disposed off as per the private party's rules.</p> <p>Drugs and consumables to be supplied by the government. In "special circumstances" private party may buy drugs/consumables (as per EDL) on an emergency basis.</p>	<p>Ambiguity regarding government staff retained with the private party (about their seniority, perks, etc.).</p> <p>"Special circumstances" for drugs and consumables not defined. Is it for emergency/life saving situations or for stock-out situations? Is there a limit (either absolute amount or as percentage of budget) of these emergency purchases?</p>	<p>budget should be put in place for the special purchases of drugs and consumables.</p>
<b>(e) Costs, Financial Provision &amp; Risks</b>		
<p>Fixed quarterly payment made to the private party, essentially for HR and maintenance costs (as supplies and consumables provided by the state government in-kind). Payment made @ Rs.1.89 to Rs.2.93 lakhs per PHC per month and @ Rs.2.87 to Rs.4.18 lakhs per CHC per month.</p> <p>Security deposit (one time) @ Rs.10,000 per PHC (which includes all SHC served by the PHC) and Rs.20,000 per CHC.</p> <p>No user charges</p>	<p>The payments to private parties seem to be based on historical experience of government budgetary support for HR. It is not clear if it takes into account the actual cost (of HR, maintenance, drugs &amp; consumables, etc.).</p> <p>Security deposit is too little, keeping in view the value of movable and immovable property handed over to the private party for maintenance.</p> <p>No user charges is fine for the "routine service" which is supported by government budget, but might be needed for the "additional services".</p>	<p>A lump-sum budget may be paid, based on actual costing which may include salary, maintenance, mobility support, and drugs and consumables.</p> <p>Deposit amount should be matched to the value of assets transferred to the private party.</p> <p>For "additional services" user charges may be thought of (if not fully supported by government budgetary support)</p>
<b>(f) Monitoring, Quality Assurance &amp; Regulatory Mechanism</b>		
<p>Quality standards focus on waste management and infection control. Reference to destructive syringes, autoclaves and compliance to State Pollution</p>	<p>The "quality indicators" are either input related or output related, ignoring the process part.</p> <p>The facility level</p>	<p>Might insist for ISO or related certification.</p> <p>Process indicators might be developed for monthly review</p>

PROVISIONS (as per MOU)	IMPLICATIONS	SUGGESTIONS
Control Board norms. Routine monthly reporting as per standard HMIS formats (similar to govt. SHC/PHC/CHC). Special performance indicators (including RCH indicators, OPD and IPD indicators). Special committee at facility and state level for performance monitoring.	monitoring/review committee seems to be the RKS committee, which might not be equipped technically for quality monitoring and related technical support. Link with district/state level QA committees (as envisaged under NRHM) not clear.	at health facility (RKS) level. Patient grievance redressal system necessary at facility level, with appellate at district (CMO/DHS) level.
<b>(g) Grievance Redressal &amp; Dispute Settlement</b>		
Emphasis on mutual and amicable dispute resolution within the govt. (Secretary Health and Chief Secretary). No reference to arbitration procedure. Jurisdiction of Meghalaya courts to prevail.	The arrangement seems difficult in view of the NGOs who are from outside the state and region.	With so many important PPP projects in place, the state might look at establishing a state level PPP cell staffed with experts, which may also act as the grievance redressal forum.  Procedures for arbitration need to be laid down unambiguously.

#### 4. Lists of Health Facilities visited

**Table 1: Lists of health facilities visited by the teams**

Sr. No.	District	Selected PHC/CHC	Health Sub Centre	Name of the NGO
1	East Khasi Hills	Ichamati CHC	Majai	Citizen's Foundation, Jharkhand Karuna Trust
		Mawsahew PHC	Wahkaliar	
			Mawphu	
			Rumnong	
		Mawlong PHC	Umwai Health Unit	Voluntary Health Association of Meghalaya (VHAM)
		Jatah PHC	Nohron SC	
Dangar/ Balat PHC	Sonatola SC (Not assessed due to road blockade)			
2	West Khasi Hills	Aradonga PHC		Karuna Trust
		Nongkhlaw CHC		Citizen Foundation
		Kynrud PHC		
		Maweit PHC		

3	Jaintia Hills	Barato PHC	Shiliang Myntang	Jaintia Hills Development Society (JHDS)
		Sahnsniang PHC	Shaniang	Jaintia Hills Development Society (JHDS)
		Umkiang PHC	Sonapur	Akhil Bhartiya Kisan kalyan Samiti (ABKKS)
4	Ri Bhoi	Umtraï PHC	Umlapel	Karuna Trust
		Jirang Dispensary		
		Warmawsaw PHC		
5	East Garo Hill	Wageasi PHC	Lower Sambrak	Bakdil
		Gabil PHC		
6	West Garo Hills	Salmanpara PHC	Anangpara	Bakdil
7	South Garo Hills	Siju PHC		

## II. Summary of Karuna Trust:

Karuna Trust currently manages five PHCs, four HSC, one health unit and one dispensary in the three districts of East Khasi Hills, West Khasi Hills and Ri Bhoi (Table-1).

**Table 2: List of facilities managed by Karuna Trust:**

District	List of facilities	Date of handover
East Khasi District	Mawasahew Primary Health Center Wakhlïar Health Sub Center Mawphu Health Sub Center Rumnong Health Sub Center	September 2009 September 2009 March 2009 March 2009
	Mawlong Primary Health Center Umwai Health Unit	March 2009 March 2009
West Khasi Hills	Aradonga Primary Health Center	June 2011 (managed by another NGO between April 2009 to May 2011)
Ri Bhoi	Umtraï Primary Health Center Umlaper Health Sub Center	September 2009 Operating but not officially handed over
	Warmawsaw Primary Health Center Jirang Dispensary	June 2011 (managed by another NGO between April 2009 to May 2011)



## 1. Service Delivery & Performance:

The types of services and performance of five facilities namely Mawasaheh PHC, Mawlong PHC, Aradonga PHC, Umtraï PHC and Warmawsaw PHC for the 6 months period i.e. from April 2011 to September 2011 is given in the table below:

**Table 3: Service delivery and performance of 5 facilities under Karuna Trust in East, West Khasi and Ri Bhoi districts**

Types of services & Performance	Name and types of facilities				
	Mawasaheh PHC	Mawlong PHC	Aradonga PHC	Umtraï PHC	Warmawsaw PHC
OPD	3406	5419	2148	3869	2698
IPD	505	95	182	124	50
Total ANC registration	19	41	67	66	79
3 ANC registration	23	11	32	35	46
Institutional Delivery	31	06	08	25	21
No. of Immunization sessions held	24	50	35	52	18
Condoms/OCP distributed	29/640	550/32	410/101	840/122	960/30
Infants treated for Diarrhea(ORS)	92	60	21	212	127
No. of patients (adults & children ) availed assured referral services	153	92	364	196	141
Hb estimation	481	208	162	373	101
Malaria slides examined & PF case +ve detected	289/0	534/19	617/164	488/46	972/62

*Source: HMIS April- Sep, 2011*

## 2. Key findings:

- KT has been entrusted with the management of most of the facilities in the table above since 2009. Two PHCs and one dispensary have been handed over to KT in June 2011, after a bad experience with another NGO. In the case of the latter facilities KT is just beginning to get organized.
- Across the board there is an increasing trend in number of patients accessing both outpatient and in patient services. For baseline data the team used data from the point of takeover of the clinic. In some cases this was zero, since the facility was non functional. In some cases the numbers were few, but now on account of regular services the numbers are high.
- KT has also set up a sub center (Umlaper) in a building that is awaiting approval from the engineering cell. This means that there are no funds for managing the center. Despite this KT of its own initiative has endured that two ANMS are resident there, because the area is very remote.

- An overarching finding across all facilities and in corresponding outreach functions is that services have improved substantially and staff is in place. All five Primary Health Centers are 24/7 and offer delivery services. None of the HSC conducts deliveries. Additional infrastructure at Warmawsaw PHC and Jirang dispensary which was handed over in June 2011 is just being put in place.
- Difficulty of recruiting and retaining appropriate Human Resources is as problematic for the NGO as it is for state managed facilities. Budgetary constraints hamper the NGO from providing additional financial incentives to staff to stay resulting in frequent turnovers. KT has attempted to manage this by ensuring that at all times there is some cover, even if through a nurse/ANM. Nevertheless this seriously affects community rapport building and the ability to provide ongoing high quality of services.
- Despite poor infrastructure in some areas, the NGO has succeeded in staffing and retaining a core of staff in all facilities. The MOs in all PHCs were observed to be taking on a leadership role and have been trained. AYUSH doctors are also available in all facilities.
- The majority of nurses and ANMs in the PHC and HSC have not yet received training in skills such as SBA, IUCD, IMNCI, particularly for nurses/ANMs. This represents a potential missed opportunity given the issues of difficult access to PHCs and CHCs. Since the NGO has managed to recruit and retain the ANMs the state needs to ensure that they are selected for training on a priority basis so that they can provide a basic package of MCH services including delivery to the community.
- Some home deliveries are being reported as SBA deliveries.
- KT has provided funds of its own to supplement and strengthen the existing infrastructure, particularly for renovations and for ambulances.
- The pharmacy in all centers was well maintained. The reach of drugs to the ASHA is also good and this is reflected in regular replenishment of the ASHA drug kit.
- Given the remote location of centers and the difficulty of access to communities, the ASHA programme represents another missed opportunity. The training of the ASHA in Module 6 is underway, but is being conducted through another mechanism, and not KT. The ASHA are seen as facilitators for immunization and institutional delivery when in fact they can provide community level care for mothers, newborns and children. Most ASHAs were appreciative of the treatment meted out to them in the facility. In some PHCs but not all, separate spaces were provided for the ASHAs. In Mawasahew PHC, the BPM was not clear on the roles of the ASHA and what Module 6 and 7 would enable them to do. The ASHAs, ANMs and one or two community representatives are the only active members of the VHSC. Despite this however bank passbooks are maintained and expenditures are taking place on activities such as sanitation, toilet construction, disposal pits,

- Range of services provided: Table 2 includes a list of services provided at each facility. Overall we observe that the facilities managed by KT are providing the services expected at each facility level. Partograms were not being used anywhere, nor were MTP services being provided. Injection Magsulf was not available in any center. IUCD insertion was undertaken only in a few PHCs but not in any of the sub centers. Sterilization services were not provided anywhere. The list of services and citizens charter was well displayed in all facilities, except the newly handed over ones. No user fees were reported by patients or in the community.
- All obstetric emergencies are referred to CHC, and all PHCs have ambulances (not clear whether they are supplied by govt. or whether NGO purchased them)
- Reporting formats and registers were found to be well maintained at both the HSC and PHC.
- Regarding RKS, while it is clear that KT has made good and effective use of the untied funds, interviews with members reveal limited understanding of the processes.
- KT appears to be providing effective monitoring and support of the staff. PHC management manuals are being used, as are service protocols. Lab services are being provided at all PHCs. RDK for malaria diagnosis is available at all PHCs, and there is a rise in number of slides examined.
- Overall KT with its experience in other states in managing PHCs demonstrates effective performance in most areas. However some quality parameters need to be streamlined and community outreach needs more strengthening, including the ASHA and VHSC programmes. One major gap which the state will need to correct in facilitating the training of ANMs in sub centers so that services are closer to the people.

### **3. Areas for Improvements:**

- There is a need to streamline the quality parameters and strengthen community outreach including ASHA and VHSC programmes.
- It is recommended that the state may initiate conducting the trainings of ANMs at Health Sub-centers so as to make the services closer to the community. The state has to develop a training plan for various cadres of staffs since the majority of nurses and ANMs in the PHC and HSC have not yet received training in skills such SBA, IUCD, IMNCI, particularly for nurses/ANMs which represents a potential missed opportunity given the issues of difficult access to PHCs and CHCs.
- There is a need to conduct orientation programmes/sessions for RKS members about the guidelines and use of untied funds since majority of members lack knowledge about it.
- There is a need to devise an incentive based package for retention of key staffs since the facilities are located in difficult and inaccessible areas and appropriate budget should be allocated for the same lest to avoid staff turnover which affects the rapport building process with the community in the long run.

### III. Summary of VHAM:

#### I. Introduction:

The team evaluated two PHCs and a HSC attached to one PHC located in East Khasi Hills district. The Government of Meghalaya had handed over two PHCs out of total 24 functional PHCs to VHAM in East Khasi Hills district since July 2009. These facilities are located in hilly terrain under Mawknrew and Mawsynram block of the district. East Khasi Hills is an administrative district and the district headquarters are located at Shillong. The district occupies an area of 2752 km<sup>2</sup> and has a population of 824,059 (as of 2011 census) and it is the most populous district of Meghalaya (out of 7 districts). The district was further divided into two administrative districts of East Khasi Hills District and Ri-Bhoi district. It has a sex ratio of 1008 females for every 1000 males and literacy rate of 84.7%. The district consists of eight community and rural development blocks. The Mawknrew block has a population of 34133, 68 villages and 5999 households and Mawsynram block has a population of 45003, 161 inhabited and 1 uninhabited village and 8276 households. The Jatah PHC and Dangar PHC are located in Mawknrew and Mawsynram blocks respectively.

#### 2. Services Delivery & Performance:

The types of services and performance of the two PHCs namely Jatah and Dangar for the 6 months period i.e. from April 2011 to September 2011 is given in the table below:

**Table 4: Service delivery and performance of Jatah and Dangar PHC**

Types of services & performance	Name & Types of facilities	
	Jatah PHC	Dangar PHC
OPD (all)	10966	5483
IPD	408	0
Total ANC registration	134	160
3 ANC registration	68	41
Institutional delivery	20	01
No. of immunization sessions held	13	27
Condoms/OCP distributed	200/29	190/33
Infants treated for diarrhea (ORS)	706	536

No. of patients (adults & children) availed assured referral services	575	107
Hb estimation	233	12
Malaria slides examined and PF case +ve detected	48 /4	462 /32

Source: HMIS April- Sep, 2011

### 3. Key Findings:

- The overall functioning of the three facilities (2 PHCs & 1 HSC) has been improved following the takeover of these facilities by the NGO by ensuring availability of staffs, maintenance of government buildings and availability of some of the essential drugs & equipments etc. The increasing footfalls in all facilities, as evidenced from the OPD/ IPD data, delivery cases and first hand impressions, at least to the fact that services have “ now ” become available in these hitherto neglected and poorly performing facilities.
- The physical Infrastructure available to the NGO was generally in good shape. The existing structures of Dangar PHC were spacious, with large compound and wards. These were further refurbished through painting, new flooring and plastering, adding of new rooms and putting new signage. An improved seating arrangement in OPD, availability of drinking water and electricity has further added on the improved status of the facilities. However, there is hardly any display of IEC materials in any of the facilities.
- Adequate residential accommodation for all staff, including Grade IV adjoining the facilities has been provided to all categories of staffs. This has been an incentive for the staff (MOs and SNs) most of whom are from outside the state (Manipur, Assam, Orissa) and some of them are residing with their families. Availability of services 24/7 in the facilities has been made possible as a result of the availability of staff.
- Though there have been improvements in the service delivery and increasing trend in OPD/IP cases over the years; the quality of services is a major issue since there are various gaps with regards to shortage of emergency/essential drugs, non-functional equipments and lack of a referral transport /ambulance system. There is no system for Bio-medical waste management in all facilities visited. There is no display and use of IEC materials at the facilities.
- Most of the staffs in these facilities have not received adequate trainings to improve their performance and service delivery. Building the skills of the MOs and the SNs through the skill based trainings for maternal and child health is necessary to provide optimal services.

- Though the RKS has become active in the last 2 years with regular meetings of members; none of the members are aware of guidelines for effective functioning of RKS. The fund is not utilized for purchase of essential items such as drugs and equipments etc.

#### 4. Areas for Improvements:

- **Infrastructure, Logistics, Drugs & Equipments:** Adequate and locally relevant IEC materials on health and public health issues should be developed, adapted, displayed at the facilities. There is a need to develop a good IEC & BCC strategy for the state, either by GoM or in collaboration with NGOs for generating mass awareness, demand generation and to promote healthy behavioral practices in the community about many health issues. Patients may be provided with booklets, pamphlets and brochures with pictorial illustrations/diagrams. The HEs and ASHAs should be trained in IPC and utilize innovative methods like skits, role play and interactive methods for community mobilization on family planning, institutional delivery, and immunization etc. Some of the essential equipments such as radiant warmer, suction machines and OT lamps should be made available and functional. Some of the emergency drugs such as Methargin, Oxytocin, Magnesium Sulphate, Mizoprostol, Diclophenic are in short supply and anti-rabies and anti-venom should be made available to manage few cases of dog and snake bites.
- **Human Resource for Health & Training:** Most of the key positions such as M.Os, GNM, ANM, pharmacists and LT were in place and most of the staffs reside in the quarters which make it possible to function as 24x7 PHCs. There is 1 AYUSH MO at each facility and practices allopathic medicines due to lack of proper mainstreaming of AYUSH and non-availability of AYUSH drugs at the facilities. This is due to the fact that state health department does not supply AYUSH medicines in NGO managed facilities. The GoM and the NGO should take up effective measures to integrate AYUSH treatment at facilities wherever AYUSH M.Os are posted and raise the demand of AYUSH services in the community through effective IEC campaigns and patients given the option to avail either allopathic or AYUSH medicine as the preferred mode of treatment. Skill upgration trainings on SBA, NSSK, IUCD, IMNCI and other disease control programmes considering the local epidemiological context should be provided to staffs for enhancing the performance of service delivery.
- **Service Delivery:** All ranges of services such as promotive, preventive and curative services are provided to a certain level except the emergency services. However, the quantity and quality of these services provided in the facilities is not at par with the desired standards. The PHCs have good OPD (all) case load i.e average 60 and 30 cases on daily basis at Jatah and Dangar PHCs respectively. The PHCs are not equipped to provide basic emergency services (including Obstetric care), newborn care and stabilization of sick newborn before referral are non-existent. The 24 hour ambulance facility which is a prerequisite for a fully functioning PHC, as also clearly

laid out in the MoU; was not accessible in both the facilities. The quality of services provided was weak and protocols for labour rooms, though available are not followed. The lack of emergency drugs in the labour room compromise the quality of delivery services provided. There is no system of bio-medical waste management and color codes bins are not in place. The training of staffs in bio-medical waste management and infection management systems is one of the crucial steps for improvement of service delivery and quality. The IMEP guidelines should be made available in the facilities.

- **EMRI:** The assured referral transport was not available in the facilities covered, this in spite of the EMRI system operating in this state since the last few years. Very limited availability and use of the EMRI ambulances as inferred from facility level and community level interactions. This is due to the allocation of few ambulances for this district. Although, road connectivity and quality of roads is quite good, there is reluctance on the part of the EMRI ambulances to travel to the villages or the facilities to pick up patients. The ambulances are generally parked in the block headquarters, like Mawsynrum, Mawkynrew, or Smith which are at least 30-40 kms away from the facility and even further from the villages. This has resulted in poor access of the EMRI vehicles. Patients were incurring a high out of pocket expenditure hiring private vehicles for referral transport. This is one area that would need to be looked into. Due to the limited time at the disposal of the team, interactions with the EMRI team at the district and state was not possible.
- **Community Processes:** The RKS became functional and active since 2009 after the VHAM took over the management of the facilities and periodic meetings have started with full involvement of RKS members. The key constraint to effective functioning of RKS is due to the fact that members are unaware and not been oriented about the RKS guidelines, use of untied funds and NRHM. There is a need to conduct regular orientation programmes for RKS members on various pertinent issues of NRHM and implementation of RKS guidelines. SHA are found to be supportive and had received trainings on module 5 & 6. The post trainings follow up, mentoring and supervision of ASHA by facilitators and other ASHA mentoring /support team is negligible with the result that the services provided by ASHA is limited and could not bring positive intervention in the community as far as counseling, motivating and educating the community on various health issues such as institutional deliveries, family planning, disease control and practice of healthy behaviors is concerned. ASHA mentoring and support groups should be established and made functional and regular mentoring and supervision should be provided. ASHAs need to work with the health educators and the ASHA facilitators to motivate the community for institutional deliveries and adopting family planning methods since majority of the families in the community have seven to eight children per family on an average.

- **Documentation & Monitoring:**

All the required registers such as the MCTS register are used and maintained. VHAM has devised a performance appraisal system for staffs and all categories of staffs are appraised on an annual basis. VHAM conducted the monitoring visits twice in a month, sometimes on a weekly basis.

#### IV. Summary of Citizen Foundation:

##### 1. Introduction:

The team evaluated five facilities i.e. 2 CHCs and 3 PHCs located in East and West Khasi Hills districts. The Government of Meghalaya had handed over two CHCs in East and West Khasi Hills districts and 3 PHCs out of 17 functional PHCs in West Khasi Hills district, to Citizen's Foundation since the period from September to October 2009. Out of five facilities, one facility i.e. Ichamati CHC falls under Shella block of East Khasi district and the rest of the facilities fall under Mairang block of West Khasi district in Meghalaya except Mawait PHC which is under Nongstoin block. The district headquarter of West Khasi Hills is located at Nongstoin and occupies an area of 5247 km<sup>2</sup>. It has a population of 385,601 (as per census 2011) scattered across 6 blocks. It has a sex ratio of 981 females for every 1000 males and a literacy rate of 79.3%. East Khasi Hills is an administrative district and Shillong is the districts headquarter. The district occupies an area of 2752 km<sup>2</sup> and has a population of 660,994 (as of census 2011) and it is the most populous districts of Meghalaya out of total 7 districts. The East Khasi Hills district was further divided into two administrative districts of East Khasi Hills district and Ri-Bhoi district. East Khasi district forms a central part of Meghalaya and covers a geographical area of 2,748 km<sup>2</sup> with a population of 824,059 scattered across 8 blocks. It has a sex ratio of 1008 females for every 1000 males and literacy rate of 84.7%.

##### 2. Service Delivery & Performance:

The types of services and performance of 5 facilities namely Ichamati CHC, Nongkhlaw CHC, Kynrud PHC, Mawait PHC and Myriaw PHC for the 6 months period i.e. April 2011 to September 2011 is given in the table below.

**Table 5: Service delivery and performance of 5 facilities under East and West Khasi districts**

Types of services & Performance	Name and types of facilities				
	Ichamati CHC	Nongkhlaw CHC	Kynrud PHC	Mawait PHC	Myriaw PHC
OPD	8634	1885	6876	2285	7548
IPD	96	55	178	181	68
Total ANC registration	161	121	153	150	115



3 ANC registration	62	33	79	46	21
Institutional Delivery	31	36	13	1	0
No. of Immunization sessions held	58	36	72	43	55
Condoms/OCP distributed	190/13	240/17	100/124	50/17	110/38
Infants treated for Diarrhea(ORS)	42	220	666	281	255
No. of patients (adults & children ) availed assured referral services			88	196	84
Hb estimation	203	5	32	0	259
Malaria slides examined & PF case +ve detected	435/8	159/6	19/0	221/0	62/0

Source: HMIS April- Sep, 2011

### 3. Key Findings:

- The facilities have become functioning following the takeover of these facilities by the NGO by ensuring availability of staffs, maintenance of government buildings and availability of essential drugs and equipments etc. The increasing footfalls in all facilities, as evidenced from the OPD/ IPD data, delivery cases and first hand impressions, at least to the fact that services have “ now ” become available in these hitherto neglected and poorly performing facilities.
- The physical Infrastructure available to the NGO was generally in good shape. All facilities visited had good infrastructure with adequate space in the OPD, wards and large. The existing structures were spacious and well maintained in most facilities. There is no waiting area for patients in most facilities and availability of potable water and electricity has further added on the improved status of the facilities.
- All the key staffs such as MO, ANM, and pharmacist were in place including AYUSH M.O. The AYUSH MOs prescribe allopathic drugs and assist in conducting deliveries.
- The CHCs/PHCs provides the basic level of primary and secondary care, and they serves as a place for normal institutional deliveries, with good stock of drugs and basic equipments. It has still not picked up though as a place for normal deliveries, partly because of very difficult access to facility. Though services are made available; the CHCs are not functioning as a fully functional CHCs and lagged far behind the norms of IPHS in almost every aspects of service delivery, HRH and infrastructure. Further, several essential services, such as sterilization services, MTP, RTI/ STI are not being provided. Assured referral transport in the form of a facility level ambulance has not been provided and no other kind of internal arrangements was made.

- Another positive aspect of the management of the facilities was in ensuring availability of adequate residential accommodation for most staffs. The availability of services 24/7 in the facilities has been made possible with the availability of staffs.
- The level and range of services provided in the facilities are not at par with the desired standards. The PHCs are not equipped to provide basic emergency obstetric services. The facility level care for new born and sick children was not existent in the facilities and none of the service providers are equipped with skills for newborn care. The PHCs and CHCs are functioning well with regard to outpatient services though IPD case load is low across most facilities. The delivery case load is typically low in all the facilities though there have been improvements in the service delivery and increasing trend in OPD/IP cases over the years; the quality of services is a an issue since there are various gaps with regards to shortage of emergency and essential drugs, non-functional equipments and lack of a proper referral transport and ambulance system. There is no system for bio-medical waste management in most facilities. Most of the staffs in these facilities have not received adequate trainings to improve their performance and service delivery. Building up the skills of the MOs and the SNs through the skill based trainings for maternal and child health is necessary to provide optimal services.
- ASHA are found to be supportive and knowledgeable about their areas of work and programme. All of them have received trainings on module 6 & 7 and have received books and modules in the local languages. Since majority of deliveries are home deliveries; JSY incentives are paid to ASHA on rare occasions and most of the incentives are related to VHND activities. The VHSC meetings are not held on rare occasions. VHND are held at ASHA's house since there is no proper AWC infrastructure. RKS though constituted are not functional properly and no regular meetings are held.
- The support from NGO is non-existent apart from taking recruitments and payment of staff salaries, which happened only on quarterly basis. The staff and doctor were unsatisfied with the salaries being paid by the NGO. There is no M&E system in place and no monitoring visits has ever conducted by the NGO since inception. There are no additional supplies or trainings which are provided from the NGO.
- The RKS members are unaware of the guidelines for effective functioning of the RKS. The untied fund is not utilized for purchase of essential items such as drugs, equipments and timely release of fund from the center is a major constrict due to the non-issuance of Utilization Certificate (UC) for previous years. The reasons cited for non-issuance of UC was due to non-cooperation by RKS village head members.

#### **4. Areas for Improvements:**

- There is a need to develop a good IEC & BCC strategy for the state, either by GoM or in collaboration with NGOs for generating mass awareness and behavioral changes in the community about many health issues. The patients may be provided with booklets, pamphlets and brochures with pictorial illustrations/diagrams. The HEs and ASHAs should be trained in IPC, and utilize innovative methods like skits, role play and interactive methods for mobilizing community for family planning, institutional delivery, immunization.
- There is a need to impart skill based trainings- SBA, IMNCI, F-IMNCI, and NSSK to various staffs so as to improve the service performance. Building up the skills of the MOs and the SNs through the skill based trainings for maternal and child health is necessary to provide optimal services. Orientation programmes on bio-medical waste management should be conducted on regular basis for paramedical staffs. The IMEP guidelines should be made available in the facilities and steps should be developed to ensure that protocols and guidelines are adhered to at all facilities through regular orientation sessions and meeting of staffs on these issues.
- The NGO need to lobby with the health department for providing AYUSH medicines. IEC materials on AYUSH may be displayed in the facilities and ASHA, ANMs, HEs can disseminate information to the community for creating demand for AYUSH services.
- The provision of support to ASHA by the BPMs at field level and block levels needs to be reinforced. There is a need to regularize the VHSC meetings on monthly basis with support from ASHA, ANM and Anganwadi workers.

## V. Summary of JHDS:

### 1. Introduction:

The team evaluated four facilities i.e. 2 PHCs and 2 HSCs located in Jaintia Hills district of Meghalaya. The Government of Meghalaya had handed over two PHCs out of total 17 functional PHCs in Jaintia Hills district, to JHDS since June 2009. The district headquarter of Jaintia Hills is located at Jowai and occupies an area of 3819 km<sup>2</sup>. It has a population of 295,612 (as per census 2011) scattered across 5 blocks. It has a sex ratio of 1008 females for every 1000 males and a literacy rate of 63.26%.

### 2. Service Delivery & Performance:

The types of services and performance of two facilities namely Barota PHC and Sahsniang PHC for the 6 months period i.e. April 2011 to September 2011 is given in the table below.

**Table 6: Service delivery and performance of 2 PHCs in Jaintia Hills districts**

Types of services & performance	Name & Types of facilities
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	<b>Barota PHC</b>	<b>Sahsniang PHC</b>
OPD (all)	9273	6117
IPD	289	21
Total ANC registration	173	170
3 ANC registration	62	05
Institutional delivery	18	08
No. of immunization sessions held	48	73
Condoms/OCP distributed	74/135	20/129
Infants treated for diarrhea (ORS)	1087	342
No. of patients (adults & children) availed assured referral services	337	33
Hb estimation	18	142
Malaria slides examined and PF case +ve detected	1282/54	889/06

Source: HMIS April- Sep, 2011

### 3. Key Findings:

- The facilities have become functioning following the takeover of these facilities by the NGO by ensuring availability of staffs, maintenance of government buildings and availability of essential drugs and equipments etc. The increasing footfalls in all facilities, as evidenced from the OPD/ IPD data, delivery cases and first hand impressions, at least to the fact that services have “ now ” become available in these hitherto neglected and poorly performing facilities.
- The physical Infrastructure available to the NGO was generally in good shape. The existing structures were spacious and well maintained in most facilities though basic amenities such as potable water, 24 hrs power back up and running water are not available except at Barota PHC. The PHCs provides the basic level of primary care, and a place for normal deliveries, with good stock of drugs and basic equipments. It has still not picked up though as a place for normal deliveries, partly because of very difficult access to facility.
- Another positive aspect of the management of the facilities is in ensuring availability of adequate residential accommodation for most staffs though staffs are not staying in the quarters due to political unrest over the disputed borderland, which is claimed by both states i.e. Assam and

Meghalaya. Though there have been improvements in the service delivery and increasing trend in OPD/IP cases over the years; the quality of services is a major issue since there are various gaps with regards to shortage of emergency/essential drugs, non-functional equipments and lack of a referral transport /ambulance system. There is no system for bio-medical waste management in all facilities visited. There is proper display and use of IEC materials at the facilities.

- Most of the staffs in these facilities have received adequate trainings to improve their performance and service delivery. There is a need to conduct training programmes for various cadres of staffs to build up their skills through skill based trainings on maternal and child health for provision of optimal services.
- The RKS has become active in the last 2 years and members are aware of the guidelines for effective functioning of the RKS. However, the fund is not utilized for purchase of essential items such as drugs, equipments and timely release of fund from the center is a major constrict faced by the NGO.

#### 4. Areas for Improvements:

- **Infrastructure:** All facilities visited had good infrastructure with adequate space in the wards, large compound and spacious wards. There should be provisions to ensure availability of potable water for patients and generator, in the event of frequent power failure at the facilities. There is a need to develop a good IEC & BCC strategy for the state, either by GoM or in collaboration with NGOs for generating mass awareness and behavioral changes in the community about many health issues. The patients may be provided with booklets, pamphlets and brochures with pictorial illustrations/diagrams. The Health Educators (HEs) and ASHAs should be trained in IPC and utilize innovative methods like skits, role play and interactive methods for community mobilization on family planning, institutional delivery, and immunization etc.
- **Human Resource for Health & Training:** Most of the key positions such as M.Os, GNM, ANM, pharmacists and LT were in place and since they do not resides in the campus; the services are not available round the clock. The M.O (AYUSH) at facilities is recently recruited and practices allopathic medicines due to lack of proper mainstreaming of AYUSH and non-availability of AYUSH drugs at the facilities. The GoM and the NGO should take up effective measures to integrate AYUSH services at facilities wherever AYUSH M.Os are posted and increase the demand of AYUSH services in the community through effective IEC campaigns and patients should be given the option to avail either allopathic or AYUSH medicine as the preferred mode of treatment. Various skill upgration training programmes on SBA, NSSK, IUCD, IMNCI and other

disease control programmes, considering the local epidemiological context should be provided to staffs for enhancing the performance of service delivery.

- **Service Delivery:** The MoU between the NGO and the GoM stipulates that promotive, preventive and curative services will be provided of a certain level including emergency services. However, level and range of services provided in the facilities is not at par with the desired standards. All the facilities are doing well with regards to outpatient clinics, but have constraints when it comes to providing in patient care. The PHCs are not equipped to provide basic emergency services (including obstetric care). In terms of the level of care, the facilities have been providing services of level 1 care. Though the 24 hour ambulance facility is a prerequisite for a fully functioning facility as clearly laid out in the MoU; this essential service was not accessible in any of the facilities evaluated. The facility level care for new born and sick children was non-existent in any of the facilities and none of the providers are equipped with skills for new born care and stabilizing sick children before further referral. All 2 PHCs are functioning well with regard to outpatient services but the IPD case load is low across all the facilities. The delivery case load is typically low in most of the facilities e.g. the 2 PHCs had 18 and 8 deliveries in last 6 months i.e. from April to September, 2011 (HMIS data source). The quality of services provided was weak although the labour rooms and protocols are available; the partograph and autoclaves were not used. There is lack of emergency drugs in the labour room which compromise the quality of delivery services provided. The waste disposal is one of the main problems and proper waste management system was not seen in any of the facilities. The colour coded bins, auto claves and hub-cutters were not available at most facilities. Regular orientations and training of staffs in bio-medical waste management and infection management systems is one of the crucial steps for improvement of service delivery and quality. The IMEP guidelines should be made available in the facilities and system should be developed so that protocols and guidelines are adhered to.
- **Community Processes:** The RKS became functional and active since 2009 after the JHDS took over the management of the facilities and periodic meetings have started with full involvement of the RKS members. One of the positive observations regarding RKS is that most of the members have become aware of and had received orientation about the RKS guidelines and use of untied funds through training sessions organized by the NGO. The Village Health and Nutrition Day (VHNDs) have been held in each village once in every month on a fixed date although the VHSC meetings are not being regularly held in each village as per scheduled. At any VHND meeting whenever held, there has been full and active participation of ANM, AWW and ASHA. ASHAs are found to be supportive and carry out their responsibilities though the ranges of services being provided are limited. All of them had received trainings on module 6. The post trainings follow up, mentoring and supervision of ASHA by facilitators and other ASHA mentoring /support team is very weak with the result that the services provided by ASHA is limited and could not bring positive

intervention in the community as far as counseling and educating the community on various health issues such as motivation for institutional deliveries, adopting methods for family planning, disease control and practice of healthy behaviors & practices are concerned. ASHA mentoring and support groups should be established and made functional and regular mentoring and supervision should be given. ASHAs need to work with the health educators (HEs) and ASHA facilitators to motivate the community for institutional deliveries and adopting family planning methods since majority of the families in the community have seven to eight children per family on an average.

- **Documentation & Monitoring:** All the prescribed and required registers are well maintained at all facilities. The NGO has devised an internal monitoring mechanism for improving the functioning and performance of these facilities. The programme coordinator, supervisor and rarely the Director of the NGO conduct monitoring visits to these facilities on an occasional basis and randomly check the monthly review reports submitted by these PHC/HSCs. There is a need to streamline and standardize the internal and external monitoring system and ensure that review visits are conducted on a regular basis. The quarterly and annual review reports may be shared and feedbacks sought from other stakeholders at district and state levels.

## V. Summary of ABKKS:

### 1. Introduction:

The AkhilBharatiyaKisanKalyanSamiti (ABKKS) is a Delhi based NGO managing the following health facilities in Jaintia Hills district

- Umkiang PHC
- Sonapur HSC
- Saipung PHC
- Saipung HSC

Turuk SC was also handed over to the NGO along with Saipung PHC but is currently non-functional.

### 2. Service Delivery and Performance:

**Table 7: Service delivery and performance of 4 facilities under Jiantia Hills district**

Types of services & performance	Name & Types of facilities	
	Umkiang PHC	Saipung PHC
OPD (all)	6429	2668
IPD	54	0
Total ANC registration	151	06

3 ANC registration	21	01
Institutional delivery	11	0
No. of immunization sessions held	47	0
Condoms/OCP distributed	71/159	0/04
Infants treated for diarrhea (ORS)	474	10
No. of patients (adults & children) availed assured referral services	370	27
Hb estimation	270	12
Malaria slides examined and PF case +ve detected	204/01	132/05

Source: HMIS April- Sep, 2011

- Non-availability of proper records at the facilities prevents correct evaluation of the progress of performance
- Institutional deliveries are not taking place at Saipung PHC and the 2 SCs visited
- No IUD insertions at the PHCs
- Hardly a few laboratory investigations are conducted due to inadequate supply of reagents and paucity of funds to procure them locally

### 3. Key Findings

- All the four health facilities are functioning in government buildings, though proper upkeep is an issue.
- Inadequate infrastructure and logistic supply has led to compromise in quality of services delivered as well as to out-of-pocket expenditure with drugs being procured through RKS funds or by the patients themselves.
- Patient satisfaction levels are low and their accessing these facilities' has more to do with lack of alternatives than anything else.
- Umkiang PHC has 1 MBBS MO & 1 AYUSH MO while Saipung PHC is manned by an AYUSH Doctor
- The clinical staffs have received relevant skill up-gradation trainings.
- High turnover of human resources in the PHC is a matter of concern. The MO I/C of Umkiang is the only clinical staff who has been working since the PHC was taken over by the NGO in 2009. Most of the health personnel on-an-average work for about 6 months



or less and move on. Instance of bribes being paid to the NGO for appointments have emerged out of service provider interviews.

- Length of service has been better in the SCs where the ANMs have been working for more than 2 years
- Lack of funds affects the functioning of these facilities – staff has not received their salary for the last 3 months, the ambulances and generators remain unused due to inability to purchase fuel. The monitoring & supervisory visits and outreach activities are also affected for the lack of mobility funds. Such issues plus the fact that the staff are being paid much lesser than what they were promised (service provider interviews) demotivates health personnel, most of whom have come from other states to work in these remote & difficult-to-access areas.
- Furthermore, there is an inability to fill-up vacancies on-time, address staff absenteeism and of course, hardly any supportive supervisory activities are undertaken
- RKS and SC Committees have been constituted during and meetings held thereafter. But funds have been highly irregular as well – Umkiang PHC has received funds only once in the last 2 years and Sonapur SC has not received any funds at all.
- The ANMs at the SC had no knowledge about VHS&NCs and their role in VHNDs. Outreach sessions are planned haphazardly – say, at the convenience of the AWW worker
- This is a direct reflection of poor management at by the NGO or the State or both. The absence of accountants at the PHCs mean that SOEs & UCs are not prepared & submitted timely, which further compounds the matter.
- The lackadaisical attitude of the NGO may also be reflected by the fact that there are no proactive measures undertaken to ensure an enabling working environment and good workforce management.
- VHNDs are usually held in the first week of the month, mostly at venues accessible to marginalized populace. The ASHAs help in promoting the event in their villages and motivate beneficiaries to attend the VHNDs. Activities carried out include awareness discourse, ANC, immunization and collection of blood slides for malaria.
- The community expressed the need for a government MO at these facilities, since the contractual MOs are unable to issue birth or death certificates, due to which they have to travel to the nearest government facility.

#### **4. Areas for Improvement**

- The NGO needs to have more ownership of the whole concept of PPP, the facilities under them and the human resources working in the PHCs and SCs
- The staffing norms as indicated in the MoU have to be adhered to and the NGO must recruit and post adequate staff in the facilities.
- Ensuring regular payments to the staff and taking care of their needs will go a long way in lifting their sagging morale as well address the issue of frequent turnover of health personnel
- Poorly maintained physical infrastructure of the facilities and residential quarters requires immediate attention
- Regular logistic supply needs to be maintained so that patients' do not have out-of-pocket expenditure for the range of assured services to be delivered at the facilities – one way of ensuring patient satisfaction and increasing access to the facilities
- The bottlenecks leading to non-release of RKS, UF and AMG funds to the facilities should be addressed
- VHNDs, which is a crucial means of providing services and increasing awareness, especially in these difficult-to-access areas, has to be strengthened in terms of better planning and better participation of both service providers and beneficiaries
- Regular supportive supervision and monitoring by the NGO is of prime importance to guarantee good quality service delivery, while at the same time understanding the barriers faced and addressing them

## **VI. Summary of Bakdil:**

### **1. Introduction:**

The team evaluated five PHCs and a HSC attached to one PHC located in East, West and South Garo Hills districts. The Government of Meghalaya had handed over three, two and two PHCs out of total 17, 18 and 7 functional PHCs in East, West and South Garo Hills districts, to Bakdil since March 2009. These facilities are located under different blocks of these three districts. The East Garo Hills district headquarters is located at Williamnagar and district occupies an area of 2603 km<sup>2</sup> with a population of 317,618 (as of 2011 census) in five blocks. It has a sex ratio of 968 females for every 1000 males and literacy rate of 75.51%. The West Garo Hills has an area of 5247 km<sup>2</sup> with a population of 385,601 (as per 2011 census) scattered across six blocks. The sex

ratio is 981 females for every 1000 males, and a literacy rate of 79.3%. The South Garo Hills is also an administrative district in the state, with an area of 1850 km<sup>2</sup> and a population of 142,574 scattered across four blocks. It is the least populous district of the state and is also one of the country's 250 most backward districts (out of a total of 640). The sex ratio is 944 females for every 1000 males and literacy rate of 72.39%.

## 2. Service Delivery & Performance:

The types of services and performance of 5 PHCs namely Salampara, Babadam, Gabil, Wageasi and Siju for the 6 months period i.e. April 2011 to September 2011 is given in the table below.

**Table 8: Service delivery and performance of five PHCs under three different districts**

Types of services & performance	Name of facilities (PHC)				
	Salampara	Babadam	Gabil	Wageasi	Siju
OPD (all)	2195	2563	4755	8914	5898
IPD	127	191	249	1549	800
Total ANC registration	69	79	71	92	151
3 ANC registration	68	56	48	57	53
Institutional delivery	48	59	29	58	60
No. of immunization sessions held	16	60	124	56	62
Condoms/OCP distributed	50/43	80/0	0	0	0
Infants treated for diarrhea (ORS)	60	36	0	180	0
No. of patients (adults & children) availed assured referral services	103	191	119	428	305
Hb estimation	86	99	0	114	113
Malaria slides examined and PF case +ve detected	193/30	1816/303	838/15	1493/195	2328/902

Source: HMIS April- Sep, 2011

## 3. Key Findings:

- The overall functioning of the six facilities (5 PHCs & 1 HSC) has been improved following the takeover of these facilities by the NGO by ensuring availability of staffs, maintenance of government buildings and availability of some of the essential drugs & equipments etc. The

increasing footfalls in all facilities, as evidenced from the OPD, IPD data, delivery cases and first hand impressions, at least to the fact that services have “ now ” become available in these hitherto neglected and poorly performing facilities.

- The physical Infrastructure available to the NGO was mostly in poor conditions although the space is reasonably good. An improved seating arrangement in OPD, availability of drinking water and electricity has further added on the improved status of the facilities.
- Another positive aspect of the management of the facilities was ensuring availability of adequate residential accommodation for most staff at the facilities. Availability of services 24/7 in the facilities has been made possible as a result of the availability of staff.
- Though there have been improvements in the service delivery and increasing trend in OPD/IP cases over the years; the quality of services is a major issue since there are various gaps with regards to shortage of emergency drug, non-functional equipments and lack of a referral transport /ambulance system. Segregation and disposal of biomedical waste is not done as per the guidelines. Biomedical waste Management bins were available at the point of generation. 100 essential medicines are available in the facilities
- There is proper display of IEC materials at most facilities visited. Family planning is not promoted by the NGO. The NGO is a Christian Missionary NGO which does not promote family planning due to some religious aspects. Due to this reason, the staffs are not promoting family planning, instead of that they are referring the people to other facilities for family planning services.
- Most of the staffs in these facilities have not received adequate trainings to improve their performance and service delivery. Building up the skills of the MOs and SNs through the skill
- Though the RKS has become active in the last 2 years with regular meetings of members; none of the members are aware of guidelines for effective functioning of RKS. The fund is utilized mainly for purchase of CCTV, laptops, furniture, generators etc
- One of the major challenges is the recruitment and retention of staffs at the facilities. Since it is a FBO; the people are being recruited internally from other Christian institutions without following proper formal procedures and processes. The vacancy posts are never advertised in local papers or on websites since the NGO believes that no locally eligible candidates would apply for such good posts. Moreover the ANMs being recruited by this NGO are moving to the other government facilities due to which sometimes it becomes a shortage for staff availability.

#### 4. Areas for Improvements:

- **Infrastructure, Logistics, Drugs & Equipments:** All facilities visited are run in government buildings with adequate space in the wards, large compound and spacious wards though the building conditions and their maintenance is areas of concern. IEC materials are well displayed at all facilities. There is a need to develop a good IEC and BCC strategy for the state, either by GoM or in collaboration with NGOs for generating mass awareness about various health issues and to bring about positive behavioral changes in the community with regards to various health, nutrition and sanitation issues. The patients may be provided with booklets, pamphlets and brochures with pictorial illustrations and diagrams. The HEs and ASHAs should be trained in IPC and utilize innovative methods such as skits, role play and interactive methods for community mobilization on family planning, institutional delivery, and immunization etc. Some of the essential equipments such as radiant warmer, suction machines and OT lamps should be made available and functional. Some of the emergency drugs such as Methargin, Oxytocin, Magnesium Sulphate, Mizoprostol, Diclophenic are in short supply and anti-rabies and anti-venom should be made available to manage few cases of dog and snake bites.
- **Human Resource for Health & Training:** Most of the key positions such as M.Os, GNM, ANM, pharmacists and LT were in place and resides in the campus which makes it possible to function as 24x7 PHCs. There is 1 AYUSH MO at each facility and practices allopathic medicines due to lack of proper mainstreaming of AYUSH and non-availability of AYUSH drugs at the facilities. This is due to the fact that state health department does not supply AYUSH medicines in NGO managed facilities. The GoM and the NGO should take up effective measures to integrate AYUSH treatment at facilities wherever AYUSH M.Os are posted and raise the demand of AYUSH services in the community through effective IEC campaigns and patients given the option to avail either allopathic or AYUSH medicine as the preferred mode of treatment. Skill upgration trainings on SBA, NSSK, IUCD, IMNCI and other disease control programmes considering the local epidemiological context should be provided to staffs for enhancing the performance of service delivery.
- **Service Delivery:** The MoU between the NGO and the GoM stipulates that promotive, preventive and curative services will be provided of a certain level including emergency services. However, level and range of services provided in the facilities is not at par with the desired standards. All the facilities are doing well as outpatient clinics, but challenged when it comes to providing in patient care. The PHCs are not equipped to provide basic emergency services (including Obstetric care). In terms of the level of care, it is currently providing services of Level 1 care. Though the 24 hour ambulance facility is a prerequisite for a fully functioning facility as clearly laid out in the MoU; this essential service was not accessible in any of the facilities visited. Facility

level care for new born and sick children was not existent in the facilities, nor was any of the providers equipped with skills for care of new born and stabilizing sick children before further referral. The disposal of waste is also one of the key issues and bio-medical waste management system was not seen in most facilities. The colour coded bins, auto claves and hub cutters were not available. Training of staffs in bio-medical waste management and infection management systems is one of the crucial steps for improvement of service delivery and quality. The IMEP guidelines should be made available in the facilities.

- Community Processes:** The RKS became functional and active since 2009 after the NGO took over the management of the facilities and periodic meetings have started with full involvement of RKS members. The key constraint to effective functioning of RKS is due to the fact that members are unaware and not received orientation on RKS guidelines, use of untied funds and NRHM. There is a need to conduct regular orientation programmes for RKS members on various pertinent issues of NRHM and implementation of RKS guidelines. ASHA are found to be supportive and had received trainings on module 6. VHSC meetings are being held once in every week at all facilities. The post trainings follow up, mentoring and supervision of ASHA by facilitators and other ASHA mentoring /support team is negligible with the result that the services provided by ASHA is limited and could not bring positive intervention in the community as far as counseling and educating the community on various health issues such as institutional deliveries, family planning, disease control and practice of healthy behaviors is concerned. ASHA mentoring and support groups should be established and made functional and regular mentoring and supervision should be provided. ASHAs need to work with the health educators and the ASHA facilitators to motivate the community for institutional deliveries and adopting family planning methods since majority of the families in the community have seven to eight children per family on an average.

## VIII. Lists of Annexures:

### i. Facilities under Karuna Trust:

**Table 9: Lists of facilities under Karuna Trust**

S.No	Name of Facilities	District	Period of functioning
1	Mawsahew PHC	East Khasi Hills	Sep'2009-till date
2	Wahkaliar HSC		
3	Mawphu HSC		2 <sup>nd</sup> March, 2009 till date
4	Rumnong HSC		
5	Mawlong PHC		

6	Umwai Health Unit HSC		
7	Aradonga PHC	West Khasi Hills	10 <sup>th</sup> June, 2011 (NESPYM Guwahati, from April 2009 to 31 May 2011)
8	Umtraï PHC	Ri Bhoi	
9	Umlapel HSC		
10	Jirang Dispensary		
11	Warmawsaw PHC		

## 1. Mawsahew PHC

Mawsahew PHC under Shella Block, East Khasi Hills lies in a remote and rugged hilly terrain and it is approximately 13 kms from Sohra, district HQ. It caters to a population of 3297 covering 22 villages. There are 3 HSCs under the PHC namely Wakhalïar, Mawphu and Rumnong. The road connectivity is good. It was a Mini PHC which got upgraded to a full PHC and has eight functional beds.

### A. Physical Infrastructure:

- The facility is in a well maintained designated government building. The citizen's charter and various IEC materials are displayed in the waiting area. There is no registration counter at the facility. There is only 1 OPD chamber for both the doctors (MOIC & MO). A dressing room is available in the facility which is accessed through the male ward.
- Basic amenities such as drinking water, sitting arrangement are available. However, supply of electricity and water is irregular. An additional water tank has been purchased from the RKS funds. A generator is available for power backup. Staff quarters with basic amenities are available.
- The labor room has one labor table. There is no facility for warm water available at the labor room. The emergency drug Inj. Magnesium Sulphate was not available in the labor room.
- There are functional incinerator, ILR and deep freezer. The radiant warmer has been non-functional for the past two months.
- There is separate male & female wards; each ward having 4 beds.
- The pharmacy & stores are maintained well and all the racks are well labeled.
- No color coded bins for waste disposal was found.

### B. Human Resources & Training:

- There are 2 doctors, an MBBS and an AYUSH; 1 GNM/2 ANM, 1 pharmacist & 1 lab technician. 5 ANMs are posted at the SCs. The MBBS MO is a retired DHS of the Meghalaya government and has served in the region for several years. With extensive experience, well

versed in the local language and the issues, he has made several changes in the facility, putting systems in place.

- The MBBS MO has gone training in NSSK, HIV/ AIDS, RNTCP and Biomedical Waste management.
- There has been frequent turnover of staff, MBBS MO joined in April, 2011. There are many newly joined staffs such as Homeo MO (joined in October, 2011), accountant and the pharmacist. There is a driver and 5 group D staff
- None of the staff in this facility is trained in SBA, IUCD or IMNCI.

#### **C. Drugs & Equipments:**

- The facility indents drugs every three months. Drug supply by the Directorate is adequate. Besides Karuna Trust also supplies drugs like multivitamins, ranitidine, Artisunate Inj and tablets Mizoprostol from its own funds.

#### **D. Service Delivery**

- OPD, IPD, MCH i.e. ANC, delivery 24 x 7, PNC and immunization services are provided. There is no user fees levied at the facility. No user fee charged in the OPD. Common diseases as seen from the OPD register are diarrhea, dysentery, skin diseases (fungal infections). Poor sanitation in this area (open defecation), dwellings include those for pigs as well and use of water from the springs for consumption led to high incidences of dysentery and diarrhea. JSSK entitlement was displayed in the MOIC's room.
- Normal delivery is conducted in the labor room. 1-2 deliveries are taking place per month. In the past six months no case of delivery referred out.
- Labor room had displayed the MH and CH protocols and also a partograms ( however not used by the staff )
- JSY : 2 beneficiaries in 2010 ; 7 night deliveries last three months
- Child health: The new born care corner was not functional; Baby warmer out of order for a long time since no AMC for equipment copy given to MO.
- Well Baby clinics are organized on Wednesdays
- Family Planning: The average child per household is 6. Very low acceptance of family planning methods. Only spacing methods are used. Sterilizations are not available in this facility.
- MTP services not available in the facility
- Diagnostics: The laboratory services include all the basic services except Blood sugar. Glucometer strips are not available.
- Dietary services are not available at the facility.
- Linen & laundry is cleaned in house and changed after the discharge of the patient.



- Referral Transport: There is an ambulance in the facility and that is the only transport available in this remote area for referral patients out to Shillong. This vehicle also doubles as the MO vehicle for transport to Shillong for meetings and for procuring medicines from Shillong. There is no private commercial vehicle in this region which is in an isolated corner of the block.
- While pregnant women are provided free ambulance services, other referred patients are charged POL expenses.

**E. Documentation & Reporting:**

- MCTS registers were available. MCTS (Mother and Child Tracking System) has not been started yet.
- The MOIC organizes a PHC level meeting every month and a sector level meeting for the AWWs and ASHAs for reviewing their work.

**F. Community Processes:**

As per the interaction with 2 ASHAs and 1 ASHA Facilitator; there are 12 ASHAs for the PHC. The quarterly meeting and sectoral meetings of ASHAs are held regularly.

- The BPM is the Block ASHA Coordinator; however he is not updated with the programme.
- All ASHAs have been trained in Module 6, but have not received HBNC kits.
- They attend the VHNDs and follow up on Immunization. However, they mentioned that they have not been able to motivate the women for sterilization.
- There are 8 members in RKS. The NGO had used RKS funds for the renovation, drugs & equipment purchase and improvement of the health facility. All works were done through local contractor as mentioned in resolution. There is proper documentation of meeting minutes and register are maintained since 25.5.11.

**G. Performance Indicators:**

**Table 10: Performance indicators based on services**

Services :	Apr-Jun' 10	Jul-Sep' 10	Oct-Dec' 10	Jan-Mar' 11	Apr-Jun' 11	Jul-Sep' 11
OPD	990	1644	2021	2471	2551	2587
IPD	1	55	54	32	67	86
ANC	20	26	37	33	18	17
3 ANC	0	0	28	42	28	17
Institutional Delivery	0	3	10	10	12	8
SBA Attended Home Delivery	0	6	10	5	11	6

Full Immunization	4	14	30	16	18	24
Immunization Session Held	48	48	48	48	48	48
Condoms Provided	0	0	505	600	660	270
OCP Provided	8	19	72	60	29	36
Infants treated for Diarrhea (ORS)	34	104	81	113	44	92
Hemoglobin Estimation	39	205	336	221	242	251
Malaria Slides Examined	36	260	172	57	78	94
Found P.F. Positive	0	3	0	0	0	0
Malaria Cases Treated	0	3	0	0	0	0
Sputum Sample Examined	0	0	0	0	0	0
Sputum Sample Found Positive	0	1	1	2	1	0
Patients put on D.O.T.S	0	1	1	2	1	0

The MCH performance of 2010-11 is given in table 11 below:

**Table 11: MCH Performance indicators in 2010-11.**

Sr. No.	Performance Indicators	Figures
1.	Total district Population	3297
2.	CBR (SRS, Jan'11)	24.4
3.	Expected Pregnancy Vs No. of pregnant women registered for ANC (%)	88/ 116 (132%)
4.	No. of pregnant women received $\geq$ ANC	70
5.	% of 3 ANC against ANC registered	60%
6.	No. of SBA assisted home deliveries reported	21
7.	No. of ID	23
8.	% of ID against total ANC registered	20%

## 2. Wakhaliar Health Sub-center

Wakhaliar SC (under Mawsahew PHC, East Khasi Hills) is located about 3 kms from the Mawsahew PHC and 25 kms from Sohra CHC. It covers 4 villages and a total population of 764. vBuses which ply on fixed timings are available once a day. The nearest village is Wakhaliar and the farthest is Konogrim (25 kms away).

**A. Physical Infrastructure**

- The SC is housed in a government building and has 2 rooms.
- There is residential facility for the staff.
- There is 1 examination table, 1 weighting scale, 1B.P apparatus, 1 stethoscope and 1 haemoglobimometer.

**B. Human Resource & Training Status**

- Two ANMs and 1 Safai Karamchari are posted at the SC.
- None of them had undergone any training.

**C. Service Delivery**

- OPD, ANC and immunization services are provided

**D. Documentation & Reporting**

- A total of 24 registers are maintained for all services provided at HSC

**E. Functioning of RKS, AMG, UF**

- The AMG & UFs have not been received in current financial year 2011-12
- The fund received earlier was utilized for repair work, wiring and painting etc

**3. Mawlong PHC**

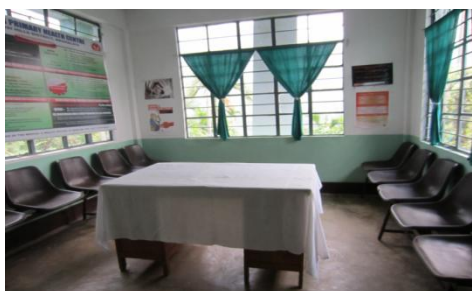
Mawlong PHC of Shella block is located approximately 13 kms from Sohra sub division and 75 kms from the Shillong, the state capital. This facility caters to a population of 3689 covering 5 villages. The facility has ten functional beds functioning 24/7. There is no SC under this facility, but the NGO has started a health unit for providing sub centre level charges. The approach road to the facility is good, but the stretch from the main road to the facility itself is not in good shape. The nearest referral centers for this facility are Sohra CHC and Ganesh Das Hospital, Shillong.

**A. Physical Infrastructure**

- The building is in very good condition and is a designated govt. building for a PHC. There is a waiting area, with sitting arrangements demarcated for the patients. Separate waiting facility and

stay facility for ASHAs has been created in a spare area of the facility. Residential quarters for all the staff including Grade IV staff are available within the campus of the facility. In two quarters (GNM & Gr.IV), electricity is not available.

- This is ten bedded PHC, with five beds each for the male and female wards respectively. The wards are very well maintained.
- The OPD timings, schedule, fee structure was displayed. A citizen's charter was also displayed in the waiting area.
- There is an excellent signages mostly in local language ( Khasi), display of informative/ educative IEC materials , including pictorials (for birth registration , nutrition) ,rosters -timings for patients & attendants stay, cleaning, changing of sheets was displayed in a notice board near the labor room. The list of available drugs, information on RKS, VHSC, and Citizen's charter was also displayed.
- There are 2 well lit OPD chambers, a dressing room and 1 minor OT
- The labor room has one labor table. It is very well maintained with a spot light, functional radiant warmer and all the emergency drugs except magnesium sulphate being available.



**OPD waiting area**



**IEC display**

- There is functional cold chain equipments, 1 Deep Freezer and 1 ILR.
- There is one ambulance in the facility for referral.
- Power back up facility, a generator and an inverter, is available and functional.
- There is provision for 24 x 7 running water.
- **Waste Disposal System:** There is no supply of multicolored bins for biomedical waste management. Waste segregation was not observed. Functional needle cutters were available. A deep burial pit is available. The staff has not been trained on waste management
- **Drugs and Equipment:** The pharmacy is very well maintained with adequate racks for storage of the drugs. The racks are labeled and essential drug list with the available drugs is displayed. This is one of the model pharmacies of the Karuna Trust (KT).
- Adequacy of drugs was observed except for AYUSH drugs which was not available. Anti snake venom and anti Rabies injections were also available. Besides the regular supply of drugs from the state government, in case of shortfall, KT also supplies drugs purchased from their own funds. This is a good practice since there is no way for the facility staff to procure drugs at short notice considering the very remote location and lack of any private chemists shop in the vicinity.



**Pharmacy with properly labeled shelves**

**Well lit and clean patient ward**

## **B. Human Resources and Training**

- The PHC was found to have adequate manpower. All positions have been filled. There are 2 MOs – 1 MBBS (who has retired from the Government services) and 1 AYUSH along with 2 GNMs and 2 ANMs at the PHC. (Two more ANMs are posted at the Umwai HSC under Mawlong PHC).
- There is 1 Lab Technician and 1 pharmacist along with a driver. There are 5 Grade IV employees.
- 1 GNM has received the NSSK training. There is no SBA or IUCD trained nurses/ ANM.
- 1 MO has been trained in Maternal Death Reviews.

## **C. Service Delivery**

- OPD, IPD, ANC, PNC, Immunization are the services provided at the facility. OPD timings are 9-4 p.m. The monthly OPD is in the range of 35-90 (the highest being in the months of June-July). Average IPD during the period April-March 2011 is 17.
- There are no user charges for OPD and IPD services.
- **Family Planning:** Only oral pills and condoms are provided at the facility. No sterilizations or IUCD insertions are carried out due to lack of motivation among the community and lack of providers.
- **Delivery services:** Round the clock delivery services are available. Delivery services started at the facility since June 2010, after the construction of a labor room. As the services began to be operationalized and word spread to nearby households, women started coming for deliveries. Deliveries picked up and within six months there were 10 deliveries in 2010.
- The facility has a spacious labor room with protocols for MH and CH (neonatal emergencies) prominently displayed in Labor room and female ward.
- MTP services are not available in the facility.

- RTI/ STI services are provided; few cases reported in the facility.
- Referral facility (an ambulance, brought by the NGO) is available from the facility.
- **Diagnostics:** There is no provision for X-ray. The lab technician for RNTCP was doing Hb, Urine, sputum tests and malaria slides. This is a designated DMC

#### **D. Documentation & Reporting:**

- Data for all services was maintained meticulously by the staff. Records of performance on MH, Immunization and FP were displayed in the form of charts in the MOs room.
- The facility provides two sets of reports upwards to the district : PHC aggregated data set and Monthly progress report to the NGO

#### **E. Ancillary services**

- Housekeeping is in-house and all the soiled linen is washed by hand.
- Dietary services are provided for the patients who make a request for it. The kitchen is non functional and there is no cook but the food is provided for by the staff, prepared in their own quarters.

#### **F. Community Processes**

##### **ASHAs Status and Functionality**

As per the FDG with 3 ASHA, 1 ASHA facilitator; there are 5 ASHA for the 6 villages served by the PHC Mawlong (most villages being small units / hamlets e.g. Village Umswai with 122 HH has 713 populations)

- Coverage: There are 5 villages in this area. Three villages – Linghar, Dalda and Sohdoit do not have ASHAs. These are inhabited by migrant population. Most ASHAs are serving population below 1000.
- ASHA facilitators appointed for each facility wise and not block wise. The AF of this facility, Mrs. Theorist has 5 ASHAs under her.
- In all blocks BPMs are also working as Block ASHA Coordinator, BPM Sohra has no knowledge or information about the ASHA programme ( name sake , didn't know about HBNC kits, no monitoring and supervision being done by him). The knowledge level of the ASHA facilitator is poor in the area of programmes and there is hardly any assistance provided to ASHA.
- ASHAs were active, accompanied patients to the facilities and attended VHNDs. (they had a good rapport with both the MOs, since they visit the facility often for meetings.)
- All ASHAs had bought the ASHA diary (old and new one), are recording the activities, VHND dates and talks given by them.
- ASHAs were invited often to the facility by the MO and given talks on various topics. The NGO provides an additional incentive of Rs.100 to the ASHAs for attending these meetings.
- All three ASHAs mentioned receiving Rs. 915 last three months. They had received training in module 6, but not doing follow up home visits for new born.

- Drug kit refilled timely, PCM, ORS and IFA utilized the most.
- During the meeting the ASHAs mentioned their satisfaction at the functioning of the facility and the good behavior of the MOs, SNs and other staff with the community. They were appreciated the availability of the sitting areas marked for them.



**ASHA Waiting room cum library in the PHC**

### **Rogi Kalyan Samitis**

The facility has made adequate use of the RKS fund in upgrading the facilities, fixing tiles on the floor, adding basic furniture, refurbishing the MOs room, providing regular electricity (power back up) and piped water (water tanks).

### **Village Health and Sanitation Committees and VHNDs**

As per the In-depth interview with 2 VHSC members; there has been no training done so far for VHSC members. The members were not active. The ASHA from this village present in the meeting was knowledgeable of the VHSC. She had brought with her the bank pass book and VHSC minutes and also the record of resolutions taken by the VHSC for its funds. VHSC funds have been used for cleaning locality (Rs. 3000 spent)

### **G. Performance Indicators:**

**Table 12: MCH Performance indicators in 2010-11**

<b>Sr. No.</b>	<b>Performance Indicators</b>	<b>Figures</b>
1.	Total district Population	3689
2.	CBR (SRS, Jan'11)	24.4
3.	Expected Pregnancy	99
4.	No. of pregnant women registered for ANC	65
5.	% of ANC registered against expected pregnancy	66%
6.	No. of pregnant women received 3 or more ANC	31
7.	% of 3 ANC against ANC registered	48%

8.	No. of ID	20
9.	% of ID against total ANC registered	31%
10.	No. of SBA attended Home Delivery reported	0

- The OPD and IPD attendance show a varying trend with both recording a maximum attendance in Jul-Sep'10.
- The ANC registered as against the expected pregnancy is 66% and the percentage of 3 ANC as against the ANC registered is 48%. Institutional deliveries have been started from 2010. A total of 20 deliveries were recorded in 2010-2011. The percentage of institutional deliveries as against the ANC registered is 31%.
- There have been no SBA attended home delivery in 2010-11, but the Oct-Nov'11 records show 11 SBA attended home deliveries, which is surprising since none of the facility staff are SBA trained. The full immunization status shows an increasing trend.

**Table 13: Performance Indicators based on services delivered**

Services:	Apr-Jun' 09	Jul-Sep' 09	Oct-Dec' 09	Jan-Mar' 10	Apr-Jun' 10	Jul-Sep' 10	Oct-Dec' 10	Jan-Mar' 11	Apr-Jun' 11	Jul-Sep' 11
OPD	2272	2377	1801	2169	2147	4365	2802	2137	2766	2985
IPD	2	12	11	11	12	96	53	37	53	39
ANC	7	23	13	24	24	15	16	10	18	28
3 ANC	0	13	3	4	10	5	11	5	4	9
Institutional Delivery	0	0	0	0	0	3	7	10	2	4
SBA Attended Home Delivery	0	9	0	0	0	0	0	0	1	1
Full Immunization	10	1	3	4	12	8	9	11	16	24
Immunization Session Held	16	15	14	15	11	14	11	31	29	30
Condoms Provided	0	12	70	90	10	140	260	320	560	700
OCP Provided	0	2	4	7	14	11	17	16	31	42
Infants treated for Diarrhea (ORS)	16	15	10	18	19	0	46	43	48	12
Hemoglobin Estimation	0	76	68	35	79	125	110	189	89	119
Malaria Slides Examined	106	177	124	71	114	659	281	226	288	246
Found P.F. Positive	4	2	0	2	2	0	4	3	11	73



Sputum Sample Examined	0	46	54	36	35	93	52	65	101	82
Sputum Sample Found Positive	0	3	2	2	3	4	3	6	9	8
Patients put on D.O.T.S	0	2	0	2	1	2	4	5	2	3

#### 4. Umwai Sub-center/Health Unit:

PHC Mawlong does not have sub centre. However, The NGO has set up a small health unit for outreach services in two rooms of a rented building. The Umwai Health Unit is a proposed SC. It covers one village with a population of 713. This has been functional since July, 2011. The unit is manned by two ANMs, who reside in the adjoining room in the facility. The services provided at the health unit include OPD, Family Planning (OCP and Condoms) and PNC. ANC services are not provided at the health unit. 2 VHNDs are carried out in a month (there are two Anganwadis). During the VHND, weight, B.P measurement and ANC are done. The Health Unit staff is maintaining meticulous data in 6 registers (by 2 residential ANM). OPD registers mention diagnosis and treatment for each patient. But the unit is not doing ANC since it does not have examination table. No generators, frequent power cuts.

**Summary:** Karuna Trust with its prior experience of managing PHCs in the many regions of the country (including the North East –Arunachal Pradesh), has considerable experience of working with the government under PPP. The NGO is providing a range of promotive and curative services in this facility. The performance of the facility shows a positive trend since the takeover by the NGO. A few areas which requires attention is building the skills of the AYUSH MO, the SNs so that they could provide at least Basic Emergency care for mothers and neonates .It is necessary to build the skills of the staff in this area , since the nearest referral centre is 75 kms from the facility and availability of emergency referral transport, besides the facility level ambulance is a constraint. Provision of outreach services is a weak area and so is mentoring of the ASHAs and building the skills for the same in the ASHA facilitators. These are areas which need to be strengthened.

#### 5. Aradonga PHC

Aradonga PHC under Riangdo block, West Khasi Hills is located at about 80 kms from the dist HQ town of Nongstoin. It is located at the one of the most outreach and farthest corners of the district, and is close to the border that the district shares with the plains of Assam state. The main highway connecting the city of Guwahati to the plains of Bihar and UP is only 18 Kms from the Aradonga PHC. So this PHC has a peculiar location that it is situated in one the most outreach and hilly areas of the district but is very closely situated and well connected to the Assam plains, and is only about 80 Kms from the city of Guwahati. The road from dist town of Nongstoin to the facility is in such a pathetic state, that the journey of 80 Kms by a

sturdy big vehicle took the team about 6 hrs. The road is quite hilly and full of potholes. This road connects the area of coal belt of the district with the Assam plains so it is highly frequented by the heavy vehicles and breakdowns of vehicles and long traffic jams are the order of the day almost on a daily basis. All of this makes the access to this facility for the people of the area very difficult and cumbersome. The support and monitoring of the facility by the district officials also becomes all the more difficult for the same reasons.

#### **A. Physical Infrastructure:**

- The facility is located at the end of the forests and hills in the plain area. The building is very spacious and well spread out, and has quite spacious residential quarters. The condition of the building is good. This facility is presently being run by the NGO Karuna Trust, who have taken over on 10 June 2011. Prior to that, it was being run by the NGO – NESPYM Guwahati, from April 2009 to 31 May 2011. During this period there was a high turn-over of the doctors and staff and the facility was not being run to the satisfaction of the community and officials. So it was taken from them and later handed over to Karun Trust. The facility caters to a population of 11646 and 54 villages. The location of the facility is peculiar and it is quite outreach from the dist HQ, and is reachable by a very bad hilly road. Approachability of the facility especially for delivery cases and other serious patients is very low. The place has good drainage system and the drains are well maintained. The campus has wire fencing all around
- The building of the hospital is quite well built and is in good condition, but space in the facility is quite insufficient, though strangely the residential quarters are quite spacious.
- The staff quarters are located very close to the facility building. Residential quarters for the staff are available in the campus for 2 doctors and 2 nurses only. But many more staff resides in the campus by sharing the quarters and also some other staff resides nearby.
- The facility has a designated govt. building with 10 beds. At present the hospital is under major renovation work to add new labor room to the facility, so a lot of make-shift arrangements have been made in present labor room as well as the ward.
- It has two OPD chambers, but has no separate a dressing room cum minor OT. It has one lab and also has one set of cold chain equipments – one ILR and one deep freezer.
- Internal space of the hospital building is not very spacious, so at present no separate space as waiting area for patients is present, the gallery of the building, and also the outside campus function as waiting area.
- The facility has one labor room which has one labor table. It is well maintained. There is one ambulance in the facility for referral transport. It has been provided by the present NGO Karuna Trust.
- No separate facilities of Chairs, Food or Beds were in place for ASHAs.

#### **B. Human Resources and Training:**

- The facility has a total of 20 personnel, with two doctors posted full time, of whom the the doctor in-charge is an MBBS with about 18 years of past exp. and is working in this facility since Sep 2011. There is 1 AYUSH lady doctor with BAMS degree, working in facility for the last 4 months and has 2 years of past exp.
- There is 1 GNM working as staff nurse with 8 yrs. of past experience and is working in this facility since last 6 months. It has total 6 ANMs.
- 1 Lab Technician, 1 pharmacist, and 2 accountants (1 from NRHM 1 from NGO) are also in position.
- The facility has 4 other grade four employees and one driver and chowkidar also.
- The doctors of the facility have received two trainings on Measles and Maternal Death Review (MDR)
- No other training to any other present staff has been given by either the govt. or the NGO. The present facility team could not give us definite information about the previous facility team under earlier NGO.

### C. Service Delivery

- **OPD & Registration** – OPD timings, and fee structure were not displayed, but the board for this was being prepared. The citizen's charter was also not displayed, but has been recently made and will be displayed soon. No separate counters for male and female were present but there was no crowding at registration desk. Counter for registration was common. Waiting time for OPD registration is 1-3 minutes and waiting time for consultation would be 5-10 minutes .No charges for OPD registration or for any tests are taken. Printed consent forms for IPD and OT are not available.
- Facility is providing services of OPD, IPD, ANC and PNC and Immunization, as well as 24/7 Delivery services OPD timing is 9 AM to 2 PM.
- The facility team had data and record only for the period since June 2011. During the quarter of July to Sep 2011, 10 deliveries have been conducted, and in Oct and Nov 2011, 8 and 2 deliveries have been conducted in the facility. This shows that the services are picking up in the facility.
- Partographs have neither been supplied nor being used.
- Services of PNC, Immunization and Management of Childhood Pneumonia / Diarrheal Diseases are being provided.
- **Family Planning:** No sterilization services. But IUCD services have been started recently in Oct 2011 and 4 insertions have been done. Oral pills and condoms are also being provided at the facility.
- **Referral facility** The ambulance provided by the present NGO Karuna Trust in the facility for referral transport is being used effectively for transport support. The ambulance is a new Mahindra vehicle with a driver also in place and is well maintained.
- **Diagnostics and lab:** The lab is providing at present services for tests of Hb, Blood grouping and RH Typing, Blood Sugar, MP Test & Vidal test & and urine for pregnancy test. X ray facility is not

available. No specific routine or system for calibration of measuring instruments is in place at present.

#### **D. Institutional Mechanism and Quality Control –**

- Rogi Kalyan Samiti (RKS) of the facility has been constituted in 2008, and funds have been received since FY 2009-10.
- Two meetings of RKS have been held in current FY (since June 2011) last one was on 19.10.11.
- No external or internal audit has been done since June 2011.
- Citizen's Charter was not displayed in facility; it has been recently made and is going to be displayed soon.
- Publicly displayed mechanism for complaints / grievances was also being designed and will be in place.
- **Flexible Financing** –Funds of total 1.75 Lakh were received for the facility in the FY 2009-10 and 2010-11 and FY 2011-12. Total fund spent in FY 2009-10 was Rs. 1.75 Lakh. In FY 2010-11 over-utilization of funds to the tune of about 25000/- was done over and above the 1.75 Lakh received, which was taken from JSY funds. In FY 2011-12 about Rs. 33000/- have been spent till now.
- **Basic Amenities** Drinking water was available for patients. It has power back up available by a genset. It has 24 hour running water facility.
- **Emergency - No** separate access to emergency dept. Minor OT and dressing room was not available. Soiled linen is washed by hospital staff, sluicing is practiced.
- **Labor Room** – Facility has one labor room with one delivery table.A new labor room is being built. Partographs are not supplied or being used. Labor room records have new born details like weight, and also the complications if any during delivery. Warm water facility was not available in labor room, and neither were the pre and post delivery rest rooms. All the emergency drugs and supplies related to labor room were available, except that the Magnesium sulphate was not available. Forceps delivery kit and surgical kits were available. Sterilized delivery sets were reportedly being used for each delivery. Reportedly women stay for 48 hours after delivery. As per the state policy, mothers with up to second child (live births), delivering in the facility, get the JSY benefit, and the facility team reported that almost all of them get this money within 48 hours. Infection control practices – hand wash, cleaning, glove, slippers and mask are being practiced.
- **Ward** -Average monthly IPD admissions are about 30. Timing for the visiting hours was not displayed.
- **Laboratory** –Lab tests had no charges. No particular timings for lab tests were on display. No separate demarcated areas in lab were in place. Practice for standardization of analyzer with the standards provided in the kits was being practiced. Lab reports register, and stock registers and indent register were maintained in the lab.

- **Pharmacy and Stores** The pharmacy is very well maintained and well stocked. Apart from the state govt supplies, substantial supply of drugs and other items have been sent by NGO as well. Racks were available in sufficient numbers in pharmacy, and are labeled. The space for store was insufficient. As per the staff all essential drugs included in the state's drug list are available. The storage room and the space in regular pharmacy were not in a good condition and were being renovated. Refrigerator is available for storage of medicines.
- **Laundry services/Housekeeping:** Soiled linen was being washed by facility staff, and sluicing was being practiced. The linen being used in wards was clean and well maintained. Laundry services are in house. Linen was well kept and clean and was available on all beds. Linen change is done with every patient discharge. Housekeeping is in-house and all the soiled linen is washed by hand by the ward boys and ward girls. MO I/C supervises the housekeeping operations. Overall cleanliness level was good, except for the mesh created due to the ongoing renovation. The structural condition of the building was good, and there were no peel-offs, seepage and cracks in the walls etc. Taps and fixtures were also well in place.
- **No Dietary services** are provided for the patients. No kitchen is run.
- **Waste Disposal System** -The system is being run in-house. Multicolored bins were not being used in the facility, and waste segregation practices were found to be inadequate. Printed Charts with instructions were not in place. Needle cutters were available and were being used. Deep burial pit and sharp pit were not constructed. Puncture proof containers are not available.
- **Security and Service** No security service or fire safety equipments were in place.
- **Reports** -The facility sends its aggregated reports to BMO office / NRHM team of the district, as well as to its NGO head office.

**D. Performance Indicators:**

**Table 14: Performance indicators in 2010-11.**

<b>Services:</b>	<b>Apr-Jun' 11</b>	<b>Jul-Sep' 11</b>
OPD	420	1540
IPD	46	231
JSY Beneficiary Paid	8	0
Full Immunization	0	15
Immunization Session Held	0	4
Condoms Provided	30	160
OCP Provided	1	0

Infants treated for Diarrhea (ORS)	7	5
High Risk Pregnant Women Referred	0	3
Hemoglobin Estimation	0	101
Urine Examination	10	41
Malaria Slides Examined	0	0
Rapid Diagnostic Kit Used	85	537
Found P.F. Positive	21	21
Malaria Cases Treated	21	14
VHNDs Held	2	10

#### **E. Community Perception:**

##### **RKS members**

- Rogi Kalyan Samiti (RKS) of the facility has been constituted in 2008, and funds have been received since FY 2009-10.
- Two meetings of RKS have been held in current FY (since June 2011) last one was on 19.10.11.
- No external or internal audit has been done since June 2011.
- Citizen's Charter was not displayed in facility; it has been recently made and is going to be displayed soon.
- Publicly displayed mechanism for complaints / grievances was also being designed and will be in place.
- Funds of total 1.75 Lakh were received for the facility in the FY 2009-10 and 2010-11 and FY 2011-12. Total fund spent in FY 2009-10 was Rs. 1.75 Lakh. In FY 2010-11 over-utilization of funds to the tune of about 25000/- was done over and above the 1.75 Lakh received, which was taken from JSY funds. In FY 2011-12 about Rs. 33000/- have been spent till now.

##### **Support from NGO to facility team**

NGO support is very strong and apart from the regular payment of salaries and regular expenses, an ambulance has also been provided by NGO. The salaries of staff are paid on monthly basis, and are deposited in their bank accounts. This is the only place of all 5 facilities where salaries are being paid in time. NGO is also paying Rs. 10000/- per month as regular operational expenses budget. Monitoring and support visits are also being done by the NGO team. The NGO has also provided a comprehensive handbook on Management of PHC prepared by it. It gives a no. of formats apart from guidance on issues of management. The NGO is also contributing its own funds in buildings renovation as well.

##### **Sub – Centre and Extension Program**

The facility is running two Sub Centers, which have been made operation very recently. The extension program of the facility was not in a good shape till now, but the team is now gearing itself for better management of the field program.

**Over-all functionality of the PHC** The facility seems to be picking up in patient load of OPD or IPD as well as delivery cases. The IPD was 1540 in Jul-Sep 2011 quarter compared to 420 in Apr-Jun 2011. IPD rose from 46 to 231 in the same period. The facility was badly run in last 2-3 yrs. But the present team has started to make it well functioning and has begun to provide critical care services. For eg. This was the only facility of all 5 visited by us, which had started IUD insertions. Most of the staff, a small team working closely resided in the campus itself and was available round the clock. The present team of two doctors one is MBBS and other one is BAMS lady doctor are well motivated and have started to build a team spirit and also the infrastructure and systems.

## 6. Umtraí PHC

Umtraí PHC comes under District:-Ribhoi, Block:-Umsning.It covers total population of 4201. Nuber of villages covered are 10. Numbers of VHSCs are 9. NGO Partner:-Karuna trust. Date on which handed over to NGO: 9th September 2009

### A. Physical Infrastructure

- The building designated for the PHC is of government. Boundary fencing is done by iron wire and no proper concrete boundary wall is present. There was no water logging inside the campus and had proper drainage system.
- There is no separate registration room. There is 2 OPD rooms; 1 OPD for adolescents.
- Citizen charter was displayed with OPD timings and schedule.
- Other IEC materials were displayed in OPD waiting area. Facilities for drinking water was available
- There are 2 wards with total 9 beds (3 beds for females and 6 beds for male patients). The wards were clean with good condition of beds and linen. Colored linens used instead of white, the reason for which given was easy to maintain cleanliness. Flooring was done with tiles (investment from NGO) for maintaining cleanliness in the ward. There were attached toilets but cleanliness was not appreciable.
- There is 1 labor room with attached newborn care room. The labor room had one delivery table.. Amongst the emergency drugs, all drugs were in labor room except Inj. Magnesium sulphate and vitamin K which are procured from pharmacy as and when required. Delivery kit was fully equipped. There is autoclave for sterilizing delivery sets at the frequency of twice a week. Partographs have been supplied to the PHC since sept.2011 but still not being used by staff.

- **Emergency department:** There is minor OT in the facility for emergency treatment with no separate access to the department. There was neither linen nor michentosch on the examination table.
- **Laboratory:** In the laboratory, there were no separate and demarcated areas for sample collection, sample processing, report printing and delivery. For collections of sample and reports, no timing is specified and not even displayed. It is done as per the convenience of lab technician. Laboratory technicians do standardize their analyzer with the standards provided with the kits.
- **Pharmacy and stores:** There was a separate room for storing and dispensing medicines. Rooms had enough racks for storage and were labeled. Room was well ventilated. Pharmacy was not having all the essential drugs as per the state list. Pharmacist: -*“Those essential drugs mentioned in state list which are not used frequently are generally out of stock.”* There was no refrigerator for storage of medicines.
- **Cold chain equipment:** Facility had deep freezer and ILR with proper maintenance of temperature and duly recorded in registers.
- **Ambulance:** PHC also had the facility of BLS ambulance for referral services. The facility of ambulance started from 7<sup>th</sup> April 2011. Before that van (vehicle not equipped for BLS) was used for referral services.
- **ASHA helpdesk:** There was a separate space for ASHA help desk where four chairs were available for ASHAs who accompany the patients to the facility. There is no facility of bed and food for ASHAs. According to PHC staff *“Not thought of extending services or facilities for ASHAs as they hardly come with patients.”*
- **Residential facility for staff:** PHC have residential facility for medical officers, nurses, and pharmacist but not for other staff like lab technician, chaukidar, cleaners. Both medical officers have to share the flat of three rooms. Likewise nurses have to share residence.
- **Other facilities:** Power backup: There is no continuous electrical supply. Generator was available which is used when patients are there or at night for emergency cases, for maintain temperature of cold chain equipment. Water facility: 24 hrs running water facility was not available in the hospital.

## B. Human Resource & Training

- In total there is staff of 16 in PHC which consists of 2 medical officers ,3 ANM at PHC and 2 ANM at SC,1 Lab technician,1Pharmacist,2 health assistants and 5 group D including sanitary assistants.
- MO-IC had undergone trainings RNTCP, IPPI, Meningococcal Meningitis, Measles catch up campaign, Programme Mgmt. tool, IUCD, Malaria Mgmt., Leprosy, RKS workshop.



- MO-AYUSH had not undergone any training. ANMs have undergone trainings in IPPI, Meningococcal meningitis, Measles catch up campaign, Programme Mgmt. tool, IUCD, Malaria Mgmt., Leprosy.

### C. Services Delivered

- **OPD:** Daily OPD, on an average is of 35-40 patients. OPD timings are from 9:00 am to 2:00 pm. After that only emergency cases are handled. Common illnesses that doctors come across are malaria, diarrhea/dysentery, typhoid, enteric fever, anaemia in women and joint pain. OPD increases on specific days like Wednesday-Immunization day, Friday-ANC day, Saturday which is local market day. Average waiting time for registration is 5-10 mins and average consultation time is 5mins.
- **IPD:** Daily IPD is of 1-2 cases and monthly average is 13 cases. There are no printed consent forms available for IPD or OT. There are no specific visiting hours for patients relatives because no public transport is there for approaching facility and the facility is in hilly region so specific visiting hours cannot be followed.
- **MCH care:** Maternal and Child Health services provided at the facility includes ANC, 24 hr delivery services, PNC, Immunization of mothers and child, management of childhood pneumonia, diarrhea, and birth and death registration as well as "**well baby clinic**" for adolescents counseling. For ANC and Immunization there are fixed days. For immunization services-immunization card are made available to mothers and children. For vaccines storage there is well functioning cold chain equipment (deep freezer, ILR) whose temperature is maintained and recorded timely in registers. All mothers are not made to stay for 48hrs after delivery. On an average mothers are made to stay for not more than 12hrs in the facility after delivery. Mothers receive JSY benefits after one week of delivery. No maternal death took place since 2009, only one IMR reported since 2009 till date.
- **Family Planning:** As for family planning services, only distribution of oral pills and condoms is done while no sterilizations or IUD insertion is being carried out as no provision for it in the facility.
- **Referral services:** For referral there is ambulance which is BLS Ambulance and its services started from 7<sup>th</sup> April 2011. Earlier van (not a proper ambulance) was used for referral services. On an average 3 cases are referred per month. Referrals are made in case of pregnancy related complications, severe diarrhea, dehydration, status epilepticus. In delivery cases, patients are referred to Khetri CHC (Assam). Other serious patients are referred to Guwahati medical college as these two facilities are near to this PHC.
- **Laboratory services:** Laboratory tests that are conducted at the PHC includes blood routine examination (HB%, TLC, DLC, ESR), blood grouping, blood sugar, blood for MP test & Widal test, blood for VDRL, stool routine examination, urine routine examination, urine for pregnancy test. There is no

provision for sputum examination for AFB at the facility so patient is referred to Mahawati PHC .This PHC is not a DOTS center so treatment of TB cases not done at the facility.

- **Radiography**-In the facility there is no provision of taking X-rays.
- **Bio medical waste management:** Biomedical waste disposal is in housed. There were multicolored bins for waste disposal and the posters of instructions for handling biomedical waste were displayed near the bins. Despite of all this, staff was not practicing biomedical waste management as per BMW guidelines. Three Needle destroyers were available and were functional .Even segregation of waste is not done properly. For collection of sharps there was no puncture proof containers with 1% sodium hypochlorite .There were two pits for waste disposal of which one was for sharps. Once the pit is filled, the waste is burnt and the pit is closed and another pit is dug at other site.
- **Housekeeping:** Services are in housed and facility was overall clean .These services are supervised by ANM and carried out by sanitary assistants.
- **Linen and laundry services:** Service is in house. Linen was present on every bed at the time of observation. Linen is changed after every patient discharge. Slucing is not being practiced for cleaning linen. Linens are washed with water and if any spot then only detergent used.
- **Infection control practices inside Labor room:** Staff practices the infection control methods like use of glove, mask, slipper, apron in the labor room.
- **Dietary services:** Till date, there is no facility for providing food to patients or their relatives. There is kitchen in the PHC but not equipped so kitchen services are not yet started.
- **Security service:** There is one chaukidar (govt. personnel, not kept by Karuna trust).There was no fire safety equipments.

#### D. Performance Indicators of Umtra PHC (Sept.2009-Nov.2011)

**Table 15: Performance Indicators based on services provided**

<b>Services:</b>	SE P' 09	OCT- DEC' 09	JAN- MAR' 10	APR- JUN' 10	JUL- SEP' 10	OCT- DEC' 10	JAN- MAR' 11	APR- JUN' 11	JUL- SEP' 11
OPD	125	1034	1224	1949	1494	1584	1536	1993	1876
IPD	1	5	24	60	38	45	51	42	54
ANC	4	49	52	33	36	39	39	29	37
3 ANC	0	9	30	7	5	2	0	16	19
Institutional Delivery	0	3	12	5	3	9	14	11	13
SBA Attended Home Delivery	0	3	20	01	01	04	09	07	14
Maternal Death	0	0	0	0	0	0	0	0	0
JSY Beneficiary Paid	0	2	12	8	0	12	14	8	4
Full Immunization	2	19	27	18	16	32	152	19	23
Immunization Session	4	13	12	26	26	29	25	25	29

Held									
Male Sterilizations	0	0	0	0	0	0	0	0	0
Female Sterilizations	0	0	0	0	0	0	0	0	0
Condoms Provided	0	0	0	80	940	940	720	710	630
OCP Provided	2	32	72	125	142	125	126	133	61
Infants treated for Diarrhea (ORS)	06	10	19	108	80	101	211	111	101
High Risk Pregnant Women Referred	0	0	0	02	04	03	01	03	01
Seriously Ill Children Referred	0	0	0	02	0	0	0	01	0
Hemoglobin Estimation	0	50	77	68	45	98	293	190	183
Urine Examination	0	14	30	20	36	57	60	65	43
Malaria Slides Examined	0	86	85	396	191	121	216	221	267
Rapid Diagnostic Kit Used	0	5	33	99	13	58	77	137	159
Found P.F. Positive	0	4	5	43	17	14	22	24	22
Malaria Cases Treated	0	4	5	43	17	14	22	24	22
Sputum Sample Examined	0	0	0	0	0	0	0	0	0
Sputum Sample Found Positive	0	0	0	0	0	0	0	0	0
Patients put on D.O.T.S	0	0	0	0	0	0	0	0	0
VHNDs Held	0	15	12	21	17	19	20	22	14

It can be made out from the table above :

- Even though number of institutional delivery is increasing, SBA attended home delivery are also being conducted at almost an equivalent rate. SBA attended home delivery observed to be at peak in months of Jul-March (winters) and Jul-Sept. (rainy season), reason for which could be locomotive issues to the facility.
- As the number of immunization sessions have increased, number of full immunization have increased simultaneously.
- Distribution of condoms and OCP increased since the facility was handed over to Karuna trust and distribution of condoms found to be more than OCP.
- During Karuna trust period, performance of facility in referring cases has improved.
- There is no provision for sputum examination and X-Ray and as the facility is not DOTS center, so treatment of TB patients not done. All other laboratory tests are being conducted at the facility as can be seen from the above table.

#### **E.Documentation/Reporting:**

- OPD/IPD registers are being maintained separately
- Labor room had records of deliveries done, complications (if any) and treatment done. Facility had not yet started maintaining the records of newborn details including weight measurement.

- In laboratory, five registers are maintained for malaria tests, urine/stool examination, blood examination, stock register, indent register
- MCTS (Mother Child tracking System) –Staff was aware of MCTS and they started reporting for MCTS in April 2011. Earlier reports were sent in other different format. From October 2011, they are reporting in prescribed format and one copy of which is to be maintained at PHC MCTS register.
- Monthly meetings and meeting at district level are being conducted regularly
- As the sub center is not fully functional, so no visit made by MO-IC and do not have supervisory checklist. The PHC was supervised lastly by SPM in month of sept.2011.

#### **F.COMMUNITY PERSPECTIVE (Umtarai PHC)**

##### **Discussion with Rogi Kalyan Samiti Members of Umtarai PHC**

- Out of 9 RKS members, 5 members participated in discussion
- RKS meetings are not conducted regularly. Last RKS meeting in PHC was held at 30/11/2010. In 2010 three RKS meetings were conducted. After that no meeting was held. No meeting held in 2011. Reason given for it by MO-IC “*Arranging meeting at block is costly because of which they did not have meeting till date as money spent in last meeting was reimbursed after long time.*”
- Only two members attended one day workshop on RKS roles and responsibilities held at Nongpoh headquarters. Only those two members who attended workshop were aware about RKS guidelines and functions of the RKS. They did not have a copy of RKS guidelines.
- RKS of Umtarai PHC get its fund from Umsling Block. Members were not aware of any other source of fund. RKS funds utilization done only in year 2010-11 while no fund utilization done in year 2009-10. For the year 2011-12, funds have been received late in last week of November 2011 so no fund utilization done in this respective year. *RKS funds expenditure* done on following heads: Boundary fencing, ASHA help desk, Generator shed, reservoir for water, referral transport (Ambulance maintenance), new electrical wiring for PHC, Furniture, Hospital equipments, Miscellaneous: Citizens charter, generator, surgical instruments.
- No fund was utilized in year 2009-10. Activities started for fund utilization in year 2010-11
- No audit (internal and external) done since 2009 July -2011 and no audit reports were present. According to one member, internal audit was done by block accountant in July 2011 and also done by NRHM. All members present were not aware about it.
- Regular income expenditure statements were available. Members were aware of only those expenditure statements which were shown in the meeting. Since meeting not held from long time members were not fully aware of all expenditure statements.
- Facility had the citizen’s charter which comprised of staff name, services available, schedule (timings of OPD).
- RKS members were aware of redressal system but were not functional as RKS members do not review complaints and no activities are carried out in this direction. For procurement of large purchases (furniture, generator); quotations are collected –tenders are filled. No service is outsourced.

- Patients are referred to either Khetri CHC (Assam,) or Guwahati medical college through ambulance and this service started from 7<sup>th</sup> April 2011.
- *Key achievements* of RKS since constitution and Karuna trust: It is possible to hold back staff for providing services in the facility itself. Earlier, there manpower was very less. Treatment has improved. Earlier medicines were dispersed weekly that is only on Saturday due to less stock of drugs. The situation has improved from then and now medicines are available on all days.
- *Problems*: Difficult to retain staff for a longer period of time due to hilly and remoteness of facility and also because of less salary in comparison to government employee for the same post. There are also problem of water supply and electricity which hinders efficient working in the facility as well as living. Accommodation provided for staff is not sufficient for the number of members working in the PHC.

### **Status and functionality of ASHAs**

- In total there are nine ASHAs; one for every village (total 10 villages). There is no ASHA in one village as it is newly formed village from hamlet and still not a revenue village.
- The support structure in place is ASHA facilitator-BPM-District coordinator. According to them, their meeting is conducted every month with ASHA facilitator at PHC but evidence was of only 3 meetings conducted in last six months.
- ASHA indent to MO-IC for drugs required through ASHA facilitator and get the drug-kit refilled every month or as per need
- Record is maintained of ASHAs who are escorting patients to the PHC. The list of beneficiaries (ASHA and patients) is sent to block and the total amount of fund for beneficiaries is thus received from the block. At the month end, records are matched and verified and payment to ASHAs is then done accordingly in monthly meeting. In last 3 months, payment of Rs. 3000 made to ASHAs for JSY.
- ASHAs have received training till module-6. Facility is not involved in any formal training of ASHA for capacity building but they do reorient them during monthly meeting.
- As per them, they go for home visits for pregnant women, newborns and malnourished children but no record shown for their home visits.
- ASHAs act as treasurer in VHSC meetings as well as maintain register of VHSC meetings. On VHND days, they inform beneficiaries and assist ANMs in immunization session and also prepare the list of dropouts both for immunization and ANC. In nearby villages (seven in number) –VHND are held once in a month but in far off villages (2) –VHND are held once in three months. On VHND days; immunization camp, family planning counseling, health talks are carried out and sometimes treatment of minor illness is also done if MO attends VHND day.
- The role of ANM on VHND is education or counseling of eligible couples, immunization, ANC. AWW (Aanganwadi worker) are concerned with ICDS related work specially concerning nutrition and also assisting ANMs in their work. In order to ensure that VHND services are used by marginalized section, ASHAs and AWW specially visit the families of marginalized section and counsel them to attend VHND and also to avail facilities at PHC.

### **Functioning of VHSCs(Village Health and Sanitation Committee):**

- Four VHSC members out of 10 from Kohadem village were interviewed.
- Out of 10 members 7 are women.
- The attendance of members in last four meetings was 60-70%.
- Main activities in the village consisted of cleaning drive for village and water sources, educating society about sanitation and nutrition, providing monetary help to BPL families, travelling expense to pregnant women who are not getting JSY benefits. Major expenditure is done for cleaning drives. "Darbarshong" a local village community donates fund to VHSC committee in case of shortage of fund. Minutes of the VHSC meetings and accounts are maintained by ASHA but no evidence (register) for it was presented. Initiative taken by VHSC in the village was construction of concrete pits for disposal of garbage.

### **Community members perception**

Eight women participated in the discussion.

- According to members, VHND is held in the village but there is no fixed day in the month. Date and timing is fixed by ANM on the basis of list of beneficiaries of two villages at a time prepared by ASHA. VHND of two nearer village is conducted together at Aaganwaadi center. Timing and date is informed to their headman in form of notice duly signed by MO-IC and they get to know through headman or ASHA and VHND day is held on the informed date and timing.
- *Services provided* on VHND are immunization, ANC, education about nutrition to pregnant mothers, counseling on family planning methods. Regular ANC is done for all pregnant women but not necessarily on VHND days or on home visits. Sometimes, pregnant mothers have to visit PHC or SC for ANC. They were not aware of any discrimination done on basis of caste of patients. Immunization services are available on all VHNDs. They had no idea whether cold chain is being maintained properly or not. Participants told that when beneficiaries assemble, then only vials are opened. Proper ANC and immunization card are maintained
- VHND is sometimes supervised and monitored by MO-IC.
  - ASHA and ANM counsel and help in birth planning .Ambulance services have started recently and it is free of cost. Complicated cases are referred to Khetri CHC (Assam) or Guwahati medical college as they are nearest facilities for referral. Pregnant women are attended within 5 mins in the facility first by ANM. Pregnant mother is then attended by doctor and if time in delivery she is allotted bed and attended by ANM. Finally delivery is conducted by doctor and ANM at the facility. As the services are free of cost so no formal charges are levied by facility. Sometimes they have to give informal charges in the form of bakshish and that too is not demanded by staff.
  - Some participants said that they do not find any difference in delivering in facility and home deliveries as home deliveries were also conducted by ANM. Others had the opinion that delivering in facility is better as more care is taken off in terms of giving drugs and maintenance of cleanliness. Participants also said that getting ambulance on time is an issue because of network problem, so difficult to get ambulance service on time and further no public transport is there.

Thus they prefer home delivery by ANM; otherwise they too prefer that the delivery is conducted in the facility. When the facility was run by government, it was difficult to find staff in the facility. Earlier, there was no facility of home deliveries by ANM. Referral facilities have also improved.

- Earlier distribution of drugs was done only on Saturday (market day). Most of the times, medicines prescribed used to be out of stock. Now there is no problem in availability of drugs. Now drugs are available on all days. Earlier doctors and ANMs were not available all days. This situation has improved and staff is available all time as their residence is in the campus itself. Community members were satisfied with the cleanliness of the facility and had positive response about the attitude of doctors and staff towards general patients/serious patients.
- According to community members, outreach activities have increased since two years. Community members are also involved in RKS and many members are also involved in VHSC.
- According to them ASHA is active only while escorting pregnant mothers and informing them about dates and timing for VHND and immunization session. VHSC meetings hardly take place. The only role of VHSC, they were aware of was construction of dustbins (concrete pits) in their villages.

## **7. Umlaper HSC**

Construction of Sub center building started in 2009 but was not passed by engineering cell so state government did not certify the building and asked to rebuild subcenter. Even though, sub center building not approved, initiative has been taken by Karuna trust and started sub center in August 2011 in the rented building. There is no residential facility for ANMs at the sub center. State government has not been informed about functioning of sub center so no grant or fund is coming for sub center.

Umtarai PHC is the nearest PHC which is at the distance of 6kms from the sub center. The nearest FRU to the Umlaper is Khetri CHC which is at the distance of 28 kms from the sub center. There is no public transport availability either from PHC or FRU to the sub center.

Umlaper sub center is at a distance of 4 km from its nearest village, Umlamphlang. There is no motor able road to the sub center and public transport is not available. It takes about 45 minutes to walk to the sub center from the village. The farthest village from the sub center is Korhadem at a distance of 8 km. The road from farthest village to sub center is motorable but no public transport is available.

### **A. Infrastructure & Equipment:**

- Rented Building
- Two rooms are available
- No residential facility for staff

- Equipments available: Examination table, weighing scale, stethoscope, BP apparatus, vaccine carrier.
- Equipments not available: Sterilizer, Labor room with delivery table and equipment

**B. Manpower and training status:**

There were 2 ANMs at the sub center and they have not received any training since joined. There was no MPW (M) and safai karmachari.

**C. Functioning of ANM (Service Delivery)**

*Routine activities of ANMs:*

- Monday and Saturday are the OPD day
- Wednesday-Immunization Session at the SC
- Friday-ANC day at SC.
- Tuesday and Thursday-Home visits (for dropout immunized and ANC, education of mothers, new pregnancy cases)
- In outreach activities: 5-6 VHNDs/ month are held where ANC, PNC, Immunization and health talk is carried out.

**B. Performance indicators of Umlaper Sub center**

**Table 16: Performance indicators based on services provided:**

Services	Sep'11	Oct'11	Nov'11
OPD	17	53	63
New ANC Registered	1	6	2
3 <sup>rd</sup> ANC Done	0	0	0
Institutional Delivery	0	0	0
SBA Attended Home Delivery	0	0	0
Maternal Death	0	0	0
JSY Beneficiaries Paid for Institutional Delivery	1	1	0
JSY Beneficiaries Paid for Home Deliveries	1	0	0
Full Immunization Done	1	0	2
Immunization Sessions Held	7	4	3



VHNDs Held	6	3	2
Condoms Provided	20	0	0
OCP Provided	2	10	4
Infants treated for Diarrhea	3	2	4

### E.Documentation/Reporting

- Registers for OPD, ANC, Drugs and Immunization are being maintained
- For MCTS, information is submitted in prescribed format at block level.
- Two meetings are held at PHC for staff and one meeting of ASHAs.
- ANMs at the sub center have not attended any meeting since last month as no meeting was held.

### 8. Jirang State Dispensary:

#### Background

District:-Ribhoi,Block:-Jirang,Total Population: 6843(No. of villages: 24),No. of VHSCs: 21

NGO Partner:-Karuna trust. Date on which handed over to NGO: June 2011(from 2009 to May 2011- NSPEYM NGO)

#### A. Infrastructure and Equipment:

The building designated for the PHC is of government. There was no boundary wall. There was no water logging inside the campus and had proper drainage system.

- **Registration:** For OPD registration, there was a separate room. Registration is done at registration desk without any demarcating counters for male, female, disabled, and IPD patients. Crowding usually does not occur at registration desk except on immunization days. Citizen's charter was displayed with OPD timings and schedule. IEC materials were also displayed in the OPD waiting area.OPD waiting area consisted of benches, chairs for patients and facility of drinking water for them for which water cool cage was kept.
- **OPD:** The state dispensary had one OPD chamber.
- **WARD/IPD:** There are two wards and total 4 patient beds (2 beds in each room).Wards were clean with good condition of beds and linen. There was attached toilet but no running water in the toilet.
- **Labor room:** Labor room was present but it was not fully equipped for conducting delivery except the availability of one labor table. Labor room was not functional as there was no delivery kit (instruments for delivery), no emergency drugs so no delivery is conducted at the dispensary.

- **Emergency department:** There was minor OT in the facility for emergency treatment with no separate access to the department. The linen present on the examination table was clean.
- **Laboratory:** In the laboratory, there were no separate and demarcated areas for sample collection, sample processing, report printing and delivery. For collections of sample and reports, no timing is specified and not even displayed. It is done as per the convenience of lab technician. Laboratory technicians do standardize their analyzer with the standards provided with the kits.
- **Pharmacy and stores:** There was a single room for storing and dispensing medicines. Room had enough racks for storage but no labeling was done. Room was not well ventilated as there was no window. Pharmacy was not having all the essential drugs as per the state list. There was no refrigerator for storage of medicines.
- **Cold chain equipment:** Facility had deep freezer and ILR but deep freezer was not in working condition. No register was maintained for recording temperature of ILR or deep freezer.
- **Ambulance:** For referral purposes, vehicle Van (not fully equipped ambulance) has been provided by Karuna trust. This service has been started since last three months. Earlier there was no facility for transport for referral services.
- **ASHA helpdesk:** There was no ASHA help desk. According to ANM *“as no delivery is conducted at the dispensary, so ASHA hardly come to the facility so no requirement of ASHA helpdesk Delivery cases are referred to Patharkhambha CHC. When they will start conducting delivery at the facility, then provision of ASHA helpdesk can be thought of.”*
- **Residential facility for staff:** PHC have residential facility for all its staff like medical officers, nurses, pharmacist, driver and chaukidar. Medical officer and pharmacist share the quarter Similarly, three ANMs share the quarter of two rooms.
- **Other facilities:**
  - ✓ Power backup: There is no continuous electrical supply. Generator was available which is used when patients are there or at night for emergency cases and at night in residence.
  - ✓ Water facility: 24 hrs running water facility was not available in the hospital.

## **B. Human Resource and Training**

- In total there is staff of 12 in dispensary which consists of 1 medical officer (BAMS), 3 ANM, 1 Lab technician, 1 Pharmacist, 1 health assistant, 1 accountant and 4 groups D including 1 sanitary assistant (cleaner).

- Trainings undergone by MO includes RKS Mgmt., Program Mgmt, Supply chain Mgmt., IPPI Trng., Meningococcal meningitis Mgmt., Measles catch-up program. ANM did not receive any training. Duration of service of all staff members in the facility was not more than 3 months.

### C. Services Delivered

- **OPD:** Daily OPD, on an average is of 20 patients. OPD timings are from 8:00 am to 4:00 pm. After that only emergency cases are handled. Common illnesses reported were of malaria, gastric enteritis, amoebiasis, RTI, skin infection. Average waiting time for registration 5-10 mins and average consultation time -5mins.
- **IPD:** IPD started in month of October 2011. Since then monthly average IPD is of 10 cases. Inpatients are admitted only during day time. ANM said “*As there is no continuous supply of electricity and water, they do not admit patients in the night and usually refer the patients to the CHC. IPD is functional as Day care.*” There are no printed consent forms available for IPD or OT. There are no specific visiting hours for patients relatives because no public transport is there for approaching facility and the facility is in hilly region so specific visiting hours cannot be followed.
- **MCH care:** Maternal and Child Health services provided at the facility includes ANC, 24 hr delivery services, PNC, immunization of mothers and child. Immunization session at the dispensary is conducted every Wednesday while sessions to be conducted at Aaganwaadi centers are not fixed and planned according to number of villages and ANM available. For immunization services-immunization card are made available to mothers and children. For vaccines storage there is cold chain equipment but deep freezer was not in working condition. Deliveries are not conducted at the facility as labor room is not functional.
- **Family Planning:** As for family planning services, only distribution of oral pills and condoms is done while no sterilizations or IUD insertion is being carried out as no provision for it in the facility.
- **Referral services:** For referral there is facility of van (not fully equipped ambulance) which is used for referral services. On an average 22-30 cases per month are referred to Patharkhambah.
- **Laboratory services:** Laboratory tests that are conducted at the PHC includes blood routine examination (HB%, TLC, DLC, ESR), blood grouping, blood for MP test & Widal test, blood for VDRL, urine routine examination, urine for pregnancy test. There is no provision for blood sugar examination, stool routine examination, sputum examination for AFB at the facility so patient is referred Patharkhambah CHC. This is not a DOTS center so treatment of TB cases not done at the facility.
- **Radiography-** There was no provision of taking X-rays.

- **Bio medical waste management:** Biomedical waste disposal is in housed. There were neither multicolored bins for waste disposal nor the IEC material (posters) for handling biomedical waste were displayed near the bins. Staff was not practicing biomedical waste management as per BMW guidelines. Needle destroyers were available and used only when there is electricity. Even segregation of waste is not done properly. For collection of sharps there was no puncture proof containers with 1% sodium hypochlorite .There was only one pit for waste disposal and no separate pit for sharps. Once the pit is filled, the waste is burnt and the pit is closed and another pit is dug at other site.
- **Housekeeping:** Services are in housed and facility was overall clean .These services are supervised by sanitary assistant (cleaner).
- **Linen and laundry services:** This service is in house. Linen was present on every bed at the time of observation. Linen is changed once a week. Slucing is not being practiced for cleaning linen. Linens are washed with water and if any spot then only detergent used.
- **Dietary services:** Till date, there is no facility for providing food to patients or their relatives. There is no kitchen in the PHC.
- **Security service:** There are two chaukidars; one for night duty and one for day time. There were no fire safety equipments.

#### D.Performance Indicators

**Table17: Performance Indicators of Jirang state dispensary (2005 -Nov.2011)**

Services	05-06	06-07	07-08	08-09	09-10	10-11	Apr'11-Jun'11	Jul'11-Sep'11	Oct'11-Nov'11
OPD	0	0	0	0	2916	6827	830	1537	598
IPD	0	0	0	0	0	0	0	0	30
ANC	0	0	0	35	79	100	7	16	5
3 ANC	0	0	0	15	50	80	3	11	No data
Institutional Delivery	0	0	0	0	0	0	0	0	0
JSY Beneficiary Paid	0	0	0	0	6	8	21	1	0
Full Immunization	0	0	0	15	32	44	12	16	3
Condoms Provided	0	0	0	270	480	450	210	230	No data
OCP Provided	0	0	19	12	16	30	15	14	8

- IPD services have been started after Karuna Trust was handed over the facility in June 2011.

- There is no provision for sterilization at the facility.
- No VHND held from June 2011 to Sept. 2011. VHNDs have been started recently in Oct'11. In October 2011-7 VHNDs were held and in November 2011, 8 sessions were held.
- No data was provided for immunization sessions and referrals made before June 2011 from the time Karuna trust was handed over the dispensary. 8 immunization sessions are held every month since June 2011. Referrals since Karuna trust joined are four referral cases as referral services started from the month of October 2011.
- As observed from the table, OPD performance has increased since year 2009 (the time, Jirang state dispensary was handed over to NGO-NESPYM) but the performance declined in April-Jun 2011 and again performance increased. In June 2011, facility was handed over to Karuna trust. OPD performance found to be increased when the facility was under PPP mode than under complete government undertaking and little better performance at NESPYM time period and in Karuna trust time period.
- As observed from the table performance indicators of services provided (OPD, ANC, 3ANC, Full immunization, distribution of Condoms and OCP) found to be better in time period when the facility is under (Public Private Partnership) PPP. As per the data, NESPYM found to be performing better than Karuna Trust but this is not judgemental as facility is handed over recently (June'2011) to Karuna trust. There was no record for laboratory tests performed before the Jirang state dispensary was handed over to Karuna Trust. There is no facility for sputum examination and DOTS as it is not DOTS center.

#### **E. Documentation/Reporting:**

- OPD/IPD registers are being maintained separately
- In laboratory, four registers are maintained for malaria tests, urine/stool examination, blood examination, stock register. Indent register is not being maintained.
- MCTS (Mother Child tracking System) – Staff was aware of MCTS and they started reporting for MCTS in new prescribed formats since June 2011 (when dispensary was handed over to Karuna Trust). Monthly reports are submitted at district Nongpoh.
- Staff meetings are conducted weekly at the dispensary to review facility related issues and performance indicators and also plan outreach activities.
- Monthly meeting is conducted at district level. In the meeting, performance indicators of facilities are reviewed and orientation about the newly launched programme is done.

The dispensary is supervised only quarterly by district official

## F. COMMUNITY PERSPECTIVE (Jirang State Dispensary)

- **Status and functioning of ASHAs:** Five ASHAs and one ASHA facilitator were interviewed on 29/11/2011. There are in total 24 villages and only 21 ASHAs. There are no ASHAs in 3 villages. The reason told by one ASHA “*these 3 villages are on border area of Assam and Meghalaya so these villages are suffering border issues.*” There is one ASHA facilitator as a support structure.
- **Meetings:** In past six months only one meeting was held for ASHAs and facilitator at the dispensary. The reason given for fewer meetings was frequent change of staff at the dispensary.
- **Drug kit:** ASHA drug kit have not been refilled since 3 months. Refilling has started recently as evident by indent voucher passed by M.O. Procedure for filling drug kit is that indent is made by ASHA to MO-IC and drug kits are refilled. In case of emergency, drug kits are prepared from Pharmacy at facility and given to ASHA.
- **Payment to ASHA:** ASHAs prepare list of beneficiaries escorted by her which are tallied by record made at PHC and payment is done at month end at PHC. No payment has been done in last 3 months to ASHA as there was no MO at the facility.
- ASHAs are trained up to Module-6. ASHAs are reoriented in the monthly meeting only. No specific steps have been taken by facility for capacity building of ASHAs.
- **Functioning of ASHA:** ASHAs are conducting home visits for pregnant women, newborns but they do not maintain any register for it. There was no evidence for their home visits. 6-10 VHND sessions /months are held. At present only immunization and ANC is carried out at VHND day. No specific measures taken to ensure utilization of VHND services by marginalized section as for them there is no specification of marginalized section as majority population there belong to BPL category.
- **Functioning of VHSCs**
  - Five VHSC members out of 10 were interviewed. Out of 10 members 6 are female members.
  - The attendance of members in last four meetings was 70-80%, no evidence for it as VHSC meeting register not shown. Only one VHSC meeting per village is conducted in a month. Main activities of VHSC in the village consisted of construction of 36 toilets in 2 last 2 years and 10 concrete dustbins, cleaning drive, cleaning of water source. “Darbarshong” a local village community or PHE donates fund to VHSC committee in case of shortage of fund.
  - ASHA acts as treasurer and minutes of the VHSC meetings and accounts are maintained by ASHA but no evidence (register) for it was presented. There is no process for village health planning. Initiative taken by VHSC in the village was construction of concrete pits for disposal of garbage.

### ➤ **Community members perception**

- Participants from the community were not aware of VHND sessions and its importance. According to them, ASHAs and ANMs are not active in outreach activities. ASHAs visit their homes only if there are pregnant women in that house. They get the information about the dispensary and immunization session from the headman of their village.
- Some participant had the view that as staff keeps on changing in the dispensary so difficult to develop trust on them, so for treatment, they prefer to go to Patharkambah CHC. While other participants agreed that since three months when staff has become stable at the dispensary, for minor ailments, they have again started to go to dispensary for treatment. They are happy with the improvement in the facility with respect to distribution of medicines as they receive all the medicines prescribed from the facility while earlier many times medicines used to be out of stock. They seem not be satisfied with IPD facility as in emergency cases only medicine is given and referred to Patharkambha CHC and not admitted in the dispensary. According to participants from community who came for discussion, facility for IPD patients should be improved.

### **9. Warmawsaw PHC**

District: Ri- Bhoi District, Population covered: 7489 (21 villages, 1365 households.)

Number of Sub Centers: 1 SC (not functional), NGO partner: Karuna Trust. Date on which handed over to NGO: June 2011 (Before Karuna Trust, another NGO named NESPYM was managing the facility for the period April'09- May'11.)

#### **A. Infrastructure/Equipment:**

Warmawsaw PHC runs in a government owned building. There was no boundary wall and no water logging observed inside the campus

- **Registration:** For registration, there was no separate room. Registration is done at registration desk without any demarcating counters for male, female, disabled but IPD registration is done separately at nursing station. Citizen's charter was displayed with OPD timings and schedule, services, number of beds, programmes related information, birth/death registration. Other IEC materials were also displayed in the OPD waiting area. OPD waiting area consisted of benches, chairs for patients and but no facility of drinking water for them.
- **OPD:** The PHC had two OPD chambers which are looked after by MO-IC and MO-AYUSH.
- **WARD/IPD:** There are two wards and total 8 patient beds. Wards were clean but the condition of beds and linen was not satisfactory.

- **Labor room:** Labor room had one delivery table which was observed to be covered by plastic and changed after every delivery case. Pre and post delivery rest room was available for female patients. There is no facility for warm water. Amongst the emergency drugs, all drugs were in labor room except Inj. Magnesium sulphate, Inj. Gentamicin and vitamin K which are procured from pharmacy as and when required. Delivery kit was fully equipped. There was only boiler and no autoclave for sterilizing delivery sets and sterilization is done before preparing for delivery. Partographs have been supplied to the PHC but still not being used by staff.

- **Emergency department:** There is minor OT in the facility for emergency treatment with no separate access to the department.

- **Laboratory:** In the laboratory, there were no separate and demarcated areas for sample collection, sample processing, report printing and delivery. For collections of sample and reports, no timing is specified and not even displayed. It is done as per the convenience of lab technician. Laboratory technicians do standardize their analyzer with the standards provided with the kits.

- **Pharmacy and stores:** There was a separate room for storing and dispensing medicines. Rooms had enough racks for storage but racks were not labeled. Room was well ventilated but floor was dirty. Pharmacy was not having all the essential drugs as per the state list. Pharmacist. There was no refrigerator for storage of medicines.

- **Cold chain equipment:** Facility had deep freezer and ILR with proper maintenance of temperature and duly recorded in registers.

- **Ambulance:** For referral services, there is facility of which Van is being used for referral purposes. Only first aid facilities are available in the van.

- **ASHA helpdesk:** There was a separate space for ASHA help desk where chairs were available for ASHAs who accompany the patients to the facility. There is no facility of bed and food for ASHAs.

- **Residential facility for staff:** PHC have residential facility for all its staff. One quarter of 5 rooms for both medical officers. There are two quarters of 5 rooms each for GNM and ANMs. 3 rooms' quarter for pharmacist. Chaukidar and laboratory technician shared two rooms' quarter. One chowkidar & driver stays outside.

- **Other facilities:** Power backup: There is continuous electrical supply. Generator was also available. Water facility: 24 hrs running water facility was not available in the hospital.

## **B. Human Resource / Training-**

- There were 2 MOs (1MBBS +1BAMS), 2GNM, 6ANM, 1Pharmacist, 1Lab Tech., 1Receptionist, 2Choukidars.
- Duration of service of all staff members in Jirang state dispensary was not more than 4 months.



- MO-IC received 2 days training on NSSK.
- MO-AYUSH received training in FW training, Training on Mental Health, Training on Malaria/Leprosy, Slide collection & smear collection training.
- No training has been organized for GNM & other staffs.

#### **C.Services Provided:**

- **OPD:** Daily OPD, on an average is of 20 patients.OPD timings are from 9:00 am to 2:00 pm.After that only emergency cases are handled. Common illnesses that doctors come across are cerebral malaria, acute gastric enteritis. Average waiting time for registration is 5 mins and average consultation time is 10 mins.
- **IPD:** Monthly average is of 14-20 cases. There are no printed consent forms available for IPD or OT. There are no specific visiting hours for patients relatives because no public transport is there for approaching facility and the facility is in hilly region so specific visiting hours cannot be followed.
- **MCH care:** Maternal and Child Health services provided at the facility includes ANC, 24 hr delivery services, PNC, Immunization of mothers and child, management of childhood pneumonia, diarrhea. Immunization sessions are conducted twice a month. For immunization services-immunization card are made available to mothers and children. For vaccines storage there is well functioning cold chain equipment (deep freezer, ILR) whose temperature is maintained and recorded timely in registers. All mothers are not made to stay for 48hrs after delivery. On an average mothers are made to stay for not more than 24 hrs in the facility after delivery.
- **Family Planning:** As for family planning services, only distribution of oral pills and condoms is done while no sterilizations or IUD insertion is being carried out as no provision for it in the facility.
- **Referral services:** For referral there is ambulance. Patients are referred to Phatarkhambha CHC.
- **Laboratory services:** Laboratory tests that are conducted at the PHC includes blood routine examination(HB%,TLC,DLC,ESR),blood grouping, blood sugar, blood for MP test& Widal test, blood for VDRL,stool routine examination, urine routine examination, urine for pregnancy test. There is no provision for sputum examination for AFB at the facility so patient is referred to Phatarkhambha CHC. This PHC is not a DOTS center so treatment of TB cases not done at the facility.
- **Radiography-**In the facility there is no provision of taking X-rays.
- **Bio medical waste management:** Biomedical waste disposal is in housed. There were no multicolored bins for waste disposal .There were posters of instructions for handling biomedical waste. Staff was not practicing biomedical waste management as per BMW guidelines. Three Needle destroyers were available and were not functional .Even segregation of waste is not done properly. For

collection of sharps there was no puncture proof containers with 1% sodium hypochlorite .There were two pits for waste disposal of which one was for sharps. Once the pit is filled, the waste is burnt and the pit is closed and another pit is dug at other site.

- **Housekeeping:** Services are in housed and cleanliness in the facility was not up to mark .These services are supervised by ANM and carried out by sanitary assistants.
- **Linen and laundry services:** Service is in house. Linen was present on every bed at the time of observation. Linen is changed after every patient discharge. Slucing is not being practiced for cleaning linen. Linens are washed with water and if any spot then only detergent used.
- **Infection control practices inside Labor room:** Staff practices the infection control methods like use of mask, apron in the labor room. Gloves used only when conducting delivery. Separate slippers not used for labor room.
- **Dietary services:** Till date, there is no facility for providing food to patients or their relatives. There is kitchen in the PHC but not equipped so kitchen services are not yet started.
- **Security service:** There are two chaukidars. There were no fire safety equipments.

#### D.Performance Indicators

**Table18: Performance Indicators of Warmawsaw PHC (Jan 09 –Sept11)**

Services	Jan-Mar'09	Apr-Jun'09	Jul-Sep'09	Oct-Dec'09	Jan-Mar'10	Apr-June'10	Jul-Sep'10	Oct-Dec'10	Jan-Mar'11	Apr-Jun'11	Jul-Sep'11
OPD	NA	734	2070	1189	775	1746	700	903	1032	992	1620
IPD	NA	16	104	55	32	301	238	102	64	54	81
ANC	28	36	26	32	25	54	31	43	40	27	53
3 ANC	11	3	10	3	18	9	16	10	20	23	10
Institutional delivery	NA	0	2	1	4	11	11	4	13	8	13
SBA attended home delivery	0	0	0	0	0	0	0	0	0	1	0
Maternal death	0	0	0	0	0	0	0	0	0	0	0
JSY beneficiar	30	8	1	0	7	3	9	10	10	0	14

<b>y paid</b>											
<b>Full immunization</b>	3	23	21	19	20	33	16	4	18	17	21
<b>Immunization session held</b>	5	9	8	13	12	13	13	7	10	7	8
<b>Condoms provided</b>	150	NA	150	60	NA	390	510	480	540	180	810
<b>OCP Provided</b>	17	18	24	33	17	45	32	30	24	24	26
<b>Infants treated for Diarrhoea (ORS)</b>	170	170	119	46	67	214	154	16	37	32	108
<b>High risk pregnant women referred</b>	0	0	0	0	0	0	0	1	0	0	0
<b>Seriously ill children referred</b>	0	0	0	0	0	0	0	0	0	0	0
<b>HB estimation</b>	0	0	0	0	0	0	0	0	0	11	91
<b>Urine examination</b>	0	0	0	0	0	19	0	0	0	0	48
<b>Malaria slides examined</b>	3	33	327	294	94	659	468	81	96	224	745
<b>Rapid diagnostic kit used</b>	9	31	47	46	47	142	79	158	35	15	104
<b>Found PF positive</b>	0	11	15	0	15	9	53	25	1	21	41
<b>Malaria cases</b>	0	15	23	22	26	51	97	70	34	34	75

<b>treated</b>											
<b>VHNDs held</b>	0	0	0	16	18	19	11	26	5	0	2

- Since April'09, another NGO 'NESPYM' was managing the facility. However, if we observe the trend of OPD attendance initially another NGO has performed well but later on their performance deteriorated. As Karuna Trust was recently handed over the facility (June'11) so we compare the performance of the two NGOs for the period Jul-Sep'10 to Jul-Sep'11, performance of Karuna Trust is better than NESPYM.
- IPD performance of NESPYM is better than Karuna Trust. (For the period Jul-Sep)
- ANC registration has increased.
- 3 ANC performances have decreased.
- There is no difference in delivery trend as compared to previous NGO.
- During the period of NESPYM, the performance has decreased compared to when it was managed by govt. (Jan-Mar'09 – managed by Govt. staffs) but after Karuna Trust the performance has gone up.
- The performance in condoms distribution has improved.

**Table 19: Performance indicators of Warmasaw PHC(2005-Sept.2011)**

<b>Services</b>	<b>05-06</b>	<b>06-07</b>	<b>07-08</b>	<b>08-09</b>	<b>09-10</b>	<b>10-11</b>	<b>Apr'11-Jun'11</b>	<b>Jul'11-Sep'11</b>
<b>OPD</b>	0	1680	4445	0	4818	5371	992	1620
<b>IPD</b>	0	0	0	0	212	705	54	81
<b>ANC</b>	0	79	122	0	129	168	27	53
<b>3 ANC</b>	0	0	0	0	34	54	23	10
<b>Institutional Delivery</b>	0	1	0	0	8	45	8	13
<b>JSY Beneficiary Paid</b>	0	9	13	64	16	32	4	14
<b>Full Immunization</b>	0	40	99	0	44	58	21	21
<b>Condoms Provided</b>	0	750	630	0	330	1220	180	810
<b>OCP Provided</b>	0	8	13	0	92	131	24	26

As per the observations, made from the table above:

- OPD performance increased in 2009 when, the PHC was handed over to NGO under PPP mode. Karuna Trust found to be better performing in comparison to NESPYM.
- IPD services started when NESPYM was handed over the facility and performance observed to be improved during the period of NESPYM as compared to Karuna Trust.
- ANC services, Institutional delivery, Full immunization, Distribution of condoms improved under PPP mode and got better off during Karuna trust period.

#### **E.Documentation/Reporting:**

- OPD/IPD registers are being maintained separately
- Labor room had records of deliveries done, complications (if any) and treatment done as well as records of newborn details including weight measurement.
- In laboratory, five registers are maintained for malaria tests, urine/stool examination, blood examination, stock register, indent register
- MCTS (Mother Child tracking System) –Staff was not aware of MCTS reporting. Only HMIS reporting done. They did not have any knowledge whether they have or not any format for reporting for MCTS. The reason given “*No accountant was there to look after these reporting .Accountant and all other staff has recently joined and there is no handholding of previous records.*”
- Staff meeting is conducted once a month at PHC and one meeting for ASHAs and AWW In monthly meetings, reports and registers are checked ,monthly performance indicators are verified, reorientation classes of ANMs for ANC,PNC,immunization and how to deal with emergencies. Only 2 meetings conducted in last 3 months. Reason given was locomotive issues.
- Monthly meeting is conducted at district level. In the meeting review the performance indicators of facilities.

#### **F.Community Perspective**

##### ➤ **Discussion with Rogi Kalyan Samiti Members of Warmasaw PHC**

Only 3 members out of six members were available for the meeting. Except Health facility in-charge, no other members are ex-officio govt. staff.

##### • **RKS meetings/Guidelines:**

RKS meetings were not held since last one year in Warmawsaw PHC. They are not aware of RKS guidelines fully. They didn't have a copy of RKS guidelines with him. As per the discussion, it was found that they haven't been oriented about the guidelines for a long time as they could not recall grievance redressal mechanism.

##### • **Flexible financing:**

*Major expenditure* was done on purchase of generator, laptop, repairing & renovation, maintenance of ambulance etc. Presently the accountant/ any other person assigned by trust maintain vouchers for day to day expenditure. At the end of month they send all the vouchers to the trust office and get reimbursed for all the expenses done in the month. For any major expenditure, they just inform the concerned person in the trust office & that person gets the work done. They usually receive untied fund on time but this financial year they didn't received untied fund. Regarding Audit, they said NRHM gets the audit done for every financial year but reports were not available with them. As most of the PHC staffs were recently appointed & proper handing over of the records & documents was not done to them, so they couldn't produce any evidence.

- **A citizen charter** was displayed at the entrance of the facility containing information such as-

Services available, Lab tests done, Grievance redressal mechanism, Beds available, Various Programmes related information. All the necessary information was displayed throughout the hospital.

- Major purchase used to be done by the NGO office so, the facility staffs doesn't know much about the procurement modalities. They usually do it without quotation.
- Those patients who require higher level of care is referred to Patharkhamba CHC. There is a van available for transporting patients.
- Most common problems found in public health facilities were discussed with the RKS members & their opinion on the problems was sought such as-
  - ✓ *Effectiveness of clinical services*- As per the members, all the essential drugs are always available in sufficient quantity so the patients need not to purchase drugs from outside & there are no incidences of stock-outs. Although they were not aware of clinical protocols.
  - ✓ *Lack of basic amenities*: all the basic facilities are available. Only safe drinking water provision needs to be provided to patients. Privacy for patients was not there. Screens for privacy of patients can be provided in the wards & OPD chambers. Triage area was not demarcated. Patients were directly admitted to the IPD wards. Signage need to be improved.
  - ✓ *Patient comfort*: as the case load is not much so the waiting time is approx. 5-10 mins. Behavior & attitude of staffs are good.
  - ✓ *Hospital waste management*: Pits were constructed for the disposal of BMW wastes. Although color coding was not followed throughout the hospital. BMW segregation was also poor. Needle destroyer was not functional. A separate sharp pit was constructed but as needle destroyer was not functional so the needles were directly disposed in the pit. Before disposal into the pits the wastes was not being disinfected. When pits get full, then they just burn the wastes and close the pit.
  - ✓ *Boarding & lodging for patient attendants*: no separate arrangement was there. They used to stay with the patients only.
  - ✓ *Diet & supervision*: no diet was provided by the PHC so the patients used to manage the diet on their own.
- **Status & functionality of ASHA & VHND:**
  - The PHC covers 21 villages. There are 21 ASHAs- one for each village. Only one village (Rajakhamai village) is not covered properly due to difficult terrain.
  - In the last 6 months, only 2 meetings of ASHAs & ASHA Facilitator have been held. The reason for not having monthly meeting is now they don't get TA for attending meetings. Previously ASHAs used to get Rs 25/- as TA for attending meetings.
  - *ASHA drug kit refilling*: When required ASHA visits the PHC with ASHA Facilitator & gives the indent to M.O./C of the PHC & if available in the PHC, it gets refilled immediately. If the items are not available in that case the PHC gives her a date to visit the facility & get the kit. In the mean time, the PHC gives indent to the District office & get the items required. For last one year, ASHAs didn't get kits refilled. Due to frequent change in manpower in the PHC, first there was no stock at PHC. When the PHC

received the indent after that they informed ASHAs & ASHA Facilitator to get the kit refilled but they didn't approached them.

- *Payment of ASHAs:* The accountant maintains the registers for different programs & calculates the ASHAs incentive based on that. At the end of month, total incentives are calculated and cash payment is being done. No payment record (to ASHAs in last 3 months) was shown to us by the accountant appointed over there.
- ASHA has been trained on Module 1-6 by state. At the facility level ASHAs are only oriented about their work in meetings. They do visits home for pregnant women, newborns & malnourished children but no evidence was produced.
- *Role of ASHA:* ASHA acts as a treasurer in the meetings of VHSC. ASHA assists ANMs in their work. VHNDs usually conducted once a month. She informs the villagers beforehand of the date of VHND. On the day of VHND, she manages the crowd & other arrangements. ASHAs make the community aware of proper nutrition, sanitation, disease control measures & other social health issues. During home visits, she counsels villagers on these issues. ASHA keep track of households of pregnant mothers and small children & during her home visits counsels them to attend VHND.
- During VHNDs, ANMs educate the villagers on proper nutrition, importance of 3 ANC's, immunization, other health talks, seasonal illnesses and measures to control them. Then ANC & immunization session is done for the people who didn't visited health facility or who can't visit the facility.
- AWW mainly provides nutritional supplements to the pregnant women, neonates & malnourished children. Contraceptives are distributed by AWW to the couples. Whereas ANM does the ANC, immunization, health talks, counsel eligible couples for adopting FP methods, counsels for proper nutrition to pregnant women & child etc.

➤ **Functioning of VHSC:**

- The VHSC committee of Umiapkhla village has 10 members (4 women, 6 men).
- They usually conduct quarterly meetings. However, in past 1 year, only 3 meetings have been conducted to discuss the utilization of untied fund.
- As of now the main activity of the committee only include construction of toilet. 14 toilets were constructed by them. As the headman was new so he didn't have any idea about the sharing of expenditures with any other village community. Minutes of meeting is maintained by ASHA. No evidence could be produced in the meeting.
- ASHA is mainly involved with record keeping only. Since 2010, no training for VHSC members was conducted so, the members are not very active & the committee is not very functional.

➤ **Women community members perception:**

- Group Discussion with six women from a nearby area of PHC was conducted.
- They were not aware whether VHNDs are conducted in their village or not. They had a rough idea about the services that are provided in VHNDs session such as immunization, ANC etc.
- ASHAs & ANMs during their home visit help the villagers in birth planning & transport facility. If the patient is admitted in the facility then they get ambulance for referral to other centre. When pregnant women visit the facility, they are attended promptly without any waiting time. Generally GNMs takes

care of the patient. If M.O. is required immediately, in that case they are informed by GNMs to attend the patient.

- According to some participants in the group discussion “*the services were good 2 yrs back as compared to present situation*”. They said earlier they found M.O. more competitive. Now days due to frequent change in manpower, they are not so satisfied with the services provided at the facility. They also can’t communicate properly to the M.O. due to language constraint.
- No charges are levied on any services provided. They get all the services & medicines free of cost.
- Some of the members wanted to visit the facility for delivery while some of them were in favor of home delivery due to mobility issue. Complicated deliveries are referred to the nearest Patharkhamba CHC. The patient is transported by the ambulance to the CHC.
- *Positive aspects:* Availability of drugs and other facilities have improved from earlier period as all the staffs are residential so doctors and other staffs are always available.
- *Recommendations of Community members:* Housekeeping needs to be improved. Diet facility can be provided as presently patients & their attendants find it difficult to manage their diet on their own. Usually GNMs attend the patient. As per the feedback from IPD patients, it was found that they were admitted one day before but none of them was still visited by M.O.
- *Gaps identified:* The activities at community level were not done satisfactorily. ANM/ASHAs are not actively working at community level. Earlier (2 yrs back) ASHAs used to visit home more often.

## **Summary**

### ➤ **Comparison Of Facility (Pre and Post PPP)-Ribhoi District**

Karuna trust has been handed over the Warmasaw PHC and Jirang state dispensary in June 2011. Before Karuna Trust, other NGO (NESP YM) was running the facilities since September 2009. Due to frequent turnover of manpower, services declined, so state government handed over the facilities to Karuna Trust. Umtra PHC was handed over to Karuna Trust in September 2009.

#### **Positive aspects:**

- Services have improved since the facilities were handed over to NGO as it could be made out from data available and the community perception. Compared to NESP YM, Karuna trust is providing better services. But still a lot has to be achieved.
- Human resource is available all the time as the staff has been provided residential facility within the campus of the health facility. Earlier as there was no residential facility for staff, it was difficult to retain staff at the facility situated in difficult areas.  
Even though there is frequent turnover of manpower, NGO manages that no staff position remains vacant. Thus staff is available all the time to provide services.
- Patients now receive the prescribed medicines from the facility itself. Availability of drugs is on all days. Earlier, most of the times medicines used to be out of stock. Earlier in Umtra PHC, medicines were prescribed only on Saturdays (local market day) due to shortage of supply of drugs.

#### **Gaps identified:**



- Even though residential facility is available, it is not sufficient to accommodate all its staff and staff members have to share the quarters. Residential facility is not having basic amenities like 24 hrs running water and electricity .Residence is also not adequate for staff to get their families to live with them. Thus it is difficult to retain the staff for longer period of time.
- Health staff is hired by NGO and as they are not government employee, they are not entitled to benefits received by government employee in health facilities not under PPP mode. There is job insecurity and also as they receive less salary in comparison to government employee.  
As a result, employees leave when get better opportunities, resulting in frequent turnover of manpower.
- It is difficult for staff to build a good rapport with the community because of frequent turnover of staffs.
- In Jirang state dispensary, facility of IPD is provided only for day time and not at night due to irregular electrical supply and patients are mostly referred so community find it better to go directly to Phatarkkhambha CHC for all treatments.
- Due to frequent change of manpower, there is poor handholding and maintenance of records.
- Lack of capacity building of manpower observed. As a result ground level workers (ASHA, VHSC members) do not have gravity of their roles and responsibilities.
- Community members in the Jirang block were not aware of outreach activities like VHND carried out by Jirang state dispensary or Warmawsaw PHC while community members near Umtraï PHC were aware of VHND days and agree that ANMs and ASHAs do visit their houses. Thus it can be made out that outreach activities are lacking in Jirang state dispensary and Warmasaw PHC which is not the situation in Umtraï PHC. The possible reason could be recent takeover of facilities by new organization and frequent change of manpower .Thus staff focuses more on activities inside the facility rather than outreach activities.

## ii. Facilities under Voluntary Health Association of Meghalaya:

**Table 20: Lists of facilities under VHAM**

S.No	Name of Facilities	District	Period of functioning
1	Jatah PHC	East Khasi Hills	Sep'2009-till date
2	Dangar/ Balat PHC		
3	Nohron SC		2 <sup>nd</sup> March, 2009 till date
4	Sonatola SC		

### 1. Jatah PHC

Jatah PHC, managed by Voluntary Health Association of Meghalaya (VHAM) belongs to the Mawkynrew Block and is located about 2 hrs away from Shillong, the state HQ. It caters to a population of 6963 and has one SC, Nohrun. The closest referral centre for this 10 bedded facility is NEGRIMS & Ganesh Das Hospital in Shillong. It is being run by the VHAM since July, 2009.

## A. Infrastructure & Equipment

- The PHC is in a designated govt. building. It is well maintained and clean but there is lack of adequate space for its optimal functioning. The facility has a large area under it; however, there is no boundary wall for demarcation.
- A citizen's charter is displayed. OPD, IPD timings and some IEC material is displayed in the waiting area.
- There is a registration counter and sitting as well as provision for basic amenities such as drinking water, toilets etc. available at the waiting area.
- There is no emergency room in the facility. There are 2 OPD chambers. There is provision for cold chain (1 ILR, 1 DF and 1 solar operated ILR/DF).
- There are separate male and female wards with 5 beds in each ward respectively.
- There is a labour room with one labour table. The approach to the labour room is through the female ward. A spot light which has been fixed using sticks for support, is currently in use in the labour room. There is no radiant warmer at the labor room.
- Suction machine was out of order. OT lamp was not functioning. Emergency drugs in the labour room are available, except inj. Magnesium sulphate. A functional autoclave for sterilization is available at the facility. The pharmacy is small with minimal drugs, kept in labeled racks. The drug store is being extended.
- There are no color coded bins in the facility for appropriate waste segregation. Functional needle destroyers were available. There is no provision for power backup at the facility.
- Staff quarters with basic amenities are available. Water supply is sometimes cited as being an issue.
- **Referral Transport-**The facility does not have a referral transport. The state has an emergency Referral Transport system (108 EMRI) in place. However, the services of the EMRI are not available to the community. It was accessed only twice by patients from this PHC area. The ambulance which has allocated to this block is parked in Smith (which is 40 kms from the facility) and travels only upto the Block headquarters of Mawkynrew and Mawringking. Patients have to travel a long distance to reach Mawkynrew block main HQ from where they can access this ambulance. There are no private vehicles for hire in the facility area for referral of patients, and even in emergencies, patients would need to wait till one of the shared (and fully loaded) taxis pass by. Vehicle hiring costs to Shillong are as high as Rs. 1500.

- **Drugs and Equipment** -The facility does not have adequate drugs , specially emergency drugs . Methargin, Oxytocin , Mag sulph , Mizoprostol , Diclophenic are in short supply . There are cases of dog bites and snake bites for which there are no anti rabies and anti venom.

Unlike the facilities managed by Karuna Trust where the medicines supplied by the state in short supply are supplemented by drugs from the NGO, in this facility VHAM has not taken such steps. In many facilities across states, RKS funds are being used to purchase drugs. In this facility, such a provision does not exist.

- Lack of AYUSH drugs is another constraint for which the AYUSH MO was not providing the services. However, the dynamic AYUSH MO, on his own initiative bought some homeopathic and Ayurvedic medicines from his personal funds and started AYUSH OPD from 12<sup>th</sup> October. The OPD has picked up and current OPD is around 30-37 per day. AYUSH medicines need to supply along with IEC on AYUSH in order to improve the demand and ensure uninterrupted provision of services.

#### **B. Human Resource & Training Status:**

- There are 2 MOs in the facility one MBBS MO and one AYUSH MO.
- There are 3 GNMs, 3 ANMs, 1 pharmacist and 1 lab technician at the facility.
- 1 MO has undergone Minilap training. The AYUSH MOs has received training in RNTCP, Leprosy and Immunization. 2 ANMs have undergone disaster management training.

#### **C. Service Delivery**

- OPD, IPD, ANC, PNC, Immunization and round the clock delivery services are provided. Deliveries were started in the facility from December, 2009. Rs. 2 is charged in OPD.
- This is the second RSBY accredited facility in the block and is performing well.
- **Delivery services:** Normal deliveries are conducted; 16 deliveries in 2010. The MMBS MO is also doing episiotomies, and forcep delivery. This has picked up in this year to 20 in six months ( April-Sept, 2011) .Three deliveries have taken place at night in November. This has been possible since the MOs residence is adjacent to the facility. Home deliveries in the same period are 50. Although these have been called as SBA attended home deliveries, they are reality deliveries at home done by dai/ relatives/ neighbours.
- A register for JSSK register is maintained; however the entitlements are yet to rolled out. Funds have not been received from the district HQ for IEC, diet (state has approved only Rs.50 for diet).
- **Child Health:** This is a weak area; services are limited to immunization through fixed days and outreach. There is no new born care corner or stabilization unit. All the staff in the facility needs to be urgently trained in IMNCI, F-IMNCI and NSSK.
- **JSY:** there has been 21 deliveries under JSY during Sept-Nov, 2011. Of this 15 were cases of ID and 6 were home deliveries. Records show that none of the home delivery cases have been paid last year. There are several payments for IDs reason being delay in fund release from the district.

- **Family Planning:** Family planning services have been started very recently. As in other facilities, no sterilization services are provided in this facility. Spacing services being provided. IUCD has been started from this year.
- **Safe Abortion services:** D & C is being done in this facility by the MOs. Most other cases are referred to Shillong.
- **Diagnostics:** Laboratory tests are conducted except for VDRL testing and stool RE. Only hemoglobin estimation is done under Blood RE. Sputum collection is done and sent to Smith PHC, which is the DMC.
- RSBY smart cards are accepted at the facility.
- **Ancillary services:** Housekeeping as well as linen & laundry are managed in house. Dietary services are not provided currently to the patients. The dietary services have been stopped as it was cited that the patient's attendants also availed of the facility and this was proving to be a constraint in the efficient functioning of the service.
- **IDSP programme is being implemented; S forms and P forms are being reported weekly.** However, zero reporting is not done.
- **School health programme:** School visits are being carried out 2-3 times in a month, covering at least two schools in a month. One of the two MOs join this team along with 1 ANM, 1 HE and 1 HA. Common cases reported in school examination are ARI, diarrhea, ear and skin infections.

#### D. Performance Indicators

**Table 21: MCH Performance indicators**

Sr. No.	Performance Indicators	Figures
1.	Total district Population	6963
2.	CBR (SRS, Jan'11)	24.4
3.	Expected Pregnancy	187
4.	No. of pregnant women registered for ANC	272
5.	% of ANC registered against expected pregnancy	145%
6.	No. of pregnant women received 3 or more ANC	199
7.	% of 3 ANC against ANC registered	73%
8.	No. of ID	21
9.	% of ID against total ANC registered	8%
10.	No. of SBA attended Home Delivery reported	50

- The OPD attendance shows a varying trend ranging from 1000 – 2000 patients in a month.

- The IPD shows an increasing attendance.
- The percentage of ANC registration as against the expected pregnancy is 145%. 3 ANC as against the total ANC registered is 73%.
- 21 institutional deliveries were recorded in 2010-11. The percentage of institutional deliveries as against the total ANC registered is 8%.
- SBA attended home deliveries was 50 in 2010-11.
- Two maternal deaths were recorded in the Jul-Sep'11 quarter.

**Table 22: Performance indicators based on services provided**

Services	Jan-Mar' 09	Apr-Jun' 09	Jul-Sep' 09	Oct-Dec' 09	Jan-Mar' 10	Apr-Jun' 10	Jul-Sep' 10	Oct-Dec' 10	Jan-Mar' 11	Apr-Jun' 11	Jul-Sep' 11
OPD	3101	4287	5160	3545	4679	6068	5410	3122	4065	5974	5828
IPD	0	0	1	1	8	40	47	33	103	178	378
ANC	19	17	63	68	54	82	64	53	73	99	108
3 ANC	9	13	23	18	31	30	55	50	64	58	61
Institutional Delivery	0	0	0	3	7	4	2	3	12	6	14
SBA Attended Home Delivery	0	0	33	26	45	10	14	16	10	25	25
Maternal Death	0	0	0	0	0	0	0	0	0	0	2
Full Immunization	42	31	38	73	23	34	76	71	65	68	66
Immunization Session Held	0	0	42	51	55	51	51	51	59	47	52
Condoms Provided	0	0	130	190	210	110	180	180	190	10	90
OCP Provided	0	0	9	9	16	1	2	7	6	14	6
Infants treated for Diarrhea (ORS)	124	255	320	223	230	399	190	97	186	380	254
High Risk Pregnant Women Referred	0	0	1	1	5	5	3	3	4	5	3
Seriously Ill Children Referred	0	0	1	4	0	1	1	3	1	7	7
Hemoglobin Estimation	0	0	0	0	0	0	0	5	35	121	121
Malaria Slides Examined	0	0	83	43	25	17	19	24	20	18	30
Found P.F. Positive	0	0	0	0	0	0	0	4	0	0	3
Malaria Cases Treated	0	0	0	0	0	0	0	4	0	0	3
Sputum Sample Examined	0	0	0	0	0	0	7	12	35	42	35
Sputum Sample Found Positive	0	2	1	0	0	0	0	0	1	2	0
Patients put on D.O.T.S	3	2	4	1	0	3	5	3	2	6	2

## **E.Documentation & Reporting**

- MCTS registers are being used along with all the other required registers.
- The MOs have been hired on a yearly contract. The NGO, VHAM has a system of performance appraisal for the staff, which is done on an annual basis. The visiting team saw the review formats and found them to be comprehensive. The performance of all the staff is rated on a few areas, for which there are weightages and final scoring is given on a range. Both the MOs have received good scores for their performance. The NGO, VHAM staff conducts monitoring visits to the facilities twice a month, sometimes weekly also

## **F.Community Processes**

- **Rogi Kalyan Samiti :** The RKS in this facility in this facility has been in place since 2007. However, it had become active after the management by VHAM. Meetings have started happening in the last two years. Quarterly meetings are a problem since the meetings are held in the BDOs office, who is the Chairman of the Samiti. Due to the non availability of the Chairman and the Secretary, meetings are often cancelled. During the last meeting held on 22.8.2011, the Samiti had taken a resolution to organize the meetings in the PHC. Minutes of the meetings and resolutions have been documented.

The Committee currently has 14 members. Availability of all members is an issue. Members take interest in the facility and visit it often. They have not received any orientation from the state on NRHM. None of the members were aware of the RKS guidelines. Funds have been received regularly and fund registers are being maintained (and were available on the day of the visit).The account has been audited.

### **ASHAs functioning:**

As per the interaction with one ASHA facilitator; she had received training on Module 6. However, she has not followed up on the ASHAs regarding the practice of their skills. Receipt of incentives is an issue due to delay in release of funds from the Block HQ. ASHAs need to work as a team with the HEs and the ASHA Facilitators to motivate the community for institutional deliveries and adopting family planning methods (large families with average children 7-8).

### **Summary :**

Managed by a dedicated team of MOs, this facility has become functional after the takeover by the VHAM. This is much appreciated by the community, since there is no other health facility in this area and earlier patients had to be taken to Mawkynrew. With the provision of the inputs, especially HR, the patient foot fall has increased considerably. However, the MOs and the SNs are constraint by the lack of essential equipments and drugs. Lack of referral transport is another constraint. All of these have limited the service delivery, especially the quality the services provided. There is a need to provide greater

support to this facility through the requisite physical inputs (infrastructure, equipment, drugs). Building the skills of the MOs and the SNs through the skill based trainings for maternal and child health is necessary to provide optimal services.

## **2.Nohron Sub-center**

Nohrun SC (under Jatah PHC, Mawkynrew Block) caters to a population of 3106. It covers 5 villages namely Bohrun, Khlieh Asean, Mawsna, N.Nongryngkoh and O.Nongryngkoh. The nearest village is Nohrun and the farthest village is 9 kms away.

### **A. Infrastructure & Equipment**

- The SC is in a government building and has 4 rooms. It is well maintained
- There is residential facility for the ANMs available at the SC in the same compound.
- The facility has an examination table and a labor table. However, no deliveries are conducted.

### **B. Manpower & Training Status**

The Nohrun SC has 1 ANM and 1 chowkidar.

### **C. Service Delivery**

- OPD, ANC, immunization are the services provided for at the SC. The Health Educator has weak BCC skills. There was no IEC displayed in the SC. The ANM's time was largely spent on catering to OPD patients and record/ register filling, leaving her with little time for outreach work. Very few VHND taking place.

## **3.Dangar PHC**

Dangar PHC of Mawsynram Block is located about 95 kms from Shillong. It caters to a population of 14,880 and has one SC, namely the Sonatola SC under it. The nearest referral centres are Mawsynram CHC (30 kms) and then the Shillong Civil Hospital (95 kms).

This 10 bedded facility was handed over to Voluntary Health Association of Meghalaya in July, 2009. The approach road to the facility is bad and takes about four hrs to cover the approximate distance of 94 kms from Shillong to Dangar

### **A. Infrastructure & Equipment**

- This is a designated govt. building, spacious and neat. Female wards are large with new furniture.
- A registration counter is present and there is a waiting area for the patients.
- There are 2 OPD chambers and 2 wards, male & female, with 5 beds each. A dressing room is available in the facility with separate access.

- There is one labour room with a labour table. There is a radiant warmer and a mucous extractor which are currently not being used. Of the emergency drugs, Inj.Magnesium Sulphate is not in supply. There is no equipment for sterilization of the delivery sets. This is carried out in the kidney tray.
- There is a laboratory which is very small and does not have a supply of the reagents or antigens for carrying out some of the basic tests.
- The condition of the pharmacy is good, with labeled racks and medicines.
- Functional cold chain equipment is available (1 LR and 1 DF).
- Residential facility for all the staff with all the basic amenities is provided for.
- There is a functional generator at the facility.
- Water supply is irregular and was cited as being a major problem.
- There is no ambulance at the facility.
- Biomedical waste management is in-house. There is an incinerator. There are no bin bags for the bins and the waste is directly disposed in the bins. There is no sharp pit at the facility.

#### **B. Manpower & Training Status**

- There are 2 MOs, 1 pharmacist, 3 GNMs, 4 ANMs (1 at SC) and 1 LT at the facility.
- Trainings such as IUCD, SBA, and NSSK etc have not been imparted to the staff yet.

#### **C. Service Delivery**

- OPD, IPD, ANC, PNC, Immunization & delivery services are provided. However, IPD load handled by the facility is very low ( 2-3 per day).On the day of the visit , there were no patients in IPD. Most cases are referred out to Shillong which is 94 kms from the facility. In the current year 7 cases have been referred out (cases of malaria, pneumonia, injury, tetanus, burn, breathing difficulty). In the previous year, 4 cases (pneumonia, uterine prolapse and rheumatic heart disease) were referred out. (Source: Referral registers of the facility). There was no case in IPD on the day of the visit.
- **Delivery services** : Although the facility has two MOs ( one MBBS MO) , 3 GNMs and 4 ANMs , few deliveries are taking place in the facility ( 8 deliveries in 2010, and 4 deliveries from Jan-Nov ,2011) . 1 Night delivery has taken place so far .The labour has been recently upgraded and has neither electricity nor running water. Radiant warmer and oxygen cylinder still in packing Most of the delivery cases of 8<sup>th</sup> Gravida, 6<sup>th</sup> Gravida and 4<sup>th</sup> Gravida are referred out
- **Diagnostics**: Laboratory tests carried out at the facility include Hb estimation, MP test, Widal test and Urine for pregnancy test. None of the other tests such as BT/ CT, TLC/ DLC are carried out as there is no provision for them. Sputum collection is done and sent to the Mawsynram CHC which is a DMC.
- Laundry services are provided for in the facility and the linen is hand-washed.
- Dietary services are not provided for IPD in the facility.



- **Referral Transport**-The facility does not have a referral ambulance. The ambulance from the 108 EMRI is parked in Mwsynrum CHC area and takes approximately 2 hours to reach this PHC. Use of this ambulance service is limited; in the current year, out of the 7 cases referred out, 6 had accessed the EMRI ambulance, from the CHC area. Out of pocket expenditure on travel is high with private taxis hired to Mawsynrum costs Rs. 3000.

#### **D. Community Processes**

##### **ASHA (based on a discussion held with nine ASHAs)**

- All the ASHAs have been working for over 2 years. ASHAs serving villages with small population ( 52-154 households) with mixed population- Khasi, Garo, Bengali, Hajong, Koch; hence number of cases ( pregnant women and children are few). Average pregnant women for institutional delivery are 4-5 cases. Home deliveries are preferred and are dominant in these areas, with an abundance of dais. Dais are given dress material (saree) by the families as a token remuneration.
  - Family Planning is a tough area for the ASHA working in villages where families prefer 6-7 children. Motivation is one area where they found the toughest and had the weakest skills. None of the ASHA had mobilized beneficiaries for sterilization. Supply of OCPs was irregular. The ASHA Facilitator supports 34 ASHAs, which is somewhat difficult for her.
  - The ASHAs had completed training till 5<sup>th</sup> Module. This was done in the PHC. 6<sup>th</sup> module training is yet to start. The ASHAs had also received a one day orientation (training) in Ayurvedic treatment, Homeopathy and Malaria (in Oct, 2011).
  - Incentives were received for immunization and VHNDs. Few of the ASHAs had received incentives for institutional deliveries. One of the ASHAs in the group had prepared 10 malaria slides, while the others did not appear confident about doing the same, in spite of the orientation. When enquired about the incentives received last year, a few mentioned a range of Rs. 2000-Rs.2400. None of the ASHAs had received payment for their incentives this year. When enquired to the ASHA Facilitator, she could not offer a reason for the nonpayment. Although she was aware of the issue, she mentioned “what can I do if the block people do not give the money!” Few ASHAs also mentioned non receipt of their TA money.
  - The participants of the discussion mentioned that drugs kits have been refilled at least twice. Two elderly ASHAs in this group of young ASHAs were active and quite vocal.
  - VHSC committees were active, having 7-8 members and using the funds for repairing of ring wells, dust bin, public toilet.
- **Rogi Kalyan Samitis**

This PHC has an active RKS ; 5 of the members were available for a discussion with the visiting team. The RKS has regular meeting and has meet 10 times in the current year. During the discussion , they mentioned that electricity and water supply are the two major problems that they are grappling with. The members had bought a Generator worth Rs. 65000 with the RKS funds. However, they are making efforts to get regular water supply in the facility. This they mentioned was due to some of the villagers damaging the pipes. The Village Headman who is a member of the RKS ( and was present in this discussion ) was aware of the problem and had addressed it in his Gram Sabha meeting. The new labour room was constructed with the initiative of these members. The members mentioned that anti snake and rabies drugs are is short supply and this is a problem since, dog bites, cat bites and snake bites cases are common in this area. They plan to get these drugs from the RKS funds.

#### E. Performance Indicators

**Table 23: MCH Performance indicators**

Sr. No.	Performance Indicators	Figures
1.	Total district Population	14880
2.	CBR (SRS, Jan'11)	24.4
3.	Expected Pregnancy	399
4.	No. of pregnant women registered for ANC	323
5.	% of ANC registered against expected pregnancy	81%
6.	No. of pregnant women received 3 or more ANC	124
7.	% of 3 ANC against ANC registered	38%
8.	No. of ID	6
9.	% of ID against total ANC registered	2%
10.	No. of SBA attended Home Delivery reported	26

- OPD attendance which started in 2009, following the takeover of this facility by the NGO in July, showed an increasing trend in 2009 and 2010, with the highest performance in the first six month (Jan-June) of 2010. But this trend reversed subsequently in the next nine months with a slight increase in 2011.
- IPD attendance shows a varying trend. The daily IPD case load is 2-3 cases. Analysis of data from facility level on IPD shows a monthly case load in the range of 6-20 which is quite less for a facility well equipped with staff and infrastructure. This is not surprising since most cases are referred out to as far as Shillong. There has been a sharp decline in the IPD cases in the last two months.

- Although the percentage of ANC registered as against the expected pregnancy is 81%., women receiving 3 ANC (as against the ANC registered) are 38%. A large number of home delivery cases are yet to be captured for ANC. ANC checkups in VHNDs are not up to the expected level. VHNDs .Most women who opt for home delivery are still reluctant to come to the facility for a checkup.
- Only 6 institutional deliveries were recorded in 2010-11. The institutional deliveries as against the ANC registered is 2%.
- 26 SBA attended home deliveries were reported in 2010-11. Although recorded as SBA conducted deliveries, these are simply home deliveries attended by *Dais* and relatives. None of the GNMs and ANMs in this facility has been trained in SBA.
- A case of maternal death was recorded between Jul-Sep'10.
- One high risk pregnant woman was referred between Jul-Sep'11 and another in November (a case of Eclampsia, Prime). Most of the cases opting for institutional delivery prefer to travel to Shillong (Ganesh Das Hospital).

**Table 24: Performance indicators based on services provided:**

SERVICES:	Jul-Sep' 09	Oct-Dec' 09	Jan-Mar' 10	Apr-Jun' 10	Jul-Sep' 10	Oct-Dec' 10	Jan-Mar' 11	Apr-Jun' 11	Jul-Sep' 11
OPD	2666	3965	3323	3287	2619	1593	1358	2492	2952
IPD	2	32	19	35	62	31	21	47	56
ANC	21	54	68	32	84	89	118	109	95
3 ANC	29	50	59	17	22	41	44	19	36
Institutional Delivery	0	0	2	1	2	0	3	1	0
SBA Attended Home Delivery	0	0	0	0	6	9	11	12	22
Maternal Death	0	0	0	0	1	0	0	0	0
Full Immunization	11	79	16	24	83	74	61	25	42
Immunization Session Held	4	10	42	92	44	51	50	43	446
Condoms Provided	60	150	30	84	0	150	480	0	60
OCP Provided	480	480	0	0	0	120	480	750	570
Infants treated for Diarrhea (ORS)	18	48	0	15	170	351	274	352	198
High Risk Pregnant Women Referred	0	0	0	0	0	0	0	0	1
Hemoglobin Estimation	0	0	0	0	0	0	0	11	4

Malaria Slides Examined	0	0	0	0	0	0	41	128	315
Found P.F. Positive	0	7	3	1	0	1	0	14	16
Malaria Cases Treated	5	3	1	3	2	1	0	6	5
Sputum Sample Examined	0	0	0	0	0	0	0	0	0
Sputum Sample Found Positive	0	0	0	0	0	0	0	0	0
Patients put on D.O.T.S	5	8	2	5	6	8	5	1	0

### iii. Facilities under Citizen's Foundation, Jharkhand:

**Table 25: Name of facilities under Citizen Foundation**

S.No.	Name of facilities	District	Period of functioning
1.	Ichamati CHC	East Khasi Hills	8 <sup>th</sup> September, 2008
2.	Majai SC		
3.	Nongkhlaw CHC	West Khasi Hills	17 <sup>th</sup> October 2009
4.	Kynrud PHC		
5.	Maweit PHC		
6.	Myriaw PHC		
7	Nongilak		

#### 1. Ichamati CHC

Ichamati CHC, of Shella block is located in the remote area bordering Bangladesh, approximately 35 kms from the Sohra region. The facility covers a population of 8055 covering 24 villages with heterogenous population of Khasis, Garos, Nepalis and Bengali speaking Hindus. This facility was handed over to the NGO, Citizen's Foundation on 8<sup>th</sup> September, 2008. This thirty bedded CHC (8 Male, 6 Female, 2 gyn and 8 paed), with a good approach road is in a designated government building and is very well maintained and clean. It has one SC under it, the Majai SC, which is currently non-functional. Ichamati has an average OPD of 100 per day (67 on the day of the visit). The nearest referral facility is the Sohra CHC and the next one is the Ganesh Das Hospital, Shillong.

#### A. Infrastructure & Equipment

- The condition of the CHC building is very good and it is a very well maintained CHC. There is a registration counter for the patients. Adequate waiting space with seating arrangements and amenities such as provision for drinking water is available for the patients.
- The OPD chambers are well lit and clean but there is no privacy for patient examination.
- A separate dressing room/ minor OT is available which functions as the emergency room.
- The pharmacy is well maintained with labeled racks for the storage of the medicines.
- There are male, female, ANC/PNC and pediatric wards.
- The labor room is clean and well maintained with. There is one labor table. The sterilizer has been non functional for the past two months.
- There is a functional radiant warmer in the labour room.
- The X-ray equipment has been non functional for the past two years.
- Functional cold chain equipments are available.
- **Infection prevention and waste management:** Color coded bins were not present in the facility. Regular bins had been labeled and were used for biomedical waste segregation. Needle destroyers were in working condition. A sharp pit is present in the facility for the disposal of the sharps.
- Staff quarters are present within the premises and are in good condition with the basic amenities. All staff is residing in the quarters.
- **Referral Transport** -Referral transport is a problem since the CHC does not have its own vehicle for referral. For referral for emergency cases, the facility uses the vehicle of the Border Security Forces. Although EMRI is operational in the state, it is not available in this area. In the villages, passengers use shared vehicles for travelling to the facilities. In one of the village, the Bishop provides his vehicle for transporting pregnant women to the facilities.

#### **B. Manpower & Training Status**

- The facility is being managed by 3 MOs, 2 MBBS and 1 AYUSH MO. There is 1 GNM and 5 ANMs. A pharmacist and lab technician are also posted at the facility. There are no specialists posted at the facility.
- The AYUSH MO has been taken on against the regular MO position and is not providing AYUSH services. Hence this cannot be considered as collocation of AYUSH in the CHC. There was no IEC for AYUSH MOs.
- There is considerable difference in the remuneration of the AYUSH MO( Rs. 16,000)and the MBBS M.O Rs.32000receive less remuneration than Allopathy MOs (, by Citizen forum) . Earlier she had received Rs.24000, now being given even lesses –.
- 1 ANM has received IUCD and SBA training.
- The AYUSH MO has undergone training in HMIS, MCH and Family Planning.

### C. Service Delivery

- OPD, IPD, ANC, PNC, immunization services are provided at the facility. Thursday is the fixed ANC day and Wednesday is the Immunization day.
- **Family planning services** are limited to the provision of only spacing methods - IUCD, OCP and condoms. NO uptake of ECP.
- **Delivery services:** Round the clock delivery services are provided. 58 deliveries were conducted in 2010 which has improved to 61, in the last 11 months in 2011. Due to the lack of specialists and blood storage unit and linkages, no C-section is done and cases are referred to the Ganesh Das Hospital in Shillong, which is the nearest FRU. On the day of the visit, only the AYUSH Lady Mo was present in the facility. She was providing allopathic medicine and was assisting the MOIC in deliveries.
- **Diagnostics:** All the basic lab tests are carried out, except for the Stool Routine Examination. Ichamati CHC is not a DMC. Only sputum collection is done at the facility.
- **Drugs and equipment:** While the pharmacy was well stocked with the essential drugs, emergency drugs such as Magnesium Sulphate and Gentamycin were not available in the labour room. Although an AYUSH MO was available in the facility, there is no AYUSH OPD being provided. There were no AYUSH drugs in the facility except the lone Livertone. The government of Meghalaya does not provide AYUSH drugs to the NGO managed facilities.
- **Ancillary services:** The housekeeping is in- house and soiled linens are washed by hand. Currently, dietary services are not provided at the facility. Citizen's charter was not displayed in the facility and Grievance Redressal Mechanism for either JSY or JSSK was not in place. There was provision of 24 hour water facility, but no provision for power backup at the facility.
- **User Fee:** Rs. 2 charged in OPD, free for pregnant women and children. None of the providers were aware of the JSSK scheme, nor was there any display of the entitlements.
- **Outreach:** VHNDs are being carried out in the villages, however, only immunization services are being provided during the VHNDs. Provision of outreach services is weak due to the none functioning of the only Sub centre Majai.
- Facility is doing malaria slide examination and also providing DOTS services

### D. Community Processes

- All ASHAs mentioned receiving Drug kits which have been refilled twice. Drug kits are refilled by giving indents to the pharmacists in the CHC.
- ASHA mentioned receiving payment in check, received within a week's time.
- Most deliveries are conducted at home by traditional Dai's. Even though the ASHAs managed to mobilize the women for ANCs in the CHC Ichamati (two women – one institutional delivery, one pregnant woman, and a case of home delivery), the women would still opt for home deliveries. Reasons given being by women interviewed.

- Labour pains started at night, so cannot go to hospital.
  - Last birth was at daytime, but no one at home , cannot go to hospital
  - Afraid to go to hospital
  - We do not get birth registration certificates from the hospital( the leaders of the area, 'Sordar' – village headman of the Jaintias )have stopped giving NOC to the immigrants ; a birth certificate can be given only, after an NOC from the Sordar), so why should we go there for delivery .
- The reason for the emphasis on birth certificates is that, this international border area is the major port of entry for Immigrants from Bangladesh, which was just visible from the national highway. The villages are composed immigrant (Bengali Hindus) from Bangladesh which is the major community in the villages. (Note: the communities in the village are heterogeneous, composed of Bengalis, Hajongs, Garos, Khasis and Nepalis. People speak a spattering of Bengali, Hindi, Assamese and all were fluent in Khasi. )
  - Of the three ASHAs, one reported deliveries from her villages (one in the CHC, Ichamati and one at home). One mentioned receiving JSY benefits of Rs. 600 twice for two cases.
  - One maternal death in Sept in one village (death within a week of giving birth, PPH probably) , 3 still births.
  - One EMRI is in the area parked in the Sohra block, not available in the villages and even for the CHC. CHC Ichamati does not have its own vehicle for referral. Currently, the facility calls the BSF's ambulance. Patients from Sumoti's village come by vehicle given by Bishop during emergencies. Other patients come by private hired vehicle.
  - ASHA's interviewed mentioned receiving, Rs. 1400, Rs.1600 and Rs. 2300 (ASHA Ms. Sumoti) in the last year. Activities for which incentives received ranges from Rs, 1200 (for VHNDs) to Rs. Rs. 75 for polio drops given in a day.
  - ASHAs mentioned having undergone training till module 6 and 7<sup>th</sup> Sept in Civil hospital, Shillong.
  - The ASHAs were aware about the untied fund Rs. 10,000.
  - ASHAs find it difficult to mobilize women for FP. Three women interviewed in the villages were not using any FP methods. ASHAs had not been able to mobilize anyone for IUCD, because of beliefs regarding weakness. Only condoms and OCP s are used. ECPuse is limited.
  - ASHA attending VHND, but ANC are not done in VHND, only done in facility. VHNDs in one ASHA's ( Ms. Tila) village is happening in her own house since there is no facility in AWC ( poor infr) , also takes place in Rama Krishna Mission compound.

### **Rogi Kalyan Samitis**

- Rogi Kalyan Samiti has been formed in this facility. However, none of the members could be accessed. The RKS register remains with the accounts personnel who were not available on the day of the visit.

## Village Health and Sanitation Committees and VHNDs

- One ASHA mentioned that in 2 villages there is one VHSC (small villages). VHSC funds in their villages have been used for installing concrete garbage bins by the road sides (visible on the way to the village), repair ring well and buy water pump for the villages. But none of their VHSCs had regular meetings. Records were maintained and up-to-date.

## E. Performance Indicators:

**Table 26: MCH Performance Indicators**

Sr. No.	Performance Indicators	Figures
1.	Total district Population	8055
2.	CBR (SRS, Jan'11)	24.4
3.	Expected Pregnancy	216
4.	No. of pregnant women registered for ANC	294
5.	% of ANC registered against expected pregnancy	136%
6.	No. of pregnant women received 3 or more ANC	273
7.	% of 3 ANC against ANC registered	93%
8.	No. of ID	66
9.	% of ID against total ANC registered	21%
10.	No. of SBA attended Home Delivery reported	0

- The OPD shows a varying trend since September 2009. On an average OPD attendance has increased tremendously although the last quarter shows a marginal decline of 78% in the OPD attendance from Jul-Sep '11 to Oct-Nov'11.
- The IPD trend is also varying but has increased from Sept. 2009.
- The women registered for ANC as against the expected pregnancy is 136% for Ichamati CHC while the 3 ANC registration against the ANC registration is 93%.
- There are no SBA attended home deliveries recorded. None of the GNMs or ANM in the facility are trained in SBA.
- 21% institutional deliveries are recorded as against the total ANC registered at the facility. Institutional deliveries were the highest in Jan-Mar '11, with 23 deliveries taking place in the three months.
- Full immunization shows a varying trend with the highest recorded in Oct-Dec'11 (49 nos.).
- All the positive cases of T.B have been treated with DOTS.

**Table 27: Performance Indicators based on services provided**



<b>SERVICES:</b>	<b>Jul-Sep' 09</b>	<b>Oct-Dec' 09</b>	<b>Jan-Mar' 10</b>	<b>Apr-Jun' 10</b>	<b>Jul-Sep' 10</b>	<b>Oct-Dec' 10</b>	<b>Jan-Mar' 11</b>	<b>Apr-Jun' 11</b>	<b>Jul-Sep' 11</b>
OPD	1050	4069	3707	4218	4416	3607	3170	4218	4416
IPD	69	146	151	357	230	289	189	357	230
ANC	9	67	74	96	104	49	45	73	88
3 ANC	11	74	61	98	107	40	28	24	38
Institutional Delivery	3	14	15	11	16	16	23	13	18
Full Immunization	9	24	14	15	23	49	10	26	24
Immunization Session Held	24	24	24	24	37	23	16	46	44
Condoms Provided	70	80	32	200	120	40	50	80	80
OCP Provided	41	90	99	14	142	16	14	0	40
Infants treated for Diarrhea (ORS)	180	210	158	205	260	140	150	220	180
Hemoglobin Estimation	8	75	77	76	137	69	37	108	95
Urine Examination	0	0	30	11	31	31	31	80	62
Malaria Slides Examined	148	230	79	93	131	151	80	242	193
Rapid Diagnostic Kit Used	0	0	0	0	45	45	56	124	61
Found P.F. Positive	1	2	0	0	1	1	0	2	5
Malaria Cases Treated									
Sputum Sample Examined	0	16	21	11	13	13	9	21	23
Sputum Sample Found Positive	2	1	0	1	5	0	5	1	5
Patients put on D.O.T.S	2	1	0	1	5	0	5	1	5

## Summary

Following the takeover by the NGO's, Citizen's Forum, CHC Ichamati which was defunct earlier has been activated and has started functioning. The facility has adequate and good quality infrastructure and a good environment, clean and well lit. Provision of basic services is adequate with good OPD services. However, the facility is not functioning at the level befitting a CHC, nor providing the services as per

IPHS. Functioning without any of the essential specialists (e.g. Gynaecologist, Anesthetist, Pediatrician, Surgeon), the CHC is not providing basic Emergency services. Facility level care for sick new born was missing. Further, several essential services, such as sterilization services, MTP, RTI/ STI are not being provided. Assured referral transport in the form of a facility level ambulance has not been provided nor any other regular arrangements organised. Outreach and community mobilization is weak, VHSCs were not active.

## **2. Myriaw PHC**

Myriaw PHC of Mairang block of district West Khasi Hills is located at about 45 kms from Mairang block headquarter and about 120 kms from the Shillong, the state capital. Myriaw is located on hilly interior area on the sides of the main road – state highway – from Shillong to district HQ town of Nongstoin. It is at a distance of about 30 Kms from the state highway, reachable through a hilly road of average road quality. The facility is located on a very high hilltop and the approach road to facility from the main road is a very difficult and narrow and treacherous road, which is in utter shambles.

The facility caters to a population of 10225, and two SCs are being run under it. It has 23 ASHAs and one ASHA Facilitator under it. It is 6 beds PHC being run in a govt. building which was being used by police and other security forces before the NGO took over the facility. No hospital was being run from this building during that period though the building was constructed for a PHC. The facility is about 45 Kms from the block HQ town of Mairang, which has a well run Sub-divisional hospital providing facilities of cesarean section deliveries and also some specialist services including routine surgeries, and works as referral hospital of the area. Though the facility has 23 ASHAs under it, but their interface with the facility is not strong as the Block level govt. run Sub-divisional hospital coordinates the ASHA program and does the most of the interaction with and payments to ASHAs.

### **A. Infrastructure and Equipments –**

- The location of the facility seems to be quite inappropriate, though it is only 1.5 Kms away from the main road, but is reachable by a very difficult hilly road. Approachability of the facility especially for delivery cases and other serious patients is very low. The approach road to the hospital, beyond the main road is very short, and is in a good condition. The building infrastructure is in a good condition. The facility is located right beside the main road junction and the small market place of the town Nongkhlaw, on an elevated spot of a small hillock and has a neat and clean and picturesque surrounding. The staff quarters are spread just beside the facility building. The place being at a height has good natural drainage and the drains are also well maintained. The campus has wire fencing all around. Drainage is good.

- It has no power back up, but has 24 hour running water facility.
- The small building of the hospital is quite well built and is in good condition, and is on hilltop and has a neat and clean and picturesque surrounding. The staff quarters are located very close to the facility building. The place being at a height has good natural drainage and the drains are also well maintained. The campus has wire fencing all around. Drainage is good.
- The facility has a designated govt. building and 6 beds. It does not have separate male and female wards. The wards are well kept.
- The building is a govt. building in a good condition, which is a small building but well kept. Located on a hilltop reachable through a very difficult and dangerous narrow road.
- It has two OPD chambers, a dressing room cum minor OT, one lab and also has one set of cold chain equipments – one ILR and one deep freezer.
- No separate space as waiting area for patients is present, the small gallery of the building, and also the outside campus functions as waiting area.
- The facility has one labour room which has one labour table. It is well maintained.
- There is no ambulance in the facility for referral.
- Residential quarters for the staff are available in the campus for 1 doctor, 1 pharmacist, 2 nurses and 2 for other staff. Total 6 quarters are available. Most of the staff and the two doctors stay in the campus.
- **Basic Amenities** -Drinking water was not available for patients, and was kept only in the MO's rooms. Sitting space for patients were the benches in the gallery. It has no power back up, but has 24 hour running water facility, water comes from the public supply to the locality.
- No separate facilities of Chairs, Food or Beds were in place for ASHAs.

## **B. Human Resource & Training**

- The facility has a total of 18 personnel, with two doctors posted full time, of whom –
  - 1 MBBS doctor with more than 10 years of past exp. and is in this facility since last more than 2 yrs.
  - 1 Ayush doctor with BHMS degree, working in facility for the last 8 months and has 6 years of past exp.
- Facility has 1 GNM working as staff nurse with 1 yr of past experience and is working in this facility since last 1 yr. It has total 6 ANMs.
- 1 Lab Technician, 1 pharmacist, 1 Health Educator are also in position.
- The facility has 2 Ward Girls and 2 ward Boys.
- The Ayush doctor who met us during the visit had not received any training, and he could not tell us about the training received by the other MBBS doctor who is also the In-charge of the facility (he was on leave)
- No other training to any other staff has been given by either the govt. or the NGO.

### C. Service Delivery

- Facility is providing services of OPD, IPD, ANC and Immunization, as well as 24/7 Delivery services OPD timing is 10 AM to 2 PM.
- **OPD & Registration** – OPD timings and fee structure were not displayed. It has computer printed consent forms available for IPD and OT. A citizen's charter was displayed in the waiting area. A user fee of Rs. 5 for OPD registration was charged, and Rs. 30 is charged for IPD admission. IEC material supplied by state govt. was displayed quite well in the waiting area and galleries as well as the rooms. No material was supplied by NGO. Counter for registration was common. There is no waiting time for OPD registration and waiting time for consultation at maximum would be up to 10 minutes.
- Though delivery services are available, but the delivery load is very low, only 3 deliveries have been done in the facility since Aug 2011.
- The reason for low no of deliveries is reportedly, lack of faith of community in the facility because of lack of advance facilities in the hospital.
- Partographs have neither been supplied nor being used.
- Services of PNC, Immunization and Management of Childhood Pneumonia / Diarrheal Diseases are being provided.
- **Family Planning:** No sterilization or IUCD services but only oral pills and condoms are being provided at the facility.
- **Referral facility** There is no ambulance in hospital, but the hospital provides transport support to some needy patients who have been referred out from this facility, in the form of Rs. 500-600 for cost of the local Sumo vehicle for taking patients to closest referral hospital of SDH Mairang, which is 45 Kms away.
- **Diagnostics and lab:** The lab is providing services for tests of Hb, TLC and ESR, Blood grouping and RH Typing, Blood Sugar, MP Test & Vidal test & VDRL and urine for pregnancy test. X ray facility is not available.
- **Institutional Mechanism and Quality Control –**  
Rogi Kalyan Samiti (RKS) of the facility has been constituted only recently in Sep 2011. Before that the flexible financing funds for this facility were being handled by the Block MO Office.  
A financial audit of the facility was done in Shillong in April 2010, when all records were called there. No other external or internal audit has been done.  
Citizen's Charter was displayed in facility.  
No publicly displayed mechanism for complaints / grievances was found.
- **Flexible Financing** –Funds of total 1.75 Lakh were received for the facility in the FY 2009-10 and 2010-11. No funds have been received in FY 2011-12. Total funds spent in three FYs respectively

since 2009-10 are Rs. 1.76 Lakh, Rs. 5444/- and Rs. 1.02 Lakh. The funds have been handled by BMO office and the facility could not give detailed information about the expenditures.

- **Emergency - No** separate access to emergency dept. Minor OT and dressing room was available.
- **Labour Room** – Facility has one labour room with one delivery table. Partographs are not supplied or being used. Labour room records have new born details like weight. Only normal deliveries are done, so complications are not recorded. Warm water facility was not available in labour room, and neither were the pre and post delivery rest rooms. All the emergency drugs and supplies related to labour room. Magnesium sulphate was available in the powder form. Sterilized delivery sets were reportedly being used. Soiled linen was being washed by facility staff, and sluicing was being practiced. Also delivery bed-sheets are autoclaved. The linen being used in wards was clean and well maintained.

Reportedly mostly women stay for 48 hours after delivery. As per the state policy, mothers with up to second child (live births), delivering in the facility, get the JSY benefit, but the facility team reported that only 1/3 of them may be getting this money within 48 hours.

Infection control practices – hand wash, cleaning, glove, and mask are being practiced. Separate slippers are not being used.

- **Ward** -Average monthly IPD admissions are about 25, but last month the no. was 15. Beds and linen were well kept, and wards were clean, airy and well lighted. Toilets were well kept and clean, but running water was not available in all toilets. The facilities were of a standard of a well run hospital. Though no particular fixed system for monitoring of toilet upkeep was reported, the status of the upkeep showed it is routinely kept well maintained. Timing for the visiting hours were not displayed, the small facility had such an informality that it may be out of place to do that.
- **Laboratory** –Lab tests had no charges. No particular timings for lab tests were on display. No separate demarcated areas in lab were in place. It was reported that they have no analyzer. Lab reports register, and stock registers and indent register were maintained in the lab.
- **Pharmacy and Stores** -The pharmacy is very well maintained and well stocked, but the racks were not available in sufficient numbers. The racks in the pharmacy were labeled, but those in store were not. As per the staff all essential drugs included in the state's drug list are available. A drug list in a hand written poster was displayed. The storage room and the space in regular pharmacy were in good dry condition and well maintained. No refrigerator is available; ILR is used for storage of some essential drugs. All the drugs supplied were from the state govt. and NGO has not done any supplies.
- **Housekeeping** - Housekeeping is in-house and all the soiled linen is washed by hand by the ward boys and ward girls. Ward boys and Ward Girls reportedly supervise the housekeeping operations. Overall cleanliness level was very good. Despite lack of sufficient space, the place was very neat and tidy and well maintained. The structural condition of the building was also very good, and there were no peel-offs, seepage and cracks in the walls etc. Taps and fixtures were also well in place.
- **No Dietary services** are provided for the patients. No kitchen is run.

- **Linen & Laundry** –Laundry services are in house. Linen was well kept and clean and was available on all beds occupied. Linen change is done is done on 2-3 days.
- **Waste Disposal System** The system is being run in-house. Multicolored bins were being used in the facility, but waste segregation practices were found to be inadequate. Printed Charts with instructions were not in place. Both needle cutters as well as the hub-cutters were available and were being used.Deep burial pit and sharp pit were not constructed. Puncture proof containers are not available.
- **Security and Service** No security service or fire safety equipments were in place.
  - **24/7 Functionality of facility** – The facility did not have high load of either OPD or IPD or delivery cases, but came across as a well functioning first port of call for nearby communities. Most of the staff, a small team working closely resided in the campus itself and was available round the clock. Some staff were local and stayed outside the campus. He also the knowledge of local language was a barrier that the facility team faced. Due to very difficult accessibility of the facility, it fails to receive many of the state govt. supplies also which are sent to all other similar facilities.

#### **Performance Data -**

This facility had not been able to provide us the performance data on Tool 3 at the time of the visit, because the doctor in-charge was not present there. They had promised to send us the data later, but had not done so. Reportedly the doctor in-charge has been mostly out on leave since then to attend to his mother's illness and the other doctor whom we had met during study had been on leave since our visit for his own marriage. He has joined back only two day back and has promised to send us the performance data in a day or two.

#### **D. Community Perspective:**

##### **ASHA Program –**

A discussion with a small group of ASHAs (3 ASHAs) was done in the facility.23 ASHAs are in place under the facility. It has one ASHA facilitator in place. All villages under the facility coverage area are covered by ASHA. In terms of support structure – they have 1 ASHA Facilitator, but no ASHA Coordinator at block level. ASHA Coordinator is in place at district level.

- In last 6 months 5 meetings of ASHAs have been held, the day of meeting is not fixed.
- Since 2008 – ASHAs have received Drug Kit s times, in 2008, 2010 and now last in April 2011. The kit has 10 drugs. Same drugs are being supplied in these 3 yrs. ASHAs said the drugs are not sufficient for the whole yr.
- The incentives paid to ASHAs are very low, only amount paid to them in last 3 months was Rs. 100 per month for organizing VHND paid from VHSC funds. Some of them have received Rs. 300 in an year for House Survey of the village.

- The facility team is not involved in the ASHA training and training and other program management is coordinated directly by BMO office. With no separate block ASHA coordinator in place, the BPMs are responsible for ASHA program also, and they are not very involved with ASHAs work. ASHAs are not taking the home visits for pregnant women, newborns and malnourished children as a priority work.
- ASHAs said that VHSCs funds have been spent on activities like, cleaning drives in the village, distributed sweets to children on some occasions, buying water filters, buckets and glass, and making of NRHM sign-board. (Interestingly a signboard of NRHM with the name of VHSC as the sponsor of the board was found in many places on the way)
- ASHAs enumerated her role in VHND as follows – creating VHND awareness, mobilizing children and pregnant women, and counseling families on cleanliness and nutrition during the VHND. ASHAs said they counsel mothers on issues like sanitation, common diseases and issues about toilet uses, and also the need for practice of regular hand wash. VHND is held on monthly basis. AWWs list the children and pregnant women of the village and held in their coverage during VHND. On the questions of how they ensure that the VHND services are used by the marginalized, ASHAs said that they have been made aware of this issue in their training and go house to house particularly to the far off sections of the village, and inform and convince all families to attend the VHND.

#### **VHSC –**

No separate discussions with VHSC members could be done.

#### **Community level FGD with Women**

A meeting with women was also not done in this facility.

#### **Sub – Centre and Extension Program**

The facility is running two Sub Centres. One SC Nongilak was visited by us. It caters to 6 villages and 3399 popn. of tribal people. It is at 5 Kms from the PHC and has a big govt. building with 9 rooms with sufficient space for residence for ANM. But ANM does not stay there. No equipments are also placed there, not even weighing machine and examination table. The SC is not in a functional status. It is accessible by a motorable road and shared taxis ply on the route. Nearest and farthest village under the SC are at 0.5 Kms and 15 Kms respectively. 4 VHNDs and 10 Immunization sessions are being held in the area under the SC, as per the record of the SC.

#### **Summary:**

The PHC is a good functional PHC serving at a basic level of primary care, and a place for normal deliveries, with good stock of drugs and basic equipments. It has still not picked up though as a place for

normal deliveries, partly because of very difficult access to facility. The supplies from state govt. for both drugs and equipments are abundant. No supplies have come from NGO.

The doctors and many staff reside in the campus and provide 24 / 7 services. The services are without doubt free of any charge for both OPD and delivery services. The team of doctors – one is a MBBS. Doctor a with substantial experience (more than 10 yrs) and other one a BHMS, make a good team.

In terms of cleanliness and maintenance it was a very well run facility, despite small building it was kept very clean and tidy. The extension program of the facility was not in a good shape, and seemed not to be in focus probably due to the very difficult outreach areas under the facility, and lack of sufficient staff. Due to the presence of well functioning referral hospital at about 45 Kms from the PHC, complicated cases are easily referred or they go themselves.

The facility was not functioning before being taken over by NGO, and was being used by forces for their stay. Now at-least the basic functionality and availability of doctors is ensured. Though the NGO is providing no other support or value addition to the process, and is not doing its proper role in paying either good enough salaries or paying them in time.

#### **Support from NGO to facility team**

NGO support is non-existent except for appointing and paying the staff. The salary is paid on a quarterly basis in cash, by the NGO staff based in Shillong, who comes to facility once in three months and pays the salary in cash. The doctor we met could not tell us if the NGO pays Rs. 10000 per month towards regular running expenses of the hospital or not, as it does with other similar facilities (the doctor in-charge was not there). The staff and doctor were quite unsatisfied by the salaries being paid. The ayush doctor we met said he is on the look for other opportunities. No monitoring visits or protocols are in place. No additional supplies or training have been given by NGO.

### **3. Nongkhlaw CHC**

Nongkhlaw CHC of Mairang block of district West Khasi Hills is located at about 18 kms from Mairang block headquarter and about 100 kms from the Shillong, the state capital. The facility is approachable through a reasonably good road and is located on the main route between state capital Shillong and the district capital Nongstoin. This facility is being run by the NGO Citizen Foundation since 13 March, 2009. The facility caters to a population of 10217, and has one functional sub-centre being run under it. Though it is designated as a CHC and the funds allocated under agreement between the NGO and state govt. are for a CHC, the services being delivered in the facility are of the level of a PHC. The facility conducts only normal deliveries and no cesarean sections, and even the no. of normal deliveries conducted is very small, maximum being 25 per quarter in the period of last 10 quarter since it is being run by this NGO. In 6 out of these 10 quarters the no. of deliveries conducted in the facility is less than 20. The services of specialist doctors are also not available, as there is no



doctor posted with specialist qualification. The facility is just 18 Kms from the block HQ town of Mairang, which has a well run Sub-divisional hospital providing facilities of cesarean section deliveries and also some specialist services including routine surgeries, and works as referral hospital of the area. The facility has 14 ASHAs under it, but they seem to have a weak link with the facility as the Block level govt. run Sub-divisional hospital coordinates the ASHA program and does the most of the interaction with and payments to ASHAs.

#### **A. Infrastructure and Equipments –**

- The facility has a designated govt. building has 30 beds but 27 are functional, and it has one female ward and one general ward. The wards are clean and well maintained and have proper air circulation and natural light as well as lighting arrangements.
- The toilets of the facility were well located and properly maintained in terms of both toilet floors, windows, latches as well as the cleanliness. Running water was available in toilets and labour rooms.
- The building is in good condition and but the space available and no. of rooms were somewhat less than what normally a CHC has, but it was quite adequate for a PHC. It has a small space as the waiting area for patients, though inside the grided area of reception and registration counter, there was adequate space with seating space where patients also could sit.
- The facility has four separate OPD chambers, a dressing room cum minor OT, one lab and also has one set of cold chain equipments – one ILR and one deep freezer.
- The facility has one labour room which has one labour table. It is very well maintained, with a newly supplied (by state govt.) spot light and two well maintained functional radiant warmers. The facility of warm water and pre and post delivery rest rooms is not available.
- The facility had remarkably well maintained multiple delivery sets. There is no ambulance in the facility for referral.
- No Power back up is present in the facility. Provision for 24 x 7 running water is available.
- Adequate residential quarters for the staff are available in the campus. All staff and the two full time doctors stay in the facility. No separate facilities of Chairs, Food or Beds were in place for ASHAs, but the facility team was quite friendly and amiable with ASHAs and it seemed ASHAs share the available spaces in facility well.

#### **B. Human Resource & Training**

- The facility has a total of 33 personnel, with two doctors in full time posting, of whom –

1 MBBS doctor has a PG Diploma in Radiology who retired from state govt. of Manipur's service in 1999, works as the facility in-charge and attends to all emergency cases too and 1 young lady Ayush doctor from Manipur state with BHMS qualification.

Other three doctors work with the facility in a part time arrangement, two doctors with MBBS qualification once a week and the third doctor with BDS comes twice a week. All three doctors are doing private practice in nearby area. The enquiry about last two-three weeks showed their contribution to the facility being quite weak.

- The facility has 3 GNMs working as staff nurses, and total 6 ANMs. Of these one ANM was posted for the sub-centre, but continued to serve at the facility also, and also stayed in the facility campus itself.
- 1 Lab Technician, 1 pharmacist, 1 Health Educator and 1 Radiographer is in position.
- The facility has 9 Ward Girls and 4 ward Boys.
- Between two doctors – the doctor In-charge and the Ayush doctor – they have received training on RNTCP, IUCD and Maternal Death Review.
- No other training to any other staff has been given by either the NGO or the Govt.

#### **D. Service Delivery**

- Facility is providing services of OPD, IPD, ANC and Immunization. OPD timing is 9 AM to 3 PM.
- **OPD & Registration** – OPD timings, and fee structure was displayed. A citizen's charter was displayed in the waiting area. Counter for registration was common, but had no crowding, and average waiting time for registration at maximum would be up to 15 minutes, though generally it was much less. Average waiting time for consultation was reported to be 20 to 30 minutes. It has printed consent forms available for IPD and OT. The registration charge of Rs. 5 per patient was the only charge being taken from patients, no other charges for any service including the lab tests were being taken. There is a system of a voluntary donation of small amount of Rs. 2, (money is donated in a donation box) but it is not forced upon the patients.

IEC material was displayed in the waiting area. Display Material was mainly that supplied by state govt. and no material supplied by NGO was found.

- The quarterly OPD in Jan – March 2009 (the NGO took over the facility on 13 March 2009) was 1749, but it went up to 7263 in next quarter of Apr to Jun 2009, and 7141 in Jul to Sep 2009. In all of next eight quarters till Jul to Sep 2011, it has been in the range of about 3200 to 5700, in 6 out of these 8 quarters being above 4000.
- The no. of IPD cases are in the range of 49 to 186 per quarter in the last nine quarters since facility being run by NGO (Apr to Jun 2009 quarter onwards, till last quarter of Jul – Sep 2011). The quarterly IPD was a dismal 15 in Jan – Mar 2009 quarter when it was taken over by NGO, which shows a clear and distinct positive trend in the period of NGO.

- **Delivery services:** Round the clock delivery services are available. The deliveries in the facility started only in Apr to Jun 2009 quarter after the facility being taken over by NGO. But despite adequate no of staff nurses and ANMs, the no of deliveries, especially in the view that this facility is a CHC, are quite low, with maximum no. of deliveries in any quarter since Apr 2009 being 25. Partographs have neither been supplied nor being used. It was clear though, that the services for delivery are actually available 24/7, as the doctors and nurses reside in the facility campus itself. The reason for low no of deliveries is reportedly, the presence of a referral hospital nearby, which also has a gynecologist lady doctor. After delivery mothers are made to stay for 2 days in the facility. BCG immunization is done only market days which comes on rotation basis after every eight days. No PNC services are reportedly being provided. Management of Childhood Pneumonia / Diarrheal Diseases is being done effectively, by the doctor in-charge, a retired govt. doctor.
- **Family Planning:** No sterilization or IUCD services but only oral pills and condoms are being provided at the facility. Recently one doctor has received IUCD insertion training but the service is yet to take off.
- **Referral facility** There is no ambulance in hospital and no other support for referral patients is being provided from hospital.
- **Diagnostics:** X-ray facility is available. The lab is providing services for tests of Hb and ESR, Blood grouping and RH Typing, Blood Sugar, and MP Test & Vidal test. Urine routine and urine for pregnancy test, and also the Sputum for AFB is being done. A well functioning X-ray machine is available. With a radiographer in place and the doctor in-charge having a PG Diploma in Radiology, this service is functional and available.
- **Institutional Mechanism and Quality Control –**  
Rogi Kalyan Samiti (RKS) has been constituted and been receiving funds under flexible financing since FY 2009-10. It has held 2 meetings in current FY. Any system for internal or external monitoring was not reported, except for reporting of expenses in the RKS meetings itself. Citizen's Charter was displayed in facility. A user fee of Rs. 5 for registration was only charge. No publicly displayed mechanism for complaints / grievances was found.
- **Flexible Financing –** Facility received Rs. 1 Lakh, Rs. 50000- and Rs. 1 lakh towards funds for RKS, Untied Funds and Annual maintenance Grant (AMG) in FY 2009-10 and 2010-11. It spent total Rs. 266545 and Rs. 332934 respectively against these three grants. It did not receive any funds under these three heads in current FY because it had a carried forward balance. The facility team could not give detailed information about these funds. It was later known that in almost all the facilities being run by the NGOs, the flexible funds are more directly guided by the NRHM office of Block Medical Officer, and often the RKS meetings are also held there itself. The facility team seemed to have less control over these resources, though they were not ready to say it openly before the study team.
- **Emergency - No** separate access to emergency dept. Minor OT and dressing room was available. The facility was seen providing basic emergency services to accident victims.

- **Labour Room** – Facility has one labour room with one delivery table, and a separate space recently equipped as new-born child care corner, but it had design flaws and had windows and was not properly packed. The hospital had two baby warmer units, both in very good condition and functional. Partographs are not supplied or being used. Labour room records have new born details like weight. Warm water facility was not available in labour room, and neither were the pre and post delivery rest rooms.

All the emergency drugs and supplies related to labor room, except magnesium sulphate was available. Multiple delivery sets were available, and sterilized delivery sets were reportedly being used. Mostly women stay for 48 hours after delivery. As per the state policy, all mothers with up to second child (live births), delivering in the facility, get the JSY benefit within 48 hours. Infection control practices – hand wash, cleaning, slipper, glove, and mask are being practiced.

- **Ward** -Total IPD admissions last month were 43 and total 161 were in last quarter. Beds and linen were very well kept, and wards were clean, airy and well lighted. The windows and doors were all in place, and at the time of visit also Female ward had 3 delivery cases and general ward also had one case. Toilets were well kept and clean, with running water available. These facilities were of a standard of a very well run hospital, well above the general condition in the govt. facilities. System for toilet upkeep was reportedly in place and its status also proved that it is routinely kept well, and it is not just one day's cleaning for the visit.
- **Laboratory** –Lab tests had no charges. No particular timings for lab tests were on display, but test facilities were reported to be open through the day timings of hospital and also 24 hours if required, as the whole team of hospital stayed in the campus. No separate demarcated areas in lab were in place. Technicians reported that they standardize their analyzer with the standards provided with the kits? Lab reports register, and stock registers are maintained in the lab.
- **Pharmacy and Stores** The pharmacy is very well maintained and well stocked with adequate racks for storage of the drugs. The racks are labeled and as per the staff all essential drugs included in the state's drug list are available, but drug list is not displayed. The storage room and the other space where drugs were kept in regular pharmacy were in good dry condition and well maintained. No refrigerator is available. All the drugs supplied were from the state govt. and NGO has not done any supplies.
- **Housekeeping** - Housekeeping is in-house and all the soiled linen is washed by hand by the ward boys and ward girls. Sister-in-charge supervises the housekeeping.
- **Linen & Laundry** –Linen was well kept and clean, though the facility has only 20 linen for 30 beds. Bed occupancy at any given time is not very high, so all occupied beds had linen. Line is changed every two days
- **No Dietary services** are provided for the patients. No kitchen is run.

Overall cleanliness level was quite remarkable good, and was not at all very clean, as if it has been done just a day before the visit. The walls were not freshly painted but were well kept, and had no peel-offs

etc, though the paint on outer walls had a damp look. The whole of small campus had good metalled pathways, and good drainage. Taps and fixtures were also well in place, it was a well kept infrastructure, nothing flashy, but well appointed.

- **Waste Disposal System** The system is being run in-house. Multicolored bins were being used in the facility, but waste segregation practices were found to be inadequate. Printed Charts with instructions were not in place. Both needle cutters as well as the hub-cutters were available and were being used. A deep burial pit and a sharp pit in place and is being used. Puncture proof containers are not available.
- **Reports** -The facility sends its reports upwards in two sets: CHC aggregated reports to BMO office / NRHM team of the district and another Monthly report to the NGO.
- **24/7 Functionality of facility -**

The ambience of the hospital showed it's round the clock functionality, when we visited the facility unannounced on the second day late evening while returning from the visit of another facility on the same route, and stopped by this facility for some data, and we found the hospital up and running, with a trauma case from a nearby road accident case being attended to by the doctor in-charge, with the presence of a no of nursing and other staff

The whole team of nurses, ANMs and ward boys and girls seemed to be quite cohesive and well coordinated, with the ambience exuding an air of warmth in the team, and they were also quite informal and friendly with the patients. Though most of the staff was from outside the state mostly from Manipur, and did not know the local khasi language, only a few local staff knew and helped the others in learning it.

#### D. Performance Indicators

**Table 28: Performance Indicators Based on Services provided:**

SERVICES:	Jan-Mar' 09	Apr-Jun' 09	Jul-Sep' 09	Oct-Dec' 09	Jan-Mar' 10	Apr-Jun' 10	Jul-Sep' 10	Oct-Dec' 10	Jan-Mar' 11	Apr-Jun' 11	Jul-Sep' 11
OPD	1800	7000	7000	4500	4500	5500	5500	3200	3200	4600	5800
IPD	15	92	186	49	46	150	151	59	99	114	161
ANC	8	52	52	40	38	78	52	35	48	52	68
3 ANC	1	11	4	3	0	2	16	22	14	22	30
Institutional Delivery	0	7	14	11	0	25	8	21	13	15	21
JSY Beneficiary Paid	0	1	0	0	0	38	2	11	72	11	11
Full Immunization	0	40	140	110	260	130	10	20	20	30	40

Immunization Session Held	10	16	12	16	16	24	38	35	16	26	28
Condoms Provided	0	50	130	250	100	160	190	140	160	40	241
OCP Provided	0	0	1	20	10	1	30	6	37	0	0
Infants treated for Diarrhea (ORS)	1	2	0	0	2	0	0	2	1	0	0
High Risk Pregnant Women Referred	0	0	0	0	1	0	3	0	1	0	2
Hemoglobin Estimation	0	0	0	0	1	48	36	14	4	20	10
Urine Examination	20	22	18	19	20	18	20	22	26	59	52
Rapid Diagnostic Kit Used	0	50	420	180	50	100	650	100	10	20	90
Found P.F. Positive	0	5	22	6	2	6	6	2	0	0	2
Malaria Cases Treated	0	5	250	10	2	5	380	2	0	0	2
Sputum Sample Examined	8	0	15	26	22	22	44	17	16	30	16
Sputum Sample Found Positive	2	0	3	1	4	2	2	0	0	3	4
Patients put on D.O.T.S	2	0	5	3	7	6	6	4	4	8	5
VHNDs Held	10	16	10	18	18	22	38	34	18	28	28

#### E. Community Perspective:

##### ASHA Program :

- A discussion with a small group of ASHAs was done in the facility, and later a group discussion with women was also done. 14 ASHAs are in place under the facility. It has one ASHA facilitator in place since April 2010, who is paid Rs. 4000 per month. The area is spread quite far, and most distant village is 35 Kms. ASHAs have received the ASHA Module 6 & 7 training in Jan 2011, and are aware of the skills taught in the training like weighing the baby, use of thermometer and watch, and basic counselling on breastfeeding and keeping the baby warm. ASHA training and other program management is coordinated directly by BMO office.

- No separate block ASHA coordinator in place, the BPM is responsible for ASHA program also, and he / she is not very involved with ASHAs work. Though at the district level, District Community Mobiliser is in position.
- The incentives being paid to ASHAs are very few. JSY incentive being paid to ASHAs is very rare as the % of institutional delivery is very low. Only other incentive ASHAs name is for organizing the VHND, at a rate of Rs. 150 per month. She is very actively involved in organizing VHNDs.
- ASHA drug kits are refilled regularly, a new complete kit (box of drugs) every year and refilling every quarterly. They said the kit has a total of 10 drugs and other supplies.
- ASHA Facilitator is doing one visit to every ASHA every month but is not very systematic in her support. Language was a major problem in conducting the discussions with group of ASHAs.
- No regular meeting of ASHAs is held at facility, and occasionally some program for them has been organized, like one school health competition was organized with ASHAs involvement.
- At BMO office level also no regular meeting of ASHAs is held on monthly basis.

#### **VHSC:**

- No separate discussions with VHSC members could be done, but issues were discussed in the group discussion with women. VHSC meetings are held a few times in year. VHSCs are mainly involved in sanitation related activities. ASHA and Village Mukhiya, called Darbar (as head of traditional unelected panchayat) are joint signatories of VHSC funds and there are a lot of problems in operation of accounts, as the Darbar reportedly demands a major cut from the VHSC funds.
- State is facing major problems in getting fresh VHSC funds released from central NRHM budget, because UC for previous years could not be issued due to non-cooperation of these village heads.

#### **Sub – Centre and Extension Program**

- Facility is running only one SC – Mawkarah, which caters to 6 villages and 4263 popn.
- It is at 10 Kms from the CHC and has a good newly built building on a spot which is at quite a height from the rest of the village, but it is not too far off from the main road. The building has a residential section also, but the ANM does not live there. VHNDs are held regularly there once a week. The building has no water supply and electricity connection till now. Water has to be fetched from quite a distant place below. The SC had some basic table and chair and an examination table and weighing machine. The ANM was on leave at the time of the visit. But the records there showed a regular SC clinic on weekly basis, and a monthly VHND.

## **Summary:**

NGO support is non-existent except for appointing and paying the staff. The salary is paid almost always on a quarterly basis in cash, by the NGO staff based in Shillong, who comes to facility once in three months and pays the salary in cash. The NGO pays only Rs 10000 per month towards regular running expenses of the hospital, which is also paid in 3 months. No monitoring visits or protocols are in place. No additional supplies or training have been given by NGO.

## **4. Kynrud PHC**

Kynrud PHC of Mairang block of district West Khasi Hills is located at about 30 kms from Mairang block headquarter and about 120 kms from the Shillong, the state capital. Kynrud town is located on a reasonably good road on the main route between state capital Shillong and the district capital Nongstoin, and is about 18 Kms from the Nongkhlaw town. The approach road to Kynrud facility from the main road is a completely kaccha road and is in a very bad shape.

This facility is also being run by the NGO Citizen Foundation since 13 March, 2009. The facility caters to a population of 7209, and 18 villages. It has 14 ASHAs and one ASHA Facilitator under it, and one sub-centre is being run under it, but the SC is located in very interior corner and is reachable only by a 4 to 5 hours journey by foot. It is 10 beds PHC being run in a govt. building which has been just recently renovated substantially.

In an interesting departure from the other NGO run facilities, Kynrud PHC also has some class 3 and class 4 staff from regular govt. cadre continuing to be in position and working along-with the doctors and staff appointed by NGO. The facility is about 35 Kms from the block HQ town of Mairang, which has a well run Sub-divisional hospital providing facilities of cesarean section deliveries and also some specialist services including routine surgeries, and works as referral hospital of the area. The facility has 14 ASHAs under it, but their interface with the facility is not strong as the Block level govt. run Sub-divisional hospital coordinates the ASHA program and does the most of the interaction with and payments to ASHAs.

### **A. Physical Infrastructure and Equipments –**

- The approach road to the hospital, beyond the main road is about 1 Km long and is in a very bad shape. It's a kaccha road which has been made worse by tractors running on it in Monsoons. In the November last at the time of visit though it was dry, still the road had huge clefts and was very difficult to negotiate for our brand new big SUV car. How difficult it would be for village people to manage to cross this patch with their pregnant mothers in their local vehicles especially in monsoons is easy to guess.



- The pathetic status of this approach road has been an issue being raised at different forums by the facility team, especially to PRI representatives, local MLA and state officials, but no initiative has been taken till now by any of them.
- The small building of the hospital is in good condition, and has been recently renovated from flexible funds of the hospital, costing around Rs. 1 Lakh. The facility is located right beside the main road junction and the small market place of the town Kynrud, on an elevated spot of a small hillock and has a neat and clean and picturesque surrounding. The staff quarters are located close to the facility building. The place being at a height has good natural drainage and the drains are also well maintained. The campus has wire fencing all around. Drainage is good.
- The facility has a designated govt. building and 10 beds, with one female ward and one general ward. The wards are well kept.
- The building is a govt. building in a good condition, which is small but well spaced out, located in a little corner on the periphery of the main village on a small elevated top. It has a small space as the waiting area for patients, three separate OPD chambers, a dressing room cum minor OT, one lab and also has one set of cold chain equipments – one ILR and one deep freezer. The facility has one labour room which has one labour table. It is very well maintained, with one well maintained and functional radiant warmer. There is no ambulance in the facility for referral. Residential quarters for the staff are available in the campus. All staff and the two full time doctors stay in the facility, though some of the staff has to share the quarters.
- It has no power back up, but has 24 hour running water facility, water comes from hilly rivulet.
- No separate facilities of Chairs, Food or Beds were in place for ASHAs, but the facility team was quite friendly with ASHAs.

## **B Human Resource & Training**

- The facility has a total of 24 personnel, with two doctors posted full time, of whom –  
1 MBBS doctor who is a retired govt. doctor with 30 years of exp. Before joining this facility 15 months back.  
1 Ayush doctor with BHMS degree, working in facility for the last 19 months and has 3 years of past exp.
- Facility has 2 GNMs working as staff nurses who have 5 yrs + past experience and are working in this facility since last 2.5 yrs and 1 yr respectively. It has total 6 ANMs.
- 1 Lab Technician, 1 pharmacist, 1 Health Educator and 1 Male health worker are also in position.
- The facility has 2 Ward Girls and 1 ward Boy.
- **Govt. Staff** –This facility also has total 7 govt. staff from regular cadre, which includes - 1 health educator and 1 Accountant.
- Between the two doctors – they have received training on RNTCP, NSSK, IUCD and Maternal Death Review.

- One staff nurse has also received training on NSSK.
- 3 ANMs have received training on MDR and two have been trained on NSSK.No other training to any other staff has been given by the NGO.

### C. Service Delivery

- Facility is providing services of OPD, IPD, ANC and Immunization, as well as 24/7 Delivery services  
OPD timing is 9 AM to 3 PM.
- **OPD & Registration** – OPD timings and fee structure were not displayed. It has printed consent forms available for IPD and OT.A citizen’s charter was displayed in the waiting area. Counter for registration was common, but had no crowding was seen this being a small facility, and average waiting time for registration at maximum would be up to 15 minutes, though generally it was much less. Average waiting time for consultation was reported to be 20 to 30 minutes. The registration charge of Rs. 5 per patient is being taken from patients in OPD, no other charges for any service including the lab tests were being taken, except for Rs. 15 being charged for birth certificate of the baby. The system of voluntary donation of small amounts exists here also, though no particular amount is insisted upon, the money is donated in a donation box. Only some IEC material supplied by state govt. was displayed in the waiting area. No material was supplied by NGO. Waiting time for registration was about 10-15 minutes. and the same for consultation was about 5 minutes.
- The average monthly OPD is about 1300, daily nos. being about 50. The quarterly OPD in Jan – March 2009 (the NGO took over the facility on 13 March 2009) was 3091, and it went up to about 4600 to 4800 in next two quarters. In all of next seven quarters till Jul to Sep 2011, it has been in the range of about 2500 to 4000, only once being below 2000 (1945).The no. of IPD cases have also been in the range of 50 to 80 per quarter, only twice being above 100, highest being 134.
- ANC cases being about 15 monthly, but in the last quarter it was 103. Round the clock delivery services are available, but the delivery load is not high. Institutional deliveries are less than 10 per quarter in all of the nine quarters since Apr 09.
- **Delivery services:** Partographs have neither been supplied nor being used. The services for delivery available 24/7, as the doctors and nurses reside in the facility campus itself. The reason for low no of deliveries is reportedly, lack of faith of community in the facility because of lack of advance facilities in the hospital. After delivery mothers are generally made to stay for 2 days in the facility, but some of them leave early. BCG immunization is done only market days which comes on rotation basis after every eight days. No PNC services are reportedly being provided. Management of Childhood Pneumonia / Diarrheal Diseases is being provided.

- **Family Planning:** No sterilization or IUCD services but only oral pills and condoms are being provided at the facility. One doctor has received IUCD insertion training recently but the service has not started yet.
- **Referral facility** There is no ambulance in hospital and no other support for referral patients is being provided from hospital.
- **Diagnostics and lab:** The lab is providing services for tests of Hb and ESR, Blood grouping and RH Typing, MP Test & Vidal test and urine for pregnancy test.
- **Institutional Mechanism and Quality Control** –Rogi Kalyan Samiti (RKS) has been constituted in 2007 and been receiving funds under flexible financing in FY 2009-10, 2010-10 and FY 2011-12. It has held no meeting in current FY. Last meeting was held in Nov 2010. Any system for internal or external monitoring was not reported, except for reporting of expenses in the RKS meetings itself. Citizen's Charter was displayed in facility. A user fee of Rs. 5 for registration was charged, and Rs. 15 for birth certificate. No publicly displayed mechanism for complaints / grievances was found.
- **Flexible Financing** –Facility received Rs. 1 Lakh, Rs. 25000- and Rs. 5000 towards funds for RKS, Untied Funds and Annual maintenance Grant (AMG) in totaling 1.75 Lakh in each of FY 2009-10 and 2010-11. The facility has recently got the renovation of the building done from the funds under these heads of flexible financing, but the payments have not yet been finally taken in the records. In this facility also the flexible funds are directly being handled by the NRHM office of Block Medical Officer, and the recent building renovation has also been directly done by the BMO office. The RKS meetings are not held properly and if ever they are held they are held at block HQ itself. It was absolutely clear that the facility team has little control over these resources.
- **Basic Amenities** Drinking water was available for patients from a pot kept for the purpose. Sitting arrangements were basically the stone benches that were part of the building structure located in the verandah of the building.
- **Emergency** - No separate access to emergency dept. Minor OT and dressing room was available. Soiled linen is washed by hospital staff, no sluicing is practiced.
- **Labour Room** – Facility has one labour room with one delivery table. The hospital had one baby warmer unit, good condition and functional. Partographs are not supplied or being used. Labour room records have new born details like weight. Warm water facility was not available in labour room, and neither were the pre and post delivery rest rooms. All the emergency drugs and supplies related to labour room, except magnesium sulphate was available. More than one delivery sets were available, and sterilized delivery sets were reportedly being used. Mostly women stay for 48 hours after delivery. As per the state policy, all mothers with up to second child (live births), delivering in the facility, get the JSY benefit within

48 hours. Infection control practices – hand wash, cleaning, slipper, glove, and mask are being practiced.

- **Ward** -Total IPD admissions last month were 44, and total 184 were admitted in last quarter. Beds and linen were well kept, and wards were clean, airy and well lighted. The recent renovation has improved the condition of ward and labor room. Toilets were well kept and clean, with running water available, and the facilities were of a standard of a very well run hospital. System for monitoring of toilet upkeep was reportedly in place, and its status also proved that it is routinely kept well, and it is not just one day's cleaning for the visit.
- **Laboratory** –Lab tests had no charges. No particular timings for lab tests were on display. No separate demarcated areas in lab were in place. Technicians reported that they standardize their analyser with the standards provided with the kits. Lab reports register, and stock registers and indent register are maintained in the lab.
- **Pharmacy and Stores** -The pharmacy is very well maintained and well stocked with adequate racks for storage of the drugs. The racks are not labeled, and as per the staff all essential drugs included in the state's drug list are available, but drug list is not displayed. The storage room and the space in regular pharmacy were in good dry condition and well maintained. No refrigerator is available. All the drugs supplied were from the state govt. and NGO has not done any supplies.
- **Housekeeping** - Housekeeping is in-house and all the soiled linen is washed by hand by the ward boys and ward girls. Medical Officer-in-charge supervises the housekeeping operations.
- **No Dietary services** are provided for the patients. No kitchen is run.
- **Linen & Laundry** –Linen was well kept and clean. Line change has no definite protocol and is need based.
- **Waste Disposal System** The system is being run in-house. No Multicolored bins were being used in the facility, and no waste segregation practices were found to be in place. Printed Charts with instructions were not in place. Both needle cutters as well as the hub-cutters were available and were being used. Deep burial pit and sharp pit were not constructed. Puncture proof containers are not available.
- **Security and Service** No security service or fire safety equipments were in place.
- **24/7 Functionality of facility** - Though the facility did not have very high load of either OPD or IPD or delivery cases, the whole of staff, a small team working closely resided in the campus itself and was available round the clock. The majority of nurses and ANMs were from Manipur, some staff and the govt. staff was local. So the knowledge of local language was a barrier that the facility team faced.

**Reports** - The facility sends its aggregated reports to BMO office / NRHM team of the district.

## F. Performance Indicators

Table29: Performance indicators in 2010-11.

SERVICES:	Jan-Mar' 09	Apr-Jun' 09	Jul-Sep' 09	Oct-Dec' 09	Jan-Mar' 10	Apr-Jun' 10	Jul-Sep' 10	Oct-Dec' 10	Jan-Mar' 11	Apr-Jun' 11	Jul-Sep' 11
OPD	3091	4858	4631	2834	3511	3251	3956	1945	2496	2874	4002
IPD	49	65	120	57	36	64	61	88	55	77	184
ANC	0	0	0	0	0	43	85	35	52	50	103
3 ANC	0	0	0	0	0	2	15	4	15	18	52
Institutional Delivery	0	4	4	3	2	0	5	2	1	9	5
JSY Beneficiary Paid	4	0	0	10	0	7	0	15	19	5	22
Full Immunization	0	0	0	0	0	31	20	5	25	34	23
Immunization Session Held	4	4	6	4	8	12	12	12	12	12	12
Condoms Provided	0	12	24	18	16	22	15	19	100	48	50
OCP Provided	0	5	0	0	3	5	4	0	10	7	12
High Risk Pregnant Women Referred	0	1	0	1	0	0	0	0	0	0	1
Hemoglobin Estimation	0	0	0	0	0	31	21	30	50	5	32
Malaria Slides Examined	0	0	0	0	0	0	0	0	0	50	113
Rapid Diagnostic Kit Used	0	0	0	0	0	44	58	23	4	15	38
Malaria Cases Treated	0	8	248	30	2	22	386	8	0	0	1
Patients put on D.O.T.S	0	0	8	6	2	5	0	0	1	2	4
VHNDs Held	0	12	12	12	12	10	10	12	12	12	12

## E.Community Perspective:

- **ASHA Program –**
- A discussion with a small group of ASHAs was done in the facility, and later a group discussion with women from the village was also done. 18 ASHAs are in place under the facility. It has one ASHA facilitator in place who is paid Rs. 4000 per month. ASHAs have received the ASHA Module 6 & 7 training in Jan 2011, and are aware of the skills taught in the training like weighing the baby, use of thermometer and watch, and basic counseling on breastfeeding and keeping the baby warm, but were not able to explain the skills, and seemed to have not learnt properly. They said that they have received these equipments during the

training - weighing machine, thermometer and watch and also the ASHA Module 6 & 7 books in local language. ASHA training and other program management is coordinated directly by BMO office and the facility team is not involved in this. No separate block ASHA coordinator in place, the BPMs are responsible for ASHA program also, and they are not very involved with ASHAs work. The incentives being paid to ASHAs are very few. Out of 3 ASHAs with whom discussions were held, only one told us to have received total Rs. 100 in last two months.

- ASHA drug kits are refilled regularly; last drug kit refill was done in Aug 2011. ASHA Facilitator is doing one visit to every ASHA every month but is not fully aware of her role. ASHA Meetings in the PHC are not held regularly, but three meetings have been done in last 6 months.
- ASHAs said that VHSCs are involved in activities like, cleaning in the village, helping the poor families in times of crisis in accessing health care. ASHAs also said that they play important role in organizing VHND, in gathering children and women and informing the village headman and the village households. On the questions of how they ensure that the VHND services are used by the marginalized, ASHAs said that they go house to house in the whole of village and inform and convince all families to attend the VHND.

#### **VHSC –**

- No separate discussions with VHSC members could be done, but issues were discussed in the group discussion with women. Issues related to VHSCs are same as in the Nongkhlaw CHC. Meetings are held a few times in year, and VHSCs are mainly involved in sanitation related activities. ASHA and Village Mukhiya, called Darbar (as head of traditional unelected panchayat) are joint signatories of VHSC funds and there are a lot of problems in operation of accounts, as the Darbar reportedly demands a major cut from the VHSC funds.
- **Community level FGD with Women in a mixed group –**
- A discussion with about 15 women from all sections of village was held in the village panchayat's community hall located in the middle of the village's main road junction.
- VHNDs are held every month on a fixed day but they could not specifically tell the day, as it falls on the market day, which does not fall on a fixed day every week, and comes after every 8 days. So the community people know from the earlier haat day, the day of next haat. The information for the next VNHD is sent by PHC to the village headman who sends a person on behalf of the panchayat to announce the VHND day on the mike throughout the village, and it is ensured that the information reaches every household of village.
- During VHND –steps of the ANC like TT Injection, Weight measurement, and Iron Foilc Acid are followed. Lack of awareness among some village families was cited as a barrier to their access to VHND services. No fee is charged in VHND for any service. ANC services are done for all

pregnant women, and there is no difference in services offered due to caste or community. Immunization services are being provided regularly, and cold chain is being maintained. But the nutrition counseling services in VHND are weak, almost nil.

- VHNDs are not visited by anybody from the facility except ANM. They also said that the treatment to pregnant mothers who go to the facility for delivery is good and equal for all with no discrimination or favor to anybody. There are no charges either for any services. Despite repeated clarifications sought from them about the charges they all said that there are no charges.
- There are no transport support facilities. They all were satisfied with the basic facilities of the hospital and the attitude and behavior of doctors and staff which they said was equal and same for all. But they said that there have been no efforts by the facility to reach out to community.
- They said that ASHA helps them greatly by escorting them to the facility.

### **Sub-center & Extension programme**

The facility is running one SC Takhong, which caters to 5 villages and 1680 popn. of mostly tribal people. It is at 25 Kms from the PHC and has a govt. building with 3 rooms but no space for residence for ANM. It is in a quite interior place, 15 Kms from the nearest road head, which takes 5-6 hrs journeys on foot. Nearest and farthest village under the SC are at 5 Kms and 8 Kms respectively. We could not visit the SC during our visit to PHC. VHND is held once a month in the SC.

### **Summary:**

The PHC is a good functional PHC serving at a basic level of primary care and a place for normal deliveries, with good stock of drugs and basic equipments. The supplies from state govt. for both drugs and equipments are abundant. No supplies have come from NGO.

The staff and doctors reside in the campus and provide 24 / 7 services. The services are without doubt free of any charge for both OPD and delivery services. The team of doctors – one is a MBBS retired govt. doctor and other one a BHMS, are a good team. In terms of cleanliness and maintenance it was a well run facility, and certain basic protocols like use of needle cutters and hub cutters were being practiced. The extension program of the facility was not in a good shape, and seemed not to be in focus basically due to the very difficult outreach areas under the facility. Due to the presence of well functioning referral hospital at about 30 Kms from the PHC, complicated cases are easily referred or they go themselves.

The facility was in a very badly run state before being taken over by NGO, and now at least the basic functionality and availability of doctors is ensured. Though the NGO is providing no other support or value addition to the process, and is not doing its proper role in paying either good enough salaries or paying them in time.

### **Support from NGO to facility team**

NGO support is non-existent except for appointing and paying the staff. The salary is paid on a quarterly basis in cash, by the NGO staff based in Shillong, who comes to facility once in three months and pays the salary in cash. The NGO pays Rs. 10000 per month towards regular running expenses of the hospital.

On calculating all the salaries of staff and running expense of Rs. 10000 per month, total Rs. 1.51 Lakh was being spent on the facility by the NGO, though the total monthly amount being paid by state govt. to NGO is Rs. 2.38 Lakh. The staff and doctor were quite unsatisfied by the salaries being paid. No monitoring visits or protocols are in place. No additional supplies or training have been given by NGO.

## **5. Mawait PHC**

Mawait PHC of Nongstoin block of district West Khasi Hills is located at about 40 kms from the district headquarter town of Nongstoin. Mawait is located on a hilltop approachable through a steep narrow kaccha road, though the distance from the main road is not much. The place is within an area which is very heavily forested and hilly, and is the farthest end of the district and the state, which shares international borders with Bangladesh. The main road connecting the Mawait from district HQ is in horrible condition, to the extent that the 40 Kms journey by a sturdy SUV car took us 3.5 Hrs. The road seems to have not been repaired since ages, and has been washed away almost completely.

The whole region seems to be very sparsely populated, there were almost no town or villages on this 40 Kms journey. The whole region is a strong coal belt, and the only activity that was visible in the region was related to coal trade, mostly lorries carrying coal. interior area on the sides of the main road – state highway – from Shillong to district HQ town of Nongstoin. It is at a distance of about 30 Kms from the state highway, reachable through a hilly road of average road quality. The facility is located on a very high hilltop and the approach road to facility from the main road is a very difficult and narrow and treacherous road, which is in utter shambles. This facility is also being run by the NGO Citizens Foundation since 12 June, 2009. The facility caters to a population of 6450, and has three SCs under it, though all three are non-functional. The facility has 39 villages under its area and 39 ASHAs and one ASHA Facilitator working in it.

Much like the whole area which seems to have been abandoned by govt. and larger society, this facility also comes across as a forlorn unit with no takers. It was the worst run among the four facilities being run by the Citizens Foundation visited by us in this study visit. It has also seen the highest turnover rate among the doctors and staff among all five facilities visited by us, and has seen 3 different MBBS doctors as well as 4 different Ayush doctors since June 2009. On one occasion it saw about 3 months with only 1 Ayush doctor, and on another occasion, right before Oct 2011, it was run without any doctor for about 3-4 months. Since Oct 2011 1 MBBS doctor and since Nov 2011 one Aysuh doctor are posted there. The team of the facility cited the difficult access of the hospital as the reason for such high turn-over of staff and the sorry state of the facility. The facility team comes across a quite de-motivated on the issue of the functionality of the hospital and quality of care. The lack of any enthusiasm in the doctor in-charge also



aggravates this. The figures of performance betray the state of affairs – quarterly OPD being as low as 875 (Jan – Mar 2010), and being about 1100 in last two quarters. Only 2 deliveries have been done in the hospital since 2009. The poorly maintained hospital building structure and its upkeep also betrays this demotivation in the team. It is 10 beds hospital officially but only 2 beds are functional at present. The facility also has one ambulance which is functional but it has no POL or fuel budget from either govt. or NGO. PHC is being run in a govt. building. The hospital has started functioning in this building only after NGO; s taking it over in June 2009, though the hospital building was constructed way back in 1997.

#### **A. Infrastructure and Equipments –**

- The main road to the facility from the dist HQ is in a pathetic state, and the approach road to the facility is also very difficult. The small building of the hospital is located on very small a hilltop has a picturesque surrounding. The staff quarters are located very close to the facility building. The place being at a height has good natural drainage and the drains are fine. The campus has no fencing.
- It is a small govt. building which is not well kept. Located on a hilltop reachable through a steep and dangerous narrow kaccha road.
- It has only one OPD chamber, no dressing room cum minor OT, one lab and also has one set of cold chain equipments – one ILR and one deep freezer. But they had only one voltage stabilizer at the time of visit which was being used alternatively for both equipments, so at the time of visit ILR was kept off and deep freezer was on.
- No separate space as waiting area for patients is present, the small gallery of the building, and also the outside portico of the building function as waiting area.
- The facility has one labour room which has one labour table. It was not maintained properly. Residential quarters for the staff are available in the campus for 2 doctors, 1 pharmacist, 2 nurses and 1 for other staff. Total 6 quarters are available. Most of the staff and the two doctors stay in the campus by sharing the available quarters, as there is no other village or town nearby. Some new section of building was under constructed for labour room.
- No separate facilities of Chairs, Food or Beds were in place for ASHAs.

#### **C. Service Delivery**

- Facility is providing services of OPD, IPD, ANC and Immunization. Counter for registration was common. There is no waiting time for OPD registration and waiting time for consultation is also not much Only OPD timings were displayed. It has no printed consent forms available for IPD and OT, hand written forms are used. A user fee of Rs. 5 for OPD registration is charged but this is also reportedly waived off for needy families. IEC material supplied by state govt. was displayed in the facility. No material was supplied by NGO.
- Delivery services are non-existent, only 2 deliveries done since 2009.

- OPD timing is 10 AM to 2 PM.
- Partographs have neither been supplied nor being used.
- Services of Management of Childhood Pneumonia / Diarrheal Diseases are being provided.
- **Family Planning:** No sterilization or IUCD services but only oral pills and condoms are being provided at the facility.
- **Referral facility** There is one ambulance in the facility with one driver also posted but no budget for POL etc.
- **Diagnostics and lab:** The lab is providing services for tests of Hb, MP Test & Vidal test and urine for pregnancy test. X ray facility is not available.
- **Institutional Mechanism and Quality Control –**  
 Rogi Kalyan Samiti (RKS) of the facility has been constituted only recently in Sep 2011. Before that no funds under flexible financing were received for this facility.  
 No financial audit of the facility has been done since 2009 by any govt. agency or NGO.  
 Citizen's Charter was not displayed in facility.  
 No publicly displayed mechanism for complaints / grievances was found.
- **Flexible Financing –**With RKS of the facility constituted only in Sep 2011, total 1.75 Lakh has been received by the facility under three heads of RKS, UF & AMG – Rs. 1 Lakh, 50000/- and 25000/- respectively. No expenditures are done as yet, meeting of RKS is proposed.
- **Emergency -** No separate access to emergency dept. No separate Minor OT and dressing room was available.
- **Labour Room –** Facility has one labour room with one delivery table. A new labour room is under construction. Partographs are not supplied or being used. No Labour room records were available. Warm water facility was not available in labour room, and neither were the pre and post delivery rest rooms. All the emergency drugs and supplies related to labour room. Magnesium sulphate and Lignocaine Hydrochloride as well as Forceps for delivery, Vacuum delivery and surgical kits were not available in the facility. Under infection control practices only hand wash, cleaning and gloves are being used. Slippers and mask are not being used.
- **Ward -**Average monthly IPD admissions are about 25 to 30. Quarterly total in last quarter was 120. The admissions were for general ailments. Only two beds which were not well maintained were functional. Two other mattresses were also present. Beds and linen not properly maintained, and general cleanliness in the ward was bad. No system of visiting hours was being followed.
- **Laboratory –**Lab tests had no charges. No particular timings for lab tests were on display. No separate demarcated areas in lab were in place. It was reported that they have no analyzer. Only a stock registers was maintained.
- **Pharmacy and Stores -**The pharmacy was not well stocked and the racks were not available in sufficient numbers. The racks in the pharmacy or store were not labeled. As per the staff most of

the essential drugs included in the state's drug list are available, some of them are not supplied. No drug list was displayed. The condition of wall, floors and windows in storage room and the space in regular pharmacy were in a dry condition but not very well maintained. No refrigerator was available. All the drugs supplied were from the state govt. and NGO has not done any supplies.

- **Basic Amenities** -No provision for drinking water was available for patients. Sitting space for patients was only one bench in the gallery.
- **Housekeeping** - Not much of Housekeeping practices were in evidence, but it is all in-house, and all the soiled linen is washed by hand by the ward boys and ward girls.Doctor in-charge reportedly supervises the housekeeping operations. Overall cleanliness level was not good. Though there was no seepage or cob-webs, peeling of paints were visible. Taps and fixtures were in place but not well maintained.
- **No Dietary services** are provided for the patients. No kitchen is run.
- **Linen & Laundry** –Laundry services are in house. Linen was not available on all beds. Linen change is reportedly done on 2 days.
- **Waste Disposal System** The system is being run in-house. No Multicolored bins were being used in the facility, and no waste segregation practices were found to be in place. Printed Charts with instructions were not in place. Only one old rusted needle destroyer was there in the hospital, which was not being used. On being tried it was functional. Deep burial pit and sharp pit were not constructed. Puncture proof containers were not available.
- **Security and Service** -No security service or fire safety equipments were in place.

#### D. Performance Indicators

**Table 30: Performance Indicators based on services provided**

SERVICES:	Jan-Mar' 09	Apr-Jun' 09	Jul-Sep' 09	Oct-Dec' 09	Jan-Mar' 10	Apr-Jun' 10	Jul-Sep' 10	Oct-Dec' 10	Jan-Mar' 11	Apr-Jun' 11	Jul-Sep' 11
OPD	0	638	2249	1325	827	1644	1365	875	797	1117	1168
IPD	0	11	127	36	37	129	57	26	15	73	120
ANC	0	28	95	48	30	79	39	24	39	67	62
3 ANC	0	8	35	15	7	17	2	1	0	6	19
Immunization Session Held	0	108	108	108	108	108	108	108	108	108	108
Condoms Provided	0	0	0	10	13	12	16	20	15	18	22
OCP Provided	0	0	0	11	13	16	20	18	24	15	17
Infants treated for Diarrhea (ORS)	0	82	110	42	42	118	60	40	100	162	90
Malaria Slides Examined	0	0	0	0	0	0	0	0	0	131	226

Rapid Diagnostic Kit Used	0	102	306	273	222	248	253	293	83	87	226
Found P.F. Positive	0	50	340	170	30	120	90	60	10	40	140
Malaria Cases Treated	0	50	340	170	30	120	90	60	10	50	140
Patients put on D.O.T.S	0	0	8	6	2	5	0	0	1	2	4
VHNDs Held	0	12	12	12	12	10	10	12	12	12	12

### Summary:

**24/7 Functionality of facility** – The facility had a very low load of either OPD or IPD cases. Delivery cases are not common. The facility is running at a bare minimum level of functionality, as the performance

indicators shown below in the graphs would also confirm. Though the staff was largely de-motivated, still it wanted to continue in the facility and was seemingly willing to work harder given the team of doctors in the leadership sustains and also the NGO and the state govt. support the facility in supplies and regular support. Due to very difficult accessibility of the facility, it fails to receive many of the state govt. supplies also which are sent to all other similar facilities.

### Support from NGO to facility team

NGO support is non-existent except for appointing and paying the staff. The salary is paid on a quarterly basis in cash, by the NGO staff based in Shillong, who comes to facility once in two to three months and pays the salary in cash. Since Oct 2011, the NGO is also providing Rs. 10000/- per month towards regular expenses of the hospital, which includes the essential POL expenses of the ambulance. The doctor said that they have to go to the dist themselves by the hospital ambulance to receive the drugs supplies, and the store there gives the supplies in instalments so minimum 3 visits have to be made in a month for supplies. No monitoring visits or protocols are in place. No additional supplies or training have been given by NGO.

### iv. Facilities under Jaintia Hills Development Society (JHDS):

Sr. No.	Name of facility	Name of district	Period of functioning
1.	Barato PHC	Jaintia Hills	June 2009
2.	Shiliang Myntang HSC		
3.	Sahsniang PHC		

4.	Shaniang HSC		
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## 1. Barato PHC

This PHC is managed by JHDS a local NGO of Jaintia Hills District. It caters to a population of about 15000 people. The area where the PHC is located is near to the Assam-Meghalaya border and the land is under dispute. Both state governments are claiming the land because of which there is unrest in the area<sup>1</sup>. This is the reason for which doctors were not willing to stay in that area and the state government decided to hand over the PHC to a NGO. JHDS is running this PHC since June 2009. The nearest referral hospital is located at Jowai which is 70 km away from the PHC.

### A. Physical Infrastructure

- The PHC building is owned by state government. The condition of the approach road to the PHC is not good. The overall condition of the PHC and the staff quarters is good.
- There is 24hrs power backup and running water available. Important information has been displayed in the PHC at various places. Since the OPD is high patients have to wait for their turn to see the doctor.
- The PHC is well equipped for emergencies, while the labor room is also well functional and is fully utilized. The Lab, Pharmacy, store and laundry are all fully functional. Number of IPD patients is quite high in the PHC and all facilities are available in the ward. No dietary services are provided. Bio medical waste management is not happening but care is taken while disposing needles and other sharp materials. There are quarters available for all staff members of the PHC including the Chowkidar. There is no ambulance in the PHC but still a driver is appointed who works as the receptionist.

### B. Human Resources & Training

- There are two medical officers (1 MBBS and 1 AYUSH). The MO in charge has been working in the same PHC since the PHC was handed over to JHDS. While the other MO (AYUSH) was on leave on the day of visit. Most of the staff in the PHC was there since 2009. The number of staff is adequate and there is no vacancy left in the PHC.
- All the staff nurses and ANM have got training for malaria and SBA. The doctor has received several trainings in last two and a half years.

### C. Services Delivered

- OPD, IPD and MCH care is provided to all patients coming to PHC. Activities happening under family planning are distribution of condoms and oral pill through outreach services,

<sup>1</sup> As reported by DAM (District Accounts Manager) of Jaintia Hills.

while IUDs are still not much used. Sterilization operations are not happening at the PHC. There is no referral transport facility available at the PHC. Not all lab tests are done in the PHC due to lack of reagents from last 4 months. Earlier all tests were done at the PHC level. There is no X ray machine in the PHC.

- Staff members do not have information about the date of constitution of the RKS but are aware that the RKS was already functional in 2009 when the PHC was taken over by the NGO. Last year the RKS members met 10 times. The internal and external monitoring is not happening very frequently. Only financial audit takes place every year.
- All the funds received in last two years have been utilized completely.

#### **D. Performance**

- It is evident from the data as well as the observations of the study team that the performance of the PHC is very good taking in to consideration the difficulty of the service area.

#### **E. Community Processes**

- The ANM of this sub centre has complete knowledge of her duties and responsibilities and performs them efficiently. She resides in a small sub centre where there is no electricity and water available at the quarter. She is maintaining all her records properly and has a complete weekly plan ready with her at the beginning of the week.
- She is working in the sub centre from last 2 years and 8 months.
- She performs home deliveries but does not perform deliveries at the sub centre.
- All her outreach activities are planned. She visits every village under her sub centre once in a month for immunization and the sessions are planned and executed with the help of ASHA and AWW of that village. She attends all VHNDs in all the villages.
- Supervisor from JHDS and PHC MO both visit the sub centre separately for monitoring the activities taking place at the SC level. Even the Director JHDS had visited the SC in the previous month. She maintains more than 20 registers at her level and spends almost 4 hours daily in filling up the details in the register and submits a monthly report to Barato PHC MO IC.
- There is no additional staff at the SC to assist or help the ANM, the Chowkidar helps her in all her activities with his limited skills and hence she feels the need of an additional health worker at the SC. Moreover there is no electricity and water supply in the SC as well as her quarter, which makes it difficult for her to stay there, especially at night.

## **2. Shiliang Myntang sub centre**

The study team visited Shiliang Myntang sub centre, which is located 20 km away from the PHC. There are four villages under the sub centre and a population of around 2500 people. The population here is predominantly tribal population belonging to the Pnar tribe. The nearest

village is 5 km away from the sub centre while the farthest village is 25 km away from the sub centre. There are motor able rods but no public transport is available. Only mode of transport is a sharing taxi.

**A. Physical Infrastructure:**

- The sub centre building is government owned. There is a quarter for the ANM and a Chowkidar. There is no electricity and water in the sub centre. All other facilities are available at the sub centre. There is a functional sub centre committee constituted at the sub centre level, which has met 12 times in last one year. The ANM does not receive any funds from the PHC or from the district. There is no untied fund available for the sub centre. She only gets medicines from the PHC.

**B. Community Perspective:**

**Women community members**

- A group of seven female members of the community dwelling in the same village where the PHC is located were gathered and a group discussion was initiated by the DAM of Jaintia Hills District. In order to fulfill the criteria of geographic representation women who had brought their children to the PHC, residing in nearby villages were also included.
- A Village Health and Nutrition Day (VHNDs) held in the village once in every month on a fixed date. in one village its every on every 8<sup>th</sup> day of the month while in other it takes place on the 22<sup>nd</sup> day of the month. In the VHNDs the services provided are weight measurement, immunization, nutritional support and ANC/ PNC care. Normally they actively participate in the VHNDs and there are no barriers for access to services. There is no fee charged for these services. Regular ANC is done for all pregnant women, all have received all 3 ANCs and it is accessible to all sections of community. Immunization services are available during all VHNDs and the cold chain is maintained properly. Proper records – ANC cards and Immunization cards – made. There are no problems faced by community in service delivery and response of facility team. Nutrition Counseling is provided in VHNDs. The LS and the PHC MO of Barato PHC visit the VHND some times.
- The ASHA and ANM help them in birth planning, and planning for transport. Ambulance is not provided from the facility, they have to arrange for a private vehicle which costs them around Rs 1500. ANM does both the ANC chek ups and also conducts the deliveries. The women are not aware of the status of facilities in hospital (bed, linen, diet, medicine, and other supplies). There are no charges levied for any facility and in any form. Women generally don't go for institutional deliveries but there are few women have gone for institutional delivery, but still there are more home deliveries happening in the village. Cases that finally end up in the health facilities are already complicated.

- There is improvement in the availability of drugs and services provided, but no one could specify areas of improvement. The hospital is open from 10 am in the morning till 4 pm in the evening. The doctor and staff are available round the clock. All other facilities (like beds, water, toilet and other basic facilities including cleanliness and diet) are now available after the NGO has taken over the PHC, earlier all these facilities were not available. The attitude of doctors and staff towards patients is good. The facility team has not made any effort to reach out to community in the area, at block level, at village level and there is no involvement of the RKS.
- The women did not know much about the VHSCs, what they knew was it has something to do with hygiene and sanitation and they have dust bins in their villages where they are supposed to throw all the garbage and other wastes.

### **Men & Women Community Members from Marginalized Groups**

- A group of ten members from the community were present for the discussion at the Shiliyang Mayntang Sub Centre. The group included 4 women and 6 men from the nearby village. The DAM conducted the group discussion with the help of the BPM.
- Village Health and Nutrition Day (VHNDs) is held in the village. Every 9<sup>th</sup> day of the month is the fixed date for VHND activities. The ASHA personally goes and provides the information to the weaker sections and far-flung hamlets. The villagers have no problems with the timing of VHNDs. On VHN day the health workers give a health talk, administer vaccines, distribute medicines, collect blood slides and provide ANC. All the BPL families in the village participate in the VHND as it is conducted in a place which is accessible to all. No fee is charged for these services. According to the group members regular ANC is done for all pregnant women, they all receive all 3 ANCs, and it is accessible to all sections of community. There are no differences in access of services by marginalized sections during VHND. Yes, immunization services are available during all VHNDs, the cold chain is maintained properly, the boxes have proper ice linings and fresh vials are opened before injecting the vaccine. People said that proper records – ANC cards and Immunization cards - made and stored. Explanation about the importance and advantages of good eating habits, type of food, safe drinking water, is given by ANM (sometimes by ASHA also). The BPM and the PHC staff visit the VHND.
- The ASHA and ANM help them in birth planning as well as arranging and transporting the patient to the hospital in case of emergency. The facility does not provide any support for transporting the patient. But recently this service has been launched in a nearby PHC i.e. Nartiang PHC (22 km away from the Sub Centre<sup>2</sup>). The ANM first attends the pregnant lady, gives medicine and refers to the PHC as there is no provision to conduct delivery at

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<sup>2</sup> As reported by the ANM of Shiliang Myntang SC.



the SC. At the PHC SSF conducts the delivery. All the facilities are satisfactory but the only problem is lack of electricity and water supply. No charges are levied for any facility

- There is improvement in the availability of drugs and services provided, but no one could specify areas of improvement. The hospital is open from 10 am in the morning till 4 pm in the evening. The doctor and staff are available round the clock. All other facilities (like beds, water, toilet and other basic facilities including cleanliness and diet) are now available after the NGO has taken over the PHC, earlier all these facilities were not available. The attitude of doctors and staff towards patients is very good.
- The village headman participated in the group discussion who is also a member of the VHSC. The headman provided the information that the meetings of VHSC are conducted 3-4 times in a year. The group members told that the ASHAs have been really helpful to them.
- The sub-centre land has been donated by the village. The government has constructed the building but there is no fencing to the sub centre compound. The villagers complained that since the land trespassing is on the rise there should be proper fencing to the SC. Moreover electricity and water supply should be there in the sub centre.
- The village head man of the Shiliang Myntang village was interviewed understand the functional status of the VHSC. The committee comprises of 11 members out of which 7 are females. Percentage of attendance in last three meetings has been more than 60 percent. The main activities of the VHSC in the village are cleaning the locality by using dust bins, procurement related to mid day meals, waste management in the village and storage of water. The major items of expenditure are mid day meals, purification of drinking water and waste management. The ASHA is the secretary of the VHSC, she maintains both the minutes of the meetings and the accounts of the VHSC. She also provides directions to on committee about what should be done and should not be done. The headman claims to have a plan prepared for the coming three years. The plan was made in a meeting which was attended by all the members of the committee. There was no innovation initiated by the VHSC in the past.

### **3. Shasniang PHC**

This PHC is managed by JHDS a local NGO of Jaintia Hills District. It caters to a population of about 9000 people. The area where the PHC is located is near to the Assam-Meghalaya border and the land is under dispute. Both state governments are claiming the land because of which there is unrest in the area. This is the reason for which doctors were not willing to stay in that area and the state government decided to hand over the PHC to a NGO. JHDS is running this PHC since June 2009. The nearest referral hospital is located at Laskein CHC which is around 50 km away from the PHC.

#### **A. Physical Infrastructure:**

- The PHC building is owned by state government. There are quarters available for all staff members of the PHC including the Chowkidar. There is no ambulance in the PHC but still a driver is appointed who works as a helper in the PHC. The condition of the approach road to the PHC is good. The overall condition of the PHC and the staff quarters is good. There is no power backup and running water available 24x7. Important information has been displayed in the PHC at various places. Since the OPD is high patients have to wait for their turn to see the doctor.
- The PHC is well equipped for emergencies, while the labor room is also well functional and is fully utilized. The Lab, Pharmacy, store and laundry are all fully functional. Number of IPD patients is not very high but all facilities are available in the ward. No dietary services are provided. Bio medical waste management is happening, there are colour coded dust bins placed in the PHC. Care is taken while disposing needles and other sharp materials. There is a pit where biomedical waste is buried.

#### **B. Human Resource & Training:**

- There are two medical officers (both AYUSH). There was a doctor couple (MO IC was MBBS and an AYUSH doctor who left a month back. Since then the AYUSH doctor at Baroto PHC is working part time and a new AYUSH doctor has been placed in November 2011.
- The MO in charge has been working in Baroto since the PHC was handed over to JHDS. Most of the staff in the PHC was there since 2009. The number of staff is adequate and there is no vacancy left in the PHC, except for the MBBS doctor (the post has been advertised).
- All the staff nurses and ANM have got training for malaria and immunization. The doctor has received several trainings in last two and a half years at Baroto PHC. The MO AYUSH has not yet received any training.
- The MO IC (AYUSH) is working in the PHC since last 1 and a half month.
- As per interview with the M.O; there are no jobs opportunities in Manipur (his native state). He is very happy with the salary that he is getting here (30,000) which according to him is quite high for an AYUSH doctor. Salary was the main reason for continuing the job since last 2 years and 8 months. The quarters are well maintained and all the facilities are available, MO AYUSH also told about the reasons for joining the PHC.-The new MO AYUSH is a resident of Jowai (the District headquarters of Jaintia). She has a clinic in Jowai where she earns around RS 10000-15000 per month. Her salary here is 20000, which again is on a higher side. She also has a plan of running her clinic simultaneously; hence it would be an additional income for her. She feels that there is more exposure at the PHC. Talking about the challenges faced the MO said that There is no facility for referral transportation or ambulance facility which makes it difficult to get all the emergency cases.

- Though the doctor is paid well, the other staff members are paid almost the half of what their NRHM counterparts are getting. Because of which there is a little discontent among the other staff members.

### **C. Services Delivered**

- OPD, IPD and MCH care is provided to all patients coming to PHC. Activities happening under family planning are distribution of condoms and oral pill through outreach services, while IUDs are still not much used. Sterilization operations are not happening at the PHC. There is no referral transport facility available at the PHC. All lab tests are done in the PHC. There is no X ray machine in the PHC.
- Staff members do not have information about the date of constitution of the RKS but are aware that the RKS was already functional in 2009 when the PHC was taken over by the NGO. Last year the RKS members met 4times. The internal and external monitoring is not happening very frequently. The JHDS supervisor and the Director JHDS visit the PHC sometimes. Only financial audit takes place every year. All the funds received in last two years have been utilized completely.

### **D. Performance of the PHC**

- It is evident from the data as well as the observations of the study team that the performance of the PHC is very good taking in to consideration the difficulty of the service area.

#### **Patient Feedback**

- OPD as well as IPD patients seem to be highly satisfied with the services provided at the PHC and the staff members. We were also told that the PHC is performing better than the earlier days when the PHC was managed by government.

## **3. Shaniang –SC**

The Shasniang sub centre is located at the PHC itself. There are eight villages under the sub centre and a population of around 3000 people. The population here is predominantly tribal population belonging to the Pnar tribe. The nearest village is 1-2 km away from the sub centre while the farthest village is 25 km away from the sub centre. There are motor able rods but no public transport is available. Only mode of transport is a sharing taxi.

### **A. Infrastructure, functionality and financing**

- The sub centre building is government owned (same as PHC). There is a quarter for the ANM. All other facilities are available at the sub centre.
- There is no sub centre committee. There are 8 VHNCs; both the ANMs posted at the sub centre have divided their villages and both of them attend the VHNDs.

- The ANM does not receive any funds from the PHC or from the district. There is no untied fund available for the sub centre. She only gets medicines from the PHC.

### **C. Community Processes:**

#### **Functioning of ANM:**

- The ANM of this sub centre seemed to be very hard working and had good knowledge about duties and responsibilities and performs them efficiently. She is maintaining all her records properly and has a complete weekly plan ready with her at the beginning of the week. The ANM got her job through an interview procedure executed by the JHDS. The post had been advertised in the local news paper and an interview was conducted through which she was selected. She is working in the sub centre from last 2 years and 8 months.
- She performs home deliveries but does not perform deliveries at the sub centre. All her outreach activities are planned. She visits every village under her sub centre once in a month for immunization and the sessions are planned and executed with the help of ASHA and AWW of that village. She attends all VHNDs in all the villages. Supervisor from JHDS and PHC MO both visit the sub centre separately for monitoring the activities taking place at the SC level. Even the Director JHDS had visited the SC in the previous month.
- She maintains 14 registers at her level and spends almost 1-2 hours daily in filling up the details in the register and submits a monthly report to Block level. There are two ANMs at the SC. They have divided work amongst themselves and alternately visit their respective villages. When one ANM goes for outreach activities the other stays back at the SC.

### **Status and functionality of ASHA and VHND**

- Four ASHAs were included in this activity as other villages were very far from the PHC. The ASHAs told that there are ASHAs volunteering from all the villages under the PHC. There is one ASHA facilitator who supports the ASHAs in their activities. They meet once in every month at the Barato PHC. The ASHAs indent the kits from the sub centre or PHC once in a year. The ASHAs are paid in cash on the basis of the diary maintained by the ASHA, the VHSC report and immunization status of their villages. They get the money in the meetings at the PHC level. They also get their honorarium and JSY money at the PHC. The facility staff is involved in the trainings and capacity building of ASHAs. Follow up of new born, counseling of pregnant women and malnourished women.
- The ASHA keeps the records of the proceedings of the VHSC. At the time of VHNDs the ASHA has to inform the beneficiaries about their activities and help the ANM in preparing blood slides and administering OPV vaccines to children. The ASHAs believe that their work addresses issues such as nutrition, sanitation, disease control measures and other social health issues. VHNDs are held once in a month. At the VHND there is a health talk,

immunization is done and ANC is provided. The AWW provides food to the children below age of 6 years and also to the pregnant ladies, take their weight measurement and provide health education, while the ANM does immunization. The ANM also makes use of pictures for better involvement and understanding of the audience. They feel that there should more medicines available with them.

- FGD with the RKS members could not happen as all the RKS members did not come to the PHC. But we discussed some issues with the village head man who on special request of the Accounts manager came for some time to the PHC. Hence the issues were discussed with the village headman, PHC MO IC and Block programme manager and Accounts manager.
- There are 11 members in the RKS, but the PHC staff is not adequately represented. The other groups from the society are adequately represented. The RKS members have met four times in the last year. Some of the key decisions taken by the RKS members are construction of a public toilet in the PHC, procurement of furniture for OPD waiting area, painting of PHC walls, arrangements for material for Public display, water arrangement for patients and purchase of Sterilizer.
- The members are aware of the RKS guidelines. The members have got an orientation from the accounts manager. They do have a copy of the RKS guidelines; it is present with the Accounts manager.
- The Accounts manager got a 3 days training on RKS; in the month of July 2010 at Shillong. According to the Accounts manager the main function of the RKS is to look after the welfare of the people and strengthening of the PHC.
- The key sources of funds available with the RKS are the RKS fund coming from government and other funds coming from public donations and philanthropists. They are receiving the funds regularly. The heads under which the expenditures are booked are; infrastructure, medical supplies, assets, stationery and water. There is no internal audit happening at the PHC, an yearly external audit is done by the external auditors (CA from Shillong). Regular expenditure statements are prepared. There is a citizens' charter displayed at the entrance of the PHC.
- No grievance redressal mechanism is in place. If people have any complaint they go to Accountant. The accountant tries to solve the problem at his level by talking to the MO IC. If it cannot be handled at their level then they got to the head of the NGO or the DM&HO.
- For the purpose of Procurements, they call for quotations and the BDO takes a decision based on the quotations. No services are outsourced.
- A "108" ambulance is parked at the Leskin CHC, which can be used by the people in case of emergencies. No other facility is provided by the PHC.
- For key achievements of RKS refer to **Error! Reference source not found.**. In addition to that recently there was a computer and printer procured through the RKS funds. Moreover the

PHC with RKS has started a baby show on an annual basis where an award to the healthiest baby of the village. The award is called as “the Best Baby award”. This was started to promote nutrition in children.

- Availability of drugs is adequate, many times the PHC buys drugs from the RKS funds but patients don't have to pay from their pocket. Essential drugs are always available (no stock outs) and no clinical protocols are available at the PHC.

### **Women community members**

The study team went to a village near the PHC and with the help of the Accounts manager, gathered few women for the group discussion. A group of eight female members of the community dwelling in the same village where the PHC is located were gathered and a group discussion was initiated by the DCPC of Jaintia Hills District.

- A Village Health and Nutrition Day (VHNDs) held in the village once in every month, but there is no fixed date.
- In the VHNDs the services provided are, immunization, health talk, distribution of condoms and OCPs. Normally they actively participate in the VHNDs and there are no barriers for access to services. There is no fee charged for these services. Regular ANC is done for all pregnant women, all have received all 3 ANCs and it is accessible to all sections of community. Immunization services are available during all VHNDs and the cold chain is maintained properly. Proper records – ANC cards and Immunization cards – made. There are no problems faced by community in service delivery and response of facility team. Nutrition Counseling is provided in VHNDs. The PHC staff visits the VHND some times.
- The ASHA and ANM help them in birth planning, and planning for transport. Ambulance is not provided from the facility, they have to arrange for a private vehicle. ANM does both the ANC check ups and also conducts the deliveries (at home). The women are not aware of the status of facilities in hospital (bed, linen, diet, medicine, and other supplies). There are no charges levied for any facility and in any form. Women generally don't go for institutional deliveries but there are few women have gone for institutional delivery, but still there are more home deliveries happening in the village. Cases that finally end up in the health facilities are already complicated.
- There is improvement in the availability of drugs and services provided, but no one could specify areas of improvement. The hospital is open from 10 am in the morning till 4 pm in the evening. The doctor and staff are available round the clock. All other facilities (like beds, water, toilet and other basic facilities including cleanliness and diet) are now available after the NGO has taken over the PHC, earlier all these facilities were not available. The attitude of doctors and staff towards patients is good. The facility team has not made any efforts to

reach out to community in the area, at block level, at village level and there is no involvement of the RKS.

- The ASHA motivates the women in the village to deliver at the PHC. She also told them that they can get Rs 700 if they deliver at the PHC.

### **Men & Women Community Members from Marginalized Groups**

- A group of seven members from the community were present for the discussion at the house of the Village Headman of a nearby village. The group included 4 women and 3 men. The DCPC conducted the group discussion with the help of the Accounts manager.
- A Village Health and Nutrition Day (VHNDs) held in the village once in every month, but there is no fixed date. The women get the information from AWW or their own children. People feel that there should be a fixed date so that they cannot miss the VHND. The ASHA personally goes and provides the information to the weaker sections and far-flung hamlets. The villagers have no problems with the timing of VHNDs. On VHN day the health workers give a health talk, administer vaccines, distribute medicines and vitamins, collect blood slides and provide ANC. All the BPL families in the village participate in the VHND as it is conducted in a place which is accessible to all. On an average there are around 30 people attending the VHND. No fee is charged for these services. According to the group members regular ANC is done for all pregnant women, they all receive all 3 ANCs and it is accessible to all sections of community. There are no differences in access of services by marginalized sections during VHND. Yes, immunization services are available during all VHNDs, the cold chain is maintained properly, the boxes have proper ice linings and fresh vials are opened before injecting the vaccine. People said that proper records – ANC cards and Immunization cards - made and stored.
- The ASHA and ANM help them in birth planning as well as arranging and transporting the patient to the hospital in case of emergency. The people feel that a lady is safe if she delivers in the hospital. She is not scared because even if there is a problem there is doctor to take care and all medicines are available. But at home if she is late in delivering the kid then she is in danger and not safe also. Help is provided immediately and transport is also provided. The hospital staff also treats them nicely.
- There is improvement in the availability of drugs and services provided, earlier when the PHC was run by the government there was no doctor available all the time. Staff at the PHC was not sufficient. Medicines were not available at but no one could specify areas of improvement. The hospital is open from 10 am in the morning till 4 pm in the evening. The doctor and staff are available round the clock. All other facilities (like beds, water, toilet and other basic facilities including cleanliness and diet) are now available after the NGO has taken over the PHC, earlier all these facilities were not available. The attitude of doctors and staff towards patients is very good.

## VHSCs

- A VHSC member was interviewed for understanding the functional status of the VHSC. The lady interviewed was a teacher in the local school. She told the team that the committee comprises of 14 members out of which 10 are females. Generally the attendance for VHSC is low. In the last meeting the attendance was only 40 percent. The main activities of the VHSC in the village are cleaning the village, use of dust bins, waste management in the village and safe drinking water for the community. The major item of expenditure was construction of public toilet (which will open soon) in the village. The ASHA is the secretary of the VHSC, she maintains both the minutes of the meetings and the accounts of the VHSC. She also provides directions to on committee about what should be done and should not be done. The main role of ASHA according to her is to take pregnant women and small children to the PHC and make them understand the importance of good health.

### **Interview with Director Jaintia Hills Development Society (NGO)<sup>3</sup>**

- The Jaintia Hills Development Society (JHDS) is managing two PHCs Jaintia Hills District. JHDS is a Christian missionary NGO and director of the NGO is the Bishop. The NGO has been working in the health sector and it is running many dispensaries (equivalent to a Sub Centre) at different places in the district. It has dispensaries at Makintary, Namdeng, Laphet, Lungsnong and Mynhine. These are all managed by nurses and are located near PHC run by government.
- When asked about the source of human resources; the Director told that there are a lot of Doctors and paramedics getting trained in Manipur who don't have jobs in Manipur due to the high saturation level in the medical sector In the state. The NGO gets people from there and posts them in these PHC. They are happy to come to Meghalaya as they are getting a job in the first place and addition to that they are paid well as compared to their counterparts in their state.
- Talking about the recruitment procedure he told us that they advertise the post in the local news papers of Meghalaya and Manipur. In addition to that they do public announcements in the villages and announcement through the church. They have a interview committee which takes the final decision on appointment of an individual.
- The NGO is a registered trust and the money comes from the state government in to the account of the trust. They get a lump sum amount for managing the PHC. It is up to the NGO how and on what head it spends the money. He did not tell us how much amount is the total amount received. But he told us that the trust has its own internal financial audit and also an



external agency comes and audits the accounts annually. They have all the audit statements of the trust.

- Monitoring and supervision of the PHCs is done by the Program Coordinator, a special post created for the purpose of monitoring and supervision. In addition to that the Director frequently visits the PHCs and SCs managed by the NGO. Also they regularly are in touch with the ANMs. They also check the monthly review reports sent by the PHC as well as the SC.
- When asked about the payment issues of non clinical and paramedical staff, the Director told us that it not easy to bring the Medical doctors to work in such adverse conditions, for that they have to pay them high salaries, which in turn is compensated from the salaries of the other staff members. They are doing this because the funds that Government is providing are not sufficient to manage a PHC properly.
- When asked about the challenges faced while running the PHC and SCs, the Director told us that basic problem is inadequacy of funds. The amount given by the Government is not sufficient for the NGO. He also said that sometimes he has to spend money from the NGOs own revenue. Retention of staff is also very difficult. The NGO gave a bonus to their staff working in the PHCs and SCs last Christmas. They are giving different incentives to them just to retain the staff.

#### **vi. Facilities under Akhil Bhartiya Kisan kalyan Samiti (ABKKS)**

<b>S.No.</b>	<b>Name of facilities</b>	<b>District</b>	<b>Period of functioning</b>
1	Jaintia Hills Umkiang PHC	Jaintia Hills	June, 2009
2	Sonapur HSC		
3	Saipung PHC		
4	Saipung		

#### **1. Umkiang PHC**

This PHC is managed by Akhil Bharatiya Kisan Kalyan Samiti (ABKKS). ABKKS is a Delhi based NGO and is managing the PHCs in Jaintia Hills District. Umkiang PHC is one of them. It caters to a population of about 15000 people. The area where the PHC is located is a very remote area and shares the border with Bangladesh. According to the DAM; due to the remote location of this PHC,

doctors were not willing to stay in this area and hence the State Government decided to hand over the PHC to a NGO. ABKKS is managing this PHC since June 2009. The nearest referral hospital is located at Silchar, Assam (Silchar Medical College), 60 km away from the PHC.

**A. Physical Infrastructure:**

- The PHC building is owned by state government. The physical infrastructure required to run a PHC is present and the PHC is well equipped but poorly maintained.
- There are quarters available for all staff members but are not livable. The MO IC is therefore not staying in the quarter provided. The rest of the staff is somehow managing with the poorly maintained quarters because they cannot even rent a house as they have not received salary since they have joined the PHC.
- There is one ambulance parked at the PHC, which has been donated by a local NGO, but it is non functional due to lack of funds. People who can pay from their pocket for the fuel can use it. In case of some poor patients the PHC staff members contribute from their own pocket to transfer the patient to a higher facility. The condition of the approach road to the PHC is good. The overall condition of the PHC and the staff quarters is not good. There is a generator but there is no money to buy the Fuel. Hence there is no power backup<sup>4</sup>. 24hrs power backup and running water available. No information was displayed in the PHC except for few posters in the OPD chamber. Since the OPD is high patients have to wait for their turn to see the doctor. The PHC is well equipped for emergencies, but there are only 1 emergency drug available in the labor room (Inj. Lignocaine hydrochloride). In the Lab only Hb testing is done. Pharmacy, store and laundry are all fully functional. Number of IPD patients is not very high in the PHC and all facilities are available in the ward. No dietary services are provided. Bio medical waste management is not happening but care is taken while disposing needles and other sharp materials. A cement tank for disposal of bio medical waste has been constructed, but not in use.

**B. Human Resource & Training:**

- There are two medical officers (1 MBBS and 1 AYUSH). The MO in charge has been working in the same PHC since the PHC was handed over to ABKKS, while the MO AYUSH has recently joined (3 months back) the PHC. The MO IC is the only clinical staff member; who is working since the inception of the partnership. Rest of the clinical staff is not older than 6 months. The non clinical staff members are all local dwellers and have been working in the PHC since 2009. There is no accountant in the PHC and the MO IC is maintaining all the PHC accounts. All other vacancies are full, but the problem is that they don't stay back for more than 3-4 months. No staff member has received salary from last 3 months.

- The entire clinical staff is from Manipur. The MO AYUSH was promised a salary of Rs 28000 per month at the time of interview but after selection he was told that he'll be getting Rs 15000 in hand, which he hasn't received yet. The MO IC also was promised a salary of 35000 and house rent extra as the quarter was not in a good condition, but he gets a salary of Rs 32000 with no additional house rent.
- All the staff nurses and ANM have got training for malaria and SBA. The doctor has received several trainings in last two and a half years. MO AYUSH is a fresh graduate from the discipline of Homeopathy and has an experience of not more than a year. Earlier he used to work in a private hospital in Manipur. The MO AYUSH has not received any training after joining this PHC.

### ***MO Interview***

- The doctor is a resident of Manipur and has completed his MBBS in 1981. He has also done a post graduate diploma course in cardiology. He has an experience of 30 plus years. He has been working in the PHC since inception of the partnership with the NGO; 2 years and nine months. He stays in a rented house near the PHC.
- The MO IC has never visited a sub centre under his PHC as there is no vehicle for him for doing outreach activities and monitoring & supervision. He regularly attends the district level meeting held at Jowai, where he has many times raised the issue of improper management/ miss management by the ABKKS NGO. The PHC got its money only last year and not after that. There is no accounts officer hence no SOE or UC has been prepared for the last financial year, also the accounts were not audited by any external auditor.
- In the month of November (18<sup>th</sup> day) one maternal death has occurred in the PHC coverage area.

Though there are not many positive aspects of the job, there were few things that he wanted to share;

- Salary promised was quite high as compared to what he was getting earlier; because of which he came to Meghalaya from Manipur. This has been the main reason for continuing the job since last 2 years and 9 months.
- He also said that he has received a lot of trainings during service and has benefited personally and professionally.
- Working in rural area also has benefited him professionally.
- He has seen a lot of rare cases during his tenure at this PHC.

Talking about the challenges faced the MO said

- Lack of funds; working without money is really difficult.
- There is no facility for referral transportation or ambulance facility which makes it difficult to get all the emergency cases.

- Though the doctor is paid well, the other staff members are paid almost the half of what their NRHM counterparts are getting. Because of which there is a little discontent among the other staff members.
- There is no fencing to the PHC compound, due to which it is not very safe at night, to stay in the staff quarter. Many drunkards and anti social elements make the life of all staff members difficult.
- The MO IC is particularly not happy with the way the NGO is running the PHC. He also told that the Director of the ABKKS is corrupt. There are no proper facilities at the PHC, the staff has not received salary since last 3 months, including the MO IC. The NGO management did not stick to any of their promises. In addition to that there is a lack of funds in the PHC. Not all medicines are available always. People do not accept them as they are not local people.

### **C. Services Delivered**

- OPD, IPD and MCH care is provided to all patients coming to PHC. Activities happening under family planning are distribution of condoms and oral pill through outreach services. Use of IUDs and sterilization operations are not happening at the PHC. There is no functional referral transport facility available at the PHC, even though there is an ambulance available at the PHC. No lab tests are done in the PHC due to lack of funds to buy reagents. There is no X ray machine in the PHC

### **D. Performance of the PHC**

- On the basis of observation it can be said that the PHC is performing well. The good performance can be attributed only to the hard work that the staff at the PHC is doing and not to the management which is particularly not performing well

### **E. Community Processes**

#### **Patient Feedback**

- The feedback of OPD as well as IPD patients (only 1 IPD patient was present in the Hospital) was mixed. Overall patients are satisfied with the PHC services, as they don't have any other option for treatment in an episode of illness. The MO IC (being Manipuri) doesn't know the local language and works with the help of a lady health worker for communicating with the patients. Hence the patients have a complaint that there should be someone who knows their language for better communication between the two. This was also reported by the MO IC.

#### **RKS Members:**

- The RKS was constituted in the year 2010-11. Till now 3 RKS meetings have been held, out of which the last one was held on 19<sup>th</sup> January 2011. There is no internal and external monitoring

happening at the PHC. There is no display of citizens' charter or any public display material. No user fees are charged.

- Funds were received only once in last 2 years which were completely utilized. Right now there is no money with the PHC. The PHC is running with the help of donations given by the patients who come to the PHC. There is a donation box placed on the PHC MOs table, where a short message is displayed "Please donate for your hospital". It's voluntary and no one is forced to pay. The PHC MO also has a register where all the records of donations received are maintained. At present the PHC is having Rs 8000 (approximately) collected in the form of donation.

## **2. Sonapur SC**

The Sonapur SC is located on the highway leading to Umkiang PHC. The Sonapur SC is 20 km away from the PHC. There are eight villages under the sub centre and a population of around 3000 people. The population here is predominantly tribal population belonging to the Pnar tribe. The nearest village is 6 km away from the sub centre while to reach the farthest village it takes 1.5 hrs walking. There are no motor able roads to any of the villages under the sub centre, other than Sonapur village through which passes the National Highway. Only mode of transport is a sharing taxi to a point after which one has to walk for 1.5 hrs to reach the village.

### **A. Infrastructure, functionality and financing**

- The sub centre building is government owned. There is a quarter for the ANM and a Chowkidar.
- There is a sub centre committee constituted at the sub centre level, which has met five times in the year 2011. The ANM does not receive any funds from the PHC or from the district. There is no untied fund available for the sub centre. She only gets medicines from the PHC.
  - There is no cold chain equipment at the sub centre, but the ANM keeps all the vaccines and injections at a nearby shop on the highway, whose owner is known to her. Also there are frequent power cuts in that area.
- There is no examination couch at the sub centre. No delivery has been conducted in the SC; neither the ANM has attended home deliveries even though there are two ANMs posted at the sub centre.

### **Status and functionality of ASHA and VHND**

The study team could not conduct a group discussion with ASHAs as none of the ASHAs came to the PHC even after sending prior information about our visit. We were told that the ASHAs didn't turn up as it was a market day and most of the ASHAs have their shops in the weekly Bazaar, hence none of them came to the PHC.

### **Functioning of ANM:**

- The ANM of this sub centre is a resident of Assam. A relative of the ANM knew the director of ABKKS personally and recommended her name for the post of ANM Sonapur. The ANM didn't seem to be very interest in doling her work. She was not wearing her uniform in the duty hours. She was not

aware of any of the details of her sub centre, for example the population under the sub centre, regular OPD at the SC, etc. she also had no knowledge about the VHNC and VHNDs and her role and responsibilities during the VHND. The sub centre was not clean and all the files were having dust on it. She has no plan for outreach activities. When we asked to some nearby people about the ANM, people told that she doesn't behave properly and we generally avoid going to her for medicines. The ANM got her job on the basis of her personal contacts. There was no interview procedure executed by the ABKKS. The post had been advertised in the local news paper but there was no interview conducted for this post. She is working in the sub centre from last 2 years and 3 months.

- She neither performs deliveries at the sub centre nor performs home deliveries. She was present at the time of a delivery in the neighborhood about a year ago, that is the only time when she has gone for a delivery in last 2 years. No outreach activity is planned. She goes to the villages for immunization sessions according to the convenience of the AWW. The SC is open 24X7 as the ANM stays in the SC building. Though there are two ANMs posted at the SC, the SC is closed on the day of outreach activities. She attends all VHNDs in all the villages.
  - There is no supervision happening from the NGO side. She maintains 9 registers at her level and spends most of the time in filling up the details in the register and submits a monthly report to PHC MO IC. She is not aware of mother and child tracing system. She also has a complaint that the ASHAs are not cooperative and hence it is difficult for her to go to the villages for her outreach activities.

### **RKS members**

- FGD with the RKS members could all the RKS members were busy in the weekly bazaar which is one of the major economic activities of the village. But we discussed some issues with the village head man who on special request of the PHC MO came for some time to the PHC. Hence the issues were discussed with the village headman, PHC MO IC and Block programme manager.
- There are 10 members in the RKS, but the PHC staff is not adequately represented. The other groups from the society are adequately represented. There are two ex officio government staff members in the RKS. The RKS members have met twice in the last year. Some of the key decisions taken by the RKS members are construction of a disposal pit in the backyards of the PHC, launching a new Adolescent Clinic (which was disapproved by the DM&HO), procurement of suction machine, hub cutter (needle cutter), medicines, gloves, oxygen cylinder and refilling of the oxygen cylinder.
- The members are aware of the RKS guidelines. The members have got an orientation from the BPM. They do not have a copy of the RKS guidelines; it is present with the BPM.
- The BPM got a week long training on RKS; in the month of December (15<sup>th</sup> day) 2010. According to the BPM the main function of the RKS is to make the health facility patient friendly. Other than that it has to work towards filling the gaps in infrastructure and consumables which are left by the

government and NGO. Hence procuring this that are short in supply or not available at the PHC. Also coordinating with the district is an important function of the RKS. The key sources of funds available with the RKS are the RKS fund coming from government and other funds coming from donations from the local people. They are receiving the funds regularly. There is no internal or external audit happening at the PHC and hence no audit report has been produced at the PHC level. Also no expenditure reports are prepared as there is no accounts officer appointed at the PHC. There is no citizens charter displayed, as it is not being provided by the district, requisition for the same was sent 6 months back.

- No grievance redressal mechanism is in place. If people have any complaint they go to the head man. The head man tries to solve the problem at his level by talking to the MO IC.
- Procurement requiring expenditure below Rs 5000 does not need any approval. But where it is more than 5000 approval from the BDO is necessary. Medical equipments and other requirements are procured from the government supplier at the district head quarter, hence all the procurements are done without quotations. No services are outsourced.
- A local NGO has donated an ambulance to the PHC. People can make use of the service by paying for the cost of fuel from their own pocket.
- One of the key achievements of the RKS is procurement of generator for the PHC as there are frequent power cut offs in the area. But due to lack of funds they are not able to fill fuel in the generator. Other achievement is that they have been successful in providing better service to the people in the community by filling up the gaps in medicines and consumables at the PHC.
- Availability of drugs is inadequate, many times the PHC buys drugs from the RKS funds and sometimes the patients have to buy drugs from outside paying from their own pockets. Essential drugs are always available (no stock outs) and no clinical protocols are available at the PHC.

#### **Women community members**

- A group of eight female members of the community dwelling in the same village where the PHC is located were gathered and a group discussion was initiated by the DAM of Jaintia Hills District. In order to fulfill the criteria of geographic representation women who had brought their children to the PHC, residing in nearby villages were also included.
- A Village Health and Nutrition Day (VHNDs) held in the village once in every month but the date is not fixed. The ASHA informs them about the date personally. In the VHNDs the services provided are weight measurement, immunization, nutritional support and ANC/ PNC care. Normally they actively participate in the VHNDs and there are no barriers for access to services. There is no fee charged for these services. Regular ANC is done for all pregnant women, all have received all 3 ANCs and it is accessible to all sections of community. Immunization services are available during all VHNDs and the cold chain is maintained properly. Proper records – ANC cards and Immunization cards – made. There are no problems faced by community in service

delivery and response of facility team. Nutrition Counseling is provided in VHNDs. No one from the PHC has ever visited the VHND.

- The ASHA helps them in birth planning, and planning for transport. Ambulance is not provided from the facility, they have to arrange for a private vehicle which costs them around Rs 500 - 1500. ANM rarely comes to the village for delivery. The women are not aware of the status of facilities in hospital (bed, linen, diet, medicine, and other supplies). There are no charges levied for any facility and in any form. Women generally don't go for institutional deliveries but there are few women have gone for institutional delivery, but still there are more home deliveries happening in the village. Cases that finally end up in the health facilities are already complicated.
- There is improvement in the availability of drugs and services provided, but no one could specify areas of improvement. The hospital is open from 10 am in the morning till 4 pm in the evening. The doctor and staff are available round the clock. All other facilities (like beds, water, toilet and other basic facilities including cleanliness and diet) are now available after the NGO has taken over the PHC, earlier all these facilities were not available. The attitude of doctors and staff towards patients is good. The facility team has not made any effort to reach out to community in the area, at block level, at village level and there is good involvement of the RKS. Communicating with the MOIC is the only problem that we face at the PHC and hence it'll be good if someone who can speak our language comes and treats our kids and family members.
- The women did not know much about the VHSCs, what they knew was it has something to do with hygiene and sanitation and they have dust bins in their villages where they are supposed to throw all the garbage and other wastes.

#### **Men & Women Community Members from Marginalized Groups**

- A group of eight members from the community were present for the discussion at the Umkiang village. The group included 4 women and 4 men from the nearby village. The DAM conducted the group discussion with the help of the BPM (umkiang).
- Village Health and Nutrition Day (VHNDs) is held in the village. No fixed date for VHND activities. First week of every month VHND takes place in the village. The villagers have no problems with the timing of VHNDs. On VHN day the health workers give a health talk, administer vaccines, distribute medicines, collect blood slides and provide ANC. All the BPL families in the village participate in the VHND as it is conducted in a place which is accessible to all. No fee is charged for these services. According to the group members regular ANC is done for all pregnant women, they all receive all 3 ANCs, and it is accessible to all sections of community. There are no differences in access of services by marginalized sections during VHND. Yes, immunization services are available during all VHNDs; the cold chain is not maintained properly. People said that proper records are not maintained information about advantages of hygiene and sanitation. The PHC staff never visits the VHND.



- The ASHA and ANM help them in birth planning as well as arranging and transporting the patient to the hospital in case of emergency. The facility does not provide any support for transporting the patient. No deliveries take place at the PHC. All the facilities are satisfactory.
- There is improvement in the availability of drugs and services provided. The hospital is open from 10 am in the morning till 4 pm in the evening. The doctor and staff are available round the clock. All other facilities (like beds, water, toilet and other basic facilities including cleanliness and diet) are now available after the NGO has taken over the PHC, earlier all these facilities were not available. The attitude of doctors and staff towards patients is very good.

### **VHSCs**

- The village head man of the Umkiang village was interviewed to understand the functional status of the VHSC. The committee comprises of 5 members out of which 2 are females. Percentage of attendance in last four meetings has been almost complete. The main activities and items of expenditure of the VHSC in the village are cleaning the village, procurement of medicines, mosquito nets, stationery for school children and NREGA mid day meals, waste management in the village and storage of water. The ASHA is the secretary of the VHSC, she maintains both the minutes of the meetings and the accounts of the VHSC. She maintains the accounts, holds the bank pass book, prepares expenditure reports and puts forward the new agenda. There was no innovation initiated by the VHSC in the past.

### **Village head man – Umkiang village**

- The village head man raised few important issues that have to be looked upon:
- The present NGO is not performing well. A better NGO should be handed over the charge of this PHC. If it is not possible for the government to hand it over to some other NGO, it would be better if the government takes it back.
- The number of staff members at the PHC is not sufficient. There should be at least two medical doctors posted here (both MBBS). The current staff members are all native to Manipur and do not know the local language which makes it difficult for us to communicate with them.
- As there is no government doctor posted at the PHC, we are not getting birth certificates and medical certificates here. For this purpose we have to go to the Khliehriat CHC which is approximately 60 km away from our village. We have to spend more than Rs 300 per visit to the CHC and it takes more than 6 hours to come back home, because of which our daily wages are also lost. Hence there should be a Government doctor posted at the PHC.
- There are no JSY funds coming to PHC, hence our community members are not getting the JSY benefits which is injustice to our community. Some provision should be made to transfer these funds to the PHC.

### **3. Saipung PHC**

This PHC is managed by Akhil Bharatiya Kisan Kalyan Samiti (ABKKS). ABKKS is a Delhi based NGO and is managing two PHCs in Jaintia Hills District. Saipung PHC is one of them while Umkiang PHC is the other. It caters to a population of about 10000 people. The area where the PHC is located is a very remote area and is near to Bangladesh and Assam Border. According to the DAM; due to the remote location of this PHC, doctors were not willing to stay in this area and hence the State Government decided to hand over the PHC to a NGO. ABKKS is managing this PHC since June 2009. The nearest referral hospital is located at Sutunga CHC, 50 km away from the PHC.

#### **A. Infrastructure**

- The PHC building is owned by state government. There are quarters available for all staff members of the PHC including the Chowkidar. The labor room in the PHC is non functional. There is one ambulance in the PHC which is donated by a local NGO but it is non functional due to lack of funds. People who can pay from their pocket for the fuel can use it. In case of some poor patients the PHC staff members contribute from their own pocket to transfer the patient to a higher facility. The condition of the approach road to the PHC is really bad. The overall condition of the PHC and the staff quarters is good.
- There is a generator but there is no money to buy the Fuel. Hence there is no power backup. Also the generator is not working and not being repaired. 24hrs power backup and running water is not available. No information was displayed in the PHC except for few posters in the OPD chamber. There is no crowding at the registration desk. OPD is not much, people don't come to the PHC as no doctor is staying here for more than 3 months. In last one year 4 doctors have been changed. PHC is not equipped to handle emergencies. The labor room is non functional. Total IPD in a month is 2-3 patients. No dietary services are provided. Bio medical waste management is not happening but care is taken while disposing needles and other sharp materials.

#### **B. Human Resource & Training:**

- There is only one medical officer in the PHC. The MO IC is a AYUSH doctor and is working in the PHC since last 2 months. The previous MO also worked here for 2-3 months and then left the job. All the clinical staff members are new (not more than 6 months old). The non clinical staff members are all local dwellers and have been working in the PHC since 2009. There is no accountant in the PHC and no one is looking after the accounts. There are still vacancies in the PHC and staff members don't stay back for long. Staff members are not getting their salaries regularly. Attendance of clinical staff is a major problem. The MO AYUSH was on leave on the day of our visit. She went on leave 2 days back without informing any of the staff members at the PHC about her date of returning. All the nurses were on leave while the post of ANM PHC is vacant.

- The entire clinical staff is from Manipur. No staff member is getting salary as promised by the NGO. The details of trainings received by the clinical staff were not available. The MO has not yet gone for any training in last 2 months.

#### ***Health Educator Interview***

- The health educator told us that no staff member is staying back for more than 6 months at the PHC. They do not get payment regularly. In last on year 4 doctors have been changed. Only one nurse is here since last one year. The NGO has not adopted any definite procedure for recruitment of clinical/ paramedical staff. All the posts have been advertized in a local newspaper in Manipur. He also came for the interview to shilling where he was asked for a bribe of Rs 45000 for giving him the job. He got the job only after he paid Rs 45000 to the NGO people.
  - The proposed salary was 9000 – 15000 but he actually got only Rs 6000, which is very low as compared to the salaries of their NRHM counterparts. Even the MO IC is getting a salary of Rs 15000.
  - The daily OPD of the PHC is not more than 20-30 patients. In last six months no one from the NGO has visited the PHC. They have sent many complaints and requests for consumables and other requirements at the PHC but no one has ever responded.
  - He also told us that a PHC MO (appointed by the NGO) ran away with all the PHC funds, since then they have not received any fund, both, from the government and the NGO.

#### **C. Services Delivered**

- OPD and IPD services are provided at the PHC. Not all services under MCH are provided at the PHC. There is no delivery happening at the PHC, also PNC is not provided at the PHC. Activities happening under family planning are distribution of condoms and oral pill through outreach services. Use of IUDs and sterilization operations are not happening at the PHC. There is no functional referral transport facility available at the PHC, even though there is an ambulance available at the PHC. No lab tests are done in the PHC (except MP test, Vidal and urine for pregnancy test) due to lack of funds to buy reagents. There is no X ray machine in the PHC.

#### **D. Performance of the PHC**

- No data was available at the PHC for evaluating the performance of the PHC. But looking at the condition of staff and the mismanagement of the NGO, we can very well say that the performance of the PHC is not good.

#### **E. Community Perspectives:**

**RKS members:** No staff member is aware of RKS. There is no monitoring or supervision happening. There is no display of citizens' charter or any public display material. No user fees are charged. No grievance redressal mechanism in place.

No funds have been released till now as there is no MBBS doctor posted in the PHC.

#### **Patient Feedback**

The feedback of OPD patients was good. There was no IPD patient in the PHC. Overall patients are satisfied with the PHC services, as they don't have any other option for treatment in an episode of illness. The two women whose feedback (about the services provided at the PHC) was taken had come to the PHC for giving BCG vaccine to their kids. The kids were not vaccinated on that day as there were no syringes available at the PHC.

#### **4. Saipung SC**

On our way to the Saipung PHC we went to Turuk SC, which is a non functional sub centre. The SC was handed over to the NGO along with the PHC Saipung. There is no staff nurse and chowkidar appointed at the SC. When we went to the SC the door were open. We entered the SC and also saw the staff quarter, but no one was found around. We also talked to a local woman who was passing by the road near the SC. The woman told us that there is no ANM in the SC from last 3 months. Earlier there was a nurse (ANM), but she never used to come to the SC. The ANM of Shnongrim SC is a native of their village and she comes every Wednesday to the village for immunization. She has a 2.5 year old child and he is completely immunized. There is no health care facility near their village. The nearest health facility is Sutunga CHC. It takes one hour to reach the PHC by private vehicle (as there is no public transport available) and one has to spend at least Rs 100 for every visit. No doctor has ever visited their village and she is doesn't know who an ASHA is. According to her all the deliveries in her village have taken place at home, very few complicated cases have been taken to Sutunga CHC.

The Saipung SC is located in the Saipung PPHC. There are five villages under the sub centre and a population of around 2000 people. The population here is predominantly tribal and speaks Biate (a tribal language which is a mixture of Pnar and Mezo languages). The nearest village is 6 km away from the sub centre (20 min walk) while to reach the farthest village it takes 4 hrs walking. There are no motor able roads to any of the villages under the sub centre, other than Lura village, which also is cut off during rainy season. Only mode of transport is a sharing taxi to a point after which one has to walk for 2 hrs to reach the farthest village.

#### **Functioning of ANM**

The ANM of this sub centre is a resident of a nearby village. She got the job through a personal contact and no interview was conducted. She has been working at the SC from last 2.5 years. She

used to work in a private hospital as a nurse before joining the PHC. The ANM didn't seem to be very happy working in the SC. She did not have any knowledge about the VHNC and VHNDs and her role and responsibilities during the VHND. The sub centre was not clean and all the files were having dust on it. She has no plan for outreach activities. The ANM got her job on the basis of her personal contacts. There was no interview procedure executed by the ABKKS. The post had been advertised in the local news paper but there was no interview conducted for this post. She is working in the sub centre from last 2 years and 5 months.

She does not conduct deliveries at the sub centre, while she has conducted 3 home deliveries in last 2 years. No outreach activity is planned. She informs the headman whenever she has to go to a village, the headman informs the AWW and ASHA and then they gather the women at the school, where immunization session is conducted. There is a second ANM posted at the SC but she is on leave since June 2011. She has no knowledge about the VHSC and VHNDs. She does not receive any funds for the SC. There is no supervision happening from the NGO side.

She maintains 20 registers at her level and spends 1-2 hrs daily in filling up the details in the register and submits a monthly report to PHC MO IC. There was no PHC level meeting held since September 2011. She is aware of mother and child tracing system.

The ANM is happy due to the fact that the SC is near to her house and she can live with her family. But does not like working in the SC. She doesn't get regular salary and the payment is also less. No staff stays here for long. They do not get any training. The doctor doesn't support them. The doctors don't teach them anything. The OPD also is very less.

#### **A. Infrastructure, functionality and financing**

- The sub centre building is government owned (Saipung PHC). There is no quarter for the ANM.
- The ANM is not doing any deliveries at the SC nor going for any home deliveries. She has received only malaria training till now. The ANM was not aware of a sub centre committee and also not aware of VHSC. The ANM does not receive any funds from the PHC or from the district. There is no untied fund available for the sub centre. She only gets medicines from the PHC. The entire infrastructure at the PHC can be used by the SC ANM.
- The ANM had kept all her registers at home and hence we could not get the data for evaluating the performance of the SC.

#### **Status and functionality of ASHA and VHND**

The study team could not conduct a group discussion with ASHAs as none of the ASHAs came to the PHC even after sending prior information about our visit. We were told that the ASHAs didn't turn up as the villages are very far from the PHC.

## **RKS members**

On the day of visit the MO IC was on leave. There is no accounts officer appointed at the PHC. The only “would be” RKS member was the BPM who told us that there is no functional RKS at the PHC level.

## **Women community members**

- A group of six female members of the community dwelling in Lura village were gathered and a group discussion was initiated by the BPM of Sutunga Block. In order to fulfill the criteria of geographic representation women residing in nearby villages were also included.
- A Village Health and Nutrition Day (VHNDs) held in the village once in every month but the date is not fixed. It happens every first week of the month. In the VHNDs the services provided are immunization, nutritional support and ANC/ PNC care, blood slides are prepared and health talk is given by the ANM. Normally they actively participate in the VHNDs and there are no barriers for access to services. There is no fee charged for these services. Some of the women go for ANC while others don't go. Immunization services are available during all VHNDs and the cold chain is maintained properly. There is no immunization card provided to the women/ mother. There are problems faced by the women as there is no regular doctor at the PHC. Nutrition Counseling is provided by the ANM during VHNDs. No one from the PHC has ever visited the VHND.
- As there is no regular doctor at the PHC, no delivery is happening at the PHC. All the deliveries take place at home.
- Drugs are available at the PHC but sometimes there is a shortage of drugs. The hospital is open from 10 am in the morning till 1 pm. The OPD functions well only if the doctor is there. The paramedical staff is good.
- There is no benefit from ASHA to the community and no VHSC members come for the VHND.

## **Men & Women Community Members from Marginalized Groups**

- A group of seven members from the community were present for the discussion at the house of the village headman of Lura village. The group included 3 women and 4 men from the nearby village. The ASHA coordinator conducted the group discussion.
- Village Health and Nutrition Day (VHNDs) is held in the village. There is no fixed date for VHND activities. The information is announced with the help of a mike and loudspeaker. According to the villagers there is scarcity of staff, drugs and medicines at the PHC. No services are provided in the VHND. The weaker and marginalized people are not benefited through the VHND. The people feel that the Hospital services are good but the problem is that there is no transportation facility available and also financial problem as they cannot spend on transportation.
- According to the group members regular ANC is done for all pregnant women, they all receive all 3 ANCs and it is accessible to all sections of community. There are no differences in access of services by marginalized sections during VHND. No, immunization services are available during

all VHNDs; the cold chain is not maintained properly. People said that no proper records are kept. Explanation about the importance and advantages of cleanliness, malaria, TB, Family Planning etc. no one visits the VHND.

- The ASHA and ANM help them in birth planning as well as arranging and transporting the patient to the hospital in case of emergency. The facility does not provide any support for transporting the patient. Quick service is given by the staff who is present at the PHC at that moment. No delivery is conducted at the PHC. There is no discrimination and everyone is treated equally. The other facilities available at the PHC are not good. No charges are levied and hence no concessions are provided.
- In the earlier days when the government used to run this PHC, it was not in a good shape, there was no staff there was no doctor. After the NGO has taken over, the PHC is functioning little better than before.
- The attitude of doctors and staff towards patients is very good and equal for everyone. No efforts have been made by the PHC staff to reach the community.
- The villagers do not feel that the ASHA is of any use for them and they have not been benefited by any of the activities of ASHA.

#### **VHSCs**

- The village head man of the Lura village was interviewed to understand the functional status of the VHSC. The committee comprises of 5 members out of which 1 is a female. Percentage of attendance in last two meetings (as only two meetings were held in last 1 year) was 100 per cent. The main activity and items of expenditure of the VHSC is cleaning of the village and preparation of food for the members attending the meeting. Also all the villagers were provided after the meeting (both the times). In addition to this there was board with the name of the village was prepared with the available funds. ASHA is the secretary of the VHSC, she maintains both the minutes of the meetings and the accounts of the VHSC. There is no planning done and there was no innovation initiated by the VHSC in the past.

#### **vii. Facilities under Bakdil:**

<b>Sr. No.</b>	<b>Name of facilities</b>	<b>District</b>	<b>Period of functioning</b>
1.	Salampara PHC	West Garo Hills	5 <sup>th</sup> March, 2009
2.	Babadam PHC		
3.	Anangpara HSC		
4.	Gabil PHC	East Garo Hills	
5.	Wageasi PHC	South Garo Hills	
6.	Siju PHC		

## 1. Salampara PHC

Salampara PHC is located in the hilly region of West Garo Hills district which is about 66 km away from Tura. The management of the PHC was transferred to Bakdil on 5<sup>th</sup> March 2009. It covers 21 villages with population of 4173. It has no transportation facilities. The PHC caters to 2 Sub centers covering 26 villages and is a 24x7 facility. The PHC was not functioning well due to acute shortage of water and terrain.

### A. Infrastructure & Equipment:

- The building is owned by Government and it is well maintained and clean. The building is good however in raining season sometimes are leakages and seepages. There was a boundary wall for demarcation. It is a 10 bedded PHC with availability of basic amenities like potable drinking water and proper seating arrangement in the OPD waiting area. There is 1 labour room with labour table. Staff quarters are available in the campus.
- Signages are available at the facility. The Citizen charter, IEC materials were properly displayed in appropriate places. There was no water facility in the facility. The staff has to fetch the water from the streams and store it in a big tank. The generator is available for power backup.
- Segregation and disposal of biomedical waste is not done as per the guidelines. Biomedical waste Management bins were available at the point of generation. 100 essential medicines are available in the Facility.
- The pharmacy is very well maintained with adequate racks for storage of the drugs. The racks are labeled and essential drug list with the available drugs is displayed. Emergency tray was also available. Sterilization of equipment's is done by autoclaving. There is one room designated for laboratory. No separate space for collection of samples.

### B. Human Resources & Training:

- The Medical officer was earlier working as a government medical officer in Nagaland. There are 3 staff nurses and 4 ANMs working in PHC. No training has been provided to any of the staff.
- 21 ASHAS were there but only 20 ASHAS are registered. District is not allowing registration of beyond 20 ASHAS. Sister in charge (Staff Nurse) is responsible for all the management and release of funds and is the signatory authority for RKS funds. As they have the residential facilities in the campus itself, so in case of any emergency staffs are available. There are 4 staff quarters 1 each for sister, doctors, technicians and ANMS.

### C. Service Delivery:



- OPD, IPD, ANC, PNC, Immunization are the services provided at the facility. OPD timings are 9-4 p.m. The number of OPD patient increase on market day i.e. thursday.
- Total 25- 30 patients on an average are treated in a month. No printed form is used.
- Family planning is not promoted from NGO. The NGO is a Christian Missionary NGO which does not promote family planning due to some religious aspects. Due to this reason, the staffs are not promoting family planning, instead of that they are referring the people to other facilities for family planning services.
- There is no provision for X-ray. The lab technician for RNTCP was doing Hb, Urine, sputum tests and malaria slides. The laundry services are in house. There is no provision of gas for cooking. Only 1 kind of diet is given to patient i.e. dal, & rice twice a day. There are no security personnel. One of the grade IV staff stays along with one ANM in the campus during night.

#### **D. Community Perspective**

- **Rogi Kalyan Samiti:** The meetings for RKS is conducted quarterly with members including village heads (panchayat head), Village representative (Teacher or any qualified person), one NGO representative, Accounts officer, ASHA, including Medical officer and Sister in charge. Sister in charge is the signatory authority for utilization of fund. The people are much aware about the RKS fund utilization but are not clear about the RKS guidelines.
- The decisions taken by the people from the community are taken into consideration for the betterment of the health care delivery at that facility and community level. Maintenance grants are also been utilized. The main expenditure is done for the purchase of generators, fitting of water pumps and there maintenance, inverters and syntax water storage.
- The only problem the people were facing was the flow of funds. For the current year it has been released in the month of September 2011. They were not able to prepare themselves for spending such a huge amount of money within a short of time. Out of which nearly Rs19000 have been utilized for buying laptop being directed by DH&HO of West Garo hills for RSBY transactions. The maintenance and united funds for 2011 is not released yet. They pay JSY Beneficiaries cash through RKS Funds.
- **ASHA and VHND:** ASHA Meeting is done every month. On an average 25 ASHA's take part in the monthly meeting. All the ASHA's are selected by the headmen and women in the village. On an average they cover a population of 130 people per village. Total 26 villages come under this Primary health center.
- All the ASHAS were provided by ASHA Drug kit and it is refilled when they visit to the Primary Health Centre. All the ASHAs are trained till Module 6.

- ASHA's were aware of their roles and responsibilities. When asked about the details they said they visit houses, maintain register, educate local villages regarding pregnancy, what should they eat during pregnancy, motivate the villages to go for institutional deliveries.
- They act as DOTS provider for tuberculosis, conduct VHND etc. They provide injections give tablets in case of fever, collect samples and carry them to the PHC for Malaria Test, comes along with the pregnant mother for institutional deliveries, motivate mother for breastfeeding.
- All total there are 26 villages and 26 VHSC are there. VHSC meetings are held twice or thrice in a year. Records are kept with ASHA.
- We could not visit the village to check the sanitation because villages are far from PHC. VHND are carried out every Thursday of the month. Along with ASHA, AWW also helps to collate the data. AWW helps in delivery also.
- Immunization status has increases from 195 in the year 2008 to 611 till March 2010.
- They get take home rations like suji, chana, biscuit etc. For young children's, pregnant mothers and lactating mothers. They were aware what services are given in the antenatal checkup- like IFA Tablets, TT injections, weighing etc.
- The group was women were supporting ASHA and their work. They all were satisfied with the services provided by the ASHA and Primary Health Centre. They get all medicines and they do not have to pay anything for the services. They get all the services free of cost.
- When asked about the comparison on the services delivered by the Government team and NGO team, they responded that all services they are getting is good. They said that they were not getting any of the basic treatment facilities which they are able to get now after being managed by the NGO. They said that earlier monthly once or twice the doctor and nurse use to come but now whenever they need health services they can come anytime. They are all happy with the response from all staffs of PHC.

## 2. Anagapara Sub center

Anagapara Sub center is 6 km away from the PHC and is located in a Government building. The center has 1 room with a partition used as a labor room. One room is allocated to ANM for her accomodation. Deliveries are conducted at the center and 2 deliveries were conducted in 2011. The center is receiving Rs.10000 as untied fund and Rs.20000 as AMG which they have utilized. The concerned PHC sister in charge and the panchayat head (NONGMA) are co-signatory of the account.

### A. Performance Indicator:

The performance indicators for the year 2009-10 and 2010-11 are given in table below:

**Table 31: Performance indicators based on Services provided**

Sr. No	Year	2009-2010	2010-11
1.	Out patient	8593	12522
2.	In patient	280	425
3.	Institutional Delivery	49	55
4.	Child immunization- 9 -11 months	55	117
5.	Child immunization-12-15 months	180	20
6.	Number of times Ambulance used for patients	75	101

- In patient increase from 280 in 09-10 to 425 in 2010-11.
- Institutional delivery increased from 49 to 55 in 2010-11
- Reduction in the malaria related cases
- No male sterilization is done and only 2 patients adopted female sterilization in year 2010-11.

#### **Challenges for Bakdil NGO**

- The other issues which come out as challenge is the recruitment of the people for their facilities. As it's a Christianity based organization the people are being recruited internally from there Christian institutions without publishing it for the common people through advertisements in newspapers or on web site of government of Meghalaya. The Bakdil NGO believes that the people are so illiterate that they would not be able to find such a competitive staff for our facilities.
- Moreover the ANMs being recruited by this NGO are moving to the other government facilities due to which sometimes it becomes a shortage for staff availability.

### **3. Babadam PHC**

Babadam PHC is situated in West Hills district. It is about 33 km away from Tura District Headquarter. The PHC was handed over to Bakdil on 19<sup>th</sup> February 2009 and caters to 47 villages and 3 HSC. The PHC is located in a hilly region with no transportation facilities. This PHC covers 513 households in 22 villages and caters approximately 3029 of population. Due to the lack of communication facilities they are having problems for the referral of the patients and the road condition is pathetic.

#### **A. Physical Infrastructure:**

- The building is owned by government. Infrastructure of the building is good however in raining season sometimes are leakages and seepages. Boundary Wall is done. There is no water logging inside the campus. It is a 10 bedded PHC. There is proper drainage system and availability of signages at the facility. Overall cleaning of the facility was good and clean bed sheet were available on all 10 beds. Citizen charter was displayed at the entrance of the hospital.
- All the services are provided free of cost, except the registration charges of Rs 2. They have extended the building and made a separate labor room with two beds and new born corner with two incubators. Fire extinguishers and trained personnel were available.

#### **B. Service Delivery**

- Overall cleaning of the facility was good, but there is lack of awareness regarding the segregation and disposal of biomedical waste. The biomedical waste Management bins were available at the point of generation. IV bottles and sets were sold to the local villages. Hospital personnel are not aware of the BMWM rules. The OPD timings are from 9 am to 2 pm and the OPD load is less on all days except for once in a week; on market day.
- 1 ambulance is available for the PHC. The hospital charges Rs 10 per km for dropping the patients.

#### **C. Human Resources**

- Adequate human resources are available at the PHC. The M.O is a retired person from the GoM and currently working for the NGO for past 2 years and has established good rapport with the community. He has not received any training for skill up gradation in the past one year and visits the facilities once in a month. The sister in charge is held responsible for all the administrative work and attends meetings at district level.
- There is 1 AYUSH M.O who practices allopathic medicine since AYUSH drugs are not made available at the facilities.
- There are 3 staff nurses and 4 ANMs recruited from Christian Missionary schools. The Sister in charge (Staff Nurse) is held responsible for fund management. She is also the signatory for release of RKS fund in which medical officer does not play any role.
- No training has been provided to Staff nurses and doctors from the side of government of Meghalaya.
- As they have the resident facilities in the campus itself, the staff's availability in case of emergency is crucial for managing emergency cases and saving lives. There are 4 staff quarters for sister, doctors, technicians and ANMS.

#### **D. Performance**

- The OPD patients increase from 5745 in 09-10 to 8264 in 2010-11.
- In patient decrease from 521 in 09-10 to 453 in 2010-11.
- Institutional delivery increased from 86 to 132 in 2010-11
- The PHC is also working efficiently with no maternal deaths for the past one year and 90% of the cases are with malaria and fungal infection. The people are being provided with mosquito nets but when they go to the fields for zoom cultivation they have to go to the forests where they get infected.

#### **E. Community Perception**

- ASHA Meeting is held every month. On an average 25 ASHA's took part in the focus group discussion. All the ASHA's are selected by their village headmen and women. On an average they cover a population of 166 people per village. All the ASHAS were provided with ASHA drug kit and got refilled at the PHC. ASHA are aware about their roles and responsibilities and provide outreach services and are trained till Module 6. They are the key member in VHSC. VHSC fund is utilized in buying stretcher, BP apparatus and weighing scale etc. For a total 47 villages; there are 46 VHSC. The VHSC meetings are held once a year. Records are kept with ASHA. We could visit the village to check the sanitation because of the distances

#### **Rogi Kalyan Samiti**

- The meetings for RKS is conducted quarterly with members including village heads (panchayat head), village representative (teacher or any qualified person), 1 NGO representative, Accounts officer, ASHA including MO and Sister in charge. The people are much aware about the RKS fund utilization but are not clear about the RKS guidelines.
- The decisions taken by the people from the community are taken into consideration for the betterment of the health care delivery at that facility and community level. AMG is also utilized and expenditure is done in construction of new labour room, installation of CCTV and Intercom facility.
- Timely release of fund is cited as one of the key issues faced by the facility/community. In 2011; RKS fund, untied and maintenance fund were not received. The other major issue for the sister in charge (staff nurse) is that for the funds utilization of PHCs they have their bank accounts nearly 35 km away for which they have to travel nearly 1 hour and 30 minutes for any transactions and have to spend nearly Rs 600 for the each visit. The JSY payment for beneficiaries is made out of the RKS funds.

#### **4. Gabil PHC**

Gabil PHC is situated in East Garo Hills district and is about 66 km away from Tura. The PHC was handed over to Bakdil on 14<sup>th</sup> February 2009. It caters to a population of 4173 in 21 villages. There is no Sub Centre for the PHC. The condition of the roads is poor with no motorable road. The PHC is located at the end of the hill top with forests surrounding it.

**A. Physical Infrastructure:**

- The PHC is located in government building which is not in a good condition and maintenance is poor. Signages were present. All the services are provided free of cost, except the registration charges which is Rs 2.
- There is display of IEC material in the hospital. Water facility is not available in the facility. The staff has to fetch the water from the streams and store it in a big tank. Availability of generator was also an additive feature for power back up. 100 medicines are available in the facility. There are 4 staff quarters 1 each for sister, doctors, technicians and ANMS.
- There is lack of awareness regarding the segregation and disposal of biomedical waste. The Biomedical waste Management bins were available at the source of generation.

**B. Human Resource & Training**

- All staffs are available at the PHC and the resident facilities in the campus itself, so in case of any emergency staffs are available. 21 ASHAS were there but only 20 ASHAS are registered. District is not allowing registration of beyond 20 ASHAS.
- No Training has been provided to the staff from both the sides (NGO and Govt.)

**C. Performance Indicator:**

The performance indicators for 2009-10 and 2010-11 are given in the table below:

**Table 32: Yearwise performance of the facility under Bakdil**

Year	2009-2010	2010-11
Out patient	8593	12522
In patient	280	425
Institutional Delivery	49	55
Child immunization- 9 -11 months	55	117
Child immunization-12-15 months	180	20
Number of times Ambulance used for patients	75	101

- OPD Patients increase from 8593 in 09-10 to 12522 in 2010-11.
- In patient increase from 280 in 09-10 to 425 in 2010-11.
- Institutional delivery increased from 49 to 55 in 2010-11
- Reduction in the malaria related cases
- No male sterilization is done and only 2 patients adopted female sterilization in year 2010-11.
- The overall tradition and culture of that place says that the villages do not like to visit the health care facilities. This may be the reason of low institutional delivery. Community members generally prefer to have a home delivery assisted by the Traditional Dai. ASHA , do not assist in home delivery

#### **D. Community Perception:**

A group of seven women were interviewed. Most of the group members were illiterate. It was found in the group that some of the women were least interested to visit the PHC.

- There are excess ASHAs for the villages covered by PHC and their involvement of ASHAs is also very low. All the women were aware of the VHND and they have good impressions about ASHA in terms of providing services. The villages get take home rations like suji, chana, matar etc for young children's pregnant mothers and lactating mothers. Those who visited the PHC responded that they get all medicines free of cost.
- As per the villagers some family denies to take immunization and this was reported by the hospital Staff to the district. The majority of the deliveries take place at home and the average size is 8-10 children and the schools are upto class V only.
- ASHA work efficiently in the area assigned to them in spite of the remoteness of the areas. Due to difficult geographical terrain; they are unable to made home visits on regular basis and conduct counseling for institutional deliveries etc though at times; their assistance is sought for making emergency referral services.
- Due to this remoteness the people from the farthest villages are travelling in group of 35 to 40 people, to get treatment for any patient to that facility and for that they have to start one day earlier from their village.

#### **Rogi Kalyan Samiti**

- The RKS members were aware of the total amount being utilized in different activities. They are taking interest in developing the facility by utilizing the RKS funds. RKS meetings are held on quarterly basis and most of the fund is utilized on computers, generators, admirals, and chairs for the OPD patients. None of the members are aware of the RKS guidelines and no orientation training has been provided by the GoM or NGO.

## 5. Siju PHC

Siju PHC is located in a hilly region in South Garo Hills district and is about 34 km away from Bagmara District Headquarter. The PHC was handed over to Bakdil on 27<sup>th</sup> February 2009. It caters to 29 villages. It has no transportation facilities and communication system. There is only 1 sub center under the PHC which is located far off without any roads and it is reachable by foot only which takes almost 5 hrs and 30 minutes. The SC is functioning well and conducts deliveries with good patient load. Due to inaccessibility reasons and time constraint; the team could not visit the sub center. The M.O of Siju PHC visits the sub center twice a month or at least once in a month for review of Sub center.

### A. Physical Infrastructure:

- The PHC itself is a 24x7 facility and runs in a government building. The condition of the building was not good. They have extended the building and made a separate labour room with two labour beds and new born baby corner with two baby incubator.
- Though the overall facility is clean and well maintained; there is lack of awareness regarding the segregation and disposal of biomedical waste. Biomedical waste Management bins were available at the source of generation. As a ritual the people in this region are following one of their religious acts in which after the delivery the placenta is been taken and buried in the courtyard of their homes.

### B. Human Resources & Training

- The Siju PHC has all the staffs in place. The M.O is MD in Gynaecology and diploma in Anaesthesia. The M.O has been working for the past 2 years and had established a rapport with the villagers. There is another AYUSH doctor who provides allopathic treatment to patients since AYUSH drugs were not made available at the facility. There are 3 staff nurses and 4 ANMs who were recruited from Christian Missionary schools.
- No training has been provided to Staff nurses and doctors from the side of government of Meghalaya.
- As they have the resident facilities in the campus itself, so in case of any emergency staffs are available. There are 4 staff quarters and there are 29 ASHA

### C. Performance Indicators:

The performance indicators for the year 2009-10 and 2010-11 are given below in the table:

**Table 33: Performance indicators based on services delivered**



<b>SIJU PRIMARY HEALTH CARE CENTRE</b>		
	2009-2010	2010-11
Out patient	7427	9785
In patient	490	585
Institutional Delivery	35	121
Child immunization- 9 -11 months	150	294
Child immunization-12-15 months	37	244
Number of times Ambulance used for patients	87	137

- OPD Patients increase from 7427 in 09-10 to 9785 in 2010-11.
- In patient increase from 490 in 09-10 to 585 in 2010-11.
- Institutional delivery increased from 35 to 121 in 2010-11

#### **D. Community Perception:**

##### **Rogi Kalyan Samiti:-**

- The meetings for RKS is conducted quarterly with members including village heads (panchayat head), village representative (teacher or any qualified person), 1 NGO representative, accounts officer, ASHA, including M.O and Sister in charge (as she is the signatory authority).
- The people are much aware about the RKS fund utilization but are not clear about the RKS guidelines. AMG are also been utilized. The main expenditure is done in the construction of the new labour room, installment of CCTV and Intercom facility.
- The only problem the people were facing was the flow of funds. For the current year they have not received any RKS, untied and maintenance fund. The total grants to be released for the current financial year is 175000 which include 100000 as RKS funds, 50000 as maintenance grants and 25000 as untied funds. Although there have been no orientation programmes for RKS fund utilization. Out of which nearly Rs19000 have been utilized for buying laptop being directed by DH&HO of West Garo hills for RSBY transactions. The maintenance and untied funds are till now not released.
- RKS fund was utilized in installing CCTV, purchase of Microscope and extension of the building with construction of the labour room with new born corner.

##### **Community Members**

- Two FGD's one with Women 6-7 women and one with both men and women of 6-7 people took participations. Most of the women were educated (till Class 5).
- All the women were aware of the VHND and aware of the services being provided during VHND. They get take home rations like suji, chana, biscut ect for young children's, pregnant mothers and lactating mothers. VHND is held in the evening and the ASHAs and tANM stays

in the village that night. Since all the villages are so far, VHND is mostly held at night or next day morning. ASHAS teach songs to children. They were aware about the services given in the antenatal checkup- like IFA Tablets, TT injections, weighing etc.

- The group was women were supporting ASHA. They all were satisfied with the services provided by the ASHA and PHC. They get all medicines and they do not have to pay anything for the services. They get all the services free of cost.
- When asked about the comparison on the services delivered by the Government team and NGO team, they responded that they are getting regular and better services for the past 2 years as compared to previous years. They said that earlier on monthly once or twice the doctor and nurse use to come but now whenever they need health services they can come anytime. They are all happy with the services from doctors, nurses, and the staff of primary health center. All the villages have the VHSC and 40% are the women members. The main expenditure of VHSC fund is on patient transportation, purchase of furniture etc

### **ASHAs and VHND**

ASHA Meeting is done every month. On an average 25 ASHA's take part of it. All the ASHA's are selected by their village headmen and women. On an average they cover a population of 130 people per village. When asked about the details they said they visit houses, maintain register, educate local villages regarding pregnancy, what should they eat during pregnancy, motivate the villages to go for institutional deliveries.

- They provide injections give tablets in case of fever, collect samples and carry them to the PHC for Malaria Test, comes along with the pregnant mother for institutional deliveries, motivate mother for breastfeeding. There are 29 ASHA for 29 villages and VHSC meetings are held twice or thrice in a year. Records are kept with ASHA. VHND are carried out every thursday of the month. Along with ASHA, AWW also helps to collate the data and she is also a part of VHND. AWW helps in delivery also.

## **6. Wageasi PHC**

Wageasi PHC is situated in East Garo Hills district. It is about 150 km away from Tura. The PHC was handed over to Bakdil on 17<sup>th</sup> February 2009. It caters to a population of 10800 covering 51 villages. There are 3 HSC under the PHC; one of which 1 sub Centre i.e. Lower Sambrak was visited. The condition of the roads is good. There is motorable road.

### **A. Physical Infrastructure**

- It runs in a good government own building with proper signages. It is a 10 bedded PHC with availability of potable water and power back up.

- There is display of IEC material in the hospital. Water facility is not available in the facility.
- Sterilization of instruments is done by autoclave machine. Calibration is not done since 2009. Pressure gauge of auto clave is nonfunctional. There is no check on quality of sterilization
- 100 medicines are available in the facility All the services are provided free of cost, except the registration charges which is Rs 2.
- Food is prepared in the chula “A traditional Method of cooking the food”. There is no LPG Gas available for cooking food for patient. Only one diet is provided to patient i.e dal and rice, twice a day. There is separate space for patient’s attendant, who wants to cook the food for themselves.
- Lack of awareness of Biomedical Waste management. The plastic waste materials got burnt in backyards and placenta are also buried in the backyard of the PHC.

#### B. Human Resource & Trainings:

**Table 34: Manpower Listing as follows:-**

Sr. No	Category of Staff	No of Post( As per MoU)	Staff Presence
1	Medical Officer	2	1
2	Accountant Cum Clerk	1	1
3	Pharmacist	1	1
4	Staff Nurse	3	3
5	Health Educator	1	
6	Lab Technicians	1	1
7	Health Assistants( M/F)	2	2
8	Driver	1/ Optional/ May be outsourced	1
9	Group D( Grade -IV)( Including Sanitary Assistant)	4	4
10	ANM		2
	Total	16	16

All the staff are available at the facility as per the MoU.

#### C. Performance Indicator

The performance indicators for the year 2009-10 and 2010-11 are given in the table below:

**Table 35: Performance indicators based on services delivered**

Year	2009-2010	2010-11
Out patient	15645	16065
In patient	485	612
Institutional Delivery	63	89

Child immunization- 9 -11 months	183	283
Child immunization-12-15 months	171	10
Number of times Ambulance used for patients	86	103

- OPD Patients increase from 15645 in 09-10 to 16065 in 2010-11.
- In patient increase from 485 in 09-10 to 615 in 2010-11.
- Institutional delivery increased from 63 to 89 in 2010-11
- Reduction in the malaria related cases No male sterilization is done and only 2 patients adopted female sterilization in year 2010-11.
- They display the performance indicator for the hospital in the Notice board. JSY beneficiaries name is also displayed for that particular month.

### C. Community Participation:

- 6 ASHAs were interacted. Each ASHA visit PHC for medicine every week. The farthest village is 22 km. Every ASHA have the bank account. All the ASHAs are trained till Module 6. Though VHSC is functioning in all villages, the release, transfer and use of untied fund is the key constraints faced. The VHSC fund for 2011 was not received till end of year.

### i) Lists of Annexures:

#### Annexure 1: Details of the Teams and Facilities Visited

SI.No.	NHSRC Member	RRC-NES Member	Name of District		Name of Facilities
1	Ms Jhimly Baruah (Team Leader)	Ms Shilpa John Consultant PH	East Khasi Hills	1	Jatah PHC
				2	Dangar PHC
				3	Mawsahew PHC
				4	Mawlong PHC
				5	Ichamati CHC
2	Mr Arun Srivastava	Dr S Basumatary Consultant PH	West Khasi Hills	1	Aradonga PHC
				2	Nongkhlaw CHC
				3	Kynrud PHC
				4	Maweit PHC
				5	Myriaw PHC
3	Mr Tushar Mokashi	Mr D Sarma Consultant CM	Jaintia Hills	1	Barato PHC
				2	Sahnsiang PHC
				3	Umkiang PHC
				4	Saipung PHC

4	Dr Roli Srivastava	Ms Asha Kumari Consultant PH (HA)	Ri Bhoi	1	Umtra PHC
				2	Jirang Dispensary
				3	Warmawsaw PHC
5	Mr Prankul Goel	Mr A S Augastine State Facilitator	East Garo Hill	1	Wageasi PHC
				2	Gabil PHC
6	Ms Nidhi Jain		West Garo Hills	3	Salmanpara PHC
				4	Babadam PHC
			South Garo Hills	5	Siju PHC

**Annexure 2: Check list of services to be provided by the PHCs according to the MoU**

SERVICES		JHDS		ABKKS	
		BAROTO	SHASNIANG	UMKIANG	SAIPUNG
<b>24 hrs emergency/ casualty services</b>		√	√	√	X
<b>OPD Services</b>					
- 6 days/ week		√	√	√	√
- 10 am – 4 pm		√	√	√	
<b>10 IP beds</b>		√	X (7)	X (8)	X (4)
<b>24 hrs labor room</b>		√	√	√	X
<b>Emergency obstetric services</b>		√	√	√	X
<b>Minor OT</b>		√	√	√	X
<b>24 hrs Ambulance</b>		X	X	X	X
<b>User fees</b>		X	X	X	X
Financial Statement					
- UC		√	√	X	X
- SOE		√	√	X	X
<b>Manpower</b>	<b>PPP Norm</b>				
Medical Officer	2	2	2	2	1
Accountant cum Clerk	1	2	1	0	0
Pharmacist	1	1	1	1	1
Staff Nurse	3	3	3	2	1
Health Educator	1	0	0	0	1
Lab Tech	1	1	1	1	1
Health Assistant (M/F)	2	0	2	2	2
Driver	1	1	1	1	1
Group D	4	2	2	2	4
<b>Total</b>	<b>16</b>	<b>12</b>	<b>13</b>	<b>11</b>	<b>12</b>