A Final Report

Evaluation of National Rural Health Mission (NRHM) in Meghalaya

Sponsored by

Directorate of Programme Implementation and Evaluation
Government of Meghalaya

Prepared by

AMC

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ACKNOWLEDGEMENT

We express our gratitude to the Directorate of Programme Implementation & Evaluation; Government of Meghalaya for entrusting the study entitled "Evaluation of National Rural Health Mission" to AMC Research Group, New Delhi.

We are grateful to NRHM, Meghalaya and their team for the complete support offered to our representative during the study.

In particular, we are grateful to Brig. Dr. K.S.Bhatnagar & Dr. Miss. Nayanmoni Pamega for their continued guidance and support through out the study.

Our thanks are also due to the concerned respondents whom we have interviewed and the field investigators for working as per a tight schedule and completing the study on time.

Maj. Gen A M Chatuvredi
Director

LIST OF ABBREVIATION

AMO – Assistant Medical Officer

ANC – Ante Natal Care

ANM – Auxiliary Nurse Midwife

APL – Above Poverty Line

ASHA – Accredited Social Health Activist

AWC – Anganwadi Centre

AYUSH – Ayurveda, Yoga, Unani, Siddha & Homeopathy

BPMU – Block Program Management Unit

BDO – Block Development Officer

BHE – Block Health Educator

BPL – Below Poverty Line

CHC – Community Health Centre

CMO – Chief Medical Officer

CH – Civil Hospital

DC – Deputy Commissioner

DMHO – District Medical and Health Officer

DOTS – Directly observed Treatment Strategy

DPMU – District Programme Management Unit

EDD – Expected Date of Delivery

FRU – First Referral Unit

HMIS – Health Management Information System

IFA – Iron & Folic Acid

IMR – Infant Mortality Rate

IPD – In Patient Department

IPHS – Indian Public Health Standards

JSY – Janani Suraksha Yojana

LHV – Lady Health Visitor

LT – Laboratory Technician

MCH – Maternal and Child Health

MD – Mission Director

MO- Medical Officer

MoHFW – Ministry of Health and Family Welfare

MoU – Memorandum of Understanding

MPHW – Multi Purpose Health Worker

NGO- Non-Governmental Organization

NRHM – National Rural Health Mission

OPD – Out Patient Department

ORS – Oral Rehydration Solution

OT- Operation Theatre

PHC – Primary Health Centre

PHN – Public Health Nurse

PNC – Post Natal Care

PPP- Public Private Partnership

PWC – Patient Welfare Committee

RKS – Rogi Kalyan Samiti

ST- Scheduled Tribe

SC – Sub Centre

SN – Staff Nurse

SPMU- State Programme Management Unit

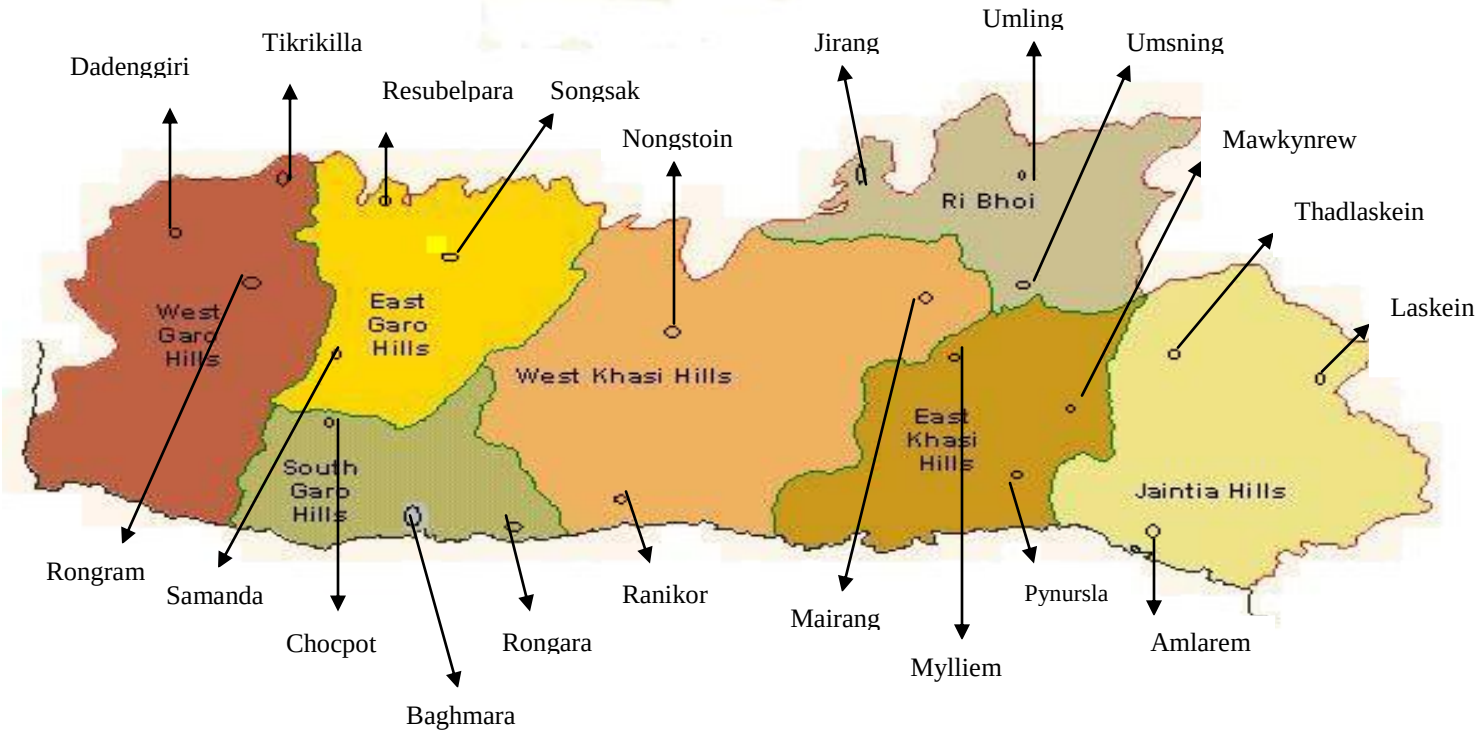
TBA – Traditional Birth Attendant

VH – Village Head

VHND – Village Health and Nutrition Day

VHSC – Village Health Sanitation Committee

Map indicating sampled blocks



Executive Summary

National Rural Health Mission (NRHM) is one of the pioneering initiatives to provide health care access through bringing in the various public health machineries under one umbrella. The local capacity building has been given central consideration through organizing various grass root training programes. However, when it comes to North Eastern states the quality health care remains a concern. In Meghalaya the rural health care system more or less lingers to be same and follow traditional practices. The health status of the state has not been improving in a steady pace. Still there is major shortage of specialized medical and para medical staff, infrastructure facilities, drugs etc. Health care is the constitutional right; therefore it should be more accessible to poor and needy. Though engagements are made at grass root level in form of ASHAs, ANM, VHSC etc. under the NRHM initiatives, it has not helped to address the health care issues in a substantial manner. In the grass root level, there has been lack of proper and effective planning, which has resulted in the slow progress of the programme in the state. The people residing in the border and remote villages are almost adopted to the traditional health care methods, due to non – availability of better health care facilities. The NRHM in the state have tremendous challenges to over come in the coming years.

The Directorate of Programme Implementation and Evaluation, Government of Meghalaya entrusted AMC Research Group, New Delhi to carry out an evaluation study on "National Rural Health Mission (NRHM)" in the state of Meghalaya to assess the impact of National Rural Health Mission (NRHM) initiatives in the intervention districts.

All the seven districts of Meghalaya were covered under the study. From each district minimum three blocks were selected for detailed survey and field visit. The survey was conducted during September-November 2010 using different category of schedules. Attempt was made to cover the beneficiaries for five years period i.e 2005-06, 2006-07, 2007-08, 2008-09, and 2009-10. Adequate care was taken by us to conduct the research within the internationally accepted standards, particularly those stipulated by the WHO/ICMR.

The following conclusions and recommendations are based on the field data analysis, and observation made by the field investigators during the course of study:

HEALTH COMPONENT

a) Community Health Centre (CHC)

- CHCs are generally required to deliver specialized health care services under NRHM. These facilities are to be equipped with suitable diagnostic and investigative facilities. Out of the total sampled CHCs more than 80% of CHCs are not equipped to deliver the intended specialized health care services. CHCs located in the border areas are having least infrastructure facilities. CHCs/PHCs run under public private partnership (PPP) is also having shortage of medical and para-medical staff.

- The posting of medical specialists in the CHCs has been a constant struggle for the state; this is due to shortage of specialists in the whole state.

- Around 50% of sampled CHCs have stated that they are not getting NRHM funds on time from district. The delay in getting the funds is due to the late approval of PIP from the Central Government. This needs to be addressed.

- All the CHCs were having registered RKS/PWC in place. The RKS meeting at each facility are supposed to be conducted once in a quarter, but in some facilities the availability of SDO/BDO as chairman is a constant struggle. As stated by the state health department now the things have improved and most of the SDO/BDO are giving more time to the RKS committees.

- At the CHCs there is no blood bank in place, the facilities are supposed to link-up with district hospitals for any requirements.

- There was shortage of medicine in all the CHCs due to irregular supply of medicines from the district. In most cases the medicines procured from districts are expired with in 3-4 months. In few CHCs there were expired medicines and injections kept in the pharmacy. While discussing the matter

with health officials, they stated that as of now there is no shortage and these are taken care off from the state and district authority.

- Initial steps have been taken by the officials for providing Bio-waste management training in all facilities and for construction of disposal pit with RKS funds.

- Most of the CHCs are having ambulances equipped with oxygen cylinders, stretcher, first aid kit etc.

- The doctors running private clinics in their quarters needs to be restricted from doing so.

b) Primary Health Centre (PHC)

- PHCs were having back-up system either generator or inverter system for smooth functioning of the facility. Majority of them have utilized RKS funds for said purchase.

- Due to the implementation of JSSK the state has started free diet, medicine and consumable especially for pregnant women ad sick children.

- At present majority of the PHC are with AYUSH doctors in place.

- All the sampled PHCs were having one general practitioner and one AYUSH doctor.

- Around 40% of PHCs have stated that there is delay in getting funds from district. This is due to the late approval of PIP from the Central Government.

- The RKS/PWC in PHCs is functioning as per the guidelines and are registered as a society. The meetings could not be held at regular quarter wise due to time constraint of BDOs as chairman.

- Institutional deliveries are picking up in most of the PHCs now, but community prefers to still follow the home delivery due to belief, custom and traditional practices. ASHA are trained actively for mobilizing the pregnant women for institutional delivery. While in the current year (2011-12) the trend of institutional deliveries in all the districts have improved.

c) Sub Centre (SC)

- All the sub centers which are having at least two deliveries per months are provided with two ANMs as per IPHS

- Around 54% of the sub centres are not having delivery tables, while only 60% of the sub centres were having electricity and water supply. For the state health department making sub centers delivery functional is a struggle in majority of the sub centers located at remote areas, due to difficult roads and non availability of electrical connection.

- The average number of villages covered by sub centre is around 7, while all the villages under these sub centres are having VHSC. While the state health department has taken initial steps to form VHSC in all the revenue villages within this year.

- Around 50% of ANM have stated that ASHAs meet them once in a month. The ASHA are trained from module 1 to 7 and in module 6 & 7 ASHA are specially trained on Home Based New Born Care (HBNC) provided with kits.

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- In every PHC and Blocks there are NRHM block and PHC accountants in place for monitoring the fund utilization and release of funds to the facilities.

- Around 62% of ANM conducts delivery at home, while 38% ANM conducts deliveries at sub centres. On an average in each sub centre area there are 305 traditional birth attendants. Mother who prefers to conduct delivery at

home is given choice, but they should be assisted by ANM, ASHA or trained traditional attendants.

d) Accredited Social Health Activist (ASHA)

- On an average 574 household population are served by ASHAs. In the selection of ASHAs involvement of doctors, VHSCs and AWWs is less than 10%.

- All of the ASHA interviewed had undergone training and were issued drug kit.

- During the last six months only 3.2% JSY cases have been facilitated by ASHA.

- The ASHA are trained from module 1 to 7 and in module 6 & 7 ASHA are specially trained on Home Based New Born Care (HBNC) provided with kits. They are also provided with incentives. The State Government has also launched ASHA benefit scheme.

- 72% of ASHAs have stated that they are facing difficulties in decision making with community leaders, while ASHA who have escorted pregnant women ad motivated couples to undergo sterilization are getting their incentives.

- Although, ASHA are not entitled for a fixed honorarium, but they are being given programme incentives, under a new incentive policy "ASHA benefit scheme".

- All the ASHAs interviewed were appointed from same village and were in the age group of 20-45 years. Most of the ANM complained about not getting the honorarium on time.

e) Rogi Kalyan Samiti / Patient Welfare Committee (RKS/PWC)

- All the sampled CHCs and PHCs RKS/PWC is formed and registered.

- In East Khasi Hills district RKS/PWC meetings are carried out quarterly, while in other remaining districts there is no uniformity due to the time constraint of SDO/BDO as chairman. Most of the RKS/PWC meetings are taking place in PHC and CHC itself.

- RKS/PWC main activities performed in all the districts were related to maintenance and renovation, buying equipments, provision of medicines. The activity like organizing health camps, private affiliation for upgrading health services, training of doctors and staff, availability of suggestion box for grievance redressal are not performed in any of the CHCs and PHCs.

- None of the RKS/PWC in CHCs and PHCs are raising funds additionally with donations and loans through various financial and donor agencies.

- Regular audit of RKS/PWC are in place at CHCs and PHCs.

- More than 50% of the RKS/PWC is not serious about RKS objectives.

- A total of 75 patients (both IPD and OPD) were interviewed, out of which only three patients were aware of RKS/PWC in the CHCs and PHCs.

f) Patients Satisfaction

- 98% of patients reported that the doctors behaviour towards them is good, while all the patients are fully satisfied with the behaviour of pharmacist and technical staff.

- Around 38% of patients have stated that nurse behaviour towards them was not good.

- All the doctors in CHCs and PHCs are adopting a friendly approach towards patients. This needs to be appreciated.

- Around 80% of patients have stated that the waiting area, dispensary room, dressing room and injection rooms are very clean, while 50% of the patients are not satisfied with the cleanliness in toilet and wards.

- 65% of the patients have stated that there is lack of seating arrangement for out patients in the health facilities.

- Around 67% of patients stated that they are not getting all medicines prescribed by doctors from pharmacy, while 64% of the patients have stated that they are getting the prescribed quantity. More than 95% of patients have stated that there are no specific medicines for animal bites in health facilities.

g) IMR, Birth and Death Rate

- As per the outcome of mission of Meghalaya, the IMR will be reduced to 30 by 2012. But in the present scenario, it seems a difficult task. In the year 2006-07 the IMR was 53, in 2007-08 it increased to 56. The present IMR (2008-09) is 58. Instead of declining it is getting increased in each year, which shows the measures taken is not effective in the grass root level. The death rate in each year is in between 7-8, while birth rate is between 24-25.

h) Institutional deliveries

- During the last four years there is tremendous fall in the institutional deliveries and rapid increase in home deliveries. According to MoHFW data on safe deliveries, Meghalaya has reported less than 45% safe deliveries. Women delivering in the health facilities is not staying for 48 hours for monitoring her recovery, it may also be due to lack of facilities. In all the sampled PHCs and CHCs most of the institutional deliveries are conducted by ANM.

i) Janani Suraksha Yojana (JSY)

- Moreover in all the districts more than 80% of the children have been immunized against important diseases. While in Garo Hills districts less than 50% of the beneficiaries received advice for PNC and family planning during pregnancy.

- 50% of the beneficiaries stated that there has been no contribution of VHSC in their village. Most the beneficiaries are not satisfied with the services rendered during VHND.

- Around 70% of the beneficiaries use private vehicles to reach ultimate place of delivery, while 80% of beneficiaries have stated that no body facilitated in arranging the transport.

j) Village Health Sanitation Committee (VHSC)

- All sampled villages under each sub centres were having VHSC, while their functioning is not effective.

- VHSC members are having differences between them in decision making.

- The Village Health Nutrition Day (VHND) is being held once in very month, while the involvement of community members is not much encouraging during the VHND.

k) Maternal Health

- Fertility in state is higher than in all other states in India, except Bihar and U.P.

- 93% of women received Ante-Natal Care (ANC) for their last birth compared with 63% of rural women

- 71% of births in the state takes place at home and 29% births takes place in health facility.

l) Child Health

- The percentage of children fully vaccinated is lower than the national average of 44 percent.

- The DPT and polio vaccine are given in a series. Many children receiving the first dose do not finish the series. Between first and third doses, the drop out rate for DPT is 24 percent and drop out rate for polio is at 31 percent.

FINANCIAL COMPONENT

- During the last three years around 62.79 crores has been released under NRHM Flexi pool, out of which 60% of the expenditure has been incurred. The above chart clearly indicated that there has been improper planning in the utilization of these funds. In the year 2008-2009, allocation of fund has come down.

- Towards equipments in the year 2007-08 and 2008-09 no funds were approved, while in 2009-2010 7 lakhs were approved. The approval of infrastructure expenditure in CHC, PHC and towards equipment is quite less to meet the essential requirements.

- During the last three years (2007-08, 2008-09 & 2009-2010) no expenditure was approved under the performance related incentive for ASHA. Most of the ASHA interviewed in the field have stated that they are not getting any honorarium on time. Even the honorarium they are getting is quite less.

- In the year 2007-08 untied funds were not approved. In the present year 2009-2010, 722.4 lakhs have been released towards untied funds, which are found to be adequate.

- ❖ The fund generated under RKS is quite less. None of the CHC and PHC are generating user charge above Rs. 100, 000. None of the RKS in East Khasi Hills, Jaintia Hills and West Garo Hills are generating user fee above Rs.50, 000.

IEC/BCC Activities

"Awareness generation activities like: health camps, street plays, door to door health campaign, wall paintings etc. is very useful in creation of health awareness among people"

Some of the activities relating to awareness on health conducted/ to be conducted by the State Health Department are as follows:

- Health melas have been conducted in all the districts since 2006 and from 2008 onwards (two melas per district @ Rs. 2.5 lakhs each)
- IEC activities are carried out by an event management company "The Living Picture Company" from the year 2008-09 to till date.
- State unit has started appointing IEC/BCC personnel from 2010-11.
- Health outreach camps using MMUs.
- Street plays are being conducted from 2008-09 using dedicated troupes for both Khasi and Garo speaking region.
- From 2010-11 onwards community events like dancing competitions, live band performance etc. will be conducted.
- IEC materials like posters, pamphlets, leaflets and banners have been printed and distributed accordingly.
- NRHM news letter has been published with 2-3 issues per year.
- A state level workshop on capacity building will be conducted for IEC personnel.
- Health SMS campaign across the state in English, Khasi and Garo.
- Print ads in newspapers, magazines are published regularly on family planning, maternal health, child health etc.

Recommendations

- Orientation programmes on utilization of untied funds needs to be carried out amongst the functionaries of health departments as wells as representatives of community towards the intended purposes for which these funds have been devolved to them. All the medical officers should be provided with training on hospital management.

- There is lack of effective monitoring by SPMU/DPMU/BPMU, which needs to be strengthened.

- There is a need for substantial improvement in health infrastructure in CHCs, PHCs and Sub-Centres for providing quality health care services under NRHM, which needs to be addressed.

- Awareness generation activities like: health camps, street plays, door to door health campaign, wall paintings etc. needs to be carried out regularly.

- There is shortage of specialist medical and para-medical staffs in health facilities for delivering specialized health care services, which needs to be filled up immediately.

- Proper auditing process (both internal and external) on utilization of RKS funds should be in place.

- There needs to be concrete supervision on the functioning of ASHAs.

- Most of the drugs available in the pharmacy are antibiotic, antipyretic, anitdiarrhoeal, vitamins etc. There are no specific drugs for cardiovascular, diabetics, vaccines for animal bites etc. available in the pharmacy. Even there is shortage in supply of drugs. To overcome the problem on shortage in supply/non-availability of specific drugs/expiry etc. in health facilities, an external consultant can be appointed for a short span of time, the consultant can carry out supervision on a random basis in health facilities and a monthly

status report can be submitted to the State Mission Director, NRHM. This needs to addressed.

- Training is the backbone of capacity building and functioning of ASHAs. So it must be done timely, properly and effectively. It has to be ensured during training that ASHAs are well aware about their jobs and responsibilities and are capable to fulfill their job responsibilities. In spite of the crucial importance of education and counseling for hygiene and sanitation, exclusive breast-feeding, complimentary feeding, family planning, ORS use, preventing early marriage and gender discrimination etc. is not being found in the agenda of ASHAs. So its importance must be emphasized during training and other meetings.

- A provision of proper, well equipped one or two ambulance on call to transport the pregnant mothers and other serious patients in border and remote areas must be made available.

- Government doctors should be restrained from private practices, instead they may be paid some extra remuneration. At present, on an average each doctors are handling atleast 50-60 patients during OPD hours and during the market days it rises to 100-120. Hence the doctors can be paid some extra remuneration.

- At present, most of the doctors are not visiting sub centres for health check ups. These needs to be improved particularly in the border and remote areas.

- Health education in schools needs to be promoted.

- There should be provision of proper disposal of bio medical waste in health facilities.

- None of the visited health facilities were having telephones; hence mobile numbers of all medical officers can be displayed at the entrance of CHCs/PHCs.

- Identity cards to ASHAs, ANMs should be ensured.

- Self Help Group representative should be a member of VHSC.

- There needs to be constant and vigil monitoring at grass root level from top officials in the health department to check the functioning of health facilities in the state.

- Blood banks needs to be set up at CHCs, by organizing blood donation camps etc.

- A performance reward scheme can be introduced, on the basis of which each year best performing districts can be rewarded. This will help in motivational aspect of the programme.

- A special training programme must be conducted for DPM and BPM, to explain their roles and responsibilities under NRHM. At present they are focusing mainly on record keeping. The DPM and BPM must be permitted to attend the RKS meetings. This needs to be addressed.

- Grievance redressal camps needs to be organized at health facilities at regular interval.

Chapter - 1

Introduction

1.1 National Rural Health Mission (NRHM)

Rural Health Care forms an integral part of the National Health Care System. Provision of Primary Health Care is the foundation of all rural health care Programmes. For developing vast public health infrastructure and human resources of the country, accelerating the socio-economic development and attaining improved quality of life, the Primary health care is accepted as one of the main instruments of action. Thus, recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care.

India has registered significant progress in improving life expectancy at birth, reducing mortality due to Malaria, as well as reducing infant and material mortality over the last few decades. In spite of the progress made, a high proportion of the population, especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition. In addition to old unresolved problems, the health system in the country is facing emerging threats and challenges. The rural public health care system in many States and regions is in an unsatisfactory state leading to pauperization of poor households due to expensive private sector health care. India is in the midst of an epidemiological and demographic transition – with the attendant problems of increased chronic disease burden and a decline in mortality and fertility rates leading to an ageing of the population. An estimated 2.5 million people in the country are living with HIV/AIDS, a threat which has the potential to undermine the health and developmental gains India has made since its independence. Non-communicable diseases such as cardio-vascular diseases, cancer, blindness, mental illness and tobacco use related illnesses have imposed the chronic diseases burden on the already over- stretched health care system in the country. Premature morbidity and mortality from chronic diseases can be a major economic and human resource loss for India.

The large disparity across India places the burden of these conditions mostly on the poor, and on women, scheduled castes and tribes especially those who live in the rural areas of the country. The inequity is also reflected in the skewed availability of public resources between the advanced and less developed states. Public spending on preventive health services has a low priority over curative health in the country as a whole. Indian public spending on health is amongst the lowest in the world, whereas its proportion of private spending on health is one of the highest. More than Rs. 100,000 crores is being spent annually as household expenditure on health, which is more than three times the public expenditure on health. The private sector health care is unregulated pushing the cost of health care up and making it unaffordable for the rural poor. It is clear that maintaining the health system in its present form will become untenable in India. Persistent malnutrition, high levels of anemia amongst children and women, low age of marriage and at first child birth, inadequate safe drinking water round the year in many villages, over-crowding of dwelling units, unsatisfactory state of sanitation and disposal of wastes constitute major challenges for the public health system in India. Most of these public health determinants are correlated to high levels of poverty and to degradation of the environment in our villages. Thus, the country has to deal with multiple health crisis, rising costs of health care and mounting expectations of the people. The challenge of quality health services in remote rural regions has to be met with a sense of urgency. Given the scope and magnitude of the problem, it is no longer enough to focus on narrowly defined projects.

The National Rural Health Mission (NRHM), a National effort at ensuring effective healthcare, especially to the poor and vulnerable sections of the society was launched (on 12th April, 2005 for a period of seven years (2005-2012)) throughout the Country with special focus on 18 states viz. Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, **Meghalaya**, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh.

The NRHM covers all the villages through village-based **"Accredited Social Health Activists" (ASHA)** who would act as a link between the health centers and the villagers. One ASHA will be raised from every village or cluster of villages. The ASHA would be trained to advise villagers about Sanitation, Hygiene, Contraception, and Immunization to provide Primary Medical Care for Diarrhea, Minor Injuries, and Fevers; and to escort patients to Medical Centers.

They would also deliver Directly Observed Treatment Short (DOTS) course for tuberculosis and oral rehydration; distribute folic acid tablets and chloroquine to patients and alert authorities to unusual outbreaks. Although these ASHAs would be honorary volunteers, there is a provision to provide them with performance-based compensation for undertaking specific health or other social sector programmes with measurable outputs, thus promoting employment for these volunteers. If rural women want counseling on important issues such as birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child, they may contact the concerned ASHA who shall be happy to provide them with all relevant guidance and assistance.

The general norm as decided under the Programme is 'One ASHA per 1000 population'. In tribal, hilly, desert areas the norm could be relaxed to one ASHA per habitation, dependant on workload etc.

Criteria for selection as ASHA

- ASHA must be primarily a woman resident of the village - 'Married/Widow/Divorced' and preferably in the age group of 25 to 45 yrs.
- ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Class. This may be relaxed only if no suitable person with this qualification is available.

The selection of ASHAs is being done by the VHSNC under NRHM. Over 3,51,000 ASHAs have already been selected from various States, out of which, more than 2,26,000 have been trained in the first module.

Janani Surakha Yojana (JSY) is another important component under NRHM. JSY is a centrally sponsored scheme to benefit pregnant women & certified poor families. The Government has introduced the Janani Suraksha Yojana to provide comprehensive medical care during pregnancy, child birth and postnatal care and thereby endeavour to improve the level of institutional deliveries in low performing states to reduce maternal mortality.

The NRHM provides broad operational framework for the Health Sector. Suggestive guidelines have been issued on key interventions like institutional deliveries, immunization, preparation of District Action Plan as well as schemes including ASHA, JSY etc. The States have the flexibility to project operational modalities in their State Action Plans.

It is envisaged that National Rural Health Mission shall be able to effectively improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

Plan of Action

- Increasing public expenditure on health
- Reducing regional imbalance in health infrastructure
- Pooling resources
- Integration of organizational structures
- Optimization of health manpower
- Decentralization and district management of health programmes
- Community participation and ownership of assets
- Induction of management and financial personnel into district health system
- Operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

1.2 Population Characteristics

The state of Meghalaya is sparsely populated due to its rugged terrains and inhospitable environment. According to the census report of 2001, Meghalaya has a total population of 2,318,822 constituting 0.22 percent population of India and 5.91 per cent of North East.

It has a density of 103 persons per sq km and ranks 24th in India in terms of population density. According to the Census of 1991, nearly 65 per cent of the population practiced Christianity. Agriculture is one of the basic means of subsistence in this tribal state. About 65.89 percent of the total working population are cultivators and agricultural labourers. The gross state domestic product or the per capita income at current prices has been calculated at Rs. 14, 726 for the year 2000-2001. Meghalaya ranks 24th in the human resource development index and 28th in the poverty index in India. The literacy rate of Meghalaya is 63.31 per cent, which is lower than the national literacy rate of 65.20 per cent. Meghalaya is rich in natural resources. However, the growth of industries in the State is still in the rudimentary stage.

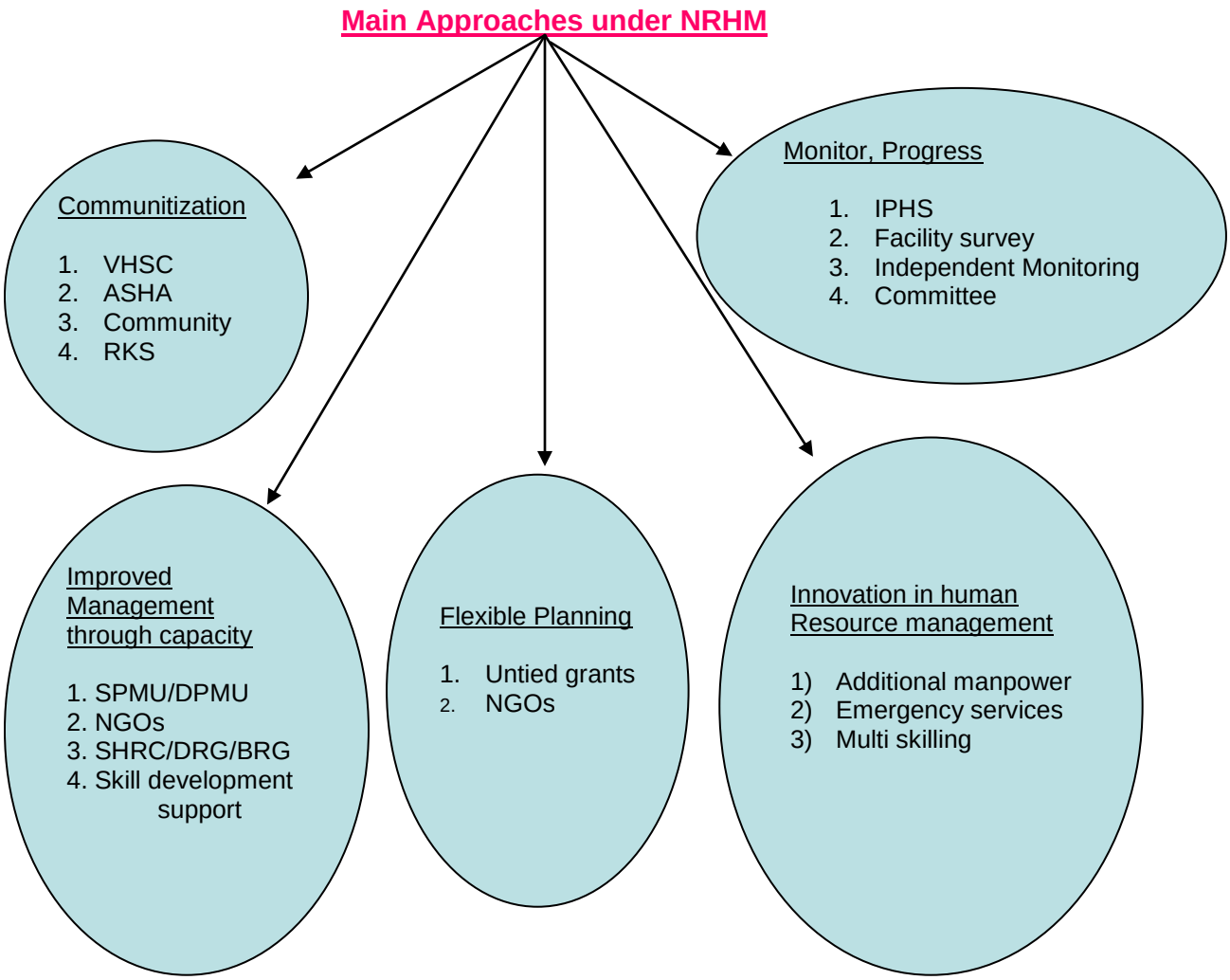
District wise breakup of population and land area (as per Census 2001)

S. No	Districts	Area in Sq Km	Population			Headquarters	Population Density (Per Sq. km)
			Male %	Female %	Total		
1.	East Garo Hills	2,603	50.9	49.1	1,88,830	Willamnagar	96.3
2.	East Khasi Hills	2,748	50.5	49.5	5,37,906	Shillong	240.5
3.	Jaintia Hills	3,819	50.1	49.9	2,20,473	Jowai	78.3
4.	West Garo Hills	3,174	50.8	49.2	4,03,027	Tura	139.6
5.	West Khasi Hills	5,247	50.8	49.2	2,20,157	Nongstoin	56.4
6.	Ri-Bhoi	2,448	51.5	48.5	1,27,312	Nongpoh	78.8
7.	South Garo Hills	1,850	51.5	48.5	77,073	Baghmara	54.6
	Meghalaya	**22,429**	**50.7**	**49.3**	**23,18,822**		**103.4**

Meghalaya is known as the "Scotland of East" for its scenic magnificence. It was inaugurated as an autonomous state on April 2, 1970 and was declared a state of the Indian Union on January 21, 1972. Meghalaya is surrounded by Assam on the north and the east and by Bangladesh on the south and the west. Spread over a geographical area of 22,429 Sq.Km, Meghalaya comprises 0.68 percent of the countries total land mass and 8.55 percent of that of the north east.

Meghalaya is home to two main tribal formations: Hynniewtreps and the Achiks. The Khasi, Jaintia, Bhoi tribes are collectively known as the Hynniewtreps people who predominantly inhabited the districts of East Meghalaya. The Garo hills is predominantly inhabited by the Garos. The Garos prefer to call themselves as Achiks.

Approaches under NRHM



1.3 Health Indicators of Meghalaya

The total fertility rate is 3.8 (NFHS 2005-06).The Infant Mortality Rate of Meghalaya is 58, the rural IMR is around 60 and urban is around 43 (SRS 2006 - 2008). The birth rate in the State is 25.2 and death rate is 7.9. Comparative figures of major health and demographic indicators are as follows:

Demographic, Socio-economic and Health profile of Meghalaya State as compared to India figures:

S. No.	Item	Meghalaya	India
1	Decadal Growth (Census 2001) (%)	30.65	21.54
2	Crude Birth Rate (SRS 2008)	25.2	22.8
3	Crude Death Rate (SRS 2008)	7.9	7.4
4	Total Fertility Rate (SRS 2008)	NA	2.6
5	Infant Mortality Rate (SRS 2008)	58	53
6	Maternal Mortality Ratio (SRS 2004 - 2006)	NA	254
7	Sex Ratio (Census 2001)	972	933
8	Population below Poverty line (%)	33.87	26.10
9	Schedule Caste population (in million)	0.01	166.64
10	Schedule Tribe population (in million)	1.99	84.33
11	Female Literacy Rate (Census 2001) (%)	59.6	53.7

Health Infrastructure of Meghalaya

Item	Required	In Position	Shortfall
Sub-centre	597	401	196
Primary Health Centre	90	103	-
Community Health Centre	22	26	-
Multipurpose Worker (Female)/ANM	504	608	-
Health Worker (Male)/MPW(M)	401	273	128
Health Assistants(Female)/LHV	103	75	28
Health Assistants(Male)	103	87	16
Doctor at PHCs	103	106	-
Surgeons	26	1	25
Obstetricians & Gynaecologists	26	0	26
Physicians	26	1	25
Paediatricians	26	0	26
Total specialists at CHCs	104	2	102
Radiographers	26	25	1
Pharmacist	129	113	16
Laboratory Technicians	129	130	-
Nurse Midwife	285	174	111

1.4 Status of NRHM Interventions in Meghalaya

There are around 406 Sub Centres (SCs), 106 Primary Health Centres (PHCs), 30 Community Health Centres (CHCs), 11 dispensaries, 10 private and 6 district hospitals in the state. A total of 16 PHCs and 26 CHCs are functioning on 24*7 basis.

The financial approval of health infrastructure facilities are as follows:

Sl. No	Health Facilities	2005-06 (Rs.in Cr.)	2006-07 (Rs.In Cr.)	2007-08 (Rs.In Cr.)	2008-09 (Rs.In Cr.)	2009-10 (Rs.In Cr.)
1	SC	0.04	0.24	5.85	1.51	9.48
2	PHC	0.00	0.64	4.58	7.61	0.33
3	CHC	4.00	0.84	1.71	2.28	0.00
4	DH	0.00	2.25	0.00	1.50	6.68
5	Equipment	0.00	0.60	0.00	0.00	0.07
6	Transport	0.00	0.00	0.00	0.00	1.17
7	Others	0.00	5.12	0.00	2.45	0.60
	Total	**4.04**	**9.68**	**12.15**	**15.35**	**18.32**

2.47% increase in financial approval of health infrastructure facilities during 2007-08 than 2006-07. In the year 2008-09 there has been an increase of 3.2% than 2007-08, but in the year 2009-10 there was increase of 2.97%, which is less than 2007-08 & 2008-09.

Though there has been steady improvement in health infrastructure, but still few people in rural and remote areas are uncovered by health care. The SPMU, NRHM is actively involved towards attaining the goal and objectives shared under NRHM.

Rogi Kalyan Samitis /Patient Welfare Committee

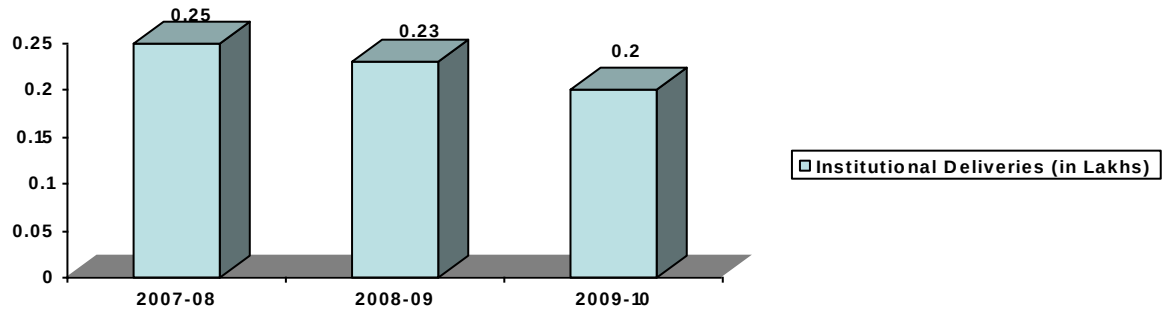
Rogi Kalyan Samiti (Patient Welfare Society) is an effective management structure. This committee, a registered society, acts as a group of trustees for the hospital to manage the affairs of the hospital. It consists of members from the local NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs / PHCs.

RKS / HMC is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services in health facilities. In Meghalaya there are around 135 RKS have been registered in DH/PHC/CHC.

Janani Suraksha Yojana (JSY)

The Janani Suraksha Yojana (JSY) is an Indian government-sponsored conditional cash transfer scheme to reduce the numbers of maternal and neonatal deaths and increase health facility deliveries in BPL families. The JSY covers all pregnant women belonging to households below the poverty line, above 19 years of age and up to two live births. The JSY integrates help in the form of cash with antenatal care during pregnancy period, institutional care during delivery as well as post-partum. This is provided by field level health workers through a system of coordinated care and health centers. Benefits for institutional delivery are more generous in rural areas and in low-performing states, ranging from Rs.600 to Rs.1, 400. A subsidy is also available to private sector providers for emergency caesareans, on referral.

The Accredited Social Health Activists (ASHA) has played a great role to make the JSY a huge success. ASHA motivates the pregnant women to opt for institutional delivery, take cares of her by coordinating with the nurse and doctors. For that JSY provides return benefit to ASHA. ASHA gets an amount of Rs 600 if she motivates and assists a pregnant woman for institutional delivery.



As on 15.5.2009, 6108 ASHA have been selected, out of which 4521 got the training. There are around 5352 VHSC and 14000 JSY beneficiaries.

Objectives

The broad objective of the study is to asses the impact of National Rural Health Mission (NRHM) initiatives in the intervention districts.

The major objectives of the study were as follows:

- To assess proper functioning of health facilities
- To generate information about the planning processes, level and quality of participation of different stakeholders, approval and systems capacity building in the planning.
- To study functioning of Rogi Kalyan Samitis (RKS), autonomy in decision making, decision making processes and efficiency.
- Quality and accountability in delivery of health services
- Taking care of needs of the poor and vulnerable sections of the society and their empowerment;
- To make recommendation on all of the above

Survey Period

The survey was conducted during September – November 2010 using different categories of schedules. All the schedules were filled up in the field simultaneously.

Sample Size

The sample sizes for the study were as follows:

Sl. No.	District	CHC	PHC	SC+Disp.	Block	Sample Village	BMOs	ANMs	ASHAs	RKS members	Beneficiaries	Non Beneficiaries
1	Jaintia Hills	3	5	8	Thadlaskein	7	1	7	14	14	70	14
					Laskein	5	1	5	10	10	50	10
					Amlarein	5	1	5	10	10	50	10
2	East Khasi Hills	2	4	11	Mylliem	5	1	5	10	10	50	10
					Mawkynrew	4	1	4	8	8	40	8
					Pynursla	8	1	8	16	16	80	16
3	West Khasi Hills	3	4	10	Nongstoin	11	1	11	22	22	110	22
					Ranikot	7	1	7	14	14	70	14
					Mairang	7	1	7	14	14	70	14
4	East Garo Hills	1	4	5	Resubelpara	12	1	12	24	24	120	24
					Songsok	10	1	10	20	20	100	20
					Samanda	7	1	7	14	14	70	14
5	West Garo Hills	1	3	7	Dadenggiri	6	1	6	12	12	60	12
					Tikrikilla	9	1	9	18	18	90	18
					Rongram	12	1	12	24	24	120	24
6	South Garo Hills	1	5	5	Chokpot	17	1	17	34	34	170	34
					Baghmara	8	1	8	16	16	80	16
					Rongara	6	1	6	12	12	60	12
7	Ri-Bhoi	3	4	8	Umling	12	1	12	24	24	120	24
					Umsning	11	1	11	22	22	110	22
					Jirang	5	1	5	10	10	50	10
	Total	**14**	**29**	**54**		**174**	**21**	**174**	**348**	**348**	**1740**	**348**

Apart from these, discussions were carried out with some of the DMHOs, DCs, BDOs, Village Heads, school teachers/headmasters & Superintendent of civil hospitals to understand their perception regarding the scheme.

Adequate care was taken by us to conduct the research within the internationally accepted standards, particularly those stipulated by the WHO/ICMR. All the respondents will be provided information on the purpose of the study.

Chapter - 2

State Profile

Meghalaya health may not have been in an ideal state a few years back, but have shown significant improvement in the recent years. With many remote tribal areas spread at all over the hilly tracts, it becomes extremely difficult to monitor the health facilities for the inhabitants of the state. Meghalaya health has shown mixed results in the study of National Family Health Survey (NFHS). At times, the condition of health in Meghalaya shared the predicaments of the entire nation, like lack of proper care during pregnancy, low immunization of new borns and infants etc.

After the implementation of National Rural Health Mission (NRHM) in the state, health facilities have shown improvement in the recent years. Although mountain tribal regions are often difficult to reach and tribes are often found to be wary of modern treatment, depending more on their age old tradition of therapy, but there has been a change in their attitude in recent times. At present there are around 406 Sub Centres (SCs), 106 Primary Health Centres (PHCs), 30 Community Health Centres (CHCs), 11 dispensaries, 10 private and 6 district hospitals in the state. A total of 16 PHCs and 26 CHCs are functioning on 24*7 basis. The Progress of institutional setup at state and district level is fair. Meeting of State & District Health Mission have been held regularly. Meeting of State Health Mission held 3 times and of District Health Missions held 53 times. Merger of societies has been completed in 7 districts 5568 VHSCs have been constituted & 2309 Joint Accounts operationalised at sub centre level. Rogi Kalyan Samities (Patient Welfare Committee) are operational at 6 DH, 28 CHCs & 99 PHCs.

The estimated birth rate and death rate by SRS in 2008 is 25.2 and 7.9, while the Infant Mortality Rate is 58, which is more compared to country's rate of 53. In Meghalaya as per the recent NFHS – 3 survey, in 2005 –06, the mean household size is 5.1 in total (4.7 in urban and 5.3 in rural). ANC coverage is 68%. Institutional deliveries were 30%. The fertility rate of Meghalaya as per NFHS-III is 3.8.

The NRHM in Meghalaya was implemented in full in the year 2006. Some of the important data on NRHM initiatives during the last four years (2006-07, 2007-08, 2008-09 & 2009-2010) is given below:

Health Component

Table 2.1: Health Facility

Sl. No	Health Facility	2006-07	2007-08	2008-09	2009-2010	2012-13 (at present)
1	CHC	27	28	28	28	**29**
2	PHC	100	104	104	106	**108**
3	Sub Centre	401	404	401	406	**420**

(Source: NRHM Meghalaya)

Table 2.1a: Health Facility in districts 2009-2010

S. No	Health Facilities*	Districts							Total
		Jaintia	Ri-Bhoi	East Khasi Hills	West Khasi Hills	East Garo Hills	West Garo Hills	South Garo Hills	
1	DH	1	1	3	2	1	2	1	**11**
2	SDH	0	0	0	0	0	1	0	**1**
3	CHCs	5	3	6	5	2	7	1	**29**
4	PHCs	18	8	23	19	16	18	6	**108**
5	St. Dispy.	1	2	5	0	0	3	1	**12**
6	SCs	76	26	66	66	73	92	21	**420**
7	UHC	2	0	13	1	0	3	0	**19**

(* DH-District Hospital, SDH-Sub Divisional Hospital, UHC – Urban Health Centre)

According to table 2.1, in the year 2006-07 there were 27 CHCs, 104 PHCs and 401 Sub Centres. In the year 2007-08 and 2008-09 there were 28 CHCs and 104 PHCs. The number of Sub Centres in the year 2007-08 was 404, but in the year 2008-09 it came down to 401. At present (2009-2010) there are 29 CHCs, 108 PHCs and 420 Sub Centres. The present number of health facility in the state is adequate, as per the norms there is a need for around 597 SC which shows a short fall of 34%. The health infrastructure in some of the facilities are lacking, which needs to be strengthened, e.g. in terms of supply of equipment, training of medical and paramedical staff, shortage of drugs, shortage of medical equipment, transportation, condition of beds etc. The highest number of CHC is in East Khasi Hills, West Khasi Hills and West Garo Hills, while only one CHC is in South Garo Hills.

The highest number of PHC is in East Khasi Hills, while the lowest number of PHC is in South Garo Hills. The highest number of sub centre is in West Garo Hills district.

Table 2.2: Estimated IMR, Birth Rate and Death rate

Sl. No	Particulars	2006-07	2007-08	2008-09	2010-11	India 2011
1	**IMR** **(per 1000 live births)**	53	56	58	52	44
2	**Birth rate** **(per 1000 people per year)**	24.7	24.4	25.2	24.1	21.8
3	**Death Rate** **(scaled on the basis of population)**	8.0	7.5	7.9	7.8	7.1

(Source: SRS)

As per the expected outcome of the mission of Meghalaya, the Infant Mortality Rate (IMR) will be reduced to 30 by 2012. But in the present scenario, it seems a difficult task. In the year 2006-07 the IMR was 53 and in the year 2007-08 it increased to 56. The present IMR (2008-09) is 58. The death rate in each year is in between 7-8, while the birth rate is in between 24-25. Even the Planning Commission of India has pointed out that birth rate, death rate and IMR are not satisfactory. There needs to strengthening of health related activities in the rural and urban areas, special focus should be thrown to rural areas with some proper planning like: proper monitoring of day to day activities carried out by ASHA, VHSC, ANM in the ground level, health awareness camps, door to door health education teams can be formed Advertisement in local language in television and print media, street plays etc.

Table 2.3: Institutional Deliveries

Sl. No	Particulars	2006-07	2007-08	2008-09	2009-2010	2011-12
1	Institutional Deliveries	20000	22000	17000	11000	**39564**

(Source: NRHM Meghalaya)

Institutional delivery is a key RCH strategy. JSY in the country has led to creation of enormous demand for institutional deliveries, while in Meghalaya it doesn't seem so. During

the last four years (2006-07, 2007-08, 2008-09 & 2009-2010) there is a tremendous fall in the institutional delivery, while in the year 2011-12 it has improved.

In the year 2006-07 & 2007-08 it was 20000 and 22000, while in 2008-09 it was 17000. Finally it has come down to 11000. According to MoHFW data on safe deliveries (2008-09) Meghalaya has reported less than 45% safe deliveries. Women delivering in the health facility is not staying for 48 hours for monitoring her recovery; it may also be due to the lack of proper infrastructure and support available in the health facility. In Meghalaya most of the institutional deliveries are conducted by ANM.

Table 2.4: JSY Beneficiaries

Sl. No	Particulars	2006-07	2007-08	2008-09	2009-2010	2011-12
1	JSY beneficiaries	3000	6000	5000	6000	16831

(Source: MoHFW)

According to table 2.4, the number of enrolled JSY beneficiaries is quite low during the year from 2006 to 2010, while in the current year it has improved.

Table 2.5: Village Health Nutrition Day (VHND)

Sl. No	Particulars	2006-07	2007-08	2008-09	2009-2010	2011-12
1	No. of monthly VHND held	2250	17205	6938	12800	37722

(Source: MoHFW)

The Village Health Nutrition Day (VHND) is to be organized once every month at the Aanganwadi Centre in the village. The Village Health Sanitation Committee (VHSC) comprising ASHA, Aanganwadi worker, ANM, Village head etc. will be involved in organizing the event. This event creates awareness amongst the villagers towards preventive and promotive aspect of health care, which will encourage them to seek health care at proper facilities. The maximum number of VHND was held in 2007-08, in this year around 17,205 VHND was held. The minimum number of VHND was held in the year 2006-07. While interacting with some of the villagers during the field study, most of them were not aware of any such activities in

their village. Most of the people in the remote and border areas don't know what NRHM is and how it benefits them? It seems that there has not been any awareness campaigns carried out by the health department in these areas.

Table 2.6: Asha training status (up to August 2009)

Total no. of ASHA	Module-1 (in nos.)	Module-2 (in nos.)	Module-3 (in nos.)	Module-4 (in nos.)
6258	5946	6059	5174	5199

(Source: MoHFW)

At present there are approximately around 6258 ASHA in the state, out of which around 95% of them have completed training under module-1, 97% of them have completed module-2, 83% have completed module-3 and module-4. Most number of ASHAs have completed training under Module-1 and Module-2. The above chart shows that around 89% of ASHAs have completed training in all the four modules. Hence 10% of ASHAs have still not undergone training, which needs to be organized.

Maternal Health

In Meghalaya, the fertility rate is 3.8, fertility in NFHS-3 is 0.8 children lower than that in NFHS-2, but is still at about the same level as in NFHS-1. Fertility in Meghalaya is higher than in all the states in India, except Bihar and Uttar Pradesh. ANC coverage is just 68%; about one-third of women received no antenatal care. Ninety-three percent of urban women received antenatal care for their last birth, compared with 63 percent of rural women. Institutional deliveries were 30%, Seventy-one percent of births in Meghalaya take place at home and only 29 percent take place in a health facility. Three-fourths of births to urban women take place in a health facility, compared with only one-fourth of births to rural women.

Child Health

One-third (33%) of children 12-23 months of age are fully vaccinated against the six major childhood illnesses: tuberculosis, diphtheria, tetanus, polio, and measles. The percentage of children fully vaccinated is lower than the national average of 44 percent. Seventeen percent

of children have received none of the recommended vaccinations. Full vaccination coverage does not vary between the urban and rural areas of the state. Sixty-six percent of children have received a BCG vaccination and 47 and 57 percent, respectively, have received at least the recommended three doses of DPT and polio vaccines. More than two-fifths of children (44%) have been vaccinated against measles. The DPT and polio vaccines are given in a series. Many children receive the first dose but did not finish the series. Between the first and third doses, the dropout rate for DPT is 24 percent and the dropout rate for polio is, at 31 percent.

Family Planning

As per NFHS – 3 the percentage of women age 20-24 who married by the age of 18 years is 24.5%. Around 42.3% in west khasi hills, 40.4% in RiBhoi, 37.3% in Jaintia Hills, 35.2% in West Garo Hills and 29.4% in East Garo Hills are marrying below legal age of 21 years which is high and need BCC intervention and awareness among youths. Around 37.6 % in RiBhoi, 31.7% in East Garo Hills, 16.2% in Jaintia Hills and 11.9% in South Garo Hills are marrying below legal age of 18 years which is high and need BCC intervention. Even West Khasi Hills have 9.9% and West Garo Hills have 6.2% of girls marrying below 18 years.

Financial Component

Table 2.7: Financial Allocation under NRHM Flexi pool

Year	Allocation (in Cr.)	Releases (in Cr.)	Expenditure (in cr.)
2006-07	24.33	19.51	2.54
2007-08	27.88	23.22	9.71
2008-09	19.72	20.06	24.83
Total	**71.93**	**62.79**	**37.08**

(Source: NRHM)

The above chart shows the financial allocation under NRHM flexi pool for last three years. In the year 2006-07, 24.33 crores were allocated, out of which only 80% funds were released and 13% expenditure was incurred. In the year 2007-08, 27.88 Crores was allocated, out of

which 83% funds were released and 42% expenditure was incurred. In the year 2008-09, 19.72 crores were allocated, out of which 2% more funds were released out of the total allocated sum, out of which 4.77 crores were spent in excess from the released sum. During the last three years around 62.79 crores has been released under NRHM Flexi pool, out of which 60% of the expenditure has been incurred. The above chart clearly indicated that there has been improper planning in the utilization of these funds. In the year 2008-2009, allocation of fund has come down.

Table 2.8: Approval towards Infrastructure

Year	Sub Centre (in Cr.)	PHC (in Cr.)	CHC (in Cr.)	Equipment (in Cr.)
2006-07	0.24	0.64	0.84	0.60
2007-08	5.85	4.58	1.71	0.00
2008-09	1.51	7.61	2.28	0.00
2009-10	9.48	0.33	0.00	0.07
Total	**17.08**	**13.16**	**4.83**	**0.67**

(Source: NRHM)

During the last four years, a total of 35.74 cr. were approved towards health infrastructure in the state. In the year 2006-07, 24 lakhs were approved towards infrastructure in Sub Centre, while in the year 2007-08 there was an increase in the approved expenses by 5.85 cr. In the year 2009-2010 it was increased to 9.48 crores. At present there are 406 Sub Centre in the state. In the year 2006-07, 64 lakhs were approved towards infrastructure in PHC, while in the year 2007-08, it was 4.5 crore and again in year 2008-09 it was increased to 7.61 cr. In the year 2009-10 it came down by 33 lakhs, which is quite less. For equipment in the year 2007-08 and 2008-09 no funds were approved, while in 2009-2010 7 lakhs were approved. The approval of infrastructure expenditure in CHC, PHC and towards equipment is quite less to meet the essential requirements.

Table 2.9: Approval for ASHA

Initiative	2006-07 (in lakhs.)	2007-08 (in lakhs.)	2008-09 (in lakhs.)	2009-10 (in lakhs.)
ASHA	502	734	618	625
Performance related incentive	251	0	0	0
Total	**753**	**734**	**618**	**625**

(Source: NRHM)

The table 2.9 clearly indicates that the expenditure approved for ASHA is not adequate. During the last three years (2007-08, 2008-09 & 2009-2010) no expenditure was approved under the performance related incentive for ASHA. This may also be one of the reasons, that ASHA in the field are not carrying out their duties in an efficient and effective manner. Most of the ASHA interviewed in the field have stated that they are not getting any honorarium on time. Even the honorarium they are getting is too less.

Table 3.0: Untied Funds

Health Facility	2006-07 (in lakhs.)	2007-08 (in lakhs.)	2008-09 (in lakhs.)	2009-10 (in lakhs.)
CHC	-	-	26	26
PHC	25.25	-	25.75	27
Sub Centre	38.2	-	39.8	44.4
VHSC	100	**-**	618	625
Total	**163.45**	**-**	**709.55**	**722.4**

(Source: NRHM)

An untied fund of Rs. 10, 000 for each Sub Centre, Rs. 25, 000 for each PHC, Rs. 50, 000 for each CHC and Rs. 10,000 for VHSC is to be released in each financial year as per the norms. According to the table 3.0, in the year 2007-08 untied funds were not approved. In the present year 2009-2010, 722.4 lakhs have been released towards untied funds, which are found to be adequate. As far as utilization of these untied funds are concerned, there needs to be a proper accounting towards the utilization of funds by the PHC, CHC, Sub Centre and VHSC.

Table 3.1: Annual Maintenance Grant

Health Facility	2006-07 (in lakhs.)	2007-08 (in lakhs.)	2008-09 (in lakhs.)	2009-10 (in lakhs.)
CHC	-	-	26	26
PHC	50.05	-	51.5	51.5
Sub Centre	-	-	39	39
Total	**50.05**	**-**	**116.5**	**116.5**

(Source: NRHM)

An Annual Maintenance Grant of Rs. 10, 000 for each Sub Centre, Rs. 50, 000 for each PHC and Rs. 100, 000 for each CHC is to be released in each financial year as per the norms. In the year 2008-09 & 2009-2010, 26 lakhs were approved for CHC, 51.5 lakhs for PHC and 39 lakhs for Sub Centre.

Chapter - 3

Community Health Centre

Community Health Centre (CHC), the secondary level health care designed for health care institutions acts primarily as a referral centre (for neighbouring PHCs) for the patients requiring specialized health care services accessible to the rural people. It caters to approximately 80, 000 population in tribal/hilly areas. The CHCs are designed to be equipped with minimum four specialists in the area of medicines, surgery pediatrics and gynaecology, 30 beds for indoor patients, operation theatre, well equipped labour room, x-ray machine, pathological laboratory, standby generator, complimentary medical and paramedical staff etc.

The CHC-wise findings of the study based on the field data analysis are as follows:

Table C1: Coverage and Availability of Infrastructure

Particulars	Districts													
	E K H		W K H			Jaintia Hills			Ri-Bhoi			WGH	EGH	SGH
	Pynursla CHC	Mawiong CHC	Nongstoin CHC	Mairang CHC	Ranikor CHC	Nongtalang CHC	Laskein CHC	Ummulong CHC	Patharkhmah CHC	Bhoirymbong CHC	Nongpoh CHC	Dadenggiri CHC	Resu CHC	Baghmara CHC
Status of Building														
Own Building	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Regular Electricity Supply	1	1	1	1	0	1	1	0	0	1	1	1	1	1
Beds	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Generator	1	0	0	1	1	1	1	0	0	1	1	1	1	0
Telephone	1	0	0	0	0	0	0	0	0	0	1	0	1	0
Running Vehicle / Ambulance	1	0	1	1	1	0	0	1	1	1	1	1	1	1
Investigative Facilities														
OPD rooms	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Consulting Rooms (AYUSH)	1	0	1	1	1	1	0	1	1	1	1	1	1	1
Consulting Rooms(Specialist) CHC	0	0	0	1	0	0	0	0	0	0	1	0	1	0
Fully Equipped Labour Room	1	1	0	1	1	1	0	1	1	1	1	1	1	0
Minor O T	1	0	1	0	1	1	0	0	0	1	1	1	1	1

General O T	0	1	0	0	0	0	0	0	0	1	1	0	0	0
Separate wards for male and female	0	1	1	1	1	1	1	1	1	1	1	1	0	1
Separate public utilities (toilets) for male & female	1	1	1	1	0	1	1	1	1	1	1	1	1	1
Sitting arrangements for patients	1	1	1	1	1	1	1	0	0	1	1	1	1	1
Facility for food	0	0	1	1	1	1	0	0	0	0	1	1	1	1
Shortage of medicine	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Linkage with Blood Banks	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Waste Disposal System	0	0	0	0	0	0	0	0	0	0	0	0	0	0

(Note: 1-Yes, 0-No)

Coverage and Availability of Infrastructure

According to table C1, out of the 14 sampled CHCs, in around 78% of the CHC the infrastructure availability is fairly good. Minimum infrastructure facility was noted in Patharkhmah (Ri Bhoi), Ummulong (Jaintia Hills), Ranikor (WKH). None of the CHC has any linkage with blood banks. Out of the 14 sampled CHC, 6 of the CHC don't have food facility for In-patients. There are no telephones in most of the CHC, which creates lots of hurdles during emergency situation. Most of the CHC are having 30 or more beds, but in most of the cases the bed sheet and pillow are not being washed even periodically. Although, CHC are having labour room, there is shortage of necessary equipments. Only three CHC are having general OT, others are having minor OTs.

There is shortage of medicines in all the CHCs, due to irregular supply of medicines from the district and state. In most of the cases the medicines procured from district have a shelf life of only three or four months. None of the CHC visited by our team is having a proper waste disposal system, in most cases medicines are being burnt or thrown in open. While interacting with the medical officer I/c, they have stated that they haven't got any training on this matter, and seem to have poor environment awareness. The evaluation team also found few expired medicines and injections in the pharmacy.

Most of the CHC are having ambulance, to transport patients who require medical attention, but most of the ambulances were bereft of necessary equipment, e.g. oxygen cylinders, stretchers, medicines etc.

The Government of Meghalaya has launched 108 emergency response services on 2nd February, 2009. The detailed services being provided by 108 ambulances in the last one year (Feb 2, 2009 to Feb 2, 2010), includes attending to 13,911 emergency cases, 2,914 emergency cases related to pregnancy, 1,600 lives saved, besides attending to 1,834 emergencies related to vehicular and non-vehicular accidents and 116 cases of child delivery. But when it comes to remote and rural areas, with poor road conditions it becomes difficult for ambulances to reach the destination on time.

Positions of Medical Staff & Paramedical Staff

As per minimum norms, CHCs are required to be manned by four medical specialist i.e surgeon, physician, gynecologist and pediatrician supported by 21 paramedical and other staff. According to table C2, regarding the position of medical and paramedical staff, in all the sampled CHC there is shortage of medical and paramedical staff. More than 85% of CHCs are without any specialist i.e surgeon, physician, gynecologist and pediatrician. Around 22% of CHC are not having radiographer and lab technician. All the CHCs were having general practitioner. The above table indicates that there is acute shortage of medical specialist in CHCs. It seems that all the CHC were sanctioned without sanctioning all the post of specialists, which should now be approved.

Table C2: Positions of Medical Staff & Paramedical Staff

Particulars	Districts													
	E K H		W K H			Jaintia Hills			Ri-Bhoi			WGH	EGH	SGH
	Pynursla CHC	Mawiong CHC	Nongstoin CHC	Mairang CHC	Ranikor CHC	Nongtalang CHC	Laskein CHC	Ummulong CHC	Patharkhmah CHC	Bhoirymbong CHC	Nongpoh CHC	Dadenggiri CHC	Resu CHC	Baghmara CHC
Position of Medical Staff														
Physician	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Surgeon	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Gynecologist	0	0	0	0	0	1	1	0	0	0	1	0	0	1
Pediatrician	0	0	0	1	0	0	0	0	0	0	1	0	0	0
AYUSH	1	0	1	0	1	0	0	1	0	0	1	1	1	0
Anesthetist	0	0	0	1	0	0	0	0	0	0	1	0	0	0
General Practitioner	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Position of Paramedical and Support Staff														
ANM	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Staff Nurse	0	1	1	1	1	1	1	1	1	1	1	1	1	1
Ward Boys	1	1	1	0	1	1	1	0	1	1	1	1	1	1
HA / LHV (Male)	0	0	0	0	1	0	0	0	0	0	1	1	0	0
HA / LHV (female)	1	1	0	0	1	1	1	1	0	0	1	1	0	1
Health Educator	1	1	0	0	1	1	1	1	0	0	1	1	0	1
Lab Technician	1	1	1	1	1	1	1	0	0	1	1	1	1	1
Radiographer	1	0	1	1	1	1	1	0	0	1	1	1	1	1
Driver	1	1	1	1	0	1	1	1	1	1	1	1	1	1
Block Program Manager	1	1	0	1	1	1	1	1	1	1	0	1	0	1
Accountant	1	1	0	1	1	1	1	1	1	1	1	1	0	1
Doctor Assistant (Compounder)	0	1	0	0	0	0	0	0	1	0	1	1	0	0
Cleaning Staff	1	1	1	1	1	1	1	1	0	1	1	1	1	1
Administrative & Other Staff	1	1	1	1	1	1	1	1	1	1	1	1	1	1

(Note: 1-Yes, 0-No)

Table C3 : Status of the Residential Facilities for Doctors and Nurses

Particulars	Districts													
	E K H		W K H			Jaintia Hills			Ri-Bhoi			WGH	EGH	SGH
	Pynursla CHC	Mawiong CHC	Nongstoin CHC	Mairang CHC	Ranikor CHC	Nongtalang CHC	Laskein CHC	Ummulong CHC	Patharkhmah CHC	Bhoirymbong CHC	Nongpoh CHC	Dadenggiri CHC	Resu CHC	Baghmara CHC
Residential Facility														
Residential Facility for doctors	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Residential Facility for Nurses	1	1	1	1	1	1	1	1	1	1	1	1	1	1

(Note: 1-Yes, 0-No)

Residential Facilities

All the CHCs are having residential facilities for doctors and nurses, but in most of the CHC there is shortage of living quarters. In most cases the rooms are being shared by two to three members.

Table C 4 : Status of Performance of Labour Room during 2009-10

Particulars	Districts													
	E K H		W K H			Jaintia Hills			Ri-Bhoi			WGH	EGH	SGH
	Pynursla CHC	Mawiong CHC	Nongstoin CHC	Mairang CHC	Ranikor CHC	Nongtalang CHC	Laskein CHC	Ummulong CHC	Patharkhmah CHC	Bhoirymbong CHC	Nongpoh CHC	Dadenggiri CHC	Resu CHC	Baghmara CHC
Total Institutional Delivery	100	0	44	359	32	65	234	0	34	22	150	97	122	250
Normal Delivery	100	0	0	359	32	65	234	0	34	22	150	97	122	250
Cesarean Delivery	0	0	44	0	0	0	0	0	0	0	0	0	0	0

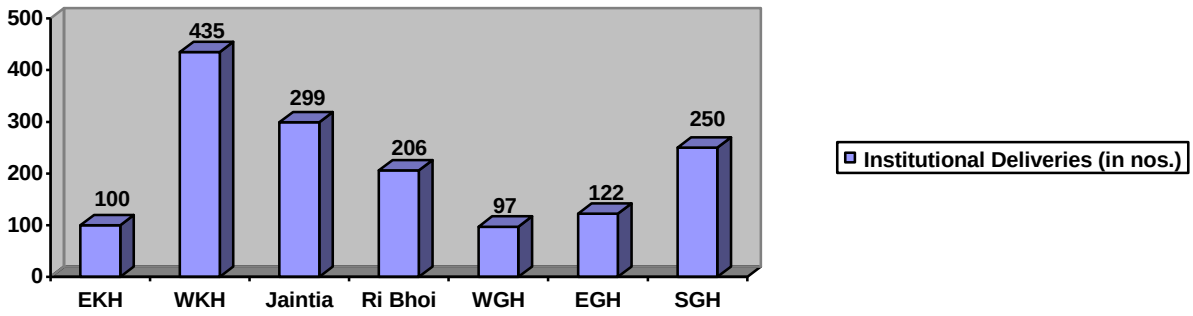


Table C4 (a): Details of institutional deliveries in sampled CHC

Performance of Labour Room

The maximum number of institutional deliveries is in West Khasi Hills and lowest number of institutional deliveries is in West Garo Hills.

Table C5 : Source and frequency of funds received under NRHM

Particulars	Districts													
	E K H		W K H			Jaintia Hills			Ri-Bhoi			WGH	EGH	SGH
	Pynursla CHC	Mawiong CHC	Nongstoin CHC	Mairang CHC	Ranikor CHC	Nongtalang CHC	Laskein CHC	Ummulong CHC	Patharkhmah CHC	Bhoirymbong CHC	Nongpoh CHC	Dadenggiri CHC	Resu CHC	Baghmara CHC
Sources of funds received														
From the District	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Directly from the State	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frequency of Receiving the Funds														
Yearly	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Half quarterly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Quarterly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Irregular	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Delay in Getting Funds (Yes -1, No-0)	0	1	1	0	1	1	1	0	0	1	1	0	0	0

(Note: 1-Yes, 0-No)

Source and frequency of funds

The CHCs are receiving the NRHM funds directly from the districts. All the CHCs are receiving the fund yearly. Out the 14 sampled CHCs, 7 CHCs are not getting the funds on time.

Table C6: Status of Rogi Kalyan Samities (RKS)

Particulars	Districts													
	E K H		W K H			Jaintia Hills			Ri-Bhoi			WGH	EGH	SGH
	Pynursla CHC	Mawiong CHC	Nongstoin CHC	Mairang CHC	Ranikor CHC	Nongtalang CHC	Laskein CHC	Ummulong CHC	Patharkhmah CHC	Bhoirymbong CHC	Nongpoh CHC	Dadenggiri CHC	Resu CHC	Baghmara CHC
Is RKS formed?	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Is it Registered?	1	1	1	1	1	1	1	1	1	1	1	1	1	1
#Frequency of RKS Meetings (in a year)	4	3	4	5	4	2	2	3	4	2	3	4	3	3
Role of RKS														
Addressing Complaints of Patients	0	1	0	1	1	1	0	0	1	1	1	1	1	0
Improvement of health facility infrastructure	1	1	1	0	1	1	0	1	0	1	1	1	1	0
Improvement of health related equipment	1	1	1	0	1	1	1	1	1	1	1	1	1	1
Improvement of lodging /boarding facility to patients and their relatives	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Improvement in support services like cleaning, laundry, diagnostic, waste disposal etc.	1	1	1	0	0	1	0	1	1	1	0	1	1	0
RKS Funds														
RKS Generate Funds	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Are the funds adequate to meet all the requirements	0	1	1	0	0	1	1	0	0	0	0	1	1	1
Utilization of Untied Funds														
Maintenance	1	1	1	0	0	0	1	1	1	1	1	1	1	1
Seeking service from private sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Repair/Renovation	1	1	0	0	0	1	0	1	1	0	0	1	0	0
Buying equipments	1	1	0	1	1	1	1	1	1	0	0	1	0	0

Buying medicines	1	1	0	0	1	0	0	1	0	0	1	0	1	1
Cleaning & Security services	0	1	1	0	0	0	0	0	1	0	1	0	0	0
Hiring contractual staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0

(Note: 1-Yes, 0-No, # =actual numbers)

Rogi Kalyan Samities(RKS)/ Patient Welfare Committee (PWC)

The Rogi Kalyan Samiti (Patient Welfare Society), a registered society, acts as a group of trustees for the hospital to manage the affairs of the hospital. It consists of members from the local NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs / PHCs. RKS / HMC is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services in health facilities. In Meghalaya there are around 135 RKS (PWS) have been registered in DH/PHC/CHC. All of the 14 sampled CHCs are having registered RKS (PWS) in place. As far as the frequency of RKS meeting is concerned, there is no uniformity. Around 65% of the RKS are addressing the complaints of patients, in most of the CHCs there were no suggestion box in the hospital. Most of the CHCs are utilizing the RKS funds for the maintenance, Repair/Renovation, buying equipments. Only few RKS are utilizing the funds for buying medicines, seeking service from private sector and cleaning and security services. None of the RKS are utilizing the funds for hiring contractual staff.

While interacting with the RKS members, most of them were not well aware of the roles and responsibilities under RKS. Only few of them were able to recall. In most cases RKS are functioning in a casual manner. None of the CHCs visited by us have installed drinking water for OPD and IPD. All the sampled CHCs are generating funds in form of user fee (in between 10000 – 22000 yearly), 50% of the CHCs have stated that the funds generated are not enough to meet their minimum requirements.

Chapter - 4

Primary Health Centre

Primary Health Centre (PHC) is the corner stone of rural healthcare. PHC are supposed to meet the health care needs of rural population. Each PHC covers a population of 20000 and is spread over about 100 villages. The activity of PHC involves curation, preventive, primitive and family welfare services. The health sector reforms under NRHM aims to increase functional, administrative and financial resources and autonomy to the field units under which every PHC gets Rs. 1, 50, 000 p.a as untied grants for local health action. In Meghalaya most of the PHCs are not functioning in an effective manner due to shortage of specialized manpower. The needy are not being able to get adequate health facilities.

The PHC-wise findings based on the data analysis are as follows:

Table 4.1: Coverage and Availability of Infrastructure

Districts →	**EKH**				**WKH**			**Ri-Bhoi**				**WGH**		
Blocks →	**Mylliem**	**Pynursla**	**Mawkynrew**		**Nongstoin**	**Mairang**		**Umsning**		**Umling**	**Jirang**	**Rongram**		**Tikrikilla**
Particulars	Pomlum PHC	Pongtung PHC	Jongksha PHC	Mawkynrew PHC	Bambrai PHC	Kynrud PHC	Nongthliew PHC	Umtrai PHC	Mawhati PHC	Byrnihat PHC	Warmawsaw PHC	Asananggiri PHC	Babadam PHC	Tikrikilla PHC
Status of Building														
Own government Building	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Rented Premises	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Rent-free Building	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Regular Electricity Supply	1	0	0	0	1	1	1	1	0	1	0	1	1	1
Beds	1	1	1	0	1	1	1	1	1	1	1	1	1	1
Generator	0	0	0	0	0	0	0	0	0	0	1	1	0	1
Telephone	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Running Vehicle / Ambulance	0	0	0	0	0	0	0	0	1	0	1	1	0	1

Investigative Facilities														
OPD rooms	1	0	0	0	1	1	1	1	1	1	1	1	1	1
Consulting Rooms (AYUSH)	0	0	0	0	0	1	0	1	0	0	1	0	0	1
Consulting Rooms(Specialist) CHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fully Equipped Labour Room	1	0	0	0	1	1	1	1	1	1	1	1	1	1
Minor O T	1	0	1	0	0	1	0	1	1	0	1	1	0	1
General O T	0	0	0	0	0	1	0	1	1	0	1	0	0	0
Separate wards for male and female	0	0	0	0	1	1	1	1	1	1	1	1	1	1
Separate public utilities (toilets) for male & female	1	1	0	1	1	1	1	1	1	1	1	0	1	1
Sitting arrangements for patients	1	0	0	1	0	1	0	1	1	0	0	1	0	1
Facility for food	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Medicine Shop	1	0	0	0	0	1	0	1	0	0	1	0	0	1

(Note: 1-Yes, 0-No)

Table 4.1: Coverage and Availability of Infrastructure (Contd.)

Districts →	**Jaintia Hills**					**EGH**				**SGH**				
Blocks →	**Amlarem**	**Thadlaskein**		**Laskein**		**Samanda**	**Resubelpara**	**Songsak**		**Baghmara**	**Rongara**		**Chocpot**	
Particulars	Dawki PHC	Nangbah PHC	Nartiang PHC	Shangpung PHC	Iooksi PHC	Banasmgre PHC	Bajengdoba PHC	Songsak PHC	Rari PHC	Siju PHC	Maheshkola PHC	Rongra PHC	Chockpot PHC	Silkigre PHC
Status of Building														
Own government Building	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Rented Premises	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Rent-free Building	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Regular Electricity Supply	1	0	1	1	1	1	1	1	1	1	0	1	1	1
Beds	1	0	1	1	1	1	1	1	1	1	1	1	1	1
Generator	1	0	0	1	0	0	0	0	0	0	1	0	1	1
Telephone	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Running Vehicle / Ambulance	1	0	1	1	0	0	0	0	0	0	1	0	1	1
Investigative Facilities														

OPD rooms	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Consulting Rooms (AYUSH)	0	1	1	0	0	1	0	1	0	1	1	0	1	0
Consulting Rooms(Specialist) CHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fully Equipped Labour Room	1	0	1	0	1	1	1	1	1	1	1	1	1	1
Minor O T	1	0	1	1	0	1	0	1	0	1	1	1	1	1
General O T	0	0	0	0	0	1	0	1	0	1	1	0	0	0
Separate wards for male and female	1	0	1	1	1	1	1	1	1	1	1	1	1	1
Separate public utilities (toilets) for male & female	1	0	1	0	1	1	1	1	1	1	1	1	1	1
Sitting arrangements for patients	0	1	1	1	0	1	0	1	0	1	0	1	1	1
Facility for food	0	0	1	0	0	0	0	0	0	0	1	1	1	0
Medicine Shop	1	0	1	0	0	1	0	1	0	1	1	0	1	1

(Note: 1-Yes, 0-No)

Coverage and Availability of Infrastructure

According to table 4.1, out of 28 sampled PHC more than 80% of PHCs were not having generators, telephone, general OT, facility for food for in patients, medicine shops etc. Although PHC are having labour room, there were shortage of necessary equipment. Most of the PHCs are not having ambulance. All the PHCs visited were having required number of beds, while the pillow and beds were not clean. Few of the PHC which were using pillows which were 5 to 6 years old and in a bad shape. Around 60% of the PHCs are not giving separate consulting rooms for AYUSH. All the PHCs are having their own building. Out of the 28 sampled PHC, only PHC Nartiang (Thadlaskein Block, Jaintia Hills district) were having a proper waste disposal system, free food facility for in patients, medicine shops etc.

Table 4.2: Positions of Medical Staff & Paramedical Staff

Districts →	**EKH**				**WKH**			**Ri-Bhoi**				**WGH**		
Blocks →	**Mylliem**	**Pynursla**	**Mawkynrew**		**Nongstoin**	**Mairang**		**Umsning**		**Umling**	**Jirang**	**Rongram**		**Tikrikilla**
Particulars	Pomlum PHC	Pongtung PHC	Jongksha PHC	Mawkynrew PHC	Bambrai PHC	Kynrud PHC	Nongthliew PHC	Umtrai PHC	Mawhati PHC	Byrnihat PHC	Warmawsaw PHC	Asananggiri PHC	Babadam PHC	Tikrikilla PHC
Position of Medical Staff														
Physician	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgeon	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynecologist	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pediatrician	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AYUSH	1	0	1	0	0	1	0	1	0	0	1	0	0	0
Anesthetist	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Practitioner	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Position of Paramedical and Support Staff														
ANM	1	1	0	1	1	1	1	1	1	1	1	1	1	1
Staff Nurse	1	1	1	1	1	1	1	1	0	1	0	1	1	1
Ward Boys	1	0	0	0	1	1	1	1	1	0	1	0	0	0
HA / LHV (Male)	0	0	0	0	1	0	1	0	0	0	0	0	0	0
HA / LHV (female)	1	1	0	0	0	0	0	0	0	0	0	1	0	1
Health Educator	1	1	1	0	1	0	1	0	1	0	0	1	0	0
Lab Technician	1	1	1	1	1	1	1	1	1	1	0	1	1	1
Radiographer	0	0	0	0	1	0	1	0	1	0	0	0	0	0
Driver	0	0	0	0	1	0	1	0	1	0	1	1	0	1
Block Program Manager	0	0	1	0	1	1	1	1	1	0	1	0	0	1
Accountant	1	0	1	1	1	1	1	1	1	1	1	1	1	1
Doctor Assistant (Compounder)	0	0	0	0	1	0	1	0	0	0	1	0	0	1
Cleaning Staff	1	0	0	1	1	1	1	1	1	1	1	1	1	1
Administrative & Other Staff	1	1	0	1	1	1	1	1	0	1	1	1	1	1

(Note: 1-Yes, 0-No)

Table 4.2 : Positions of Medical Staff & Paramedical Staff (contd.)

Districts →	Jaintia Hills					EGH				SGH				
Blocks →	Amlarem	Thadlaskein		Laskein		Samanda	Resubelpara	Songsak		Baghmara	Rongara		Chocpot	
Particulars	Dawki PHC	Nangbah PHC	Nartiang PHC	Shangpung PHC	Iooksi PHC	Banasmgre PHC	Bajengdoba PHC	Songsak PHC	Rari PHC	Siju PHC	Maheshkola PHC	Rongra PHC	Chockpot PHC	Silkigre PHC
Position of Medical Staff														
Physician	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgeon	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynecologist	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pediatrician	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AYUSH	0	1	1	1	1	0	1	1	1	1	0	0	1	0
Anesthetist	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Practitioner	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Position of Paramedical and Support Staff														
ANM	0	1	1	1	1	1	1	1	1	1	1	1	1	1
Staff Nurse	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Ward Boys	0	0	1	0	1	1	1	0	1	0	1	0	0	0
HA / LHV (Male)	0	0	1	0	0	1	1	0	1	0	1	0	0	0
HA / LHV (female)	1	1	1	1	0	0	1	1	1	1	0	1	1	1
Health Educator	1	1	1	1	0	1	1	1	1	1	1	0	1	0
Lab Technician	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Radiographer	0	0	0	0	0	1	0	0	0	0	1	0	0	0
Driver	1	0	1	1	0	1	1	1	1	1	1	1	1	1
Block Program Manager	1	0	0	0	1	1	0	0	0	0	1	1	1	1
Accountant	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Doctor Assistant (Compounder)	1	0	0	0	0	1	0	0	0	0	1	0	0	0
Cleaning Staff	1	0	0	1	1	1	0	1	0	1	1	0	1	0
Administrative & Other Staff	0	1	1	0	1	1	1	0	1	0	1	0	1	1

(Note: 1-Yes, 0-No)

Manpower

All the sampled PHC are having one general practitioner, while 50% of the PHC are not having AYUSH doctor. As per the NRHM norms, PHC should at least have two doctors (one may be a AYUSH doctor or a lady medical officer). All the PHCs were having lab technicians, health assistant, staff nurse, and pharmacist. Around 28% of PHC are not having cleaning staff.

Table 4.3 : Status of the Residential Facilities for Doctors and Nurses

Districts →	EKH				WKH			Ri-Bhoi				WGH		
Blocks →	Mylliem	Pynursla	Mawkynrew		Nongstoin	Mairang		Umsning		Umling	Jirang	Rongram		Tikrikilla
Particulars	Pomlum PHC	Pongtung PHC	Jongksha PHC	Mawkynrew PHC	Bambrai PHC	Kynrud PHC	Nongthliew PHC	Umtrai PHC	Mawhati PHC	Byrnihat PHC	Warmawsaw PHC	Asananggiri PHC	Babadam PHC	Tikrikilla PHC
Residential Facility														
Residential Facility for doctors	1	1	1	0	1	1	1	1	1	1	1	1	1	1
Residential Facility for Nurses	1	1	1	0	1	1	1	1	0	1	1	1	1	1

(Note: 1-Yes, 0-No)

Table 4.3 : Status of the Residential Facilities for Doctors and Nurses (Contd.)

Districts →	Jaintia Hills					EGH				SGH				
Blocks →	Amlarem	Thadlaskein		Laskein		Samanda	Resubelpara	Songsak		Baghmara	Rongara		Chocpot	
Particulars	Dawki PHC	Nangbah PHC	Nartiang PHC	Shangpung PHC	Iooksi PHC	Banasmgre PHC	Bajengdoba PHC	Songsak PHC	Rari PHC	Siju PHC	Maheshkola PHC	Rongra PHC	Chockpot PHC	Silkigre PHC
Residential Facility														
Residential Facility for doctors	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Residential Facility for Nurses	1	1	1	1	1	1	1	1	1	1	1	1	1	1

(Note: 1-Yes, 0-No)

Residential Facilities

All the PHCs are having residential facilities for doctors and nurses (excluding PHC Mawkynrew and Mawhati), but in most of the PHC there is a shortage of quarters. In most cases the rooms are being shared by More than two members. According to the field team, in around 75% of PHC the doctors are running private clinic in their allotted quarters and the lab test are conducted in the PHC. Even in few of the PHC the team found that during the OPD hours the doctors were running the clinic.

Table 4.4 : Status of Performance of Labour Room during 2009-10

Districts →	EKH				WKH			Ri-Bhoi				WGH		
Blocks →	Mylliem	Pynursla	Mawkynrew		Nongstoin	Mairang		Umsning		Umling	Jirang	Rongram		Tikrikilla
Particulars	Pomlum PHC	Pongtung PHC	Jongksha PHC	Mawkynrew PHC	Bambrai PHC	Kynrud PHC	Nongthliew PHC	Umtrai PHC	Mawhati PHC	Byrnihat PHC	Warmawsaw PHC	Asananggiri PHC	Babadam PHC	Tikrikilla PHC
Total Institutional Delivery	60	0	0	0	0	18	0	0	3	0	8	147	0	148
Normal Delivery	60	0	0	0	0	18	0	0	3	0	8	147	0	148
Cesarean Delivery	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 4.4 : Status of Performance of Labour Room during 2009-10 (Contd.)

Districts →	Jaintia Hills					EGH				SGH				
Blocks →	Amlarem	Thadlaskein		Laskein		Samanda	Resubelpara	Songsak		Baghmara	Rongara		Chocpot	
Particulars	Dawki PHC	Nangbah PHC	Nartiang PHC	Shangpung PHC	Iooksi PHC	Banasmgre PHC	Bajengdoba PHC	Songsak PHC	Rari PHC	Siju PHC	Maheshkola PHC	Rongra PHC	Chockpot PHC	Silkigre PHC
Total Institutional Delivery	3	0	202	112	0	25	40	35	0	28	0	23	43	10
Normal Delivery	3	0	202	112	0	25	40	35	0	28	0	26	43	10
Cesarean Delivery	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance of Labour Room

The maximum number of institutional deliveries were carried out in Jaintia Hills district, while lowest number of deliveries was carried out in Ri Bhoi district.

Table 4.5 : Source and frequency of funds received under NRHM

Districts →	**EKH**				**WKH**			**Ri-Bhoi**				**WGH**		
Blocks →	**Mylliem**	**Pynursla**	**Mawkynrew**		**Nongstoin**	**Mairang**		**Umsning**		**Umling**	**Jirang**	**Rongram**		**Tikrikilla**
Particulars	Pomlum PHC	Pongtung PHC	Jongksha PHC	Mawkynrew PHC	Bambrai PHC	Kynrud PHC	Nongthliew PHC	Umtrai PHC	Mawhati PHC	Byrnihat PHC	Warmawsaw PHC	Asananggiri PHC	Babadam PHC	Tikrikilla PHC
Sources of funds received														
From the District	1	1	1	1	1	1	1	1	1	1	0	1	1	1
Directly from the State	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Frequency of Receiving the Funds														
Yearly	1	1	1	1	0	1	1	1	1	1	0	1	1	0
Half yearly	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Quarterly	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Irregular	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Delay in Getting Funds (Yes -1, No-0)	0	0	0	1	0	0	0	1	0	0	0	1	0	1

(Note: 1-Yes, 0-No)

Table 4.5 : Source and frequency of funds received under NRHM (Contd.)

Districts →	**Jaintia Hills**					**EGH**				**SGH**				
Blocks →	**Amlarem**	**Thadlaskein**		**Laskein**		**Samanda**	**Resubelpara**	**Songsak**		**Baghmara**	**Rongara**		**Chocpot**	
Particulars	Dawki PHC	Nangbah PHC	Nartiang PHC	Shangpung PHC	Iooksi PHC	Banasmgre PHC	Bajengdoba PHC	Songsak PHC	Rari PHC	Siju PHC	Maheshkola PHC	Rongra PHC	Chockpot PHC	Silkigre PHC
Sources of funds received														
From the District	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Directly from the State	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frequency of Receiving the Funds														
Yearly	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Half yearly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Quarterly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Irregular	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Delay in Getting Funds (Yes -1, No-0)	1	0	1	0	0	1	0	1	0	1	0	0	1	1

(Note: 1-Yes, 0-No)

Funds

All the PHC are getting funds directly from district, while PHCs run under PPP are getting the funds directly from state. More than 90% of the PHCs are receiving the funds on yearly basis. Around 40% of the PHCs have stated that there is delay in getting the funds from district.

Table 4.6: Status of Rogi Kalyan Samities (RKS)

Districts →	**EKH**				**WKH**			**Ri-Bhoi**				**WGH**		
Blocks →	**Mylliem**	**Pynursla**	**Mawkynrew**		**Nongstoin**	**Mairang**		**Umsning**		**Umling**	**Jirang**	**Rongram**		**Tikrikilla**
Particulars	Pomlum PHC	Pongtung PHC	Jongksha PHC	Mawkynrew PHC	Bambrai PHC	Kynrud PHC	Nongthliew PHC	Umtrai PHC	Mawhati PHC	Byrnihat PHC	Warmawsaw PHC	Asananggiri PHC	Babadam PHC	Tikrikilla PHC
Is RKS formed?	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Is it Registered?	1	1	1	1	1	1	1	1	1	1	1	1	1	1
#Frequency of RKS Meetings	3	4	4	4	1	2	2	2	6	3	1	12	3	3
Role of RKS														
Addressing Complaints of Patients	1	1	1	0	1	1	1	1	1	1	0	1	1	1
Improvement of health facility infrastructure	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Improvement of health related equipment	1	0	0	0	1	1	1	1	0	1	1	1	1	1
Improvement of lodging /boarding facility to patients and their relatives	1	0	1	0	1	1	1	1	0	1	1	0	1	0
Improvement in support services like cleaning, laundry, diagnostic, waste disposal etc.	1	1	0	0	0	1	1	1	0	1	1	0	1	0
RKS Funds														
RKS Generate Funds	1	1	1	1	1	0	0	0	2	1	0	0	1	1
Are the funds adequate to meet all the requirements	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Utilisation of Funds														
Purchase of Equipments	1	1	1	1	1	0	0	0	0	1	0	1	1	1
Improvement of Infrastructure	1	1	1	1	1	0	0	0	0	1	0	0	1	1
Maintenance	1	0	0	1	1	0	0	0	0	1	0	1	1	1
Seeking service from private sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Repair/Renovation	1	1	0	0	1	0	0	0	0	1	0	0	1	1
Buying medicines	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cleaning & Security services	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Hiring contractual staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0

(Note: 1-Yes, 0-No, # =actual numbers)

Table 4.6: Status of Rogi Kalyan Samities (RKS) (Contd.)

Districts →	Jaintia Hills					EGH				SGH				
Blocks →	**Amlarem**	**Thadlaskein**		**Laskein**		**Samanda**	**Resubelpara**	**Songsak**		**Baghmara**	**Rongara**		**Chocpot**	
Particulars	Dawki PHC	Nangbah PHC	Nartiang PHC	Shangpung PHC	Iooksi PHC	Banasmgre PHC	Bajengdoba PHC	Songsak PHC	Rari PHC	Siju PHC	Maheshkola PHC	Rongra PHC	Chockpot PHC	Silkigre PHC
Is RKS formed?	1	1	1	1	1	1	1	1	1	1	1	0	1	1
Is it Registered?	1	1	1	1	1	1	1	1	1	1	1	0	1	1
#Frequency of RKS Meetings	2	4	4	1	3	2	2	3	2	3	2	0	3	4
Role of RKS												0		
Addressing Complaints of Patients	0	0	0	0	1	1	1	1	1	1	1	0	1	1
Improvement of health facility infrastructure	0	1	1	1	1	1	1	1	1	1	1	0	1	1
Improvement of health related equipment	0	0	0	1	1	1	1	1	1	1	1	0	1	1
Improvement of lodging /boarding facility to patients and their relatives	0	0	0	0	1	1	1	1	1	1	1	0	1	0
Improvement in support services like cleaning, laundry, diagnostic, waste disposal etc.	0	0	0	0	1	1	1	1	1	1	1	0	1	1
RKS Funds														
RKS Generate Funds	1	0	0	1	1	0	0	1	0	1	0	0	1	1
Are the funds adequate to meet all the requirements	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Utilisation of Funds														
Purchase of Equipments	0	0	0	1	1	0	0	1	0	1	0	0	0	1
Improvement of Infrastructure	0	0	0	1	1	0	0	1	0	1	0	0	1	0
Maintenance	0	0	0	1	1	0	0	1	0	1	0	0	1	1
Seeking service from private sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Repair/Renovation	0	0	0	1	1	0	0	1	0	1	0	0	1	0
Buying medicines	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Cleaning & Security services	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Hiring contractual staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0

(Note: 1-Yes, 0-No, # =actual numbers)

Rogi Kalyan Samities (RKS)/ Patient Welfare Committee (PWC)

The RKS/PWC in PHCs is not functioning in an effective manner. RKS/PWC has a very important role to play in PHCs, which are not being followed, because of lack of knowledge and non-interest. Around 80% of RKS are not generating any additional funds. Most of the untied funds are spent on maintenance and repair renovation of health facility and staff residents. There is no uniformity in the frequency of RKS/PWC meetings. The few RKS/PWC are generating funds in the form of user charge. During teams visit to the field, PHC Nartiang was the only PHC which is utilizing the RKS money in a proper and efficient manner. There should be a reward system for health facility which is performing up to the standard based on a patient satisfaction survey. This may help to boost the moral of medical staff and interest may be shown by them for a efficient functioning of RKS/PWC.

Chapter - 5

Sub Centre

A sub health centre (Sub-Centre) is the most peripheral and first contact point between primary health care system and the community. As per the population norms, one sub centre is established for every 3000 population in hilly areas. A sub centre provides interface with the community at the grass root level, providing all the primary health care services. The sub centres are considered as one of the important component under the programme. Most of the sub centres functioning in the state are below the expectations. While compared to the sub centres in Khasi hills, sub centres in Garo hills are showing improvement. In most of the sub centres in garo hills, particularly West Garo Hills district institutional deliveries are being conducted in sub centres.

There needs to be further improvement in the quality care and manpower. Most of the sub centres are having only one ANM in place. There is no separate health worker in any of the visited sub centre. The building condition of most of the sampled sub centres were not up to the standard. Around 50 sub centres were visited by the teams during the field study. The data analysis based on the field data is as follows:

Table 5.1: Coverage and Availability of Infrastructure

Districts →	**EKH**										**EGH**				
Blocks →	**Mylliem**				**Pynursla**			**Mawkynrew**			**Samanda**	**Resubelpara**		**Songsak**	
Particulars	Umlympung sc	Liewlong sc	Umthlong sc	Lawsohtun sc	Pyrnai sc	Mawkliaw sc	Nongtyngur sc	Thangsning sc	Mawlyngnot sc	Kharang sc	Mandalgre sc	Khaldang sc	Samkalakgre sc	Jamge sc	Gokulgre sc
Own building	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Rented premises	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Delivery table	0	1	0	0	1	1	1	1	1	1	0	1	0	0	1
Medical equipments	0	1	0	0	1	0	0	1	0	0	0	1	0	0	1
	0	0	0	0	1	1	0	1	1	0	0	0	0	0	1

Electricity															
Water supply	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Number of ANM posted in SHC	2	1	1	1	1	1	2	2	2	1	2	1	1	1	1
ANM staying in sub centre	1	0	0	0	0	1	1	0	1	1	1	0	0	0	0
#Number of villages covered by SHC having ASHA in position	8	7	4	6	4	5	10	4	4	4	4	6	4	7	5
#Number of villages covered by SHC having VHSC in place	11	7	4	6	4	4	10	4	4	4	4	6	4	7	5
Essential Drug Kit provided	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

(Note: 1-Yes, 0-No, # =actual numbers)

Table 5.1: Coverage and Availability of Infrastructure (contd.)

Districts →	**WKH**										**WGH**				
Blocks →	**Nongstoin**			**Mairang**				**Ranikor**			**Dadenggiri**	**Rongram**		**Tikrikilla**	
Particulars	Umiap sc	Mawlieh sc	Mawdoh sc	Mawnai sc	Mawshut sc	Jakhong sc	Nongliput sc	Nongnah sc	Gillagora sc	Khonjoy sc	Romgre sc	Waribokgre sc	Baljek sc	Rangsagre sc	Hollaidanga sc
Own building	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1
Rented premises	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Delivery table	0	0	0	0	0	0	0	0	0	1	0	1	1	1	1
Medical equipments	0	1	0	0	0	0	0	0	0	1	0	1	1	1	1
Electricity	0	1	0	0	0	0	0	0	0	1	0	0	1	0	0
Water supply	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0
Number of ANM posted in SHC	2	1	1	1	2	1	1	2	1	1	2	2	1	2	2
ANM staying in centre	0	1	0	0	1	0	1	0	0	1	1	0	0	1	0
Number of villages covered by SHC having ASHA in position	7	19	8	6	7	6	6	5	7	15	4	6	3	5	6
Number of villages covered by SHC having VHSC in place	7	19	7	7	6	6	5	4	7	15	4	6	4	5	5
Essential Drug Kit	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

(Note: 1-Yes, 0-No)

Table 5.1: Coverage and Availability of Infrastructure (contd.)

Districts →	Ri-Bhoi							Jaintia Hills						
Blocks →	Umsning			Umling			Jirang	Thadlaskein					Amlarem	
Particulars	Umroi sc	Iapngar sc	Sonidan sc	Narang sc	Amjong sc	Baridua sc	Umsong sc	Tyrshang sc	Sohphoh sc	Mihmyntdu sc	Nynkrem sc	Nonglatem sc	Sohkha sc	Darrang sc
Own building	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Rented premises	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Delivery table	1	1	1	0	0	0	0	1	1	1	1	1	1	0
Medical equipments	1	1	1	0	1	1	0	1	1	0	1	1	1	1
Electricity	0	0	0	0	0	1	0	1	1	0	0	1	0	0
Water supply	1	1	1	0	0	0	0	0	0	0	0	0	1	0
Number of ANM posted in SHC	1	2	2	2	2	1	2	2	2	2	2	1	1	1
ANM staying in centre	0	1	1	1	1	1	1	1	0	1	1	1	1	1
Number of villages covered by SHC having ASHA in position	11	7	6	13	11	20	24	6	6	2	3	6	5	6
Number of villages covered by SHC having VHSC in place	13	7	6	13	10	11	20	6	6	2	3	7	5	6
Essential Drug Kit	1	1	1	1	1	1	1	1	1	1	1	1	1	1

(Note: 1-Yes, 0-No)

Table 5.1: Coverage and Availability of Infrastructure (contd.)

Districts →	SGH					
Blocks →	Baghmara		Rongara		Chocpot	
Particulars	Karukol sc	Nengkong sc	Damba Aga sc	Balpakram sc	Kenegre sc	Mitapgre sc
Own building	1	1	1	1	1	1
Rented premises	0	0	0	0	0	0
Delivery table	0	0	0	0	0	0
Medical equipments	1	1	0	1	1	0
Electricity	0	1	1	0	1	1
Water supply	0	0	0	0	0	0
Number of ANM posted in SHC	1	1	1	1	1	1
ANM staying in centre	1	0	1	1	0	1
Number of villages covered by SHC having ASHA in position	5	10	6	5	14	8
Number of villages covered by SHC having VHSC in place	5	5	6	5	4	8
Essential Drug Kit	1	1	1	1	1	1

(Note: 1-Yes, 0-No)

Infrastructure

All the sub centres are having their own building, except in most of the places the building condition is not good. Around 54% of the sub centre were not having delivery table. Around 50% of the sub centres are having one ANM, as per the norms there should be two ANM in each sub centre under NRHM. 40% of the sub centres are not having electricity and water supply. There were few sub centres keeping expired medicine. None of the sub centres are having a waste disposal pit; sub centres are either throwing it in open or burning it.

Only in 60% of the sub centres ANM are staying in the sub centre. In sub centres nearer to the borders they feel unsafe to stay in the night, while in some places the building condition is not good and some of them stay in their own home in the village with their families. The average number of villages covered by sub centre is 7, while all the villages under these sub centres are having VHSC in place. The functioning of VHSC in villages are not up to the mark. In few of the villages visited we saw dustbins being distributed by VHSC. While interacting with the local people, they are not much aware of the VHSC and their functioning. While interacting with the VHSC committee members, we came to know that there are differences between them in decision making. RKS/PWC can play a vital role by having a coordination meeting with the VHSC members to sort out their problem, which is not happening.

Table 5.2: Status of Programme Intervention

Districts →	**EKH**										**EGH**				
Blocks →	**Mylliem**				**Pynursla**			**Mawkynrew**			**Samanda**	**Resubelpara**		**Songsak**	
Particulars	Umlympung sc	Liewlong sc	Umthlong sc	Lawsohtun sc	Pymai sc	Mawkliaw sc	Nongtyngur sc	Thangsning sc	Mawlyngnot sc	Kharang sc	Mandalgre sc	Khaldang sc	Samkalakgre sc	Jamge sc	Gokulgre sc
Involvement in selection of ASHA (Yes-1, No-0)	1	1	0	1	0	0	0	1	0	1	1	0	1	0	0
Meeting with ASHA															
Weekly	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Fortnightly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monthly	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1
Rarely	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Never	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Has ASHA reduced the workload? (Yes-1, No-0)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
ASHA contribution to NRHM															
Mobilizing community to avail health services.	1	1	1	1	0	0	1	0	0	1	1	1	1	0	0

Identify and accompanying complicated delivery cases.	1	1	1	0	0	0	1	0	0	0	1	1	0	0	0
Providing health information to the community	1	1	1	1	0	0	1	1	0	0	1	1	1	0	0
Providing new born baby care	1	1	1	0	0	0	1	0	0	0	1	1	0	0	0
Survey work	0	0	0	1	0	1	1	1	1	1	0	0	1	0	1

(Note: 1-Yes, 0-No)

Table 5.2: Status of Programme Intervention (contd.)

Districts →	**WKH**										**WGH**				
Blocks →	**Nongstoin**			**Mairang**				**Ranikor**			**Dadenggiri**	**Rongram**		**Tikrikilla**	
Particulars	Umiap sc	Mawlieh sc	Mawdoh sc	Mawnai sc	Mawshut sc	Jakhong sc	Nongliput sc	Nongnah sc	Gillagora sc	Khonjoy sc	Romgre sc	Waribokgre sc	Baljek sc	Rangsagre sc	Hollaidanga sc
Involvement in selection of ASHA (Yes-1, No-0)	0	1	0	1	0	1	0	1	1	1	1	1	0	1	0
Meeting with ASHA															
Weekly	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0
Fortnightly	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Monthly	0	1	0	1	0	1	0	1	0	1	0	0	0	1	1
Rarely	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Never	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Has ASHA reduced the workload? (Yes-1, No-0)	0	1	0	1	0	1	0	1	0	1	1	1	1	1	1
ASHA contribution to NRHM															
Mobilizing community to avail health services.	0	1	0	1	0	1	0	1	1	1	0	0	1	1	1
Identify and accompanying complicated delivery cases.	0	1	0	1	0	1	0	1	1	1	0	0	1	0	1
Providing health information to the community	0	1	0	1	0	1	0	1	1	1	1	1	1	1	1
Providing new born baby care	0	1	0	1	0	1	0	1	0	1	0	0	1	1	1
Survey work	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

(Note: 1-Yes, 0-No)

Table 5.2: Status of Programme Intervention (contd.)

Districts →	Ri-Bhoi							Jaintia Hills						
Blocks →	Umsning			Umling			Jirang	Thadlaskein					Amlarem	
Particulars	Umroi sc	Iapngar sc	Sonidan sc	Narang sc	Amjong sc	Baridua sc	Umsong sc	Tyrshang sc	Sohphoh sc	Mihmyntdu sc	Nynkrem sc	Nonglatem sc	Sohkha sc	Darrang sc
Involvement in selection of ASHA	1	1	1	1	1	0	1	1	1	1	1	1	0	1
Meeting with ASHA														
Weekly	0	1	0	0	0	0	0	1	1	1	1	1	1	1
Fortnightly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monthly	1	0	1	1	1	1	1	0	0	0	0	0	0	0
Rarely	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Never	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Has ASHA reduced the workload?	0	1	0	1	1	1		1	1	1	1	1	1	1
ASHA contribution to NRHM														
Mobilizing community to avail health services.	1	0	1	1	1	1	0	1	1	1	1	1	1	1
Identify and accompanying complicated delivery cases.	1	1	1	1	1	1	0	1	1	1	1	1	1	1
Providing health information to the community	1	0	1	1	1	1	1	1	1	1	1	1	1	1
Providing new born baby care	1	0	1	1	1	1	1	0	0	0	1	1	1	1
Survey work	0	0	0	0	0	0	0	0	0	0	0	0	0	0

(Note: 1-Yes, 0-No)

Table: 5.2 Status of Programme Intervention (contd.)

Districts →	SGH					
Blocks →	Baghmara		Rongara		Chocpot	
Particulars	Karukol sc	Nengkong sc	Damba Aga sc	Balpakram sc	Kenegre sc	Mitapgre sc
Involvement in selection of ASHA (Yes-1, No-0)	1	1	1	1	1	1
Meeting with ASHA						
Weekly	1	1	1	1	1	1
Fortnightly	0	0	0	0	0	0
Monthly	0	0	0	0	0	0
Rarely	0	0	0	0	0	0
Never	0	0	0	0	0	0
Has ASHA reduced the workload? (Yes-1, No-0)	1	1	1	1	1	1
ASHA contribution to NRHM						
Mobilizing community to avail health services.	1	1	1	1	1	1
Identify and accompanying complicated delivery cases.	1	1	1	1	1	1
Providing health information to the community	1	1	1	1	1	1
Providing new born baby care	0	0	0	0	0	0
Survey work						

(Note: 1-Yes, 0-No)

Programme Intervention

Around 32% of ANM were not involved in selection of ASHA, while 34% of ANM have stated that ASHA meet them on weekly basis and 54% of them have stated that they meet ASHA once in a month. 84% of ANM have stated that ASHA has helped in reducing their work load. More than 90% of ANM have stated that ASHA are mobilizing the community to avail health services, while 34% of ANM have stated that ASHA's involvement in identifying and accompanying complicated delivery cases

is very limited. More than 50% of ANM have stated that ASHA are not focusing on new born baby care.

Table 5.3 : Status of Funds received under NRHM

Districts →	**EKH**										**EGH**				
Blocks →	**Mylliem**				**Pynursla**			**Mawkynrew**			**Samanda**	**Resubelpara**		**Songsak**	
Particulars	Umlympung sc	Liewlong sc	Umthlong sc	Lawsohtun sc	Pynai sc	Mawkliaw sc	Nongtyngur sc	Thangsning sc	Mawlyngnot sc	Kharang sc	Mandalgre sc	Khaldang sc	Samkalakgre sc	Jamge sc	Gokulgre sc
Have received the grant for sub centre	1	1	1	1	1	1	0	1	1	1	1	1	1	0	1
Have opened a bank account	1	1	1	1	1	1	0	1	1	1	1	1	1	0	1
Is it a joint account	1	1	1	1	1	1	0	1	1	1	1	1	1	0	1
Other account holder															
Village Head	0	1	1	1	1	1	0	1	1	1	1	1	1	0	1
ASHA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AWW	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VHC Member	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Utilization of the grant/ untied funds															
In repairing and Renovation	1	1	1	1	1	1	0	1	1	1	1	1	1	0	1
In purchasing equipments	1	1	1	1	0	0	0	0	0	1	1	1	0	0	1
In buying medicines	1	1	1	1	1	1	0	1	1	0	1	1	1	0	1
For electricity supply	0	0	0	0	0	1	0	1	1	0	0	0	1	0	0
For water supply	0	0	0	0	1	1	0	0	1	1	0	0	1	0	0

(Note: 1-Yes, 0-No)

Table 5.3: Status of Funds received under NRHM (contd.)

Districts →	WKH										WGH				
Blocks →	Nongstoin			Mairang				Ranikor			Dadenggiri	Rongram		Tikrikilla	
Particulars	Umiap sc	Mawlieh sc	Mawdoh sc	Mawnai sc	Mawshut sc	Jakhong sc	Nongliput sc	Nongnah sc	Gillagora sc	Khonjoy sc	Romgre sc	Waribokgre sc	Baljek sc	Rangsagre sc	Hollaidanga sc
Have received the grant for sub centre	0	1	0	1	1	1	1	1	1	0	1	0	1	1	1
Have opened a bank account	0	1	0	1	1	1	1	1	1	0	1	0	1	1	1
Is it a joint account	0	1	0	1	1	1	1	1	1	0	1	0	1	1	1
Other account holder															
Village Head	0	1	0	1	1	1	1	1	1	0	1	0	1	1	1
ASHA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AWW	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VHC Member	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Utilization of the grant/ untied funds															
In repairing and renovation	0	0	0	0	1	0	0	0	1	0	1	0	1	1	1
In purchasing equipments	0	1	0	1	1	1	1	1	1	0	1	0	1	1	0
In buying medicines	0	1	0	1	1	1	1	1	0	0	0	0	0	1	0
For electricity supply	0	0	0	0	1	0	1	0	0	0	0	0	1	0	0
For water supply	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

(Note: 1-Yes, 0-No)

Table 5.4 Status of Funds received under NRHM (Contd.)

Districts →	Ri-Bhoi							Jaintia Hills						
Blocks →	Umsning			Umling			Jirang	Thadlaskein					Amlarem	
Particulars	Umroi sc	Iapngar sc	Sonidan sc	Narang sc	Amjong sc	Baridua sc	Umsong sc	Tyrshang sc	Sohphoh sc	Mihmyntdu sc	Nynkrem sc	Nonglatem sc	Sohkha sc	Darrang sc
Have received the grant for sub centre	1	0	1	1	1	1	1	0	0	1	1	1	1	1
Have opened a bank account	1	0	1	1	1	1	1	1	1	1	1	0	1	1
Is it a joint account	1	0	1	1	1	1	1	1	1	1	1	0	0	1
Other account holder														
Village Head	1	0	1	1	1	1	1	1	1	1	1	0	0	1
ASHA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AWW	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VHC Member	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Utilization of the grant/ untied funds														
In repairing and renovation	1	0	1	1	1	1	1	1	1	1	1	1	1	1
In purchasing equipments	1	0	1	1	1	1	1	1	1	1	1	1	1	1
In buying medicines	0	0	0	0	1	0	0	0	0	0	0	0	0	0
For electricity supply	0	0	0	0	1	1	0	1	1	0	1	0	0	0
For water supply	0	0	0	0	1	0	0	1	1	1	0	0	0	0

(Note: 1-Yes, 0-No)

Table 5.4: Status of Funds received under NRHM (Contd.)

Districts →	SGH					
Blocks →	Baghmara		Rongara		Chocpot	
Particulars	Karukol sc	Nengkong sc	Damba Aga sc	Balpakram sc	Kenegre sc	Mitapgre sc
Have received the grant for sub centre (Yes-1, No-0)	0	1	1	0	1	1
Have opened a bank account	0	1	1	0	1	1
Is it a joint account	0	1	1	0	1	1
Other account holder						
Village Head	0	1	1	0	1	1
ASHA	0	0	0	0	0	0
AWW	0	0	0	0	0	0
MO	0	0	0	0	0	0
VHC Member	0	0	0	0	0	0
Utilization of the grant/ untied funds						
In repairing and renovation	1	1	1	1	1	1
In purchasing equipments	1	1	1	1	1	1
In buying medicines	1	1	0	1	1	0
For electricity supply	0	1	1	0	1	1
For water supply	0	0	0	0	0	0

(Note: 1-Yes, 0-No)

Funds

22% of sub centres have not received the funds for the current financial year (2009-2010). More than 50% of the sub centres are not having a joint account. Most of the annual maintenance fund and untied funds are spent on repair, renovation and purchasing of equipments, while 30% of ANM also spends it for supply of electricity and water. It was observed that in South Garo Hills district ANM had spent around 65% of the funds for purchase of refrigerator in the year 2009-2010. There is no monitoring by the officials to check the funds flow in sub centre.

Table 5.5: Status of Service delivery

Districts →	**EKH**										**EGH**				
Blocks →	**Mylliem**				**Pynursla**			**Mawkynrew**			**Samanda**	**Resubelpara**		**Songsak**	
Particulars	Umlympung sc	Liewlong sc	Umthlong sc	Lawsohtun sc	Pymai sc	Mawkliaw sc	Nongtyngur sc	Thangsning sc	Mawlyngnot sc	Kharang sc	Mandalgre sc	Khaldang sc	Samkalakgre sc	Jamge sc	Gokulgre sc
Do ANM conduct deliveries	1	1	0	0	0	0	0	0	0	1	1	0	0	0	0
Place of conducting deliveries. 1-At home, 2- At sub centre.	1	1	0	0	0	0	0	0	0	1	1	2	2	1	2
Number of deliveries conducted in a month, on an average.	2	2	0	0	0	0	0	0	0	1	2	0	0	0	0
Where the complicated deliveries sent?															
Dai	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PHC	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0
CHC	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
District Hospital	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Private Practitioner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of traditional birth attendants in the area	3	4	0	0	0	0	2	0	0	0	2	0	0	2	0

(Note: 1-Yes, 0-No)

Table 5.5: Status of Service delivery (Contd.)

Districts →	**WKH**										**WGH**				
Blocks →	**Nongstoin**			**Mairang**				**Ranikor**			**Dadenggiri**	**Rongram**		**Tikrikilla**	
Particulars	Umiap sc	Mawlieh sc	Mawdoh sc	Mawnai sc	Mawshut sc	Jakhong sc	Nongliput sc	Nongnah sc	Gillagora sc	Khonjoy sc	Romgre sc	Waribokgre sc	Baljek sc	Rangsagre sc	Hollaidanga sc
Do ANM conduct deliveries	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1
Place of conducting deliveries. 1-At home, 2- At sub centre.	1	1	1	2	1	2	1	1	2	2	1	0	1	2	1
Number of deliveries conducted in a month, on an average.	2	2	4	3	2	4	2	1	1	3	2	0	3	2	4
Where the complicated deliveries sent?															
Dai	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PHC	0	0	0	0	0	1	0	0	0	0	0	0	1	1	1
CHC	1	0	1	0	1	0	1	0	1	1	1	1	0	0	0
District Hospital	0	1	1	1	1	1	0	1	0	0	0	0	1	0	0
Private Practitioner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of traditional birth attendants in the area	0	6	0	6	0	6	0	6	7	1	0	0	0	0	2

(Note: 1-Yes, 0-No)

Table 5.5: Status of Service delivery (Contd.)

Districts →	Ri-Bhoi							Jaintia Hills						
Blocks →	Umsning			Umling			Jirang	Thadlaskein					Amlarem	
Particulars	Umroi sc	Iapngar sc	Sonidan sc	Narang sc	Amjong sc	Baridua sc	Umsong sc	Tyrshang sc	Sohphoh sc	Mihmyntdu sc	Nynkrem sc	Nonglatem sc	Sohkha sc	Darrang sc
Do ANM conduct deliveries	1	1	1	1	1	0	1	1	0	1	1	1	1	1
Place of conducting deliveries. 1-At home, 2- At sub centre.	1	1	1	1	1	0	1	1	0	1	1	1	1	1
Number of deliveries conducted in a month, on an average.	2	2	2	3	2	0	2	1	0	5	2	1	6	2
Where the complicated deliveries sent?														
Dai	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PHC	0	0	0	0	0	1	0	0	0	0	0	0	0	1
CHC	1	0	1	1	0	0	0	1	1	0	0	0	1	1
District Hospital	0	1	0	0	1	0	1	0	0	1	1	1	0	1
Private Practitioner	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of traditional birth attendants in the area	20	0	6	3	5	10	8	2	2	0	0	2	2	5

(Note: 1-Yes, 0-No)

Table 5.5: Status of Service delivery (Contd.)

Districts →	SGH					
Blocks →	Baghmara		Rongara		Chocpot	
Particulars	Karukol sc	Nengkong sc	Damba Aga sc	Balpakram sc	Kenegre sc	Mitapgre sc
Do ANM conduct deliveries	1	1	1	1	1	1
Place of conducting deliveries. 1-At home, 2- At sub centre.	1	1	1	1	1	1
Number of deliveries conducted in a month, on an average.	3	2	1	6	3	1
Where the complicated deliveries sent?						
Dai	0	0	0	0	0	0
PHC	1	1	1	1	1	1
CHC	0	0	0	0	0	0
District Hospital	0	0	0	0	0	0
Private Practitioner	0	0	0	0	0	0
Number of traditional birth attendants in the area	3	2	2	4	3	3

(Note: 1-Yes, 0-No)

Service delivery

Around 62% of ANM conducts delivery at home, while 38% of ANM conducts deliveries at sub centre. On an average two deliveries are conducted by ANM in a month. 28% sent complicated delivery cases to PHC, while 36% sent complicated delivery cases to CHC and district hospital. On an average in each sub center area there are 3-5 traditional birth attendants.

Chapter - 6

Beneficiaries

This chapter presents the characteristics of the beneficaries and household, distribution of households and the problems of their waste disposal , stagnation of waste water, mosquito breeding around the house and system of medicine preferred by them. It also covers distribution of beneficiaries by the information about availability of health worker, facilities and transport used to transport serious patients, their knowledge about NRHM, ASHA and its activities, VHND, VHSC and JSY, background characteristics of JSY beneficiaries, registration of JSY beneficiaries, information about JSY card, role of ASHA during the pregnancy of the beneficiaries, place of delivery and reason for not opting for institutional delivery, transportation of the beneficiaries to reach the health institution, waiting time at the health facility, type of delivery, amount spent at the health facility and satisfaction regarding services made available in the health facility. Reason for the JSY beneficiary to opt for home delivery, in spite of cash incentives being available under the JSY Scheme for institutional delivery, cash incentive received by the beneficiary under JSY scheme, utilization of government health facility in the last 6 months, characteristics of the respondents who have availed the services in government health facility in last 6 months, client satisfaction regarding behaviour of health worker, privacy and availability of medicines, user fees and extra charges, services for the BPL patients, Outbreak of some diseases (Malaria, Measles, Gastroenteritis, Jaundice and Other Diseases) in the respondents' area in the last six months, action to be taken for selected diseases (diarrhoea, high fever, persistent cough, loose motion, persistent cough and breathing problems for a child), awareness about spacing methods and ideal gap between 1st and 2nd child and awareness about modes of getting AIDS, source of information about AIDS and general awareness.

The study findings based on the data analysis are as follows:

Details of Births, Breast feeding, Immunization (Table 7.1)

All the beneficiaries in West Garo Hills district have immunized their child against important diseases. Moreover in all the districts more than 80% of the children have

been immunized against important diseases. While in Garo Hills districts less than 50% of the beneficiaries received advice for PNC and family planning during pregnancy. All the beneficiaries breast feed their child.

Role of ASHA and VHSC (Table 7.2)

More than 90% of the beneficiaries have heard of ASHAs in the Garo Hills districts. Only 17.6% of beneficiaries in East Khasi Hills district stated that ASHAs held discussions about DOTS service. Around 50% of beneficiaries attend health day at the village. 50% of the beneficiaries stated that there has been no contribution of VHSC in their village. Most the beneficiaries are not satisfied with the services rendered during VHND.

JSY scheme (Table 7.3)

Less than 50% of the beneficiaries in East Khasi Hills district and West Khasi Hills district are aware of JSY scheme, while more than 70% of beneficiaries in Garo Hills districts are aware of JSY scheme. Most of the beneficiaries get information about JSY scheme from ASHAs and ANMs.

JSY card (Table 7.4)

Less than 50% of beneficiaries have stated that they have got JSY cards, while 50% of beneficiaries faced difficulties in getting JSY cards in East Khasi Hills district and Jaintia Hills.

Reasons for not opting for institutional delivery (Table 7.5)

Most of the deliveries are conducted at home. While less than 30% of beneficiaries delivered in health facilities. Only in West Garo Hills, South Garo Hills and East Garo Hills district institutional deliveries are conducted in sub centres.

Transportation (Table 7.6)

Around 70% of the beneficiaries use private vehicles to reach place of delivery, while 80% of beneficiaries have stated that no body facilitated in arranging the transport.

Satisfaction (Table 7.7)

At the time of deliveries, beneficiaries are accompanied by their neighbours or relatives. None of the interviewed beneficiaries were accompanied by ASHAs, ANM, AWW. More than 80% of the deliveries were normal, while 5.9% deliveries in West Garo Hills and 3.4% in South Garo Hills district were ceasareen. Most of the beneficiaries were satisfied with the services available at the health facilities.

Cash incentive (Table 7.8)

90% of the JSY beneficiaries in all seven districts are receiving cash incentives. Average amount received by beneficiaries as cash incentive is Rs.700. Around 81.2% of the beneficiaries in East Khasi Hills district utilize the money for buying medicines for self, while most of the beneficiaries in other remaining districts spend it on child care.

Reason for opting for home delivery (Table 7.9)

Most of the beneficiaries opt for home delivery, as it is convenient, and transportation to the health facility is inconvenient and difficult.

Awareness (Table 7. 10)

Around 30% of the beneficiaries are not aware of Nischay Pregnancy Test Kit. Most of the beneficiaries are getting NPTK from PHCs, while few others get it from ASHAs. Less than 25% of the beneficiaries got advice on the basis of pregnancy test results.

Knowledge about health hygiene (Table 7. 11)

More than 70% of beneficiaries in all seven districts are aware of immunization, while only 30% of beneficiaries are aware of proper garbage disposal. Whenever any of the family members has loose motions lasting for more than 24 hours, beneficiaries take them to the nearest health facility. For spacing between two births, beneficiaries prefer oral pills or condoms.

Table 7.1: Details of Births, Breast feeding, Immunization

	Districts						
Particulars	**E K H**	**W K H**	**Jaintia Hills**	**Ri-Bhoi**	**WGH**	**EGH**	**SGH**
Child been immunized against important diseases	91.1	89.2	89.5	88.7	100	95.4	92.8
Have Immunization card	88.2	88.2	82.4	89.8	100	100	95.7
Received TT injection during pregnancy	91.1	93.2	92.8	91.7	100	98.4	100
Received advice for post natal care during pregnancy	58.8	52.7	62.4	58.7	41.1	43.4	46.5
Received any family planning advice during pregnancy	61.7	58.4	52.4	58.1	41.1	42.4	46.1
Did breast feed the child	100	100	100	100	100	100	100
When first breast feed the child?							
Within 1 hr. of delivery	76.4	77.2	82.4	86.8	82.3	89.2	92.8
Within 6 hr. of delivery	23.6	22.8	17.6	13.2	17.7	10.8	7.2
Within 24 hr. of delivery	0				0		
Average Age till exclusively breast feed the child (in months)	12	12	12	9	6	6	6

	Districts

Particulars	E K H	W K H	Jaintia Hills	Ri-Bhoi	WGH	EGH	SGH
Have heard of ASHA	76.4	81.4	80.5	78.5	100	92.1	89.5
ASHA carry a kit	70.5	78.5	82.1	84.5	82.3	81.5	87.1
Did ASHA held discussion about							
Personal hygiene	55.8	52.1	68.4	76.1	88.2	84.2	79.8
Water safety at home	55.8	58.7	44.8	79.1	94.1	89.2	92.7
Hand washing practices	55.8	51.9	62.1	77.6	94.1	86.8	92.5
Safe disposal of garbage	55.8	56.8	65.8	75.2	94.1	89.5	92.4
Construction of HH Toilet	44.1	42.1	59.8	68.8	82.3	85.7	88.9
Use of covered container	52.9	54.5	52.4	64.8	88.2	86.7	82.1
Janani Suraksha Yojana	52.9	62.5	69.8	79.5	94.2	92.1	95.4
Institutional delivery	55.8	52.4	75.6	79.8	94.3	92.1	92.5
ANC/NC/PNC care	38.2	54.1	78.5	80.1	92.8	89.5	88.4
Child care	52.9	60.5	72.8	79.8	94.7	92.4	91.1
Nutrition relate issues	50.0	59.8	81.1	85.4	92.3	88.9	92.4
Family planning	26.4	55.4	65.4	75.0	94.1	88.2	92.1
Dots service	17.6	48.5	50.2	54.8	52.9	52.7	51.4
Attended any health day at AWC or village level	47.0	49.1	52.1	51.7	47.0	46.5	48.1
Village Health & Sanitation Committee							
Is there any VHSC in the village	52.9	51.2	55.6	51.2	47.1	48.2	49.1
Contribution of VHSC (Multiple answers)							
Constructed Community Toilet	35.2	39.5	40.2	44.5	29.4	29.8	28.7
Arranges transport for patients	41.1	40.8	42.7	41.5	47.2	42.5	44.5
Organize health day	41.1	40.1	39.7	39.8	47.8	42.4	44.8
Have attended /participated in any of Village Health Nutrition Day	47.0	48.1	52.1	50.2	32.4	38.7	39.1
Services got from VHND(Multiple answers)							
Information on Nutrition	47.0	48	48.7	46.5	47.1	44.8	46.9
Immunization service to children	61.7	65.8	70.2	70.8	35.2	`42.8	44.2
New born / children	32.3	35.2	42.1	40.5	29.4	32.5	33.6
Antennal care	41.1	42.5	44.8	41.5	32.5	38.9	35.9
Post Natal Care	38.2	35.2	34.8	36.1	23.5	28.5	24.6
Family Planning	35.2	32.1	31.0	35.4	17.6	25.1	24.0
Personal Hygiene	26.4	26.5	26.7	25.9	29.4	26.8	28.7
General Cleanliness	38.2	36.8	39.7	35.9	35.2	35.2	36.8

Table 7.2: Details of ASHA, her activities and VHSC

Table7.3: Details of J S Y Scheme

	Districts						
Particulars	**E K H**	**W K H**	**Jaintia Hills**	**Ri-Bhoi**	**WGH**	**EGH**	**SGH**
Janani Suraksha Yojana Scheme							
Are aware about the JSY Scheme	41.1	48.9	56.38	54.2	76.4	72.8	71.0
Sources of information about JSY Scheme (Multiple answers)							
Doctor	10	15.2	18.2	11.5	29.4	24.2	21.1
ANM	40	52.1	49.8	52.1	41.1	48.2	46.7
ASHA worker	30	50.1	52.4	50.2	47.1	48.9	52.9
Anganwadi Centre / Worker	00	10.1	0	0	0	0	0
Gram Panchayat	20	15.5	0	15.2	0	14.5	0
NGOs/SHGs	00	0	0	0	00	0	0
Radio/TV/Newspaper	0	0	0	0	0	0	0
Pamphlets	0	0	0	0	0	0	0
Hoardings at health facility	0	0	0	0	0	0	0
Timing of hearing about JSY Scheme							
Before Pregnancy	13.1	15.8	36.2	31.5	47.1	48.2	41.5
During Pregnancy	60.8	56.8	49.2	51.8	29.4	28.5	22.9
After Delivery	26.1	27.4	14.6	16.7	23.5	23.3	35.6
Place where beneficiary was registered for JSY Scheme							
District Hospital	21.2	21.8	19.8	19.5	17.6	17.8	16.9
Sub-divisional Hospital	10.5	10.5	9.9	9.2	5.8	6.4	5.9
CHC/ Rural Hospital	5.2	4.9	5.1	5.2	5.8	5.1	5.2
PHC	52.6	54.7	56.3	55.3	47.4	49.1	46.8
Sub-centre	0	0	0	5.5	11.7	10.2	11.1
Anganwadi centre	0	0	0		0	0	0
Govt. Accredited Pvt. Hospital	0	0	0		0	0	0
At home	10.5	8.1	8.9	5.3	11.7	11.4	14.1
Person who motivated to register for the JSY Scheme							
ASHA approved	47.0	46.6	47.6	45.2	41.1	42.4	42.5
ANM approved	29.4	29.9	30.3	31.3	35.4	34.2	34.6
MPW approved	0	0	0	0	0	0	0
AWW approved	23.6	23.5	22.1	23.5	23.5	23.4	22.9
Family members / Relatives	0	0	0	0	0	0	0
Neighbours / Friends	0	0	0	0	0	0	0
Self	0	0	0	0	0	0	0
Person who registered the beneficiary for the JSY Scheme							
Doctor	31.4	31.8	32.1	31.8	35.2	34.8	33.5
LHV	6.2	5.4	5.3	6.2	0	0	0
ANM / FHW	50.0	48.9	51.1	50.5	47.2	48.3	48.2
Anganwadi worker	6.2	5.4	5.7	5.8	0	0	0
ASHA	6.2	8.5	5.8	5.7	17.6	16.9	18.3

Particulars	E K H	W K H	Jaintia Hills	Ri-Bhoi	WGH	EGH	SGH
JSY card received by the beneficiary	35.7	34.8	35.2	36.1	29.4	30.1	29.8
ASHA worker facilitate in getting JSY card	26.6	26.8	28.7	26.9	35.2	33.5	36.1
Beneficiary faced difficulty in procuring JSY card	7.1	0	6.4	0	00	5.2	0
Type of difficulties faced by the beneficiary (Multiple reasons)							
JSY card not available	42.8	0	48.2	0	0	47.2	0
Procedure too cumbersome	57.2	0	51.8	0	0	0	0
Was asked to pay money	0	0	0	0	0	0	0
Beneficiaries received advice from ANM/ASHA during pregnancy for the following Multiple answers)							
Diet	61.5	62.5	59.8	58.7	47.1	48.9	51.1
Danger signs	59.2	58.2	57.8	78.5	100	100	100
Delivery care	85.7	85.8	88.2	87.9	100	100	100
Breast feeding	83.2	87.5	88.8	82.9	100	100	100
New born care	78.6	79.8	75.9	82.4	52.9	62.4	66.8
Family planning	64.2	58.2	55.4	59.8	35.2	39.8	42.5
Beneficiary, during antenatal period told about the following (Multiple answers)							
Date for next ANC	87.6	88.5	88.2	86.4	82.3	85.4	88.2
Place for next ANC	85.4	85.7	88.5	78.5	47.1	52.4	55.9
Date of expected delivery	81.8	78.8	79.5	77.6	23.5	29.9	32.2
Place of delivery	54.5	52.1	49.5	48.7	29.4	32.5	31.5
Referral place	12.1	0	0	0	0	0	0
Mode of transport	0	0	0	0	0	00	0
Person to accompany	0	0	0	0	0	0	0

Table 7.4: Details of J S Y Card

Table7.5: Place of delivery and reasons for opting institutional delivery

	Districts

Particulars	E K H	W K H	Jaintia Hills	Ri-Bhoi	WGH	EGH	SGH
Place of delivery							
At home	53.3	53.4	54.1	54.6	44.5	49.2	48.8
Dist. Hospital / Sub-div. Hospital	26.4	25.5	26.1	24.9	0	0	0
CHC	0	0	0	0	11.7	11.2	12.8
PHC	20.3	21.1	19.8	20.5	11.7	10.5	9.5
Sub-centre	0	0	0	0	32.1	29.1	28.9
Trust/NGO Hospital	0	0	0	0	0	0	0
Govt. Accredited Pvt. Hospital	0	0	0	0	0	0	0
Reasons for opting institutional delivery (Multiple reasons)							
Money under JSY	0	0	0	0	0	0	0
Better access to inst. Delivery	0	0	0	0	0	0	0
Quality services in the area	0	0	0	0	0	0	0
Support given by ASHA	0	0	20.5	0	17.6	15.2	14.2
Availability of Transport	0	0	0	0	0	0	0
Previous delivery in institution	0	0	0	0	0	0	0
To have safe delivery	100	100	100	100	100	100	100
No alternate service available	0	0	0	0	0	0	0

Table 7.6: Transport of the beneficiary to reach the Health institution

	Districts						
Particulars	**E K H**	**W K H**	**Jaintia Hills**	**Ri-Bhoi**	**WGH**	**EGH**	**SGH**
Received referral slip from ASHA to access delivery services	14.2	11.5	15.2	14.8	11.7	12.1	11.9
Faced difficulty in reaching health institution	14.2	11.8	14.9	14.8	11.7	11.5	12.8
Difficulty faced in reaching the health institutions (Multiple reasons)							
Delivery was late in the night	33.3	36.8	35.2	34.2	35.2	34.8	33.9
Did not have sufficient money	66.7	63.2	64.8	65.8	64.8	65.2	66.1
Lack of immediate transport	0	0	0	0	0	0	0
Mode of transport used by beneficiary to reach the ultimate place of delivery							
Govt. ambulance	26.6	25.8	22.8	21.5	17.6	18.2	16.2
Private Vehicle	73.4	74.2	77.2	78.5	70.8	68.5	71.1
Vehicle arranged by local Health committee	0	0	0	0	5.8	5.4	5.2
Other (Walk)	0	0	0	0	5.8	7.9	7.5
Person facilitated in arranging the transport							
No one, self	87.5	88.2	82.6	81.2	70.5	75.4	76.1
ASHA	12.5	11.8	17.4	14.3	6.1	5.4	4.9
ANM	0	0	0	0	11.7	10.8	11.1
Village Health Committee	0	0	0	4.5	11.7	11.1	11.2
Others	0	0	0	0	00	0	0
Beneficiary received money for transport expense	20.0	18	0	0	0	0	0

Table 7.7: Type of delivery, waiting time and satisfaction regarding services available in the health facility

	Districts						
Particulars	**E K H**	**W K H**	**Jaintia Hills**	**Ri-Bhoi**	**WGH**	**EGH**	**SGH**
Person who accompanied beneficiary to the health institution at the time of delivery							
ASHA	0	0	0	0	0	0	0
ANM	0	0	0	0	0	0	0
AWW	0	0	0	0	0	0	0
Neighbours	33.4	35.2	30.0	34.6	75.4	72.5	75.6
Relative	66.6	64.8	70.0	65.4	24.6	27.5	24.4
Other	0	0	0	0	0	0	0
Waiting time at the facility until someone attended the beneficiary(in minutes)	15	15	20	15	20	20	15
Type of delivery							
Normal	86.7	88.2	86.4	91.0	94.1	92.1	93.5
Assisted	13.3	11.8	13.6	9.0	0	4.5	6.5
Ceasarean	0	0	0	0	5.9	0	3.4
Satisfaction regarding the services available at the health facility							
Fully satisfied	88.8	85.6	84.9	89.7	94.1	91.2	93.1
Partially satisfied	4.2	3.5	4.2	4.1	0	2.5	0
Not satisfied	8.0	10.9	12.9	6.2	5.9	6.3	6.9
Reason for not satisfied with the services at the health facility							
Staff were rude	41.6	35.2	30.8	29.8	0	10.2	11.7
Facility was not clean	58.4	64.8	65.2	68.2	100	89.8	85.8
Facility was not adequate	0	0	4.0	2.0	0	0	2.5
Other	0	0	0	0	0	0	0

Table 7.8: Cash incentive received by the beneficiary under JSY Scheme

	Districts						
Particulars	**E K H**	**W K H**	**Jaintia Hills**	**Ri-Bhoi**	**WGH**	**EGH**	**SGH**
Beneficiary received cash incentive under JSY Scheme	91.6	92.8	90.5	94.6	94.1	95.2	93.8
Average amount received by beneficiary as cash incentive	700	700	700	700	700	700	700
Received the cash incentive :							
In one go	100	100	100	100	100	100	100
In installments	0	0	0	0	0	0	0
Time of the receipt of the cash incentive by beneficiary							
At registration time	0	0	0	0	0	0	0
At ANC check up	0	0	0	0	0	0	0
Much before delivery	0	0	0	0	0	0	0
Within one week before EDD	0	0	0	0	0	0	0
Immediately after delivery	31.3	32.5	30.1	29.7	41.1	39.5	40.5
Within a week after delivery	56.2	57.0	57.8	59.7	41.1	46.3	44.2
Later than 1 week after delivery	12.5	10.5	12.1	11.6	17.8	14.2	15.3
Other	0	0	0	0	0	0	0
The person who delivered cash incentive to the beneficiary							
Medical Officer	100	100	78.5	100	0	0	0
Nursing staff	0		21.5		29.5	30.1	28.9
Accountant/Clerk	0	0	0	0	70.5	69.9	71.1
ANM/Sub-centre	0	0	0	0	0	0	0
Gram panchayat	0	0	0	0	0	0	0
ASHA	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0
Faced difficulty in getting incentive money	0	0	0	0	5.8	4.2	4.5
Type of difficulty faced by the beneficiary							
Was paid by Cheque / Draft	0	0	0	0	0	0	0
Had to pay to get the money	0	0	0	0	0	0	0
Procedure too cumbersome	0	0	0	0	0	0	0
Time taken was too much	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0
Utilization of Incentive money(Multiple answers)							
For buying medicine for self	81.2	78.2	70.2	76.9	29.4	30.5	31.8
Spent on child care	64.7	72.5	71.8	77.8	76.4	79.8	81.2
Spent on care of other family members	37.5	35.4	28.7	30.5	21.5	24.5	26.1
Husband took away	12.6	10.2	9.8	5.8	11.7	10.1	9.8
Other	0	0	0	0	0	0	0

Table 7.9: Reason for opting home delivery in spite of better facility / cash incentive available for institutional delivery

	Districts						
Particulars	**E K H**	**W K H**	**Jaintia Hills**	**Ri-Bhoi**	**WGH**	**EGH**	**SGH**
Reason for opting home delivery (Multiple reasons)							
Home delivery convenient	100	100	96.4	95.1	94.1	95.3	94.6
Fear of stitches / caesarean	0	0	0		0	0	0
Indifferent behaviour of facility staff	0	0	0		0	0	0
Cultural / Social reasons	0	0	0		0	0	0
No transport services available	0		3.6	4.9	5.9	4.7	5.4
Too expensive / Can't afford	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0

Table 7.10 Awareness about Nischay Pregnancy Test Kit

	Districts						
Particulars	**E K H**	**W K H**	**Jaintia Hills**	**Ri-Bhoi**	**WGH**	**EGH**	**SGH**
Beneficiary aware of N P T K	54.1	52.7	50.8	54.2	70.5	70.6	69.8
Places from where beneficiary obtain NPTK							
ASHA	30.8	28.5	26.7	29.2	23.5	22.8	24.1
ANM	0	0	0	0	6.0	4.5	5.2
AWW	0	0	0	0	0	0	0
PHC	69.2	71.5	73.3	70.8	70.5	68.7	70.7
Other	0	0	0	0	0	0	0
Person who helped in conducting the test							
ASHA conducted the test	20	18.5	16.7	19.2	11.7	14.5	16.1
Self, with help from others	20	19.5	17.9	18.2	17.8	15.7	11.8
Self, alone	26.6	28.9	29.7	30.5	70.5	69.8	72.1
Other	33.4	33.1	35.7	32.1	0	0	0
Whether beneficiary given any guidance on the basis of pregnancy test result							
No advice given	21.5	19.8	20.1	20.5	23.5	22.5	23.1
Advised for ANC	78.5	80.2	79.9	79.5	76.5	77.5	76.9
Advised for MTP	0	0	0	0	0	0	0
Advised for FP services	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0
What did beneficiary do after the test result							
Registered for ANC	100	100	100	100	100	100	100
Had pregnancy terminated	0	0	0	0	0	0	0
Started using FP services	0	0	0	0	0	0	0
Nothing, result was negative	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0

Table 7.11: Knowledge about health, hygiene and related matters

	Districts						
Particulars	**E K H**	**W K H**	**Jaintia Hills**	**Ri-Bhoi**	**WGH**	**EGH**	**SGH**
Beneficiary aware of immunization	77.6	74.5	72.8	77.1	70.5	72.5	71.8
Important steps for prevention of diarrhea (Multiple reason)							
Hand washing	78.5	75.8	74.6	78.2	94.1	92.1	90.5
Use of safe water	86.4	79.8	82.5	84.6	88.2	87.9	88.4
Use of covered container	58.3	54.2	56.1	51.8	82.3	78.8	86.4
Proper garbage disposal	32.4	32.0	34.1	31.2	23.5	28.2	26.2
Action to be taken if a family member has loose motions lasting for more than 24 hours (Multiple reasons)							
Stop giving oral fluids/foods	11.2	10.2	8.9	11.3	23.5	20.1	21.5
Give more fluid/liquid	0	0	0	0	0	0	0
Start giving ORS	14.8	15.8	19.8	21.5	29.4	28.4	26.7
Take to RMP	0	0	0	0	0	0	0
Take to nearest Govt. Health facility	100	100	100	100	100	100	100
Consult ASHA	0	0	11.2	10.4	11.7	11.2	13.2
Try home remedies	0	0	0	0	0	0	0
Family planning method preferred if a couple does not want any more child (multiple reasons)							
Male sterilization	0	0	0	0	0	0	0
Female sterilization	100	100	100	100	100	100	100
Other	0	0	0	0	0	0	0
Methods available for spacing between two births(Multiple reasons)							
IUD	0	0	0	0	0	0	0
Oral pills	100	100	100	100	100	100	100
Condom/Nirodh	100	100	100	100	100	100	100
Withdrawal	0	0	0	0	0	0	0
Safer period method	0	0	0	0	0	0	0
What to do if had unprotected sex and do not want to become pregnant (Multiple reasons)							
Take ECP (I Pill)	0	0	0	0	0	0	0
Seek advice from ANM	24.2	22.5	26.1	22.8	29.4	28.1	27.9
Seek advice from Doctor	100	100	100	100	100	100	100
Do nothing	0	0	0	0	0	0	0
Beneficiary heard about HIV/AIDS	67.6	62.1	59.2	61.1	52.9	51.6	52.7
Beneficiary aware of any prevention of Parent to Child Transmission (PPTCT) centre nearby	5.8	4.5	4.8	5.1	5.8	4.9	5.2

Chapter - 7

Status and Performance of ASHA

One of the key component of NRHM is to provide every village in the country with a trained female community health activist "ASHA (Accredited Social Health Activist). The ASHA has to work in the community for the rural poor. She has to motivate every household and generate awareness in the community for ANC, PNC, safe delivery practice, immunization, importance of breast feeding, family planning and sanitation etc. Though ASHA are not paid any salary she would be entitled for performance linked incentive under different programmes. ASHA are provided with a basic drug kit excluding AYUSH drugs, as they are not trained in it. She also acts as a depot holder for contraceptives and IEC materials developed for villages. ASHA are selected by community, out of the residents within the community. Equipping ASHAs with knowledge and skills are very much important for ASHAs to perform the assigned roles in an efficient manner, for which ASHA are provided with various training programmes under different modules.

This chapter assesses the status, performance, roles and responsibilities etc. of ASHA in the state. The findings are based on the field data analysis:

Table 7.1: Status of ASHA

Sl. No	Status	In Numbers
1	Number of ASHA interviewed	348
2	Average household population served by ASHA	574
	Method of Selection	**Percentage (%)**
1	Selected / nominated on recommendation of ANM	27.0
2	Selected / nominated on recommendation of village head	34.0
3	Selected / nominated on recommendation of Aanganwadi worker	9.0
4	Selected / nominated on recommendation of VHSC	8.0
5	Selected / nominated on recommendation of community	15.0
6	Selected / nominated on recommendation of doctor	7.0
	Others	
1	ASHA undergone training	100.0
2	ASHA issued drug kit	100.0

Status of ASHA

A total of 348 ASHA were interviewed from all the seven districts. On an average 574 household population is served by one ASHA. Around 34% of ASHA were selected on the recommendation of village head, while 27% of them were selected by ANM. The total number of ASHA selected by VHSC, AWW & Community were 39%. The lowest number of ASHA selected were by doctors. In the selection of ASHA, involvement of doctors, VHSC and AWW is less than 10%. All of the ASHA interviewed had undergone training and were issued drug kit.

Table 7.2: Role and Performance of ASHA

Sl. No	Initiative	Percentage (%)
1	ASHA providing DOTS	48.0
2	JSY cases facilitated by ASHA in last six months	3.2
	Number of Cases	
1	Children with diarrhea given ORS	27.0
2	Oral Pills cycle distributed	45.0
3	Malaria patients given drugs	3.8
4	VHND days organized	2.5
	Percentage on average incentive received by ASHA on an average during one month	
	JSY	40.6
	Sterilization	21.8
	VHND	40.6

Role and Performance

The table 7.2 shows that 48% of the ASHA are providing DOTS. During the last six months 3.2% JSY cases have been facilitated by ASHA, which is quite less. Around 45% of orals pills have been distributed, while only 3.8% drugs has been given to malaria patients. 40.6% of ASHA have received incentives for JSY and VHND, while only 21.8% of ASHA received incentives for sterilization.

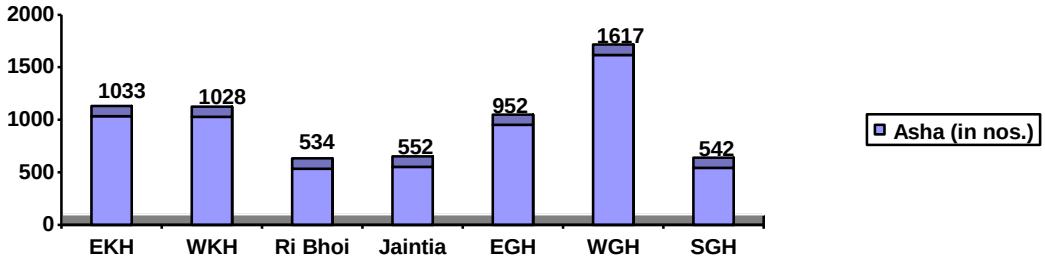
Table 7.3: Types of difficulties and support required by ASHA

Sl. No	Difficulties faced	Percentage (%)
1	Funds not available in time	46.8
2	Adequate training is not provided	37.5
3	Delayed supply of drugs	18.7
4	Decision making with community leaders is difficult	72.5
5	Inadequate facilities for institutional deliveries	43.7
	Support required	
1	More training for ASHA and Community members	62.5
2	Honorarium should be paid timely	59.3
3	Monthly Fixed remuneration	71.8

Constraints

Around 72.5% of ASHA have stated that they are facing difficulties in decision making with community leader. More than 40% of ASHA have stated that the facilities for institutional deliveries are inadequate and the funds are not available on time. 62.5% of ASHA have stated that more training should be provided for ASHA and community members, while 71.8% ASHA have stated that ASHA must be paid a monthly fixed remuneration.

Table 7.4: Number of ASHA



The highest number of ASHA is from West Garo Hills district, while the lowest number of ASHA is from Ri Bhoi district. At present there are around 6258 ASHAs in the state. All the ASHAs interviewed were appointed from same village in which they are working and are in the age group of 20 to 45 years.

Chapter - 8

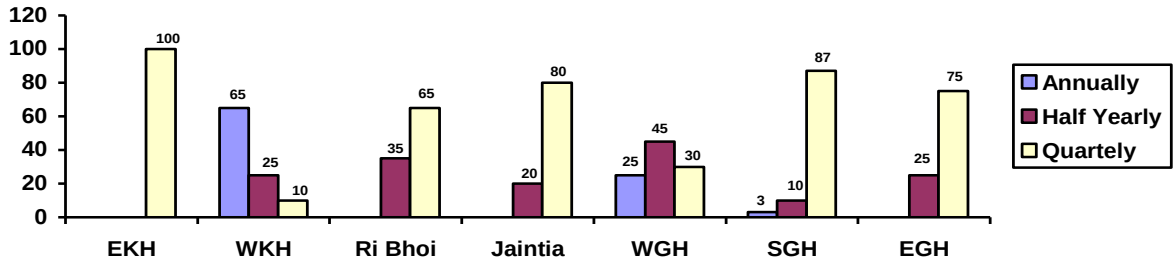
Role, awareness and involvement of RKS

Under the National Rural Health Mission (NRHM), one major strategic intervention is up gradation of health facility, for providing sustainable quality care with accountability and people's participation along with total transparency. Hence it is in this context Rogi Kalyan Samiti (RKS)/ Patient Welfare Society (PWS) is formed in hospitals for ensuring a degree of permanency and sustainability in various health related matters.

The RKS/PWS is a simple yet effective management structure. This is registered society; act as a group of trustees for the hospitals to manage the affairs of the hospitals. It consist of member from NGO's, local elected representative and officials from Government sector who are responsible for proper functioning and management of the health facilities. The RKS/PWS functions as a NGO, which may utilize all government assets and services, to impose user charges and shall be free to determine the quantum of charges on the basis of local circumstances. It may also raise funds additionally with donations and loans through various financial and donor agencies. In Meghalaya at present all the CHC and PHC are having RKS in place, while in most of the CHC and PHC RKS is not functioning in a full fledged manner. The RKS member's involvement in day to day affairs is very limited.

This chapter assess the role, awareness and involvement of RKS from the sampled 14 CHC and 29 PHC. The RKS findings based on the in depth-interviews and focus group discussions are as follows:

Table 8.1: Frequency of RKS meetings (in %)



RKS meetings

In all of the 14 CHC and 29 PHC RKS is formed and registered. In East Khasi Hills district all the sampled CHC and PHC are conducting the RKS meetings on quarterly basis. Whereas in the remaining districts there is no uniformity followed for conducting the meetings. In West Khasi Hills district, in around 65% of sampled CHC and PHC RKS meetings are conducted annually, while in West Garo Hills district around 45% of sampled CHC and PHC RKS meetings are conducted half yearly. As per the RKS guidelines, the meeting shall be held at least once in every quarter. Even in few of the CHC and PHC the agenda for RKS meeting is not being prepared in advance and circulated. Most of the RKS meetings take place in the PHC and CHC itself.

Table 8.2: Activities Conducted by RKS (in %)

Sl.No	Activity	EKH	WKH	Ri Bhoi	Jaintia	WGH	EGH	SGH
1	Health Camps	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2	Private affiliation for upgrading services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
3	Maintenance and Renovation	65.0	55.0	75.0	55.0	60.0	75.0	65.0
4	Scientific disposal of hospital waste	0.0	0.0	0.0	12.5	0.0	0.0	0.0
5	Training of doctors and staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0
6	Provision of medicines	10.0	11.0	15.0	12.0	13.5	10.2	11.8
7	Provision of drinking water and cleanliness for patients	5.0	14.0	2.5	10.0	6.5	4.8	3.2
8	Availability of suggestion box	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	Improved boarding lodging facilities for patients	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	Buying equipments	20.0	20.0	7.5	23.0	20.0	10.0	20.0

RKS Activities

The main functions performed by RKS in most of the districts were activities related to maintenance and renovation of facilities and living accomodation, buying equipment, provision of medicine, provision of drinking water and cleanliness for

patients. The activities like organizing health camps, private affiliation for upgrading services, training of doctors and staff, availability of suggestion box for grievance redressal etc. are not done in any of the CHC and PHC. The reason for poor attention towards these activities may be due to lack of interest on the part of RKS.

Table 8.3: User charges generated under RKS annually (in %)

Sl. No	Amount	EKH	WKH	Ri Bhoi	Jaintia	WGH	EGH	SGH
1	Below Rs.20,000	57.1	33.3	20.0	25.0	50.0	35.0	0.0
2	Rs. 20, 001 to Rs. 50, 000	28.5	16.7	0.0	37.5	0.0	25.0	33.0
3	Rs. 50, 001 to Rs. 100, 000	0.0	16.6	20.0	0.0	0.0	12.0	14.0
4	Above Rs. 100, 000	0.0	0.0	0.0	0.0	0.0	0.0	0.0
5	User Charge not generated	14.4	33.4	60.0	37.5	50.0	28.0	53.0

User charges

Out of the sampled CHC and PHC, the collection from user charges generated under RKS is quite less. None of the CHC and PHC are generating funds from user charge above Rs. 100, 000. None of the RKS in East Khasi Hills, Jaintia Hills and West Garo Hills are generating funds above Rs.50, 000/ from user charges. None of the RKS in the state are raising funds additionally with donations and loans through various financial and donor agencies. The study team found that audit reports was not furnished at CHCs and PHCs. But the team received verbal information about audit reports having been conducted.

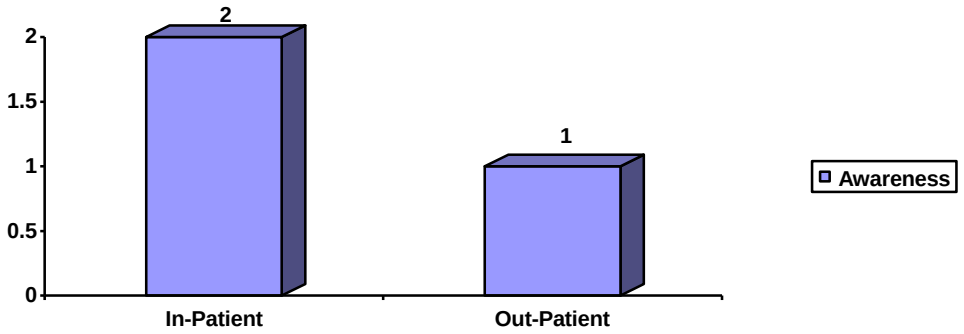
Table 8.4: Constraints faced in smooth functioning (in %)

Sl. No	Constraint	EKH	WKH	Ri Bhoi	Jaintia	WGH	EGH	SGH
1	Members not serious about RKS objective	50.0	65.0	60.0	60.0	55.0	62.0	65.0
2	Tendency of members to avoid meeting	2.5	5.0	10.0	10.0	12.5	5.0	15.0
3	Most of the meeting is one sided	0.0	0.0	0.0	0.0	0.0	0.0	0.0
4	Decisions not implemented on time	0.0	0.0	0.0	0.0	0.0	0.0	0.0
5	Delay in funds	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Constraints

The smooth functioning of RKS helps in upliftment of services at the health facilities. More than 50% of RKS members in the district were not serious about RKS objective. More than 10% of the members from West Garo Hills and South Garo Hills had the tendency to avoid meeting. However, all the RKS members have stated that all the decisions made in meeting are implemented on time.

Table 8.5: Awareness of RKS amongst In and out patients (in nos.)



Awareness

A total of 75 in patients and out Patients were interviewed out of which only 3 patients (both IPD & OPD) were aware of the existence of RKS in the CHCs and PHCs. Such low awareness can be attributed to the the lack of information disseminated to the patients.

Chapter - 9

IPD and OPD

This chapter describes the patients (both IPD & OPD) satisfaction towards the behaviour of hospital staff, interaction between patients and doctors, cleanliness of health facility, space adequacy, availability of medicines, amenities. In-patients are patients who is admitted in the facility. Out patients are those who visit for out door treatment in the centres. The findings of this chapter helps in judging the level of satisfaction of patients towards health facility.

Background Characteristics

Around 37% of patients were in the age group of 31-50 years, while 34.7% of them were in the age group of up to 20 years. Only 11% of the patients were in the age group of above 50 years. More than 60% of the patients visiting the health facilities were female. 65% of the patients interviewed were from CHC, while 35% were from PHC.

Table 9.1: Background Characteristics

Age -Group	Percentage (%)
Age	
< 10 years	13.0
11-20 years	21.7
21-30 years	17.3
31-50 years	37.0
Above 50 years	11.0

Sex	Percentage (%)
Male	39.0
Female	61.0
Health Facility	**Percentage (%)**
CHC	65.0
PHC	35.0

Staff Behaviour and Privacy

According to table 9.2, 98% of the patients reported that the doctors behaviour towards them is good, while all the patients are fully satisfied with the behaviour of pharmacist and technical staff. But when it came to nurse's behaviour, 38.2% of the patients stated that nurse behaviour towards them was not good. All the patients have told that privacy is being maintained at the place of examination.

Table 9.2: Staff Behaviour and Privacy

Sl.No	Staff Behaviour	Percentage (%)
1	**Doctor Behaviour**	
	Good	98.0
	Not Good	2.0
2	**Nurse Behaviour**	
	Good	61.8
	Not Good	38.2
3	**Pharmacist Behaviour**	
	Good	100.0
	Not Good	0.0
4	**Technical staff Behaviour**	
	Good	100.0
	Not Good	0.0
5	**Patients reported positive towards privacy at the place of examination**	100.0

Interaction

More than 90% of the patients have stated that doctors listen to their description of ailment patiently and respond to their questions. All of them are satisfied with the treatment provided by doctors. This shows that the present doctors are adopting a friendly and humane approach towards their patients. Which needs appreciation. Since most of the doctors are from their own region, patients feel free and relaxed while describing their ailment.

Table 9.3: Interaction between patient and doctor

Sl.No	Interaction	Percentage (%)
1	**Doctors listen to description of ailment patiently**	
	Yes	94.0
	No	6.0
2	**Doctor responded to questions**	
	Yes	98.0
	No	2.0
3	**Satisfied with the treatment provided by doctor**	100.0

Cleanliness

Cleanliness is very much essential in our day to day life. A clean surrounding leads to a healthy life. In health facility where patients get treated should follow daily practice of keeping their indoor and outdoor clean. More than 80% of the patients have stated that the waiting area, dispensary room, dressing room and injection room are very clean, while 11% of them have stated that the dispensary room is not kept clean. All the patients are satisfied with the cleanliness in OPD and laboratory rooms. While below 50% of the patients are not satisfied with the cleanliness of toilet and wards. During the teams visit to the health facility, it was observed that in most of the health facility toilets in wards are not cleaned regularly and properly. All the facility visited were having cleaning staff. The bed linen is not cleaned regularly.

Table 9.4: Cleanliness of the facility

Cleanliness	Percentage (%)		Cleanliness	Percentage (%)		Cleanliness	Percentage (%)
Waiting Area			**Dispensary Room**			**X-Ray Room**	
Very Clean	81.9		Very Clean	80.1		Very Clean	98.0
Some what clean	18.1		Some what clean	8.9		Some what clean	2.0
Not Clean	0.0		Not Clean	11.0		Not Clean	0.0

OPD Room			**Laboratory**			**Injection Room**	
Very Clean	100.0		Very Clean	100.0		Very Clean	85.0
Some what clean	0.0		Some what clean	0.0		Some what clean	13.0
Not Clean	0.0		Not Clean	0.0		Not Clean	2.0
Dressing Room			**Toilets**			**Wards**	
Very Clean	98.0		Very Clean	38.0		Very Clean	56.0
Some what clean	2.0		Some what clean	32.0		Some what clean	34.0
Not Clean	0.0		Not Clean	30.0		Not Clean	10.0

Space Adequacy

Around 100% of the space adequacy was reported in dispensary, OPD and dressing rooms, while more than 65% of the patients have reported that, there is a lack of seating arrangement for patients in the waiting area, in the health facility. 25% of patients have stated that there is inadequate space in wards.

Table 9.5: Space Adequacy

Adequacy	**Percentage (%)**		**Adequacy**	**Percentage (%)**		**Adequacy**	**Percentage (%)**
Waiting Area			**OPD Room**			**Ward**	
Yes	85.0		Yes	100.0		Yes	75.0
No	15.0		No	0.0		No	25.0
Dispensary Room			**Dressing Room**			**Sitting**	
Yes	100.0		Yes	98.0		Yes	35.0
No	0.0		No	2.0		No	65.0

Medicines

Around 76.5% of the patients stated that they are not getting all medicines prescribed by the doctor from pharmacy, while 64% of the patients have stated that they are getting the prescribed quantity. All the patients are satisfied with the quality of medicines they are getting. More than 95% of the patients have stated that there are no vaccines for animal bites available in the health facility. During our teams visit to health facilities, it was noticed that the CHC and PHC managed through PPP are

having excessive quantity of medicines. With the result large quantities of medicines expire and get wasted, while the Government run CHC and PHC are running short of medicines. The NGOs basically procure the medicine directly from state, while the government PHC and CHC are getting medicines from district. Most of the doctors in the PHC and CHC have complained about the inadequacy of medicines being supplied from district. The medicines are not issued as per the indent of health facility, but many times it is issued as per the interest of the drug incharge at the district. In most of the government run CHC and PHC, there many expired medicines were kept in the store room. The team also found expired medicines in the pharmacy. Even in most of the nurses duty room in CHC and PHC expired injections were found. This shows that there is no proper monitoring and a mechanized system followed for the distribution of medicines in the state. Even there is no proper system followed for disposal of expired medicines. During the teams visit they found that in few PHC and CHC they return tham to districts, in some cases they burn it in open, in some others they throw it in the open, while there are very rare number of PHC and CHC who are having a disposal system. There is no proper maintenance of drug stock register, most of the pharmacist have told that they haven't got any training in this regard.

Table 9.6: Medicines

Are all medicines prescribed by the doctor available in pharmacy?	Percentage (%)		Do you get the prescribed quantity of medicines from pharmacy?	Percentage (%)
Yes	23.5		Yes	64.0
No	76.5		No	36.0
Quality of medicines			**Do the health facility have vaccine for animal bites?**	
Good	100.0		Yes	3.8
Not Good	0.0		No	96.2

Amenities

According to table 9.7, none of the health facility is having a television or telephone. Only 15% of the health facility are having canteen facility. All the health facility are having a laboratory. More than 60% of the health facility are not having X-ray machines and ambulance.

Table 9.7: Amenities in health facilities

Facilities	Percentage (%)		Facilities	Percentage (%)		Facilities	Percentage (%)
Television			**Canteen**			**Telephone**	
Yes	0.0		Yes	15.0		Yes	0.0
No	100.0		No	85.0		No	100.0
Ambulance			**Laboratory**			**X-ray**	
Yes	38.0		Yes	100.0		Yes	23.0
No	62.0		No	0.0		No	77.0

Chapter - 10

Conclusions and Recommendations

The following conclusions and recommendations are based on the field data analysis, and observation made by the field investigators during the course of study:

HEALTH COMPONENT

a) Community Health Centre (CHC)

- CHCs are generally required to deliver specialized health care services under NRHM. These facilities are to be equipped with suitable diagnostic and investigative facilities. Out of the total sampled CHCs more than 80% of CHCs are not equipped to deliver the intended specialized health care services. CHCs located in the border areas are having least infrastructure facilities. 35% of the CHCs were not having generators.

- The posting of medical specialists in the CHCs has been a constant struggle for the state; this is due to shortage of specialists in the whole state.

- All the sampled CHCs were having shortage of residential facilities for doctors and nurses. In most cases rooms are being shared by 2-3 persons.

- Around 50% of sampled CHCs have stated that they are not getting NRHM funds on time from district.

- All the CHCs were having registered RKS/PWC in place, while there is no uniformity in the RKS meetings. Most of the CHCs are using RKS funds for maintenance, repair/renovation and equipments. None of the CHCs were having suggestion box and water purifier in IPD and OPD.

- Out of the 14 sampled CHCs, three CHCs are having general OT, while remaining were having minor OT.

- At the CHCs there is no blood bank in place, the facilities are supposed to link-up with district hospitals for any requirements.

- There is shortage of medicine in all the CHCs due to irregular supply of medicines from the district. In most cases the medicines procured from districts are just within 3-4 months of their expiry date. In few CHCs there were expired medicines and injections kept in the pharmacy. While discussing the matter with health officials, they stated that as of now there is no shortage and these are taken care off from the state and district authority.

- Initial steps have been taken by the officials for providing Bio-waste management training in all facilities and for construction of disposal pit with RKS funds.

- In few CHCs particularly in Jaintia Hills district, East Khasi Hills district, South Garo Hills, West Khasi Hills doctors were not present during OPD hours. Majority of doctors in CHCs are running private clinics in their quarters.

b) Primary Health Centre (PHC)

- PHCs were having back-up system either generator or inverter system for smooth functioning of the facility. Majority of them have utilized RKS funds for said purchase.

- All the sampled PHCs were having required number of beds, while pillows and beds were not clean.

- Around 60% of PHCs are not having separate consulting rooms for AYUSH. Apart from PHC Nartiang none of the PHCs were having proper waste disposal system.

- All the sampled PHCs were having lab technicians, health assistant, staff nurse and pharmacist. While 28% of PHCs are not having cleaning staff.

- In 75% of PHCs doctors are running private clinics in their allotted quarters and lab test for clinic are conducted in PHC.

- Around 40% of PHCs have stated that there is delay in getting funds from district.

- The RKS/PWC in PHCs are not functioning in a effective manner. Around 80% of PHCs are not generating any additional funds.

- In most of the PHCs institutional deliveries are not taking place, due to non availability of a lady doctor/specialist. In most of the PHCs, there were no patients in IPD.

c) Sub Centre (SC)

- There needs to be further quality and manpower improvement in sub centres. Most of the sub centres are having one ANM. There is no separate health worker in any of the sampled sub centres.

- Around 54% of the sub centres are not having delivery tables, while only 60% of the sub centres were having electricity and water supply. None of the sub centres are having waste disposal pit.

- The average number of villages covered by sub centre is around 7, while all the villages under these sub centres are having VHSC.

- Around 50% of ANM have stated that ASHAs meet them once in a month.

- 30% of ANM have stated that ASHAs involvement in identifying and accompanying complicated delivery cases is very limited. More than 50% of ASHAs are not focusing on new born post natal baby care.

- There is no monitoring by the health officials to check the funds utilization in sub centres.

- Around 62% of ANM conduct delivery at home, while 38% ANM conduct deliveries at sub centres. On an average in each sub centre area there are 3-5 traditional birth attendants.

d) Accredited Social Health Activist (ASHA)

- On an average 574 household population are served by one ASHA. In the selection of ASHAs involvement of doctors, VHSCs and AWWs is less than 10%.

- All of the ASHA interviewed had undergone training and were issued drug kit.

- During the last six months only 3.2% JSY cases have been facilitated by ASHA.

- Around 40% of ASHAs have not got any performance incentive for JSY, VHND and sterilization.

- 72% of ASHAs have stated that they are facing difficulties in decision making with community leaders, while 40% of ASHAs have stated that facilities for institutional deliveries in health facilities are inadequate and the funds are not available on time.

- Around 70% ASHAs have stated that ASHA must be paid a fixed remuneration.

- All the ASHAs interviewed were appointed from same village and were in the age group of 20-45 years. Most of the ANM complained about not getting the honorarium on time.

e) Rogi Kalyan Samiti / Patient Welfare Committee (RKS/PWC)

- All the sampled CHCs and PHCs, RKS/PWC is formed and registered.

- In East Khasi Hills district RKS/PWC meetings are carried out quarterly, while in other remaining districts there is no uniformity. Most of the RKS/PWC meetings are taking place in PHC and CHC itself.

- RKS/PWC main activities performed in all the districts were related to maintenance and renovation, buying equipments, provision of medicines. The activity like organizing health camps, private affiliation for upgrading health services, training of doctors and staff, availability of suggestion box for grievance redressal are not performed in any of the CHCs and PHCs.

- None of the RKS/PWC in CHCs and PHCs are raising funds in addition to the user charge by way of donations and loans through various financial and donor agencies.

- Audit reports of RKS/PWC are not furnished at CHCs and PHCs.

- More than 50% of the RKS/PWC are not serious about RKS objectives.

- A total of 75 patients (both IPD and OPD) were interviewed, out of which only three patients were aware of RKS/PWC in the CHCs and PHCs.

f) Patients Satisfaction

- 98% of patients reported that the doctors behaviour towards them is good, while all the patients are fully satisfied with the behaviour of pharmacist and technical staff.

- Around 38% of patients have stated that nurse behaviour towards them was not good.

- All the doctors in CHCs and PHCs are adopting a friendly approach towards patients. This needs to be appreciated.

- Around 80% of patients have stated that the waiting area, dispensary room, dressing room and injection rooms are very clean, while 50% of the patients are not satisfied with the cleanliness in toilet and wards.

- 65% of the patients have stated that there is lack of seating arrangement for out patients in the waiting area of health facilities.

- Around 67% of patients stated that they are not getting all medicines prescribed by doctors from pharmacy. More than 95% of patients have stated that there are no specific medicines for animal bites in health facilities.

g) IMR, Birth and Death Rate

- As per the outcome of mission of Meghalaya, the IMR will be reduced to 30 by 2012. But in the present scenario, it seems a difficult task. In the year 2006-07 the IMR was 53, in 2007-08 it increased to 56. The present IMR (2008-09) is 58. Instead of declining it is getting increased every year, which shows the measures taken is not effective at the grass root level. The death rate in each year is in between 7-8, while birth rate is between 24-25.

h) Institutional deliveries

- During the last four years there is tremendous fall in the institutional deliveries and rapid increase in home deliveries. According to MoHFW data on safe deliveries, Meghalaya has reported less than 45% safe deliveries. Women delivering in the health facilities are not staying for 48 hours for monitoring her recovery, it may also be due to lack of facilities. In all the sampled PHCs and CHCs most of the institutional deliveries are conducted by ANM.

i) Janani Suraksha Yojana (JSY)

- In all the districts more than 80% of the children have been immunized against important diseases. While in Garo Hills districts less than 50% of the beneficiaries received advice for PNC and family planning during pregnancy.

- 50% of the beneficiaries stated that there has been no contribution of VHSC in their village. Most the beneficiaries are not satisfied with the services rendered during VHND.

- Most of the deliveries are conducted at home. While less than 30% of beneficiaries conducted deliveries in health facilities. Only in West Garo Hills, South Garo Hills and East Garo Hills district institutional deliveries are conducted in sub centres.

- Around 70% of the beneficiaries use private vehicles to reach Health facility, while 80% of beneficiaries have stated that no body facilitated in arranging the transport.

- Most of the beneficiaries opt for home delivery because they feel it is convenient.

j) Village Health Sanitation Committee (VHSC)

- All sampled villages under each sub centres were having VHSC, while their functioning is not effective.

- VHSC members are having differences between them in decision making.

- The Village Health Nutrition Day (VHND) is being held once in every month, while the involvement of community members is not much encouraging during the VHND.

k) Maternal Health

- Fertility rate in the state is higher than in all other states in India, except Bihar and U.P.

- 93% of urban women received Ante-Natal Care (ANC) for their last birth compared with 63% of rural women

- 71% of births in the state takes place at home and 29% births takes place in health facility.

l) Child Health

- The percentage of children fully vaccinated is lower than the national average of 44 percent.

- The DPT and polio vaccine are given in a series. Many children receiving the first dose do not finish the series. Between first and third doses, the drop out rate for DPT is 24 percent and drop out rate for polio is at 31 percent.

FINANCIAL COMPONENT

- During the last three years around 62.79 crores have been released under NRHM Flexi pool, out of which 60% of the expenditure has been incurred. There has been improper planning in the utilization of these funds. In the year 2008-2009, allocation of fund has come down.

- No funds were approved for equipments in the year 2007-08 and 2008-09, while in 2009-2010 7 lakhs were approved. The approval of infrastructure expenditure in CHC, PHC and towards equipment is quite less to meet the essential requirements.

- During the last three years (2007-08, 2008-09 & 2009-2010) no expenditure was approved under the performance related incentive for ASHA. Most of the ASHA interviewed in the field have stated that they are not getting honorarium on time. Even the honorarium they are getting is quite less.

- In the year 2007-08 untied funds were not approved. In the present year 2009-2010, 722.4 lakhs have been released towards untied funds, which are found to be adequate.

- The fund generated under RKS is quite less. None of the CHC and PHC are generating user charge above Rs. 100, 000. None of the RKS in East Khasi Hills, Jaintia Hills and West Garo Hills are generating user fee above Rs.50, 000.

Recommendations

- Orientation programmes on utilization of untied funds needs to be carried out amongst the functionaries of health departments as wells as representatives of community towards the intended purposes for which these funds have been devolved to them.

- There is lack of effective monitoring by SPMU/DPMU/BPMU, which needs to be strengthened.

- All the medical officers should be provided with training on hospital management.

- There is a need for substantial improvement in health infrastructure in CHCs, PHCs and Sub-Centres for providing quality health care services under NRHM, which needs to be addressed.

- Awareness generation activities like: health camps, street plays, door to door health campaign, wall paintings etc. should be carried out.

- There is shortage of specialist medical and para-medical staffs in health facilities for delivering specialized health care services, which needs to be filled up immediately.

- Proper auditing process (both internal and external) on utilization of RKS funds should be in place. More funds should be generated by RKS by way of donations and loans etc.

- There needs to be better supervision on the functioning of ASHAs.

- Most of the drugs available in the pharmacy are antibiotic, antipyretic, anitdiarrhoeal, vitamins etc. There are no specific drugs for cardiovascular, diabetics, vaccines for animal bites etc. available in the pharmacy. Even there is shortage in supply of drugs. This needs to addressed.

- To overcome the problem on shortage in supply/non-availability of specific drugs/expiry etc. in health facilities, an external consultant can be appointed for a short span of time, the consultant can carry out supervision on a random basis in health facilities and a monthly status report can be submitted to the State Mission Director, NRHM.

- Training is the backbone of capacity building and functioning of ASHAs. So it must be done timely, properly and effectively. It has to be ensured during training that ASHAs are well aware about their jobs and responsibilities and are capable to fulfill their job responsibilities. ASHAs must be given instruction for providing guidance on hygiene and sanitation, exclusive breast-feeding, complimentary feeding, family planning, ORS use, preventing early marriage and gender discrimination etc. to beneficiaries. So its importance must be emphasized during training and other meetings.

- One of the main reasons for downfall in ASHAs effective functioning is non availability of fixed remuneration, while most of them have also stated that even they are not getting honorarium on time. This needs to be addressed.

- A provision of proper, well equipped one or two ambulance on call to transport the pregnant mothers and other serious patients in border and remote areas must be made available.

- Government doctors should be restrained from private practices, instead they may be paid some extra remuneration. At present, on an average each

doctors are handling atleast 50-60 patients during OPD hours and during the market days it rises to 100-120. Hence the doctors can be paid some extra remuneration.

- At present, most of the doctors are not visiting sub centres for health check ups. These needs to be improved particularly in the border and remote areas.

- Health education in schools needs to be promoted.

- There should be provision of proper disposal of bio medical waste in health facilities. Guidelines pertaining to disposal of bio medical waste should be circulated to all the health facilities.

- None of the visited health facilities were having telephones; hence mobile numbers of all medical officers can be displayed at the entrance of CHCs/PHCs.

- Identity cards to ASHAs, ANMs should be ensured.

- Self Help Group representative should be a member of VHSC.

- There needs to be constant monitoring at grass root level from top officials in the health department to check the functioning of health facilities in the state.

- There should be linkages with blood banks and health facilities.

- A performance reward scheme can be introduced, on the basis of which each year best performing districts can be rewarded. This will help in motivational aspect of the programme.

- A special training programme must be conducted for DPM and BPM, to explain their roles and responsibilities under NRHM. At present they are focusing mainly on record keeping. The DPM and BPM must be permitted to attend the RKS meetings. This needs to be addressed.

LIST OF SOME OF THE MEDICINES AVAILABLE IN PHARMACY

Anti - biotic

1. Amoxicillin Capsules & Syrup
2. Ampicillin Capsules & Syrup
3. Cephalexin Capsules & dry Syrup
4. Ciprofloxacin Capsules
5. Doxycycline Capsule
6. Cotrimoxagole tablet
7. Cephadrocil
8. Ofloxacin
9. Erythromycin
10. Satifloxacin
11. Agithromycin
12. Livoflexacin
13. Roxythromycin

Anti Pyretic & Analgesis

1. Paracetamol tablets
2. Nimesulide tablet
3. Ibuprofen + Paracetamol tablets

Anti - diarrhoeal

1. Norflox tablet
2. Metron
3. Agithromycin tablet
4. Furagolidane syrup
5. ORS powder
6. Ciprofloxacin
7. Ronithroxycin

Vitamin

1. R.Fol (Folic acid+B12 Complex Syrup)
2. Liver tonic (Livact, Livodor)

Anti - Allergic

1. Cetrizeine tablet
2. Cetrizeine Syrup

Anti - Spasmodic

1. Spasvenipolz

PHOTOGRAPHS

CHC Nangbah (not functioning since last 3 years), Jaintia Hills district

Balpakram Sub Centre (South Garo Hills district)

Boldakgre Sub Centre (West Garo Hills district)

Bio-medical waste burnt outside the sub centre

Condition of road from Ranikor to Khonjoy (West Kasi Hills district)

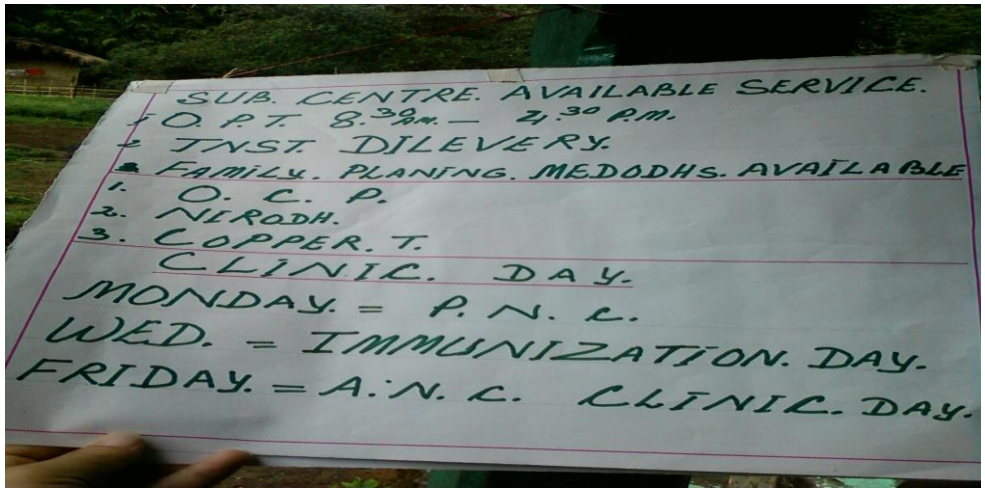


Chart showing service available at sub centre

Darrang Sub Centre under Dawki PHC

Mitapgre sub centre under Chockpot PHC

Condition of Beds and pillows in health facilities

Bio-medical waste being burnt in front of the health facility

Annexure – ‘B’

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