Inception Report

Project Management Agency under Meghalaya Health Systems Strengthening Project (MHSSP)

October, 2021

Expanding Horizons. Enriching Lives.

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TABLE OF CONTENTS

List Of Abbreviations

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
BHI	Bureau of Health intelligence
CHCs	Community Health Centres
CMO	Chief Medical Officer
CORT	Centre for Operations Research and Training
CPMU	Central Programme Management Unit
D & E Cell	Demography and Evaluation Cell
DFID	Department for International Development
DHS	Demographic Health Surveys
DWCD	Department of Women and Child Development
EDL	Essential Drug List
EOI	Expression of Interest
FLW	Frontline Worker
GIS	Geographical Information Centre
GMP	Good Manufacturing Practices
GST	Goods & Services Tax
HMIS	Health Monitoring and Information Systems
HR	Human Resources
HWCs	Health & Wellness Centres
IBF	Input-Based-Financing
ICT	Information and Communication Technology
IPA	Internal Performance Agreements
IPHS	Indian Public Health Standards
JSY	Janani Suraksha Yojana
LSE	London School of Economics
MHIS	Meghalaya Health Insurance Scheme
MHSSP	Meghalaya Health Systems Strengthening Project
MIS	Management Information Systems
MNCH	Maternal Newborn Child Health
MoHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
MPHS	Meghalaya Public Health Standards
MTEP	Medium Term Expenditure Plan
MWCD	Ministry of Women and Child Development

NABH	National Accreditation Board of Hospitals and Healthcare Providers
NEDSS	North Eastern Drug and Services Society
NHM	National Health Mission
NHSRC	National Health Systems Research Centre
NQAS	National Quality Assurance Standards
NRHM	National Rural Health Mission
OPD	Outpatient Department
PAD	Project Appraisal Document
PDIA	Problem Driven Iterative Adaptation
PDO	Project development objective
PHCs	Public Health Centres
PMA	Project Management Agency
PMU	Programme Management Unit
PPP	Public Private Partnership
PPT	Power Point Presentation
PRI	Panchayati Raj Institution
QA	Quality Assurance
RBF	Results-Based-Financing
RFP	Request for Proposal
RKS	Rogi Kalyan Samiti
RMNCH+A	Reproductive Maternal Newborn Child & Adolescent Health
SAG	Scheme for Adolescent Girls
SBCC	Social and Behavior Change Communication
SCEP	State Capability Enhancement Project
SHG	Self Help Groups
SHRC	State Health Resource Centre
SOPs	Standard Operating Procedures
SPMU	State Programme Management Unit
STGs	Standard Treatment Guidelines
TA	Technical Assistance
TBA	Traditional Birth Attendants
ToR	Terms of Reference
TWB	The World Bank
VHSND	Village Health, Sanitation and Nutrition Day
WHO	World Health Organization

1 Executive Summary

Meghalaya is one of the seven sister states located in the north-east of India. Meghalaya has a unique socio-cultural and linguistic makeup with a high tribal population (86%). The Khasis, Garos and Jaintias form the largest ethnic groups in the state. Meghalaya is a predominantly agricultural state with about 80% of its population depending entirely on agriculture for their livelihood. Though the state is one of the poor states of India, it's per capita health expenditure (₹2,366) is among the top 10 states with the highest health spending. The percentage of households covered by a health scheme or insurance stands at 34.6%, compared to the national average of 28.7%[1].

- In terms of key health indicators, with 39 deaths per 1,000 live births, Meghalaya's IMR is higher than the national average of of 34. Further, there is a huge rural-urban divide, with rural IMR (40) being 15 points higher than the urban. Malnutrition among children remains one of the key concerns for the state, with more than 46 percent of under-five children are stunted, 12 percent are wasted, and 26 percent are underweight. Further, the state also needs to address the poor health infrastructure as well as the shortage of health professions, especially since the public health sector is the main source of healthcare in the state (for over three-fourths of households), including for 83% of rural households (NHFS-4)[2].
- The Government of Meghalaya is committed to improving the health status of its citizens. With technical and financial support from the World Bank, the Department of Health and Family Welfare (DoHFW) and the Government of Meghalaya is implementing the 'Meghalaya Health Systems Strengthening Project' (MHSSP) in the state. It is a five-year project to improve accountability, quality and utilization of health services in the state. Managed by IPE Global, the Project Management Agency (PMA) has been set up to provide technical assistance to the Government of Meghalaya's 'Meghalaya Health Systems Strengthening Project (MHSSP)' to enhance capacity, quality and utilization of health services in Meghalaya. The MHSSP is an opportunity to leverage the state's socio-economic advantages and upsurge its healthcare services for the future.
- The PMA was initiated on 16th September 2021. The mandate of PMA may be seen as consisting of two inter-related components: (a) TA for implementing the project-specific activities such as procurement, financial management, IT and technical training of hospital staff etc. and (b) TA for the design and implementation of sector reforms and development plan.
    - Supply side strengthening: PMA would provide technical assistance to identify the bottlenecks and challenges in the delivery of health services in the state and recommendations that support the *allocative and technical efficiency* of the available resources.
        - There is a need to urgently address the high proportion of vacant positions (35%) for medical officers at Primary Healthcare Centres (PHCs) and (31%) nurses at PHCs and Community Health Centres (CHCs) in the state. The state also requires specialized HR such as surgeons. The PMA will support developing strategies to augment the health workforce both trained doctors and the nursing care. Strategies such as nursing skill labs, virtual classroom for in-service trainings and skillings etc., need to be designed to the needs and requirements of the state.
        - Moreover there is a need to develop Meghalaya's medical and nursing education sector to produce talent to address the health care needs in the long-term as well.

[1] https://www.orfonline.org/expert-speak/healthcare-meghalaya-uphill-battle/
[2] http://rchiips.org/NFHS/NFHS-4Reports/Meghalaya.pdf

- Efforts towards strengthening of health facilities especially the Health & Wellness Centres (HWC) to address issues related to poor health infrastructure in the state.
- The World Bank's Investment of USD 40 million in the MHSSP is a catalytic funding and an opportunity to strategic policy decisions such as PPP instruments to meet the health demands of its citizens, especially in the areas of preventive and promotive care. Further PPPs may be adopted to address gaps in functionality such as bio-medical waste management, housekeeping and catering, diagnostic centres, setting up nursing colleges, and referral transport. The PMA will support in reviewing the impact of existing PPPs in the state and develop strategies to further refine and strengthen them.
- Strengthen the drugs and medical supplies procurement to ensure the universal provision of essential drugs and set up and operationalize the "North Eastern Drug and Services Society (NEDSS).

- Demand-side interventions: With critical gaps in health care attainments, especially in the rural areas, the PMA will support investigating the bottlenecks, strategizing the solutions and implementing the initiatives to augment the uptake of health services in the state. The emphasis is on community mobilization and participation in maternal and child health services.
  - A community-based monitoring framework has been recommended in Meghalaya's state health policy as a key measure to empower the decentralized monitoring committees at all levels, both rural and urban, to seek the community's feedback in a structured manner. Further initiatives such as social audits to strengthen service delivery would be supported by the PMA.

- The Inception Period has provided the team with the opportunity of building relationships, undertake site visits and develop an initial situation analysis to articulate the action plans to tackle the defined result areas under the project. The details of the same are provided in the subsequent sections.

2 Introduction

2.1 Components of MHSSP

The Meghalaya Health System Strengthening Project (MHSSP) will be implemented over a 5-year period[3] with an outlay of USD 50 million[4] consisting of an IBRD loan of USD 40 million and a contribution of USD 10 million from Government of Meghalaya. The project development objective (PDO) is to improve management capacity, quality and utilization of health services in Meghalaya. The project has the following four components:

- Improving accountability, management and strengthening governance,
- Strengthening systems to improve the quality of health services,
- Increasing coverage and utilization of health services, and
- Contingent emergency response.

The Project Appraisal Document (PAD) of the World Bank identifies the following major constraints which are sought to be addressed through the project:

- Weaknesses in accountability, management and services delivery systems, and
- Weak management capacity leading to a range of systemic gaps in service delivery, quality of services and rational deployment and management of human resources:

To address the issues impacting the "performance" of public health system in the State, a mix of Results-Based-Financing (RBF) and Input-Based-Financing (IBF) approaches will be deployed. For this purpose, the project outlays have been divided into the following three components[5]:

- Component-1: Improving accountability, management and strengthening governance (USD 18 million): This component will provide performance incentive grants to health agencies (e.g. Directorate of Health Services) and health facilities (e.g. district hospitals). The incentive grants will be provided upon achievement of pre-defined performance milestones which will be set out in what is termed "Internal Performance Agreements (IPAs)". Three levels of IPAs are proposed to be used: (a) agreements between the Department of Health & FW and DHS (MCH &FW), DHS(Medical Institutions) and Megha Health Insurance Agency; (b) tripartite agreements between the two Directorates (DHS-MI and DHS-MCH&FW) on one side and selected District hospitals and higher level facilities on the other; and (c) agreements between district administration and selected CHCs and PHCs.
- Component-2: Strengthening systems to improve quality of health services (USD 22 million): This component has a number of sub-components such as development and implementation of quality assurance (QA) programmes; development of tools and provision of technical assistance (TA) to improve HR supply, planning and management; strengthening procurement and supply chain management system; and development of innovative ICT solutions to strengthen planning, implementation and monitoring systems.
- Component-3: Increasing coverage and utilization of health services (USD 10 million): This component will support strengthening (a) Megha Health Insurance Scheme (MHIS), (b) primary

[3] The agreement between the World Bank and the Government of India / Government of Meghalaya was signed on 31st August, 2021.
[4] Rs 375 crore approximately.
[5] There is no up-front outlay for the fourth component.

health care through Health and Wellness Centres (HWCs) and (c) community level interventions and engagement.

2.2 Mandate of PMA

A total of 8 TA agencies will be selected to support the implementation of the project. These include the following:

1. Project Management Agency (PMA): This TA component has been awarded to IPE Global Limited
2. TA for Social Behaviour Change Communication
3. Third Party Verification : This component has been awarded to Sutra Consulting
4. TA for Medical Care Assessment
5. TA for Human Resource for Health
6. Health Benefit Package Study
7. Meghalaya Health Insurance Scheme Redesign
8. TA for Integrated package for improving nutrition

As per the Request for Proposal (RfP) document that was released for the selection of agency, the PMA's scope of work would include the following:

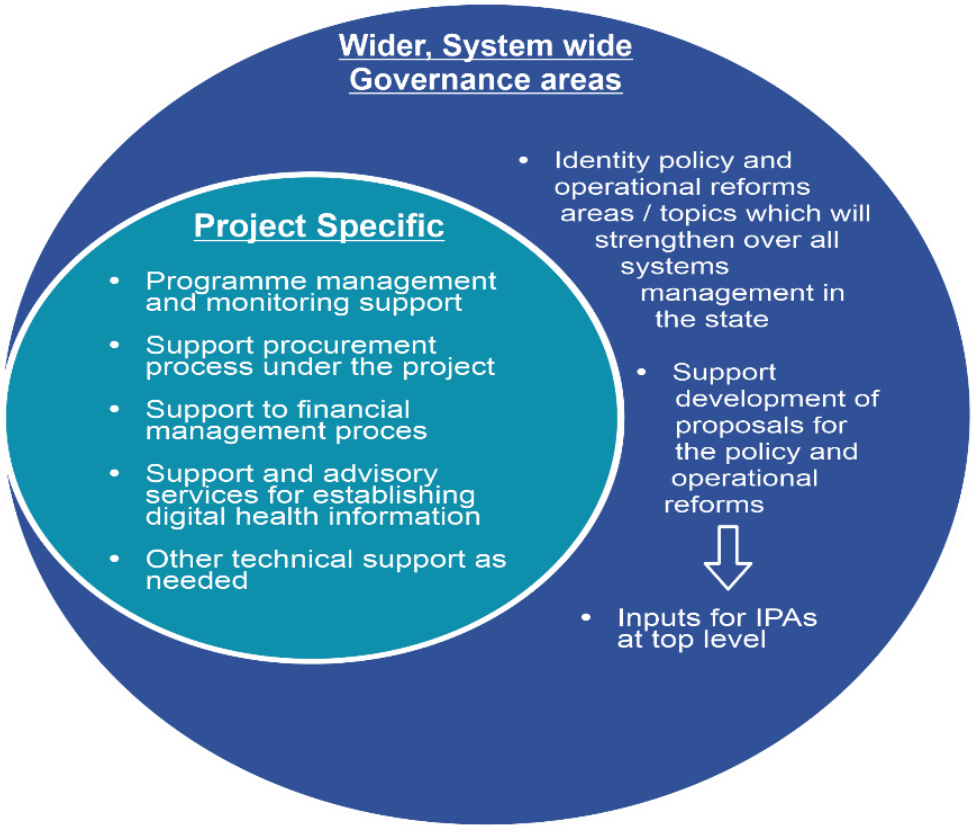
- Provide programme management and monitoring support to the project
- Support to procurement process under the project
- Support to financial management process for the project
- Support and advisory services in establishing digital health information system for the project
- Additional technical support as required.

While the scope of work listed in the RfP appears to be limited to the project, the PAD defines the PMA role in much wider sense. More specifically, para 2 on page 6 of the PAD defines the role of PMA as follows:

"The Project Implementing Entity shall…… recruit, and maintain throughout Project implementation, a project management agency to support measures intended to strengthen administrative structures responsible for health system management, including technical support and training for administrators at the state and district levels for planning, management and technical issues."

In effect, the PMA mandate may be seen as consisting of two inter-related components : (a) TA for implementing the project specific activities such as procurement, financial management, IT and technical training of hospital staff etc. and (b) TA for the design and implementation of sector reforms and development agenda. In particular, PMA's work in domain (b) will be focussed at identifying reforms milestones which could be used as part of higher level IPAs. This is depicted in the diagram below.

Figure 1: Mandate of Project Management Agency (PMA)



3 A brief situational analysis of health sector in Meghalaya

3.1 Literature review

3.1.1 State Health Policy, 2021

The Government notified the Meghalaya Health Policy, 2021 on 9th March, 2021. The Policy advocates adoption of a positive health care model that touches upon socio-economic determinants of the people. It calls for using techniques from the State Capability Enhancement Project (SCEP) which uses frameworks such as Problem Driven Iterative Adaptation (PDIA) approach. Some highlights from the Policy document, relevant for specific action under the MHSSP, are as follows:

- Foster an environment where decentralization takes centre stage and break hierarchical barriers in healthcare administration [para 1.1 (iv)]
- Build a robust data architecture that will support development and implementation of health reforms [para 2]
- Focus on rights based framework…. Yearly household visits to generate awareness on how to access various services by the State [para 3]
- Focus on public health ….. guidelines for attracting and retaining doctors serving in remote areas, guidelines for specialists' attraction and retention [para 4.2]
- PPP for preventive health care and allowing private insurance companies to enter positive healthcare model [para 4.3]
- Train SHGs for demand generation and people's participation [para 4.4]

- Inter-departmental convergence to ensure supply of safe water, sanitation through appropriate and effective sewerage and drainage systems, waste disposal and management systems ….. [para 4.6]
- Encourage locally grown food, seasonal food and food items which are not chemically treated; encourage healthy farming practices, concept of nutri-gardens, growing of herbal and medicinal plants and food forests…… [para 4.7]
- Address the invisible costs which are borne by residents after exhaustion of MHIS cap [para 5]
- Establish Public Health Academic and Research Institution in collaboration with Public Health Foundation of India to implement ADARSH[6] project [para 5]

3.1.2 NEDSS Report version 1.1 (20-08-2021)

In 2015, Ministry of Health and FW, Govt of India, issued the "Operational Guidelines for Free drugs Initiative" aimed at ensuring that a set of essential drugs based on the level of public health facilities is made available free of cost to all who access these facilities. The key features of the guidelines are as follows:

- States should notify a policy for universal provision of essential drugs, which should be widely publicized as an entitlement, and disseminated through posters, wall writing and hoardings in all public health facilities and other vantage points and also through different media.
- States should also undertake orientation workshops for doctors to promote prescription of generics and rational drug use.
- All medicines must be sourced from Good Manufacturing Practices (GMP) compliant manufacturers through robust procurement mechanisms, and post supply testing of every batch before distribution.
- States should set up robust IT backed procurement, quality assurance, warehouses, and supply chain systems that are benchmarked for key management processes with the best practices in this field. Adherence to such practices of procurement, supply chain management, quality assurance and prevention of wastage, and sound monitoring mechanisms for these would be essential pre-requisites for continued central funding under this initiative.
- All drugs procured, distributed and prescribed under this initiative shall be generic drugs.
- States could either develop their own Standard Treatment Guidelines (STGs) or adapt the STGs published by the MoHFW that would be shared with all the States.
- A system of prescription audits would be required to be put in place to ensure prescription of generics and rational use of drugs.
- States must have a facility wise Essential Drug List (EDLs) and display them prominently at each facility.
- A Grievance Redressal System, including a toll free call centre and using various social and electronic media, other than facility level written complaints box, and /or Help Desk may be set up as required. This should be monitored by the Rogi Kalyan Samiti (RKS).

To implement the initiative, the State proposes to set up "North Eastern Drug and Services Society (NEDSS" and a detailed report has been prepared in this regard. Briefly, it is proposed to replicate the TNMSC model, which is also implicit the MoHFW guidelines. The PMA has examined this report and would like to make the following observations / suggestions:

- The MoHFW guidelines require that only GMP certified manufacturers be allowed to participate in the procurement process. For a small state like Meghalaya, where the volume for a given medicine is bound to be a fraction of what it would be for a bigger state, say, Tamil Nadu, restricting eligibility to manufacturers may not yield satisfactory results. The NEDSS report suggests, therefore, that

[6] **AD**option of **A**lternative models for **R**esponding to **SH**ortage of medical specialists.

dealers and suppliers may also be allowed to bid[7]. However, PMA's feedback from consultations that it held with a few domain experts suggests that this may also not yield satisfactory results.

- The pharmaceuticals industry supply chain system consists of Carry and Forward (C&F) Agents, Wholesalers, Distributers and Retailers. A C&F Agent normally deals with more than one manufacturer and PMA's enquiries reveal that most of the medicine supplies to the State are from the C&F agents based in Guwahati. As such, it may be worthwhile to consider restricting the eligibility to such C&F agents who are dealing with at least, say, 30% of the items in the EDL that the state proposes to procure.
- The Jan Aushadhi Kendra scheme[8] being implemented by the Bureau of Pharma PSUs of India (BPPI) allows distributors to establish pharmacies in government owned premises. As such, it would be worthwhile to explore feasibility of structuring a partnership between the State Government and the BPPI under which BPPI takes the responsibility to ensure availability of generic medicines in the pharmacies of the government hospitals.
- The proposed Society will have to employ a minimum number of staff and maintain a minimum level of physical infrastructure. Given the volume vis-à-vis the volumes that TNMSC handles, the NEDSS will require a much larger level of handling changes than the 1.5% handling charge that the TNMSC applies.
- If the state chooses to go ahead with NEDSS option, the following may be considered:
    - include the Finance Department as a member of the Governing Body,
    - the MD of the Society may be appointed by the Establishment Division on a fixed tenure basis (through invitation of applications instead of nomination so that we get a willing person),
    - the MD may be the ex-officio Member Secretary of the Governing Body and Chairman of the Executive Committee - this arrangement will balance the authority and accountability of the position; and
    - unless the NEDSS aims to work for all states in the NE region, its name should be " Meghalaya Medical Services Society (MMSS)".

3.1.3 SUTRA Consulting Report – Regional Plan and Strategy for Up-gradation of secondary and tertiary health care facilities in North-Eastern Region by 2030

The North Eastern Development Finance Corporation Ltd. had commissioned a study for developing a regional plan and strategy for upgradation of secondary and tertiary health care facilities in the North Eastern region by 2030. Among others, the scope of work of the assignment included (a) mapping existing health facilities in the region (on a census basis), (b) suggesting measures for their upgradation, (c) suggesting measures for creating speciality and super—speciality facilities in district hospitals, (d) suggesting measures to improve doctor-population ratio in the NE region to national levels, and (e) suggesting measures for increasing PPP modalities (for improving functionality) in the hospitals in the region. For developing recommendations, the agency conducted detailed study in a sample of hospitals in every state. For Meghalaya, the sample included 8 district hospitals and 20 CHCs.

Some of the key recommendations made in the report, relevant for consideration under the MHSSP, are as follows:

[7] Please see para 4 under Next Steps section on page 11 of the report.
[8] Please see compensation package details given in the table on page 24 of NEDSS report.

- Since dearth of HR is one of the main reasons for non-functional status of various wings, appropriate HR policies which are perceived to be pro-employee, need to be put in place.
- Transparency in policies, including criteria for promotion and benefits for doctors working in rural areas, need to be in place.
- PPP may be adopted to address gaps in functionality. These may include bio-medical waste management, housekeeping and catering, diagnostic centres, setting up nursing colleges, and referral transport.

3.1.4 Technical and operational guidelines (for) implementation of 15th Finance Commission health grants through local governments

A part of the 15th Finance Commission grants to the States has been earmarked for strengthening the health sector. These grants are to be utilized through the local governments over 5 years [2021-22 to 2025-26] and the Ministry of Health & FW has released detailed guidelines for implementing the health grants.

State-wise rural and break up of the grants are already indicated in the Finance Commission. Share of Meghalaya is Rs 311 crores out of total health grants of Rs 70, 051 crores over 5 years.

The health grants are to be used for the following purposes:

- Rural areas:
  - Construction of buildings for building-less Sub-Centres, PHCs and CHCs;
  - Conversion of rural PHCs and Sub-centres into Health and Wellness Centres;
  - Support for diagnostic infrastructure to primary health care facilities; and
  - Establishment of block level Public Health Units[9].
- Urban areas:
  - Support for diagnostic infrastructure to primary health care facilities; and
  - Establishment of Urban Health and Wellness Centres.

Every State has been asked to developing its own guidelines for deciding the criteria for resource envelope and component wise target distribution among the districts / RLBs and ULBs.

As per the guidelines issued by the Department of Expenditure, Govt of India, the concerned Zilla Panchayat / Autonomous District Council is to handle / implement the rural components of health sector grants in close coordination with the District Health Department under the overall supervision of the District Collector (not at Block Panchayat or Gram Panchayat level), because the components require technical experience as well as exposure in relevant subjects. However, rural local bodies below the district level (as the case may be), such as Block /Taluk level Panchayats, and Gram Panchayats / Village Councils must be involved in planning and monitoring of these components for the health facilities located in their jurisdiction. Similarly, at the district level, the urban local bodies are to handle / implement the urban components of health sector grants in close coordination with the District Health Department under the overall supervision of the District Collector.

[9] Three specific functions have been identified for the PHUs: (a) public health functions such as surveillance, (b) public health lab and (c) data compilation and analysis.

It is significant to note that the guidelines allow PPP arrangement for setting up HWCs in urban areas[10]. Given that the State is already having experience of managing a number of health facilities in PPP mode, it should be relatively easy for it to implement the urban component of 15th FC health grants in the urban areas.

Similarly, the allocation for strengthening diagnostic services in rural areas can also be used relatively easily since the State already has well established PPP arrangements for these services which could be further expanded / strengthened.

3.1.5 Meghalaya's NHM PIP 2021-22

Meghalaya's post-NPCC discussion outlay for NHM for FY 2021-22 is pegged at Rs 34895.92 lakh comprising of Rs 34026.54 lakh for rural component and Rs. 869.38 lakh for urban component.

Major items of expenditure (rural and urban combined) under the PIP include the following:

- Human resource – Rs 7203.85 lakh
- Procurement – Rs 5459.50 lakh
- Community interventions – Rs 4120.96 lakh
- Service delivery – Rs 3168.10 lakh
- PPPs – Rs 3015.33 lakh
- Infrastructure – Rs 2847.49 lakh
- Infrastructure maintenance – Rs 2338.00 lakh
- Untied funds for RKSs and VHSNCs – 1270.20 lakh

The PPPs include outlays for (a) free diagnostic services and (b) grants to NGOs managing 2 CHCs, 19 PHCs and 1 State dispensary which are being run in PPP mode.

3.1.6 Meghalaya Community Participation and Public Services Social Audit Act, 2017 and Rules 2019

The Meghalaya Community Participation and Public Services Social Audit Act, 2017 [Act No. 7 of 2017] was notified on 4th April, 2017 and the Rules for implementing the Act were notified on 2nd July, 2019.

The responsibility for implementation of the Act has been assigned to an autonomous institution, namely, Meghalaya Society for Social Audit and Transparency (MSSAT), which was established in 2014-15 and was already carrying out social audits for the flagship schemes like MGNREGA, IAY/ PMAY-G, NSAP etc. The Governing Body of the MSSAT is chaired by the Chief Secretary and has a total of 14 members, consisting of 11 ex-officio members and 2 NGOs and 1 private individual. The Director of MSSAT acts as the Convenor of the Governing Body.

The MSSAT mandate includes (a) setting up a system of concurrent audit by involving trained civil society organizations, (b) advising the State on all matters concerning implementation of the Act, (c) review monitoring and grievance redressal mechanism(s) from time to time and recommend improvements required, (d) prepare annual reports to be laid before the Assembly by the State Government.

[10] Please see para 2.2.1 (vii) of the Guidelines.

Schedule-I to the Act provides the list of programmes and public services which would be included under the social audits taken up under the Act. For Health, there are two entries : (a) health services including immunization and (b) services rendered by the nearest Sub Centre / PHC / CHC.

Rule 3 of the Rules, 2019 provide for gradual expansion of the scope of social audit.

The MSSAT website provides a number of reports providing details of social audits carried out. Extracts from one such report, providing details of social audit of health at village Kynrud, block Mairang, district West Khasi Hills, carried out during 17-22 November, 2017 is given at **Annex-1**.

The findings from the social audits can be used for rewarding or counselling of officers in-charge of the concerned PHC / CHC.

3.2 Findings from the field visits

The Team Leader and Public Health and QA expert of the PMA undertook a 4-day field visit during 5-8 October, 2021 to a sample of health facilities covering the following:

- Nongkhlaw CHC managed by NGO Citizen Foundation (5th October);
- Kynrud PHC managed by NGO Karuna Trust (5th October);
- Williamnagar civil hospital (6th October);
- Tura civil hospital (6th October)
- Dewagre Sub-Centre (7th October)
- Nangkhrwa Sub-Centre (7th October)
- Samanda PHC (7th October)
- Rongjeng CHC (8th October)

During the visits, the team met and interacted with the facility managers and had a first hand look at the facility building and other infrastructure. In two locations (Nongkhlaw and Williamnagar), the team also held brief discussions with members of self-help groups.

The facility visits were made using a check list and a facility wise summary of findings is given at **Annex-2.** The overall impressions of the team from the field visits is summarised below:

- In general, staff (both in the PPP facilities as well as government operated ones) was found to be sincere, in spite of challenges faced.
- In PPP run facilities, the staff salaries are paid by the NGO concerned from out of grants give to them by the Government. For all other items, funds and supplies are made by the Government, treating the facility at par with other government facilities. This a very good arrangement. Staff at both the facilities, however, reported about delays in payment and irregular increment in salary.

Box-1

It is noted that the MoUs executed with the NGOs do not provide any formula for providing annual increment. This opens the arrangement to ad-hocism which can be addressed through execution of an updated MoU which allows annual increment linked to the same index that regulates provision of DA to Government staff. While doing so, a minimum level of performance can also be introduced.

- Most challenges in facilities relate to building infrastructure, staff quarters in need of repair and expansion.
- Jan Aushadhi Kendras (JAKs) located within the premises of the hospital face the challenge of no sale and losses. This could be due to prescription habits of doctors and also availability of generic medicines for free from facility pharmacist.

Box-2

The hospital pharmacy issues medicines free whereas the JAK has to charge. Since both are stocking generic medicines, the JAK revenues are obviously influenced by the availability of medicines in the hospital pharmacies. In other words, it is not sustainable to have both systems – free medicines from hospital pharmacy and not-free medicines from JAK.

- Bio medical waste management processes are present in all facilities but segregation of waste was found to be weak.
- Suggestion boxes are present in all facilities but not in use in most facilities. In one case, the MO mentioned that he reads the feedback, but no record was maintained.

4 (Proposed) Sector Reform and Development Agenda

4.1 Meghalaya Public Health Standards (MPHS)

The project provides a once in life time opportunity to review the current system and define the target health system that should guide the State's efforts in strengthening its public health system. In this regard, the Indian Public Health Standards (IPHS) should be used as a reference point. It is, therefore, suggested that a Task Force may be set up to develop what may be called the Meghalaya Public Health Standards (MPHS). Among others, the MPHS document should specify the following:

- The number and type of institutions that the system will aim to reach. Besides the number of sub-centres, PHCs, CHCs and civil hospitals, the system articulation should also integrate existing specialised institutions such as MCH hospitals[11];
- The service package that each type of institution will provide;
- Infrastructure [Buildings, including residential buildings for the core technical staff, equipment], required to deliver the services;
- Identification of services that will be directly provided (through government staff) and the functions / services that may be outsourced locally by the concerned RKS or by the state through suitably structured PPP; and
- Staffing norms (after taking into account the functions /services that may be outsourced), *including the grades in the concerned cadres for the personnel in the system*.

[11] It should also be an objective of the exercise to align the PHC network with the revenue administration system. In particular, it is to be examined whether there should be a CHC at every block headquarter so that the jurisdiction of a CHC and the block public health unit [required to be set up under 15th FC health grants] are co-terminus.

Box-3

The Team was provided with copies of following notifications : [notification dated 1st August 2007 indicating staffing norms for hospitals, CHCs, PHCs and Sub-Centres; two Notifications dated 7th September, 2007 indicating staffing norms for Women and Children hospitals, MIMHANS hospital and three levels of trauma centres; and another Notification dated 19th March, 2014, updating staffing norms for new PHCs. These Notifications do not specify the corresponding services package and do not reflect the effect of State's Health Policy recommendation regarding outsourcing of non-clinical functions and / or clinical support functions such as pathology and teleradiology PPPs which are under implementation since 2017. As such, the need for evolving State's equivalent of IPHS remains.

A number of milestones can be drawn from this exercise as elements of IPAs such as the following:

- *Submission of MPHS by the Task Force*
- *Notification of MPHS by the Government*
- *Submission of Implementation Plan*

4.2 Medium Term Expenditure Plan (MTEP)

Developing a medium term expenditure plan, using the MHSP as the basis for costing, should be the next exercise. Among others, the costs calculated on the basis of MPHS will provide estimates of (a) manpower costs, (b) budget required for outsourced services, (c) cost of medicines, (d) cost of additional buildings that need to be constructed (to meet the MPHS norms) as well as cost of repairs and rehabilitation of existing buildings, (e) cost of equipment to be purchased and (f) grants to be provided to NGOs, RKSs and VHSNCs etc.

4.3 Gap Assessment : Web-based, modular application for health resource mapping and management

The next logical step for strengthening the public health system would be the gap assessment exercise. For this, a web-based, modular application may be developed for health resource mapping and management.

4.4 Infrastructure consolidation and strengthening plan

The next step would be to develop the infrastructure strengthening / consolidation plan that takes into account all sources of funding [NHM, MHSSP, 15th FC health grants etc.].

4.5 Restructuring / re-organisation of the Directorate

It is noted that 'developing a strategy and management framework for HRH' is a separate and specific technical assistance (TA) component of the MHSSP and the TA agency, that may be selected for the exercise, will be undertaking a functional review of the existing wings of the Directorates. The purpose of including this aspect in the PMA's Inception Report is to underline the criticality of Directorate reorganization for successful implementation of MHSSP. In particular, PMA would like to suggest the following for consideration of the Government in this regard:

- The activities of the TA for (HRH) should be dovetailed to and synchronized with that of the Task Force that may be set up to develop MPHS, MTEP and MHSCP documents.
- Creating a dedicated and independent Planning and Monitoring Division should be one of the specific objectives of the re-organization[12]. This suggestion is made in light of recommendations made in this regard by the Karnataka Task Force headed by Dr Sudarshan. The relevant part of the Task Force report is given at **Annex-3** for ready reference.

Box-4

Ideally, the three components – MPHS, MTEP and the infrastructure consolidation plan should become part of what may be called the Meghalaya Health System Consolidation Plan (MHSCP) and should be got endorsed by the Cabinet, perhaps after a presentation in the State Assembly. This document should then become the guiding / reference document for future investment decisions.

Availability of medical manpower, particularly the specialists, will be more critical than other factors. Therefore, detailing of MHSCP should be guided by estimated availability of medical manpower.

4.6 Review / revise and notify Delegation of Administrative and Financial Authority of DHSs, DMHO and officers in-charge of Civil Hospitals, specialised hospitals, CHCs and PHCs

While the functional review and reorganization would take time, there is an urgent need to review, revise and notify an updated Order / Notification delineating administrative and financial authority of the Directors of Health Services, District Medical and Health Officers and officers in-charge of Civil Hospitals, Specialized Hospitals, CHCs and PHCs.

4.7 Review and revise HR Policies (Service Rules)

The Meghalaya Health Service Rules, 1982 provided for a total of 281 posts for doctors in various grades, consisting of 182 Grade-III posts (entry level), 28 Grade-II posts, 23 Grade-I posts, 6 Senior Grade posts and the remaining as leave / training / deputation reserve posts. The Rules did not provide for a separate specialists' or public health cadre.

The Service Rule, 1990 provide for two separate cadres – a general duty stream and a specialists' stream. Appointment to both the streams is at the Grad-III level on direct recruitment basis; to the post of Medical and Health Officer in the general duty stream and to the post of Junior Specialist in the specialist stream[13]. A very good feature of the 1990 Rules is that promotion to Grade-II [first promotion] shall depend on total qualifying length of continuous service and availability of the posts[14]. Appointment to Grade-I, however, is not automatic and is based on selection, subject to qualifying criteria specified in the Rules[15]. The Rules also provide for direct recruitment to Grade-I of the Specialist stream. Further, appointment to Senior Grade is open to both the streams.

[12] The web-based information system should eventually be managed by the Planning and Monitoring Division.
[13] It is not clear from the Rules whether the Junior Specialists will enjoy a higher pay scale or a higher starting pay (within a common pay scale).
[14] Rule 9 (2).
[15] Rule 9 (3).

It is noted that the TA for HRH will look at all aspects of HR policies for all categories of clinical, technical and administrative cadres. In this regard, the PMA would like to make the following suggestions:

- The Service Rules may be updated to provide for the following:
  - Three separate cadres – a general duty medical officer cadre, a specialist cadre and a public health cadre; these should be broadly structured along the arrangement in place in Tamil Nadu
  - Post of Block Medical Officer [important in view of 15th FC recommendation regarding Block Public Health Unit]
  - Mandatory induction training
  - Allotment to districts upon joining through counselling
  - Automatic promotion to at least one higher level (as already provided)
  - Mandatory posting at identified remote / difficult locations for a fixed duration [e.g. for 2 years during the first 5 years of service, allowing candidates to time their difficult area posting[16]].
  - Rotation policy / guidelines for the district to follow.

It is also suggested that the State may use its PG quota to attract MBBS doctors from the open market [any State of India] to work in the difficult locations for a fixed period [e.g. 2 years]. The State of Himachal Pradesh used this strategy to address the shortage of doctors in Lahaul-Spiti and other remote areas of the State.

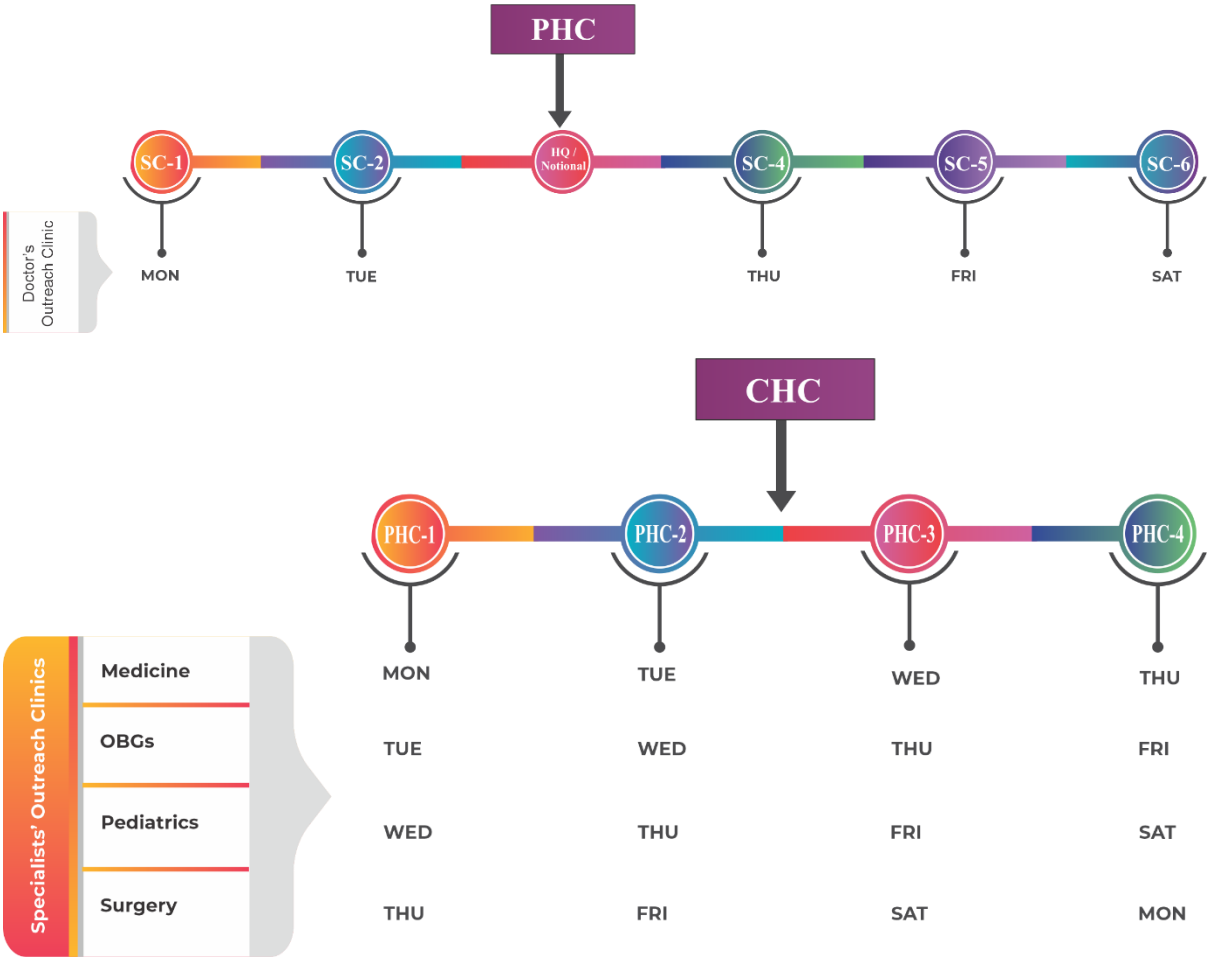
Box-5

It was noted during the field visit that a substantial number of Medical Officers are under the so-called F3 mechanism [an ad-hoc arrangement allowing extension of tenure at 4 monthly intervals] because the State Public Service Commission has not been able to conduct regular recruitment. This is a very de-motivating factor and needs MOST URGENT attention of the State. A solution to the problem, adopted by some other states is to take over the secretarial functions of recruitment, while involving the State PSC in the meetings of the Selection Board.

4.8 Strengthening routine PHC system

According to the 1983 MoHFW publication "Job responsibilities under of PHC system", the PHC Medical Officer is expected to hold weekly extension clinics at the Sub-centres (in addition to clinics at the PHC)[17]. Similarly, the specialists posted at the CHC are expected to hold weekly outreach clinics at each of the PHCs under its jurisdiction. This is illustrated in the diagrams given below.

[16] A system prevalent for the Probationary Officers in the State Bank of India.
[17] This is re-iterated in the IPHS 2012 for PHC – please see Annexure-7 (job responsibility of Medical Officer and other staff at PHC, IPHS Guidelines for PHC, 2012).



During the brief field visit, the PMA team did not find much awareness about the design underlying the jurisdiction / command structure, namely, one PHC supervising 6 Sub-centres (including a notional Sub-Centre attached to the PHC itself) and one CHC supervising 4 PHCs.

It is suggested that the system of outreach clinics by the PHC Medical Officers may be revived. Besides providing hand on training to the ANMs, this will help in identifying cases (e.g. elective surgeries) which may need to be referred to hospitals.

4.9 Policy and operational framework for public – private partnerships in the health sector

The Government of Meghalaya announced its Public-Private Partnership Policy in July, 2021. As per the Press Note dated 19 July, 2021 (copy given at **Annex-4**), there will be two types of PPPs:

- Large Infrastructure Projects (PPP) - Projects that require large investments, typically more than Rs. 10 Cr. e.g. major roads projects, hydro power projects etc.
- Community Infra Projects (CPPP) - Projects that require smaller investments, typically less than Rs. 10 Cr. e.g. a processing plant. Under CPPP, the community shall be actively involved and contribute through the entire process. The community will not only provide the land, but their consent would also be taken at critical junctures. At the end of the project cycle, the assets along with the land would be passed back to the community.

The above policy will be useful for creating infrastructure in all sectors, including the health sector, such as hospitals, training centres and bio-medical waste management facilities etc. However, there are many other areas where the private sector expertise can be exploited for public benefit. Many States have, therefore, developed and adopted health sector specific policy and operational framework. See, for example, Health PPP Policy adopted the Government of Chhattisgarh in 2012 (**Annex-5**).

Having a health sector specific PPP Policy and Operational framework serves many purposes : it informs the potential partners about the priority areas that the State has identified for partnerships and the institutional arrangements that are being made available to steer the partnerships. Above all, it brings much transparency to the entire process, thereby promoting partnerships and minimizing scope for litigation. It is, therefore, suggested that a health sector specific PPP Policy may be developed and adopted with the Cabinet approval.

4.10 (Suggested) priority areas for PPP

Some of the activities which could be more effectively managed under PPP modality are given in the table below for consideration of the Government:

Table-1: Suggested PPP areas

Activity area	Advantages PPP modality offers	Remarks
Establishing ANM / Nursing Schools attached to Civil Hospitals	Private partner invests in training infrastructure with the public hospital as the practice area. The private partner also pays an attachment fee to the HMS / RKS of the hospital. Hospital technical staff ay be allowed to be guest faculty	Fee structure to be jointly developed Part of seats (25-30%) may be sponsored by the Government to train ASHAs as ANM / Nurse[18]
Pharmacies in government hospitals	Assured availability of generic medicines in public hospitals HMS/RKS is given annual medicine budget, to be used for reimbursement against medicines issued to patients	C&F agents may be invited to participate in a bid to set up pharmacies in a sample of district hospitals Alternatively, BPPI may be invited to set up pharmacies in the sample hospitals
Hub and spoke system of diagnostic labs	Assured availability of free diagnostic services to patients	Model exists in Jharkhand; pathology and radiology services being provided at district hospitals

[18] National Health Policy 2017 (para 11.6) recommends preferential selection of ASHA into ANM, nursing and paramedical course

Activity area	Advantages PPP modality offers	Remarks
	HMS/RKS is given annual medicine budget, to be used for reimbursement against tests done	"discount w.r.t. CGHS rates" was used for selection of partner.
Bio-medical waste management	Collection and disposal outsourced to a specialised agency on a per bed per day rate basis. Facility available to all public and private hospitals.	Under implementation in Chhattisgarh since 2012.
Helpline (service 104) for assistance and complaint / grievance registration	Access to information for general public in regional / local language Independent grievance / complaint registration system	Under implementation in Chhattisgarh (since 2012)

4.11 Urban Health: Introduce voucher system for primary health care in urban areas, redeploy doctors to public health facilities in rural areas

Voucher system has emerged as a more cost effective way for delivering healthcare services in the urban areas where most of the private healthcare providers are available. The approach involves the following:

- Defining the package of services (e.g. MCH care from detection of pregnancy till the child is 2 years old)
- Defining the criteria for selection of private provider (e.g. minimum bed strength, willingness to create dedicated arrangements to serve the voucher holders)
- Defining the target group (e.g. slum dwellers)
- Negotiating the prices for various services with the service providers
- Issuing the vouchers to the target group families

In many ways, the approach will qualify the State's Health Policy objective of involving private providers for preventive care (see para 4.3 of the State Health Policy, 2021). The 15th FC has also recommended PPP approach for the urban areas.

The voucher approach can be introduced in two way – (a) where the voucher holders will visit the private hospitals empanelled for the scheme or (b) where the existing Urban Health Centres are handed over to the private providers to organize and deliver the services. Both approaches should be explored. In either case, however, introduction of voucher system will free up the Medical Officers and other staff who can be re-deployed in the rural areas where there is, admittedly, an acute shortage of medical personnel.

4.12 Capacity building interventions

4.12.1 Appoint Hospital Managers in Civil Hospitals

The IPHS recommends that professionally qualified hospital managers be appointed to assist the Medical Superintendents. Experience in other States suggests that this helps in improving quality of services and faster accreditation of the hospital. It is, therefore, suggested that the State may recruit and appoint such persons in all civil hospitals as well as specialised hospitals such as the MCH hospitals.

4.12.2 Public Health Management training course for Medical Officers

Public health management skills are crucial for effective implementation of public health programmes. With the 15th Finance Commission directive about establishing Public Health Units at the Block level makes it even more important that all Medical Officers have certain minimum level of knowledge and skills about public health issues. It is, therefore, suggest that a suitable public health management training course is designed and implemented for all Medical Officers, particularly those who are posted at the PHCs and CHCs. This could be implemented in partnership with NEIGRIHMS, Public Health Foundation of India (PHFI) or International Institute of Health Management Research (IIHMR), New Delhi.

4.12.3 Capacity building of HMS / RKS for client feedback and grievance redressal

One of the key tasks that was assigned to the HMS / RKS related to client feedback and grievance redressal. The non-official members were of the HMS / RKS were expected to lead on this. It was, however, noted during the field visit that while a suggestion box was affixed in and around the reception of every hospital that was visited, these were hardly used by the clients visiting the hospital. It is, therefore, suggested that a suitable training capsule is designed for orienting the non-official members of the HMSs / RKSs about the critical role that they can play towards client satisfaction and grievance redressal.

4.12.4 Training and orientation of traditional healers

Training and orientation of traditional healers is one of the key strategies recommended by the WHO for strengthening primary care systems. There are several examples where such programmes have created a win-win situation. For example, in a TB control programme, orientation of traditional healers in case detection and DOT provider not only improved effectiveness of TB control programme, it also enhanced the traditional healers' image in the community. It is, therefore, suggested that a suitable training course is designed and implemented in collaboration with the relevant government departments (e.g. Forest Department, Tribal Welfare Department) and Autonomous District Councils.

4.12.5 Training and handholding of TBAs

Before the Janani Suraksha Yojna (JSY) pushed all States into a blind rush for institutional deliveries, ignoring the risks [19], the focus used to be on ensuring skilled attendance at birth. As such, the operational strategies included (a) identification of 'at-risk' pregnancies and ensure that these are brough to hospitals, (b) domiciliary deliveries conducted by the ANM and (c) training of traditional birth attendants (TBAs). Among the many strategies that were employed by various states for training of TBAs, Tamil Nadu approach stood out. Under this, the TBAs were identified and brought to identified MCH hospitals for a 7-day residential skill development course followed by a re-visit to the hospital at 6-monthly intervals. The TBAs were also twinned with the nurses / trainers at the hospital for contact over telephone[20].

[19] Hospital acquired infection for baby and the mother and hypothermia for the baby (during the travel back to home from the hospital) are two most common risk factors.
[20] The author had visited this project in 1990.

The National Health Policy, 2017 has brought the focus back on 'skilled attendance at birth' and has set a target of ensuring at least 90 % deliveries having skilled attendance at birth (see NHP, 2017: para 2.4.2.1 b). Since a significant portion of deliveries in the state are still taking place at home[21] and not all of these can be handled by the ANMs, it is suggested that the TBAs are given skill development training at the MCH hospitals in Shillong, Jowai and Tura.

4.13 Demand Generation

The State has a well structured and vibrant network of self help groups (SHGs) which is steered by the Meghalaya State Rural Livelihood Society (MSRLS). During its field visit, the Team met and interacted with a number of SHG members (at Longkhlaw and Williamnagar). Based on these interactions, the Team would like to suggest that the Project may engage with the MSRLS [through a jointly developed and executed Memorandum of Understanding] to utilize the SHG network for demand generation and promotion of good practices. These may include (a) promotion of kitchen gardens (b) awareness on adolescent health issues such as menstrual hygiene, (c) advocacy for right age at marriage and (d) preventing teenage pregnancies.

4.14 Mainstream Social Audit findings for rewarding / counselling of officers in-charge of PHCs / CHCs

The findings from the social audit should be utilized to rewarding / counselling the officers in-charge of CHCs / PHCs and / or the CHC / PHC Teams. For example, if there are no-complaints, a letter of appreciation could be issued by the DMHO. In case of complaints, however, meetings may be held with the CHC / PHC team to identify the factors and remedial measures taken to address the issues underlying the complaints.

4.15 GST and 12A exemption and 80G certification for the State Health Society, District Health Societies and HMSs/RKSs

The autonomous societies at the State, district and hospital / health facility levels were created under NRHM to promote autonomy, involvement of the stakeholders and resource generation. However, it is observed that these institutions are largely paper organizations, being used primarily for funds flow purposes. However, these are now required under law to obtain GST number. This has created avoidable procedural burden on them.

In order to improve the functioning of these societies, which were sponsored by the Government of India in the first place, it is suggested that the matter may be taken up with the Govt of India for the following:

- Exemption from the requirement of having to obtain GST registration number;
- Exemption from income tax [under 12A] and
- Allowing exemption under Section 80G so as to encourage donations.

[21] A qualitative study conducted during October-December, 2016 in the Bhoirymbong CHC area found that home deliveries are a preferred norm. See "Factors influencing the place of delivery in Rural Meghalaya, India" by Amrita Sarkar, Ophelia Mary Kharmujai, Wallambok Lynrah and Neilatuo U Suokhrie: Journal of Family Medicine and Primary Care, 2018 Jan-Feb, pages 98-103.

5 (Proposed) Innovations

5.1 Hospitals' Autonomy

As mentioned above, funds for the CHC/ PHCs under PPP are routed through two channels: (a) grants to the NGO to cover salaries and allowances and (b) direct transfers to the facility in-charge for all other requirements, including the untied grant for the HMS/RKS. This allows the NGO a certain level of autonomy which is not available to the government owned facilities. Since there already exists a Hospital Management Society for every hospital, which has been assigned the task of managing the affairs of the hospital, there is no reason why the resources for salaries and allowances for the hospital can not be transferred to the District Health Society or the Hospital Management Society. There already exist a number of Societies which are employing staff and paying their salaries, there is nothing new in the idea. The approach, therefore, merits piloting. Three options are available for piloting the idea for a district hospital which are summarised in the table below, along with their relative advantages.

Option	Advantages / *challenges*
Model-1 : Grants in aid, covering salaries, allowances for the district hospital are released to the District Health Society.	Operational control for all hospitals / health facilities in the district can be gradually handed over to the District Health Society. This will also help implement decentralized management of cadres. *Hospitals may still not feel fully autonomous.*
Model-2 : Grants in aid, covering salaries, allowances for the district hospital are released to the concerned Hospital Management Society.	Hospitals are fully autonomous. *The State will have too many entities to deal with.*
Model-3 : Grants in aid, covering salaries, allowances for the district hospital are released to the District Health Society. The DHS, in turn, releases funds to the concerned HMSs/RKSs.	This may be the middle ground for hospital autonomy, but can be discovered only over a longer time period.

It is suggested that a not-so-well-performing district hospital be chosen and the PDIA approach suggested in the State Health Policy be applied to document improvements, challenges encountered and solutions found.

5.2 Production and promotion of washable / reusable sanitary napkins by SHGs

Public Health QA Expert of the PMA works as a volunteer for a project that promotes use of washable / reusable sanitary napkins. The concept can be developed into an economic activity for the SHGs in the State.

5.3 Bio STPs in new buildings and replacement of sceptic tanks with bio-STPs

Generally, septic tanks are good for the environment. However, they can also cause the leachate seeping into and polluting the ground water. An environmentally friendlier solution is bio-STP which prevents leachate. The PMA has come across a news item about piloting of Bio-STP in East Jaintia Hills[22].

It is suggested that the Bio-STPs may be adopted as a standard item for all constructions under the project.

5.4 Community owned and managed Anganwadis

Improving nutrition is an important components under the MHSSP and a separate TA is being recruited to address the issue. In this regard, the PMA would like to suggest that the following initiatives may also be studied before finalizing the interventions / action plan:

- Nagaland Communitisation initiative
- Chhattisgarh Phulwari initiative.

6 Kick-off meeting

An introductory meeting of the PMA team with the DHSs, and PMU was held on 12th October 2021 in the NHM Conference room. The meeting was chaired by Shri Ram Kumar, Joint Secretary and Mission Director (NHM) and Project Director (MHSSP). Shri Sampath Kumar, Principal Secretary and Commissioner, Health & FW and Smt M.N. Nampui, Secretary Health & FW joined virtually. A 2-part presentation was made in the meeting – a short presentation on IPE Global activities made by Shri Himanshu Sikka, followed by a presentation made by the PMA Team Leader outlining the health sector reform / development agenda that may be pursued under the project. A copy of the presentation is given at **Annex-6.**

Shri Sampath Kumar advised that the PMA work closely with the PMU to understand ideas and progress on MHSSP. Shri Ram Kumar suggested that an in-person meeting of PMA team with the PS will be arranged after the Puja holidays. In the meantime, a copy of the PMA presentation will be shared with the PS for his perusal.

7 Concluding remarks

7.1 Timelines and deliverables

The timelines for project specific deliverables are already specified in the technical proposal submitted by IPE Global in response to the RfP. These are given below and will be adhered to:

- Inception phase: (month 1-4)
  - Inception Report – 1 month
  - Web portal with statis content – month-3
  - Grievance redressal module – month-4

[22] New item " EJH first dist to implement Faecal Sludge Management, Septage Plant projects :DC" published in Shillong Times on 03.10.2021.

  - Monthly / quarterly reports – at the end of every month / quarter
- Project Implementation phase : (month 5-53)
  - Procurement monitoring module – month-5
  - Contract management module - Month-8
  - Financial progress module – month -9
  - Integrated dashboard of the project – month-10
  - Monthly / quarterly reports – at the end of every month / quarter
- Knowledge transfer, sustainability and handover phase (month 54-60)
  - Monthly / quarterly reports – at the end of every month / quarter
  - Final report – month 60

The above deliverables and timelines will be suitably adjusted and a revised list / timeline will be prepared after the Government have selected the activities to be pursued from out of the proposals listed above. It may, however, be mentioned, that it may not be possible for all activities to be taken up as part of PMA activities; these will be examined after the Government decisions on the proposals made above are known.

7.2 Coordination of TA

It is noted that there are v a total of 8 TA agencies who will support the PMU. It is suggested that a TA Coordination Group (TACG) may be constituted with PMU-TL as the Convener and the team leaders of each of the TAs as members. The TACG may meet on a monthly basis and the PMA monthly reports may reflect the progress of all TAs.

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Annexures
ANNEX 1

Extracts from

OBSERVATIONS AND FINDINGS OF THE PILOT SOCIAL AUDIT UNDER THE MEGHALAYA COMMUNITY PARTICIPATION AND PUBLIC SERVICES SOCIAL AUDIT ACT, 2017

During the pilot social audit conducted from 17th – 22nd November 2017

Village: Kynrud
Block: Mairang C & RD Block
District: West Khasi Hills

1.4. Health Department.

1.4. A. Services under the PHC (PHC Kynrud-Run under PPP mode, Karuna Trust.)

1.4.A.(i).Infrastructure: No issue.(Very neat, clean and hygienic place with good infrastructure, equipment, medicine, staff, facilities, water and toilets).

1.4.A.(ii).Ambulance: No issue. Functional ambulance for too and fro transport to pregnant mother and infant.

1.4.A.(iii). Service: No issue. OPD service from Monday to Saturday. Emergency and delivery facilities available every day at every time.

1.4.A.(iv). No attendance to pregnant women: Service available rounds the clock but on the 19/11/17 night one mother (Stora Nongrang) delivered by herself without the nurse's help at the time of delivery. The Chowkidar responded that he was fast asleep and hence could not summon the nurse in time.

Decision of the Panel during the Social Audit Public Hearing: 1.4.A.(i) , (ii), (iii) : No comments
1.4.A.(iv). Staff behaviour: The PHC department instructed all the nurses to be alert and do their duties as per the department norms during their day and night shift duties. The (ten) 10 minutes delay in attending the pregnant women during the stage of labour might pose health accidents and such negligence should not be repeated.

1.4. B. Services under the Heath Sub Centre.

1.4.B.(i). No regular meetings held under the VHSNC: The VHSNC meeting did not happen regularly. Last meeting held was on 24/12/16. The meeting happened only while receiving the United Fund of Rs.10000/- . All the money has been withdrawn as cash and spent for expenditure as decided by the committee.

1.4.B.(ii). ASHA Salary: No issue. On an average ASHA is getting Rs.1000/- only per month for services. ASHA is trained.

1.4.B.(iii).Documents and Registers: No issue. ASHA dairy and Village Health Register & Malaria Dairy are properly maintained.

1.4.B.(iv).No Medical kits: No medical kits available for emergencies and also no medicine available along with them. ASHA has been provided medical kits like sling weighing scale and thermometer.

Decision of the Panel during the Social Audit Public Hearing: 1.4.B.(i). No comments 1.4.B.(ii), (iii) . No comments 1.4.B.(iv). The department concern Responded that they provide proper medical kits needed by ASHA. Action Taken Reports received from the Department : 1.4.B.(i). The O/o District Medical and Health Officer had instructed the Medical Officer that VHSNC meetings has to be conducted every month since it is the only platform where issues on Health, Sanitation and Nutrition could be addressed at the village level along with the support of other departments. 1.4.B.(iv). The Medical Officer I/c Kynrud PHC was instructed to give further directions to all ASHAs that all ASHA Kits has to be replenished from the PHC.

1.4. C. JSY Scheme. 1.4.C.(i). Non –receipt of the JSY payment: 6 (six) Nos. of women namely; 1) Rikmen L. Mawnai. 2) Shaihun L. Mawnai, 3) Rikmenlang Marbaniang, 4) Saphina Marngar, 5) Habina Kharsyntiew, 6) Kelbina Marngar. did not get the JSY payment due to not having bank account whereas 10 (ten) nos. namely ; 1) Daiamon L.Mawnai, 2)Daphishisha Kharsyntiew, 3) Eberes Kharsyntiew, 4) Synjuklang Kharsyntiew, 5) Sngurlang Kharsyntiew, 6) Eris Rani,7) Multina Marbaniang, 8) Daplin Marbaniang, 9) Lamdalin Ryntathiang, 10) Elismery Lyngkhoi of the women did not get the money even after completion of all medical checkup and injection doses.

Decision of the Panel during the Social Audit Public Hearing: 1.4.C.(i).Panel did not comment on the payment of JSY to those who have completed the medical checkups and instructed to all beneficiaries who don't have bank account to open a bank account so that the money can be transferred soon. Action Taken Reports received from the Department : 1.4.C.(i). Per JSY norms all JSY beneficiaries have to provide valid documents to avail the incentives and must have Bank Account. In some cases pregnant women deliver in other institutions of which Kynrud PHC will not be able to pay but the incentives has to be paid by the Health institution where the delivery happens.

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ANNEX 2

FINDINGS FROM FIELD VISIT 5-8 OCTOBER 2021

Facilities visited by the team on the 5th October 2021; Nongkhlaw CHC and Kynrud PHC, West Khasi Hills.

ABOUT	QUESTIONS	NONGKHLAW CHC	KYNRUD PHC
Location	A. How accessible is the facility to the community? B. Visible signboard? C. Internet access?	Easy accessibility with clear direction and signage. CHC managed by NGO Citizen Charter. 3 PHCs attached	PHC is near the community and has a good approach road. Good signboard display. PHC run by Karuna Trust. Internet is present but not reliable.
Infrastructure	A. Building condition? B. Staff quarters?	CHC is in fair condition, well maintained, repairs required, staff quarters present and sufficient. Border Fencing needed.	Building in good condition, well maintained and clean. Staff quarters are sufficient and occupied by staff from outside the locality. Grad IV staff and ANM are locals.
Staffing	A. Staff in the facility and its attachments? B. Any induction training? C. In service trainings? D. Shortages in staffing?	1 MBBS, 1 Ayush, 1 Dentist, 1 Volunteer MBBS.4 Staff Nurse, 6 ANM, Pharmacist, 10 Grade IV staff. No induction trainings for anyone. In service trainings are frequent and being attended at DMHO. Staff is enough. One cook and laundry person from the Grade IV.	No MO who is MBBS (new MBBS will join in the coming months), 2 MO Ayush and 1 Dentist. 2 Staff Nurses. 17 staff in total. Manages one sub centre. One day briefing to MO on joining the PHC but no induction training. In service trainings are regular and attended by staff at DMHO
Basic necessities	A. Water supply. B. Electricity C. Sewage disposal D. Solar panels? E. Rainwater harvesting?	PHE supply and has rainwater harvesting. Electricity is not regular and CHC require rewiring in some areas. No solar panels. Sewage is alright.	PHC has solar panel provided by Selco Foundation and can cover the electricity requirements. Also, has a generator. Have rainwater harvesting. Sewage no issues.
Transportation	Ambulance present? Any other?	Have an Ambulance	Ambulance present
Minimum assured services including OPD, Indoor and Emergency	A. Are all three services present and functioning? B. Footfall in OPD, Indoor, & Emergency.	Has all three. OPD patients on average 50-60. Indoor patients mostly in summer months about 7-8. In a year, there are about 20-30 inpatients. Mostly delivery, Diarrhoea & RTI. Not much emergency cases	Has OPD and Inpatient. OPD is about 80-100 during market days and 60 daily on average. Not many inpatients - the few are mainly for delivery and common ailments requiring IV fluids. PHC is far from main road so no road traffic accidents
Secondary level healthcare services (Desirable services)	Are there desirable healthcare services like Dermatology, Super specialities, etc.?	None. Dental Chair is not functioning	None.

ABOUT	QUESTIONS	NONGKHLAW CHC	KYNRUD PHC
Pharmacy & medicines?	A. Is there a reference list used to indent? B. Stock and supply? C. Any other pharmacy in the facility for generic medicines? D. Would a PPP model be feasible? Factors promoting or inhibiting partnerships?	No reference list. Regular and sufficient supply from District. No additional pharmacy	Reference drug list displayed outside the Pharmacy on the wall and can be seen by all. The Supply from district is regular and if not available Karuna Trust purchases and brings to PHC a there are no pharmacies around.
Diagnostics	A. Pathology lab? B. Radiology? C.Any PPP model in place? D. Lab technician/ Radiographer in place?	Presence of a Lab for pathology and lab tech conducts blood test. X-ray machine is present but not functioning.	Pathology lab is present for minimal blood tests
Waste Management	A. Bio medical waste management? B. Sharp pit? Compost pit? Kitchen solid waste? Segregation?	Newly repaired waste management unit with segregation done. Has all the facilities for disposal. Kitchen and solid waste is being cleared 2-3 times a week. Outsourced for collection and pay monthly.	Has all necessary systems for waste management. PHC has an herbal garden
National Health and Family Welfare Programmes & NHM services conducted?	All programmes being conducted?	Yes, all National programmes and NHM services are being conducted.	Yes, all National programmes and NHM services are being conducted. Funds have been regular after Covid.
Quality control mechanisms?	A. Quality Assurance assessment conducted? B. Kayakalp awards?	Self-assessment via format done. Kayakalp assessment done and received some points	Kayakalp winners for 3 years (2017-18, 2018-2019 & 2019-2020).
Rogi Kalyan Samiti/ Hospital Management Committee	A. RKS in place? B. Meeting frequency. C. Who are members? D. Funds received and spent? E. Process followed for expenditures. F. What are general items or spending on?	RKS in place and members meet twice a year. Members include BDO, Block Accountant, MS Mairang Hospital, Headman of Nongkhlaw and MO CHC. Funds spent on repairs and buying of electric wires, minor repairs, etc.	RKS in place but only meet once a year. Members are not active. To spend RKS funds the committee decides in the meeting and sends the proposal to the BDO.
Insurances, MHIS, PMJAY, etc.	A. Committee on MHIS in place. B. Mechanisms on fund expenditure. C. what is the funds spent on? D. How much received in a period of time?	Committee present and meet on what to spend funds on, then send proposal to Block Coordinator for MHIS on spending. Most is spent on reimbursement of medicines purchased by beneficiaries. Pre Covid they get about 1,30,000 annually.	MHIS funds request for use from Karuna Trust office via a proposal submission and permission to use.
Record maintenance	Weekly reports, Monthly reports submitted to? Stock registers?	Regular reports sent to DMHO office	Regular reports sent to DMHO office

ABOUT	QUESTIONS	NONGKHLAW CHC	KYNRUD PHC
Any grievance redressal mechanisms in place?	A. Any present? B. How often are they being addressed? C. Any feedbacks received?	Presence of complaint box but no direction on how to use and also nothing written on box. No feedback ever received. Box is placed in the entrance to the OPD.	Suggestion box present but location is at the entry of the PHC and is often missed. No feedback or suggestions received so far.
Meetings with ASHAs and SHGs members	SHG meetings discuss on health issues? ASHA and VHSNC meetings on health? Who do they address the concerns with?	Met with 2 members of SHGs- Groups talk about health issues in the community in their meetings. Any complaint or request is made to the ASHA who brings up the issue with the MO CHC. ASHA is active and up to date with her work and records. She reports to the ASHA counselling facilitator at the block. There are 26 SHGs in the area and 2 VHSNC who focuses on cleanliness.	We did not conduct any here.
Problems and Issues raised	What improvements needs to be done? Challenges to be addressed?	MO requested repair of the X ray machine and dental chair. MO informed they are not happy with the salary, also no increment for 7 years now. ASHA feels money they receive is too little for the large amount of activities they perform.	Salary complains with no increment for many years. Request for salary increase. Electricity wiring needs to be repaired.
Good practices	What stood out of the normal?	1. Has the updated annual data on staff, villages served, population. 2. Has the name and numbers of drs and staff in the wards for patients to call.	1. CNAA action plan updated for the year, 2. list of medicines in clear view and can be used as reference.
OBSERVATION	Both NGO run facilities complained of low salary and not receiving increments in time.		

On the 6th of October, the team visited the Williamnagar Civil Hospital, East Garo Hills and Tura Civil Hospital, West Garo Hills and spoke to the Medical Superintendents. Also, met with the District Medical and Health Officer, East Garo Hills for her thoughts and suggestions.

ABOUT	QUESTIONS	WILLIAMNAGAR CIVIL HOSPITAL	TURA CIVIL HOSPITAL
Location	A. How accessible is the facility to the community? B. Visible signboard? C. Internet access?	well located and central, Good and visible signage. Good internet access.	well located and central, Good and visible signage. Good internet access.
Infrastructure	A. Building condition? B. Staff quarters?	Building is in good condition and well maintained. Staff quarters are good and sufficient. Hospital has outsourced a canteen and general store inside the premises.	Building is in good condition and well maintained. Staff quarters are good and sufficient.
Staffing	A. Staff in the facility and its attachments? B. Any induction training? C. In service trainings? D. Shortages in staffing?	Staff is alright. 26 Medical Officers and sufficient staff. No induction training but regular and frequent in service, skills trainings being provided to all staff.	64 MO, shortage of nursing and allied staff. No induction training but regular and frequent in service, skills trainings being provided to all staff. Tura has a ANM training centre for 20 seats. Possibility of GN training if hostel facilities are extended.
Basic necessities	A. Water supply. B. Electricity C. Sewage disposal D. Solar panels? E. Rainwater harvesting?	Good water supply through PHE pipelines and also a bore well. No rainwater harvesting nor solar panels. Electricity compensated by large generators.	Good water supply through PHE pipelines. No rainwater harvesting nor solar panels. Electricity compensated by large generators.
Transportation	Ambulance present? Any other?	Ambulance	Ambulances
Minimum assured services including OPD, Indoor and Emergency	A. Are all three services present and functioning? B. Footfall in OPD, Indoor, & Emergency.	Yes, on all. OPD patients about 70-80 per day with about 10 -20 inpatient a day. There are Medicine, Obs & Gynae, Surgery and Paediatrics specialists.	Yes, on all. OPD patients about 70-80 per day with about 10 -20 inpatient a day. There are Medicine, Surgery and Paediatrics specialists. MCH services at MCH hospital Tura.
Secondary level healthcare services (Desirable services)	Are there desirable healthcare services like Dermatology, Super specialities, etc.?	Dermatology. A new oxygen plant was being inaugurated and has all necessary arrangements for pipelines installed.	

ABOUT	QUESTIONS	WILLIAMNAGAR CIVIL HOSPITAL	TURA CIVIL HOSPITAL
Pharmacy & medicines?	A. Is there a reference list used to indent? B. Stock and supply? C. Any other pharmacy in the facility for generic medicines? D. Would a PPP model be feasible? Factors promoting or inhibiting partnerships?	WCH has an attached Aushadhi Kendra pharmacy in the premises for generic medicines. Good supply from district. State Reference drug list is available for monthly indent. Aushadhi pharmacy vendor complains of not enough sales of generic drugs as most Drs prescribe Branded medicines and patients can get them in private pharmacies.	TCH has an attached Aushadhi Kendra pharmacy in the premises for generic medicines. Good supply from district. State Reference drug list is available for monthly indent. Aushadhi pharmacy vendor complains of not enough sales of generic drugs as most Drs prescribe Branded medicines and patients can get them in private pharmacies and also not enough supply from suppliers. There are MHIS empanelled pharmacies in the town that patients can purchase branded medicines.
Diagnostics	A. Pathology lab? B. Radiology? C.Any PPP model in place? D. Lab technician/ Radiographer in place?	Lab technician present and also a radiographer. Sometimes there are short of reagents but they buy them from MHIS funds.	Lab technician present and also a radiographer. Pending bills for lab reagents. Need staffing for dialysis, ICU.
Waste Management	A. Bio medical waste management? B. Sharp pit? Compost pit? Kitchen solid waste? Segregation?	Has all necessary systems for waste management.	Has all necessary systems for waste management. Training on Vermicomposting/Bio pesticides was conducted.
National Health and Family Welfare Programmes & NHM services conducted?	All programmes being conducted?	Yes, all National programmes and NHM services are being conducted.	Yes, all National programmes and NHM services are being conducted.
Quality control mechanisms?	A. Quality Assurance assessment conducted? B. Kayakalp awards?	Kayakalp winner 2019-2020 and had purchased an industrial laundry machine with the money.	
Rogi Kalyan Samiti/ Hospital Management Committee	A. RKS in place? B. Meeting frequency. C. Who are members? D. Funds received and spent? E. Process followed for expenditures. F. What are general items or spending on?	Hospital management committee present. Meeting is once a year. DC is Chair of RKS. Other members include an NGO Mother's Union (Secretary), other community elders, MO and a few others.	Hospital management committee present. Meeting is once a year. DC is Chair of RKS. Other members include school teachers, NGOs, other community elders, MO and a few others. Some donation received from NGO members. RKS funds being utilised for COVID management
Insurances, MHIS ,	A. Committee on MHIS in place. B.	MHIS usage through a purchasing committee of 8 Medical Officers	MHIS usage through a purchasing committee of 8 Medical Officers

ABOUT	QUESTIONS	WILLIAMNAGAR CIVIL HOSPITAL	TURA CIVIL HOSPITAL
PMJAY,etc.	Mechanisms on fund expenditure. C. what is the funds spent on? D. How much received in a period of time?	and Hospital Staff. Annually receive about 23 lakhs. Medicines are being bought from the MHIS funds when not available in generic.	and Hospital Staff. Average monthly receipt around 15,00,000/- Expenditures are medicine bills, investigation bills and patient reimbursements.
Record maintenance	Weekly reports, Monthly reports submitted to? Stock registers?	Regular reports sent to DMHO office	Regular reports sent to DMHO office & DHS
Any grievance redressal mechanisms in place?	A. Any present? B. How often are they being addressed? C. Any feedbacks received?	A few suggestion boxes placed around the hospital and are being used by patients. The MS opens these boxes, reads and addresses the feedbacks. However, there is no documentation of the feedback and suggestions received or how they were addressed.	Suggestion boxes key could be handed to NGO members who will look at complaints and address them with MO for action.
Meetings with ASHAs and SHGs members	SHG meetings discuss on health issues? ASHA and VHSNC meetings on health? Who do they address the concerns with?	Met with multiple members from various SHGs groups. There are 2295 SHG members in Williamnagar. No group discusses health issues. We encouraged them to think about it and also to be active in bringing health issues in the community to healthcare workers.	We did not conduct meetings here
Problems and Issues raised	What improvements needs to be done? Challenges to be addressed?	MS requested an extension of the hospital as he needs to increase beds for MCH services. There are 2-3 deliveries at the hospital per day.	Staffing required for shortages, funds to clear pending bills.
Good practices	What stood out of the normal?	1. Patient's rights and responsibilities clearly displayed	
OBSERVATIONS		GST being required by the hospital for purchases. Health facilities should be exempted from GST. To be addressed. Generic medicines not being bought from the Aushadhi pharmacy vendor as Doctors often prescribe branded drugs rather than generic. Also, the same supply of generic medicines is available at the hospital pharmacy for free, so patients will not buy them from the vendor. Hence low sales.	Generic medicines not being bought from the Aushadhi pharmacy vendor as Doctors often prescribe branded drugs rather than generic. Also, the same supply of generic medicines is available at the hospital pharmacy for free, so patients will not buy them from the vendor. Hence low sales.

The next day 7th October 2021 the team visited two subcentres Dewagre and Nengkhra subcentres, attached to Dobu PHC in East Garo hills. The afternoon after the team visited Samanda PHC. Medical Officers of all three facilities were present along with the staff.

ABOUT	QUESTIONS	DEWAGRE SUBCENTRE	NENGKHRA SUBCENTRE	SAMANDA PHC
Location	A. How accessible is the facility to the community? B. Visible signboard? C. Internet access?	Part of DOBU PHC. Located near the village school and is accessible. Low internet availability.	Part of DOBU PHC. Good location on the main road with good signage. Good internet access	PHC was a little away from the main road and interior. NO signage from road which made us loose our way. Internet connectivity was fair.
Infrastructure	A. Building condition? B. Staff quarters?	Building is old but manageable. ANM stays at the Subcentre in the same building.	Building is in good condition. Staff quarters present and functioning. Some staff are locals and stay close to subcentre	Building was old and needs repair. Staff quarters are not sufficient and the ones available needs repair. 2 subcentres attached to PHC
Staffing	A. Staff in the facility and its attachments? B. Any induction training? C. In service trainings? D. Shortages in staffing?	The subcentre has enough staff. There are 2 ANMs, 1 Health Assistant and 1 chowkidar. They take care of 10 villages. In service trainings attended at Williamnagar CH or Vocational Training centre.	Staff is good with 2 ANM, 1 chowkidar, 1CHO, 4 HA,1 MPW. They look over 10 villages. In service trainings attended at Williamnagar CH or Vocational Training centre.	Staff composition: 1 MO,1 BD, 4SN, 1G4, 1 pharmacist, 1 Lab tech,1 CHO, 2 chowkidar, 6ANM, 3MPW and BPM. In service trainings attended at Williamnagar CH or Vocational Training centre.
Basic necessities	A. Water supply. B. Electricity C. Sewage disposal D. Solar panels? E. Rainwater harvesting?	NO water supply but water is drawn from the river nearby. Solar panels yet to be installed in this subcentre. Electricity is not regular with frequent power cuts. Vaccines are picked up from PHC on Immunisation days. No refrigerator.	Water supply is PHE pipe lines from stream and has a storage tank. Selco Foundation has installed the Solar panels at this subcentre.	Water supply is pipe line from stream, Rain water harvesting present. Has solar power from Selco Foundation,
Transportation	Ambulance present? Any other?	None	None	Ambulance and an MLA donated community van

ABOUT	QUESTIONS	DEWAGRE SUBCENTRE	NENGKHRA SUBCENTRE	SAMANDA PHC
Minimum assured services including OPD, Indoor and Emergency	A. Are all three services present and functioning? B. Footfall in OPD, Indoor, & Emergency.	ANM does clinical duties 3 days and 2 days of outreach/VHND in the villages	ANM does clinical duties 3 days and 2 days of outreach/VHND in the villages.	Has OPD and Inpatient. Not too much emergency services as it far from the main road. The facility receives about 10 average OPD a day, most Inpatients are deliveries and GIT problems.
Secondary level healthcare services (Desirable services)	Are there desirable healthcare services like Dermatology, Super specialities, etc?	N/A	N/A	No room for dentist and no dental chair & equipment.
Pharmacy & medicines?	A. Is there a reference list used to indent? B. Stock and supply? C. Any other pharmacy in the facility for generic medicines? D. Would a PPP model be feasible? Factors promoting or inhibiting partnerships?	Reference list is available for monthly indents. Receives regular supply from PHC.	No reference list available for monthly indents but receives regular and sufficient supply from PHC	Reference medicine list on wall displayed. Medicines receive from DMHO but supply is often not sufficient.
Diagnostics	A. Pathology lab? B. Radiology? C. Any PPP model in place? D. Lab technician/ Radiographer in place?	Blood slides collected and sent to PHC for Malaria Diagnosis.	Blood investigations	Pathology lab functioning for blood work.
Waste Management	A. Bio medical waste management? B. Sharp pit? Compost pit? Kitchen solid waste? Segregation?	Has a sharp pit and place to dispose Bio medical waste	Has a sharp pit and place to dispose Bio medical waste	Has sharp pit, pit burial. Herbal garden present
National Health and Family Welfare Programmes & NHM services conducted?	All programmes being conducted?	Yes, all National programmes and NHM services are being conducted.	Yes, all National programmes and NHM services are being conducted.	Yes, all National programmes and NHM services are being conducted.

ABOUT	QUESTIONS	DEWAGRE SUBCENTRE	NENGKHRA SUBCENTRE	SAMANDA PHC
Quality control mechanisms?	A. Quality Assurance assessment conducted? B. Kayakalp awards?			Kayakalp runner up 2019-2020
Rogi Kalyan Samiti/ Hospital Management Committee	A. RKS in place? B. Meeting frequency. C. Who are members? D. Funds received and spent? E. Process followed for expenditures. F. What are general items or spending on?		**Dobu PHC** received about 1,75,000/- from RKS. Members include BDO, MO, village headman, Teachers, Church leaders and local influencer. They hold 2 meetings a year. The amount was spent on water filters, surgical kits, sterilisers, repair of boundary wall, etc.	RKS funds received about 1,75,000/- Members include BDO, MO, VHM/village elders, GSU member. Meeting frequency every quarterly but not in recent days. RKS funds spent on ambulance repair, stationary and medicines from private pharmacies.
Insurances, MHIS, PMJAY, etc.	A. Committee on MHIS in place. B. Mechanisms on fund expenditure. C. what is the funds spent on? D. How much received in a period of time?		**Dobu PHC** receives about 2 lakhs. The MO with staff members during meetings decide on expenditure and submit the proposal to coordinator. They spend the money on emergency medicines, help desk for MHIS counter and a laptop and printer.	In 2021 MHIS funds received 1lakhs and was spent on constructing a soak pit, waste collection chamber, Ambulance repair and new tyres, Solar lamp post and medicines for MHIS patients.
Record maintenance	Weekly reports, Monthly reports submitted to? Stock registers?	Weekly and monthly reports sent to PHC	Weekly and monthly reports sent to PHC	Regular reports sent to DMHO office
Any grievance redressal mechanisms in place?	A. Any present? B. How often are they being addressed? C. Any feedbacks received?	Communities speak to ASHA and they in turn inform the MO.	Communities speak to ASHA and they in turn inform the MO.	PHC has a suggestion box that contained complain forms but not one used. There was no proactive promotion of the suggestion box.

ABOUT	QUESTIONS	DEWAGRE SUBCENTRE	NENGKHRA SUBCENTRE	SAMANDA PHC
Meetings with ASHAs and SHGs members	SHG meetings discuss on health issues? ASHA and VHSNC meetings on health? Who do they address the concerns with?	Sector meeting every 19th of the month. Attendees ANM, Supervisor, 8 Anganwadi ,10 ASHA, Block accountant, and PHC MO. Also, discusses ASHA incentives and health issues in the communities.	Sector meeting every 19th of the month. Attendees ANM, Supervisor, 8 Anganwadi ,10 ASHA, Block accountant, and PHC MO. Also, discusses ASHA incentives and health issues in the communities.	We did not conduct any here.
Problems and Issues raised	What improvements needs to be done? Challenges to be addressed?	No water supply and irregular electricity	DOBU PHC MO requires a vaccinator, PHC building repairs, request for one more MO. Water supply is irregular from the public supply. Rainwater harvesting is being done but only has one storage tank and requires another one.	Samanda PHC request for building expansion. Rooms too small. No room for Dentist and no dental chair and equipment. MO request to look into regularising service for all MO under 3 F. NHM salary issues brought up.
Good practices	What stood out of the normal?			
Observations		Are ANM authorised to prescribe /dispense Antibiotics? There were a range of antibiotics on the medicine indent list other than clotrimoxazole.		

The last day, 8th October 2021 of the field visit, the team visited Rongjeng CHC, East Garo Hills.

ABOUT	QUESTIONS	RONGJENG CHC
Location	A. How accessible is the facility to the community? B. Visible signboard? C. Internet access?	well located and easy approach. Close to highway. Good signage and accessible. Good internet connectivity
Infrastructure	A. Building condition? B. Staff quarters?	Building is in fair condition. Staff quarters are however in bad conditions with windows falling off. Number is insufficient. Local staff stay around the area.
Staffing	A. Staff in the facility and its attachments? B. Any induction training? C. In service trainings? D. Shortages in staffing?	Staff is ok with 4 MO, 1 Dental, 1 Ayush ,1 Pharmacist, 1 Lab tech, 1 X-ray technician, 7 SN and 1 ANM at PHC and sufficient Grade IV staff ,2 are solely responsible for cooking and laundry. In service trainings attended at Williamnagar CH or Vocational Training centre.
Basic necessities	A. Water supply. B. Electricity C. Sewage disposal D. Solar panels? E. Rainwater harvesting?	Water supply is from bore well and PHE dept. (piped). No rainwater harvesting and no solar panels installed as yet. 9 sub centres have been installed with solar panels.
Transportation	Ambulance present? Any other?	2 ambulances present
Minimum assured services including OPD, Indoor and Emergency	A. Are all three services present and functioning? B. Footfall in OPD, Indoor, & Emergency.	Has all services. OPD footfall is about 40-50 daily with more than 70 during market days. Inpatient services include 3-4 patients a day due to Road Traffic Accidents.
Secondary level healthcare services (Desirable services)	Are there desirable healthcare services like Dermatology, Super specialities, etc.?	Dentist received a new chair from the National Oral Health Program and there is another chair which requires minor repair.
Pharmacy & medicines?	A. Is there a reference list used to indent? B. Stock and supply? C. Any other pharmacy in the facility for generic medicines? D. Would a PPP model be feasible? Factors promoting or inhibiting partnerships?	District supply of medicines but not sufficient for sub centres. Reference list present. Empanelled pharmacies for MHIS beneficiaries.
Diagnostics	A. Pathology lab? B. Radiology? C.Any PPP model in place? D. Lab technician/ Radiographer in place?	X-ray present but not functioning. Lab tech needs counselling on chronic alcoholism, Lab is functioning. USG mobile machine recently received. Not installed as there is no technician.
Waste Management	A. Bio medical waste management? B. Sharp pit? Compost pit? Kitchen solid waste? Segregation?	Has all necessary systems including sharp pit and burial pits. However, the waste segregation is not done properly. Septic tank needs to be replaced.
National Health and Family Welfare Programmes &	All programmes being conducted?	Yes, all National programmes and NHM services are being conducted.

ABOUT	QUESTIONS	RONGJENG CHC
NHM services conducted?		
Quality control mechanisms?	A. Quality Assurance assessment conducted? B. Kayakalp awards?	PMMVY awarded in 2019, Kayakalp consolation in 2020-21
Rogi Kalyan Samiti/ Hospital Management Committee	A. RKS in place? B. Meeting frequency. C. Who are members? D. Funds received and spent? E. Process followed for expenditures. F. What are general items or spending on?	RKS funds spent in minor equipment, injections and disinfectants, purchase of Vitamins, etc. Members include BDO, CHC MO, etc.
Insurances, MHIS, PMJAY, etc.	A. Committee on MHIS in place. B. Mechanisms on fund expenditure. C. what is the funds spent on? D. How much received in a period of time?	Could not be discussed
Record maintenance	Weekly reports, Monthly reports submitted to? Stock registers?	Regular reports sent to DMHO office
Any grievance redressal mechanisms in place?	A. Any present? B. How often are they being addressed? C. Any feedbacks received?	CHC has suggestion box which is used as a trash bin. Unused and ignored by all including health staff.
Meetings with ASHAs and SHGs members	SHG meetings discuss on health issues? ASHA and VHSNC meetings on health? Who do they address the concerns with?	We did not conduct any here.
Problems and Issues raised	What improvements needs to be done? Challenges to be addressed?	Staff quarters insufficient and in bad condition, septic tank needs to be replaced. Lab Tech needs counselling as its affecting his work-HR issue.
Observations		Training for staff on how to segregate waste as the bins were not properly used. Fire extinguisher was missing. Staff quarters badly in need of repair.

ANNEX 3

Extracts from the
Final Report of the Task Force on Health & Family Welfare,
Government of Karnataka (April, 2001)

14.2 PLANNING AND MONITORING

Health services must meet current needs and the management must have the capacity to adapt them to such needs. It would, therefore, be necessary to review the system periodically in terns of both content and adequacy. The character and content would be influenced by the population projections and also by the need to cater to under-serviced areas in the State. Any modifications or extension of services have implications in terms of staff, training and financial outlay. It is therefore necessary to have an in-built ability for carrying out such reviews and in the preparation of perspective plans.

It has been separately recommended that the Department should have a strong, unified system of reporting as part of the Health Management Information System. This would necessarily have to form part of the planning and monitoring structure of the Department. These activities would call for the establishment of a **Planning and Monitoring Division.**

Present structure

There is, at present a Joint Director in the Office of the DHS in charge of planning. The post is currently designated as Joint Director (Health and Planning). The JD (H&P) is assisted by a Deputy Director (Planning) with supporting staff.

The functions of this post include preparation of the annual plans, five-year plans, and preparation of the monthly monitoring reports (MMR) which deals with financial and physical progress and the Karnataka Development Plan which deals with staff and organizational issues, that are submitted to Government.

An important function is the preparation of the Annual Report of the Department on time. The Preparation of these reports involves obtaining information from all units in the Directorate, including the Programme Officers on a monthly basis. Coordination and constant interaction with the other Divisions and sections in the office of the DHS are essential elements of the post. However, the JD (H&P) has no direct responsibility for preparation of the reports of the projects such as KHSDP and IPP. It obtains the information for incorporation in the reports that are produced.

The JD (H&P) is concerned with the preparation of only schemes relating to the Plan. Non-Plan elements are prepared by the Chief Accounts Officers cum Financial Adviser. This is because the latter are more concerned with staff and maintenance issues. However, information on the latter is incorporated in the reports mentioned above.

The JD (H&P) is also in charge of the Bureau of Health Intelligence.

Role of the Planning and Monitoring Division

The planning process in the office of the DHS is restricted in scope and serves the immediate administrative needs of routine reporting. The process of preparation of Plan schemes is also fairly well established, as well as statistical reporting in specified formats. These are essential activities in themselves but the constant internal monitoring of performance, particularly the sensitive appraisal of available information, is near absent. The Planning Unit, which should be designated as the Planning and Monitoring Division in view of its importance, should play a more central role in the management of information systems within the Directorate. It should be responsible for all information flows, appraisal of such information and feed back of such appraisal to the functional divisions concerned. Currently, the appraisal of performance is within the functional divisions concerned, which would renter it routine. Also, a total appreciation of the functioning of the Directorate would not be available to the Director.

The improvement in the Health Management Information System (HMIS) has been considered elsewhere in this Report. The reporting system is envisaged as common to the Department and not in sectional components, more related to individual programmes, as at present. With this change in the structure and focus of the HMIS, it would be logical to place its management under the Planning and Monitoring Division.

Functions of the Planning and Monitoring Division

1. Coordination of all reporting activity as part of the unified system of the HMIS and providing the information that other Divisions would require on the basis of the unified HMIS;

2. Coordination of all statistical activity in the Department, at various levels, including ensuring of quality of data, and processing and analysis of such data in the prescribed manner as may be required for various purposes;

3. Production of the Annual Report, periodic reports such as the Monthly Monitoring Reports, Karnataka Development Plan, and such other prescribed reports. The reports of the projects such as IPP and KHSDP should be incorporated so that there is one report for the entire health department;

4. Monitoring progress in implementation of Plan programmes and schemes each month to enable mid-course corrections to be made;

5. Preparation of Annual Plans and Five year Plans of the Department, coordinating with the other wings such as Medical Education, State Institute of Health and Family Welfare and the like;

6. Preparation of a perspective plan for the Health Sector and its updating at appropriate intervals;

7. Organization and management of the Geographical Information System that is recommended for establishment;

8. Organization and management of the Computer System that is recommended for establishment.

The Current Statistical System in the Health Department

The statistical system within the Department has developed in a rather ad-hoc manner. The statistical and reporting system at headquarters could be said to consist of three distinct wings as follows:

a) The Bureau of Health Intelligence (BHI)
b) The Demography and Evaluation cell (D & E Cell)
c) The statistical units / personnel attached to some Divisions on an independent basis.

The BHI is the unit that generates the Annual Administration Report and all statistical reports, excluding those relating to the RCH programme. It is also responsible for collection and collation of information on health indicators, including the macro indicators from the RCH programme. One important responsibility of the BHI is collection and processing of data relating to morbidity and mortality.

Its responsibilities include the following –

a) Compiling periodical reports on rural health services and national programmes for the Government of India, in addition to reports for the State Government;

b) Preparation of the Annual Report, Annual Administration Report and the Status Reports of the Directorate;

c) Maintenance of statistics on Health and Medical Institutions and their bed strength;

d) Annual morbidity and mortality statistics;

e) Quarterly Progress Report on the Rural Health System;

f) Monthly Health Condition Report;

g) Report on indoor and outdoor patients treated and deaths among inpatients;

h) Collection / compilation of information on snake bites and thresher accidents;

i) Half yearly report on doctors working in rural and urban areas;

j) Furnishing information for the Statistical Abstract of Karnataka, Karnataka at a Glance and similar publications to the Directorate of Economics and Statistics.

The Demography and Evaluation Cell is located in the State Family Welfare Bureau. It is a responsible for monitoring and evaluating the family welfare and RCH programmes and for rendering operational the Community Needs Assessment Approach of the RCH programme. It has ten field evaluation workers, all based at Bangalore, for carrying out field verification and survey relating to prevalence of family welfare methods. However, they are evidently used for other work too.

In addition to the BHI and D&E Cell, statistical personnel are located in the Transport Section, Planning Sector, health Education Division and with the Programme Officers in charge of leprosy, malaria and filaria, TB, control of blindness, AIDS, goitre and communicable diseases.

The BHI is under the JD (Health and Planning) while the D&E Cell is under the Additional Director, RCH who also controls the unit in the Transport Section. The independent units come under the respective officers concerned. These statistical units are independent of each other and there is little coordination between the three wings.

All statistical posts are filled by deputation from the Directorate of Economics and Statistics, except for the ten field workers who are employees of the Health Department.

There are no statistical posts at the Division level. At District level there are four posts of Assist Statistical Officers, with one officer separately for (a) family planning, (b) immunization, (c) TB control and (d) leprosy. The ASO for family planning and ASO for immunization come under the DHO while the other two are under their respective Programme Officers. These sets of four ASOs are currently only in the old twenty districts. The posts have not been created in the seven new districts.

There is no statistical staff in hospitals, except in teaching hospitals where there would be a Lecturer in Statistics.

It would be relevant to note that certain statistical/ reporting activities relating to RCH and the PHCs are carried out by independent agencies with minimal coordination with the DHS. The Programme Research Centre located in the Institute of Social and Economic Change computes RCH indicators on the basis of surveys of 1000 households. Reports are not regularly received by the DHS and there would appear to be little feedback into the health management system of the conclusions of such surveys. The Centre for Operations Research and Training (CORT) carries out a facility survey for assessing availability of drugs and equipment in the PHCs. These reports are also sporadically received by the DHS. It would be desirable to ensure greater involvement of the DHS in these activities so that the results of the surveys augment management information for improvement of the services.

Need to establish a Geographical Information System

The establishment of a GIS is recommended. The system would be most useful for assessing the adequacy of health services and planning future needs. It would be a most useful management and planning tool. Incidentally, the computer system that would have to be established for this purpose could, at appropriate levels, also be used for Health Management Information System.

Structural Changes

It would be evident that if the planning process in the health sector has to be unified, as indeed it should, it would be necessary to recognize the need for basic structural changes. Such changes would include (a) unifying the statistical functions at all levels and of the various units, (b) the inclusion of the reports of distinct projects such as the IPP and KHSDP within the unified reporting system, and (c) coordination within the Department with the Chief Accounts Officer/ Financial Advisers of the Department itself and of the special projects,

The distribution of the posts in the various statistical/ reporting units, as would be seen from the table 14.1, is very uneven. The D & E Cell is headed by an officer, designated as Demographer, of the rank of Joint Director of the Bureau of Economics and Statistics while the BHI is headed by an Assistant Director of Statistics. There is no uniformity in the work load and the levels of posts seem to have been determined more by what was acceptable to the sanctioning authorities than any rational considerations of workload, position in the hierarchy, etc.

The efficiency of the HMIS and GIS, the ensuring of quality of data, the management of the computerized system of maintenance and analysis of data and production of monitoring reports for better management would depend on the structure of the reporting and statistical system. If the system has to perform at peak efficiency and be able to serve its purpose, it would be necessary to consider certain structural changes.

In principle, it would be desirable to have a unified statistical and reporting system so that the planning and monitoring requirements are adequately met. That Planning unit in the office of the DHS may be designated as the Planning and Monitoring Division, as suggested earlier, and assigned a central role of information management and appraisal, with the functions indicated.

Structural changes at Headquarters

The Planning and Monitoring Division should be constituted with the following sections:

- The Reporting and Monitoring Section for production of reports based on the analytical statements generated by the Computer Section, and for preparation of all monitoring reports required by Government or needed for internal management;
- The Computer Section for information processing
- The GIS Section for assisting in monitoring and planning
- A Perspective Planning Section which would formulate the Perspective Plan, the Five Year Plans and the annual plans, monitor plan implementation, prepare and continuously update the perspective plan of the Department and monitor implementation of the Health and Population Policy of the State.

This Division should be responsible for the following:

- Strategic Planning of activities of the entire health system, including long term planning;
- Coordination with the Zilla Panchayats to ensure that the health plans of the districts are formulated, including taluka and Gram Panchayat plans, and integrate them into State Health Plan;
- Assess budget resources for current and future needs, taking into consideration population, level of services, norms for services and other relevant parameters;
- Assess human resources and all material resources on a continuing basis.

All statistical and reporting functions in the headquarters should be unified. The various wings and units referred to earlier would form part of the Planning and Monitoring Division. These would include the BHI and the D & E Cell. There is a senior officer of the rank of Joint Director on deputation from the Directorate of Economics and Statistics, who heads the D & E cell. This officer could be the Joint Director in charge of HMIS, the GIS and all statistical reporting within the Directorate. This Joint Director could be designated as **Joint Director, Health Information System.** This officer would be the Chief Statistical Officer and Head of the HMIS/ Monitoring Section.

The Perspective Planning Section would be under a separate Joint Director. The post could be designated as **Joint Director, Planning.**

A GIS should be established in the Planning and Monitoring Division, as part of the HMIS, with the necessary computer capacity and operators. A system of requisite capacity should be installed, with the appropriate software, which would permit display and analysis of multiple parameters.

A well-equipped computer section would have to be established in the Planning and Monitoring Division to store all relevant information, produce reports in standard formats, carry out analytical studies and generally serve the purposes of the HMIS. A Systems Engineering/ Manager would be necessary, who could be appointed on contract or through deputation, since this would be a single post. This officer would also be responsible for the technical supervision and maintenance of the GIS.

A website would have to be developed and maintained which would provide information on all aspects of the health services, including names of officers and locations of facilities, budget details and progress reports. This would provide transparency of the management of the system and also permit interventions by the public for whom the system is meant. The present website developed in the KHSDP could be the basis for this expanded and common departmental website.

Structural changes at District level

Strong statistical units would have to be established in the offices of the DHO/ DMO and all reporting and statistical functions in the district should be placed under them so far as their jurisdictions are concerned. A computer cell in their offices would also have to be set up. These cells would generate reports in standardized formats, which would be sent to Headquarters for consolidation and analysis. However, analysis at the district level would also be carried out so that monitoring by the DHO / DMO is possible at the district level. The Programme Officers of the district would get the reports in the formats they need from this cell.

Two Assistant Statistical Officers, with two clerical assistants and one Computer Operator would have to be appointed for each district. The reporting format would be a unified document and at defined periodicity. This would imply that processing the report for consistency and quality of data would be that much easier and not require too much clerical attention.

Posts of two Assistant Statistical Officers should be provided in each of the seven new districts. There are at present 80 posts of Assistant Statistical Officers (on the basis of 4 per district in the old 20 districts). On the basis suggested above, there would be a surplus of 40 Assistant Statistical Officers of whom 14 would have to be allocated to the seven new districts. The resultant surplus of 26 posts could be used to financed partially the posts of computer operators and clerical assistants in the districts. It would be useful to carry out a review after two years of the workload of these officers to assess whether two officers are required in the smaller districts or whether more than two are necessary in the larger ones.

The computer unit in the office of the DHO would also provide the facility of the GIS for local monitoring and planning.

The central role of the Planning and Monitoring Division

The role of the Planning and Monitoring Division, as envisaged herein, is much wider than what it is at present and its responsibilities are much heavier. It is the Division that **plans for and monitors the performance of the Department**. In view of this expanded role, the Planning and Monitoring Division may be headed by an Additional Director.

The Additional Director, Planning and Monitoring would, as indicated elsewhere, be responsible for functions relating to liaison with voluntary and community organizations, and human resources development including training. In effect the Additional Director, Planning and Monitoring would oversee four Joint Directors, namely (i) Joint Director, Health Information System (ii) Joint Director, Planning (iii) Joint Director, Voluntary Organizations

and (iv) Joint Director, Human Resources Development. In addition, the Additional Director would oversee the Systems Engineer / Manager.

It has been suggested that a Commission on Health should be established. This body would require information and assistance. It is recommended that the Planning and Monitoring Division be the secretariat of the Commission.

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ANNEX 4

GOVERNMENT OF MEGHALAYA
Office of the Chief Minister
Media & Communications Cell
Shillong
***

Press Release | July 19

Note on Meghalaya State Public Private Partnership Policy
July, 2021

1. Objective

a. Promote growth by attracting investments while safeguarding and promoting the interests of the communities.

2. Definition

a. The Department of Economic Affairs, GOI, refers to PPP as a Partnership between a public & private sector for creation / management of infrastructure for public purpose for a specified period of time on commercial terms & procured through a transparent open procurement system.

3. Requirement of a PPP Policy

a. The State has a severe deficit of infrastructure, be it roads, telecom or power. For instance, the road density in the State is only 47.8 Km per 100 square km which is way lower than the national average of 180. The per capita annual consumption of electricity in the State, at 880 kWh, is also much below the national average of 1,200 kWh.
b. To achieve the vision of being among the Top 10 Indian states within the next 10 years, it would be required to not just deficit these gaps, but surpass the national average on many counts.
c. All these would require massive investments, estimated at about Rs. 25,000 Cr over the next 10 years. The Government with an annual budget size of approx. 17,000 Cr (of which the development budget is only about Rs. 3,000 Cr) does not have the quantum of resources to undertake all these activities.
d. A State Public Private Partnership Policy would help us leverage investments along with sector specific expertise from the private sector.

4. Types of PPPs

a. Large Infrastructure Projects (PPP)
   i. Projects that require large investments, typically more than Rs. 10 Cr. eg. Major roads projects, Hydro power projects etc.

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b. Community Infra Projects (CPPP)
   i. Projects that require smaller investments, typically less than Rs. 10 Cr. eg. a processing plant
   ii. Under CPPP, the community shall be actively involved and contribute through the entire process. The community will not only provide the land, but their consent would also be taken at critical junctures. At the end of the project cycle, the assets along with the land would be passed back to the community.

5. Benefits of PPP Policy

Quality infrastructure has a multiplier effect and forms the basis for long term development.

a. Economic Growth
b. Utilizing private sector's efficiencies
c. Employment opportunities for the local
d. Capacity building in the State
e. Creating New Assets & Strengthening Existing Assets

6. Role of the Government

a. In any PPP project, the State Government will be involved throughout the project's lifecycle but as a facilitator and enabler, while the private sector will assume the role of financier, builder and operator of the service.
b. Safeguarding the interest of the community
c. The State Government can also provide VGFs, stamp duty waivers etc. as and when required.
d. Setting up a Dispute Redressal mechanism

7. Proposed Institutional Framework

a. An Empowered Group of Ministers (EGM), headed by the Hon'ble Chief Ministers, shall be set up to approve projects greater than Rs. 50 Cr.
b. An Empowered Committee on Infrastructure (ECI), headed by the Chief Secretary, shall be set up to approve projects upto Rs. 50 Cr.
c. A State PPP Cell, headed by a senior Secretary from the planning department shall be set up as the nodal agency. It would be housed within MIDFC under the Planning Department
d. Land belonging to Government Departments or taken on lease from communities/individuals shall be used for the project. And all provisions related to the Meghalaya Land Transfer Act, 1971 will be applicable to ensure that the rights of the communities/individuals are protected.

ANNEX 5

Government of Chhattisgarh
Health & Family Welfare Department
Mantralaya

DKS Bhawan, RAIPUR

// Notification//

Dated : 9th July, 2012

Number F 21-03/2011/9/17: With a view to encourage private sector participation for strengthening health services, the State Government hereby notifies Public-Private-Partnership Policy (2012), namely:-

" Public-Private-Partnership Policy for strengthening health services in Chhattisgarh"

1 Introduction

Recognizing the need for large scale investments in the health sector, the limited resources that the State has and the financial and managerial ability available in the private sector, the Government of Chhattisgarh welcomes Public-Private Partnerships as an effective mechanism for strengthening health services in the State. This is in tune with the National Health Policy 2002 which states that " … this Policy welcomes the participation of the private sector in all areas of health activities – primary, secondary or tertiary ".

In keeping with the above mandate, the State Government has notified separate policies for encouraging private sector investment for establishment of medical colleges and super-specialty hospitals and nursing homes in the State. The State recognizes, however, that for social sectors like health, the private investment and enterprise should also be used in strengthening the services being provided through existing public health infrastructure. Similarly, there are several non-governmental and voluntary organizations doing excellent work in the health sector who need to be supported by the Government for expanding and strengthening their work. This policy statement accordingly sets out the framework for encouraging private participation in the health sector in the State.

2 Defining Public-Private Partnerships

The "Draft National Policy on Public-Private-Partnership (PPP)", issued by Department of Economic Affairs, Government of India in October, 2011, defines PPP as an arrangement between a government entity and a private sector entity for the provision of public assets or services through investments being made by the private entity and/or management being undertaken by the private sector entity, for a specified period of time. Some of the commonly adopted forms of PPPs included in this definition are management contracts (where an existing public asset may be handed over to a private entity for a defined period), Build-Own-Transfer (BOT) and its variants, Build-Lease-Transfer (BLT), Design-Build-Operate-Transfer

PPP POLICY FOR HEALTH SECTOR IN CHHATTISGARH

(DBOT) and Operate-Maintain-Transfer (OMT) etc. According to this definition, outsourcing of certain services, for example, contracting a private sector entity to organize diet services in public hospitals, is not a Public-Private-Partnership, nor is Build-Own-Operate considered as a preferred PPP mode.

Recognizing that Public-Private-Partnership can be an effective instrument for improving and strengthening existing public health assets, this policy adopts a broader definition of the term which defines "Public-Private-Partnership" as a contractual agreement between the public and the private sectors, whereby the private operator commits to provide public services that have traditionally been supplied or financed by public institutions. This broader definition includes outsourcing as well as such other alternatives under which the government entities may engage private service providers to deliver services on their behalf or where non-governmental and voluntary organizations are assisted in expanding their services. In other words, this Policy-Paper views the PPP as an arrangement that not only encourages private investment for creating new health care infrastructure but also includes the following others forms of partnerships:

a) Contracting private sector institutions for managing existing public health facilities / hospitals located in the remote areas.

b) Engaging private sector institutions for management of support services in public hospitals such as diet service, laundry service and waste management etc.

c) Contracting private sector institutions for organizing mobile medical units for providing services in remote areas, emergency transport services for patients and for transportation services for beneficiaries of government services such as pregnant women.

d) Contracting private sector entities for providing specialist / specialty services at the public hospitals such as special OPD block, setting up of diagnostic facilities /services at public health institutions or operation and management of equipment installed at public health institutions.

Accordingly, this policy statement sets out the framework for Public-Private-Partnership whose main objective is to improve availability and quality of health services available to the common people on a sustained basis through strengthening the existing public health infrastructure and to increase the coverage and quality of public health services with the help of private sector.

3 Policy objectives

Essentially, the objective of this policy is to improve effectiveness of existing public health services through sustained efforts in improving the coverage and quality of services being provided and to provide for an institutional arrangement which enables selection of private partners through easy-to-follow procedures, while maintaining full transparency.

PPP POLICY FOR HEALTH SECTOR IN CHHATTISGARH

The main objectives of the health sector PPP policy are as follows:

i. To expand the network of health facilities and to strengthen the services being provided through the same.

ii. To provide a stable, transparent and conducive policy and administrative environment which enables effective utilization of private investment and managerial capacities for strengthening public health system.

iii. To improve access to quality health services, specially in remote and inaccessible areas in a cost effective manner through partnerships with all willing private sector health care providers- Non-Governmental Organizations (NGOs), Community Based Health Organizations (CBHOs), charitable trusts, philanthropic organizations, and commercial private sector.

iv. To establish systems and procedures for selection and accreditation of non-governmental / private service providers for delivery of health services on behalf of the state government.

v. To establish transparent and independent (third party) mechanism for performance monitoring of PPP projects.

vi. To establish systems for capacity building of PPP project partners in the State.

4 Guiding principles for design and implementation of health sector PPPs

The need identification, design, implementation, monitoring and evaluation of the health sector PPPs in the State of Chhattisgarh shall be governed by the following guiding principles:

i. There will be a fair and transparent system to facilitate and encourage PPP projects which shall incorporate the principles of 'fair practice' and 'mandatory disclosure'.

ii. It will be ensured that the projects are planned, prioritized and managed with a focus on benefits to the general public.

iii. There will be a transparent and competitive process for selection of private partners, which may provide, where appropriate, preference to organizations working on a 'not-for-profit' basis, where appropriate. To the extent feasible, 'e-procurement' mechanism may be used for selection of partners.

iv. It will be ensured that there is a competent monitoring and control mechanism for the projects during their life cycle. Wherever needed, arrangements will be made for Project Management Unit (PMU) and Dispute Resolution Mechanism. In particular, a pre-bid conference will always be a necessary step in the selection process whether or not the bidding is in two stages ["Expression of Interest" followed by "Request for Proposal"] or in a single stage ["Request for Proposals" sought through open advertisement].

3

PPP POLICY FOR HEALTH SECTOR IN CHHATTISGARH

v. It will be ensured that, to the extent possible, each project provides for pre-determined, measurable performance standards so that the services being provided by the private sector can be assessed and incentive or penalty can be determined. User fee payable by the users shall also be linked to performance.

vi. Unsolicited proposals will always be entertained following the "Swiss challenge" mechanism.

vii. Different models of engaging with the private sector partners such as Design-Finance-Build-Operate-Transfer (DFBOT), Design-Finance-Build-Own-Operate (DFBOO), Social Marketing & Franchising, Joint Ventures, Service Agreements etc. will be adopted based on appropriateness for the identified activity or service.

viii. The partnerships already executed in accordance with national guidelines such as those under Revised National Tuberculosis Control Programme shall continue to be governed by the respective operational frameworks / guidelines.

5 Priority Areas of Health sector PPPs in Chhattisgarh

While there is a vast scope for health PPPs in the State, the immediate priority areas to be pursued will be as follows:

i. Outsourcing of non clinical support services in government hospitals, e.g. network of diagnostic facilities / services, cleaning and waste management, infrastructure maintenance, security, diet-services, laundry services, hospital automation systems etc.
ii. Expansion of mobile health services and emergency transport system.
iii. Creating telemedicine / tele-health facilities in state/ district / sub-district level hospitals.
iv. Outsourcing 'Operationalization and Management (O&M) of Primary Health Centres / Community Health Centres / Civil hospitals and other facilities, particularly in remote areas.
v. Setting up super specialty blocks / research centre in existing district hospitals.
vi. Establishment of IT platforms for process automation in medical college hospitals, district hospitals, civil hospitals and CHCs etc.
vii. Establishment of network of pharmacies in medical college hospitals, district hospitals, civil hospitals and community health centres etc.
viii. Establishing 'third party monitoring / investigation' system to monitor the qualiy of construction, procurement and services, e.g. accreditation of private drug testing labs for quality testing of government procured medicines.
ix. Setting up and managing of blood banks / blood storage units in the medical college hospitals, district hospitals, civil hospitals and community health centres.
x. Upgradation and strengthening of educational institutions under the Department, including establishment and operation of "e-education" system.
xi. Upgradation and strengthening of training institutions for the capacity building and skill upgradation of personnel working with the Department.

PPP POLICY FOR HEALTH SECTOR IN CHHATTISGARH

The above priority areas are illustrative and the below mentioned Empowered Committee for the implementation of this policy will be competent to make amendments to the list from time to time.

6 Institutional arrangement

6.1 Empowered Committee for Public-Private Partnership (Health)

An Empowered Committee for Public-Private Partnership (Health) will be established to steer and guide the design and implementation of health sector PPPs. The composition of the Committee will be as follows:

- Principal Secretary Health & Family Welfare — Chairperson
- Representative of Department of Finance (at least Deputy Secretary level) — Member
- Representative of Planning Department — Member
- Representative of Law Department — Member
- Commissioner, Health Services — Member
- Director, Medical Education — Member
- Director, Family Welfare — Member
- Director, SIHFW — Member
- Director, AYUSH — Member
- Director, State Health Resource Centre — Member
- Mission Director (NRHM) — Member
- Director, Health Services — Member Secretary

The Empowered Committee will perform the following functions:

i) Review and revise the priorities for PPP projects from time to time.

ii) Determine the procedure for preparing the projects; in particular to decide the cases where the services of technical advisers are required. Where necessary, particularly for infrastructure related projects, it will be ensured that project has been developed through due process, viz. 'Pre-feasibility analysis' and 'Value for Money' analysis.

iii) To determine the procedure for according administrative and financial approvals to the projects. In cases where state budget funds are to be used, financial approval shall be obtained from the competent authority as prescribed in the delegation of financial power rules.

iv) Review the progress of projects under implementation and issue directives for improvement, where necessary.

v) Consider unsolicited proposals and decide the follow up action on the same.

PPP POLICY FOR HEALTH SECTOR IN CHHATTISGARH

vi) Provide guidance and directives for creating an enabling environment through preparation of manuals and other materials and training etc.

vii) Where necessary, issue directives taking into account the guiding principles.

viii) Consider and deliberate on such issues related to Public-Private Partnership as the Committee may consider necessary.

The Empowered Committee shall meet once every quarter or more frequently, as may be decided by the Chairperson.

6.2 Public-Private Partnership (Health) Cell

A Public-Private Partnership (Health) Cell shall be established in the Directorate of Health Services. The expenditure on the Cell shall be met from the funds available under National Rural Health Mission (NRHM).

Public-Private Partnership (Health) Cell shall perform its tasks under the guidance of the Empowered Committee and with technical assistance from the State Health Resource Centre (SHRC) and other technical advisers.

The Cell will also act as the secretariat of the Empowered Committee.

6.3 Role delineation

The roles and responsibilities of the PPP Cell, State Health Resource Centre and technical consultants shall be as follows.

State Health Resource Centre	PPP (Health) Cell	Technical Adviser
Selection of Transaction Adviser / Legal consultant (where required)		
Prepare Expression of Interest (EoI) / Request for Proposal (RfP) documents and conduct final assessment for selection	Participate in final assessment. Process for approvals	
Selection of partners for projects approved by the Empowered Committee		
Review Expression of Interest (EoI) / Request for Proposal (RfP) documents, if requested. Participate in evaluation	Review and approval of Expression of Interest (EoI) / Request for Proposal (RfP) documents. Release advertisements and uploading on web.	Pre-feasibility analysis, costing and Viability Gap (VG) estimation (where required). Prepare Expression of Interest (EoI) / Request for Proposal (RfP) documents.

PPP POLICY FOR HEALTH SECTOR IN CHHATTISGARH

State Health Resource Centre	PPP (Health) Cell	Technical Adviser
	Approval of EOI / RFP / evaluation reports / contract document. Where necessary, arrange meeting of Empowered Committee for financial approvals. Execute contracts on behalf of government and release funds as per the same.	Bid process management, including pre-bid meeting, bid evaluation. Preparation of contract / agreement. Note: These tasks can be assigned to SHRC in cases where Transaction Adviser is not engaged
Third party monitoring / Investigation		
Design framework for 3rd party monitoring. Selection of agencies for monitoring. Analyse monitoring / feedback reports and propose corrective actions where needed	Release of funds. Release will be automatic if the feedback report confirms progress as anticipated in agreement /contract. Otherwise, for corrective action, approval of Empowered Committee will be obtained, where necessary, after consideration and review of recommendations from 3rd party monitoring system.	
Capacity building of personnel / agencies in PPP		
Design training programmes, e.g. office bearers of the Jeevan Deep Samitis Organise training programmes	Finalize nominations for the training programmes Ensure that personnel nominated for training programmes are assigned to positions which involve substantial work related to PPPs.	

7. This policy will be subject to policies and directives on Public-Private Partnerships issued by the Finance Department from time to time.

By Order and in the name of the Governor

Sd/-
(Ajay Singh)
Principal Secretary
Government of Chhattisgarh
Health & Family Welfare Department

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ANNEX 6

17-10-2021

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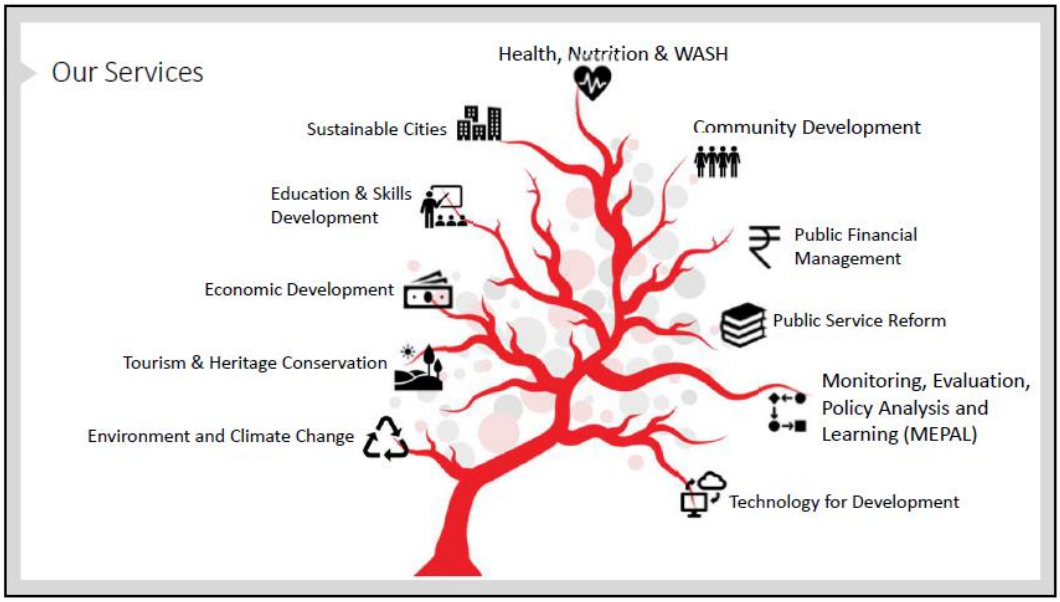
17-10-2021


Our Services
Health, Nutrition & WASH
Sustainable Cities
Community Development
Education & Skills Development
Public Financial Management
Economic Development
Public Service Reform
Tourism & Heritage Conservation
Monitoring, Evaluation, Policy Analysis and Learning (MEPAL)
Environment and Climate Change
Technology for Development


Glocal Footprint
Meghalaya
Chhattisgarh
Delhi
Haryana
Himachal Pradesh
Jammu & Kashmir
India – Headquarters
United Kingdom
Kenya
Ethiopia
Bangladesh
Philippines
Myanmar
Nepal
Karnataka
Kerala
Madhya Pradesh
Odisha
Rajasthan
West Bengal
Bihar
Uttar Pradesh
7 international and 16 offices across India focussed on
Making Development a Ground Reality
Work closely with NITI Aayog, MoHFW, MWCD, NHA, etc.
Sharing Knowledge – Peer Reviewed Journals, Outlook POSHAN Awards
Signatories to UN Global Compact
South-South Connect: MoU with Africa Healthcare Federation; Call to Action
Industry Partnerships: NATHEALTH, CII, FICCI and others

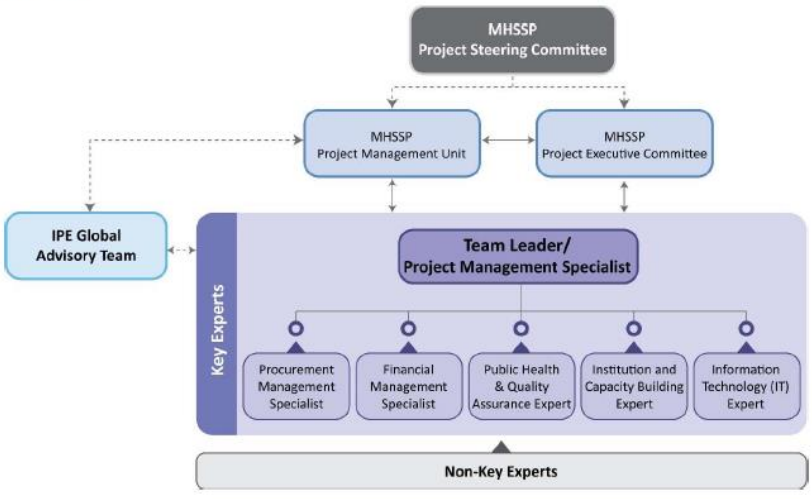
2

What We Do : Health, Nutrition and WASH

We provide large-scale support to implement sector-wide approaches as well as stand-alone policy reviews, strategy development and MEL services.

Technical Areas	Health System Strengthening	Community Engagement	Innovative Financing	Innovation and Technology
• RMNCH+A • Family Planning • Non-Communicable Diseases • Communicable Diseases • Nutrition Improvement • Water, Sanitation and Hygiene	• Procurement and SCM • HR for Health • Public Private Partnerships • Epidemic Control and Disease Surveillance • Public Financial Management	• SBCC and IEC • Participatory, Learning and Appraisal • Human Centric Design • Behavioural Economics • Equity and Gender Responsive Planning	• Development Impact Bonds • Blended Finance Solutions • Insurance and Loan Products • Risk Guarantees • Social impact funds	• AI Based Solutions • HMIS • Commercial Validation of Tech Products (POCs) • Process Automation • Dashboards

Team Structure



3

Our Approach: Focus Areas and Scope of Work

Understanding of PMA Role

The MHSSP seeks to enhance DoHFWs ways of working and the citizens ways of accessing service. Together, they will make public health services in Meghalaya more efficient, equitable, quality driven and accountable. The role of the PMA is to facilitate this.

PMA role will be played in the context of a stretched health system, developing an appetite for reforms, technology and accountability.

- As a **technical** group, provide expert inputs, assistance and to carry out tasks identified under specific domains under MHSSP;
- As a **project management** support agency, help PMU in planning, implementation, and monitoring of MHSSP activities and compliance requirement;
- As a **capacity building** catalyst, strengthen the PMU, DoHFW and facilitate knowledge management and staff training for sustainability of interventions.

Part 2: Proposed Health Sector Reform and Development Agenda

Suggestions by PMA for MHSSP

J P Misra, Team Leader, PMA

THE WORLD BANK

IPE GLOBAL
Expanding Horizons. Enriching Lives

Context

- MHSSP aims to improve
  - Management capacity – accountability, governance [ref: para 11-PAD]
  - Quality through strengthening systems
  - Coverage and utilization of services
- IPAs (as a key tool to achieve project objectives) at 3 levels
- Top level IPAs aimed at creating enabling environment for lower levels to perform
- PMA mandate : support measures intended to strengthen administrative structures responsible for health system management
- Proposed Reform / Development ideas / suggestions are aimed at strengthening health system management and creating the enabling environment for field units

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Ideas/Inspiration

- Documents review
  - Meghalaya Health Policy 2021
  - National Health Policy 2017
  - World Bank PAD for MHSSP
  - NEDSS Report
  - Sutra Consulting Report
  - MoHFW guidelines on 15th FC Grants
  - Ayushman Bharat guidelines
  - Meghalaya NHM PIP 2021-22
  - Meghalaya Social Audit Act / Rules, 2017/2019
- Discussions with stakeholders during Field visits [05-08 October, 2021] : Nongkhlaw CHC, Kynrud PHC, civil hospitals Williamnagar and Tura, Sub-centres Dawagre and Nengkhra, PHC Samanda and CHC Rongjeng. Consultations with SHGs at Nongkhlaw and Williamnagar. Meeting with DMHO Williamnagar.

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Initial Impressions from Field Visit

- Motivation/sincerity levels are quite encouraging among the field staff, in spite of difficulties
- Shortcomings are mainly on account of challenges at the HQ level in providing an enabling environment for the field staff to perform better.

What follows are the suggestions / ideas aimed at system strengthening and creating the enabling environment .....

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1. Develop and Notify Meghalaya PHS

- Define the System Architecture
  - Use IPHS as reference point and modify the same in the context of the State (e.g. shortages of specialists)
  - Identify non-clinical and clinical support services which can be outsourced [helps to identify HR / equipment which need not be hired / procured]
  - Include a full-time position of Hospital Manager for civil hospitals and specialized hospitals
- Define the timeline to achieve the standards, taking into account HR gaps.

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6

2. Web Application for Resource Mapping and Management

- Modular
- Covers all levels and field units
- All aspects, all sources – HR, Infrastructure, equipment, medicines, funds, services delivered (including NHM services), monthly reports, grievance redressal etc.
  - provides real time information
  - enables general public to access information (reduces RTI load on government)
  - strengthens surveillance and outbreak response preparedness ability of the State

[NHP para 2.4.3.3.c: federated, integrated health information architecture]

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3. Develop Medium Term Expenditure Plan

- Meghalaya PHS as the basis
- Two components – own costs and cost of outsourced activities (helps to seek budget)
- Approval of State Cabinet.

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4.Review and Re-organize

- Reorganization of Directorate
  - Integration of NHM staff / positions
  - Independent Planning and Monitoring Unit
- Review, revise and notify Delegation of Administrative and Financial Authority
  - Directorate level
  - DMHO and District Programme Managers (technical)
  - Medical Superintendent of civil hospitals / specialized hospitals
  - Officers in-charge of CHCs and PHCs
- Reorganize MHO Cadre
  - GDMO
  - Specialists [NHP para 11.3]
  - Public Health Managers [NHP para 11.8]
- Review recruitment rules

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5. Revisit HR Policies

- Resolve 3F issue
- Mandatory induction training
- Mandatory rotational postings [NHP para 11.2]
- Decentralise cadre management
- Addressing doctor's shortage in remote areas
  - Identify locations
  - Ensure residential quarters with basic amenities [water, solar power, rain water harvesting system etc.]
  - Mandatory first posting for Bond holders
  - Offer State PG quota to open market MBBS to those willing to work in identified locations for 2-3 years [HP experience]

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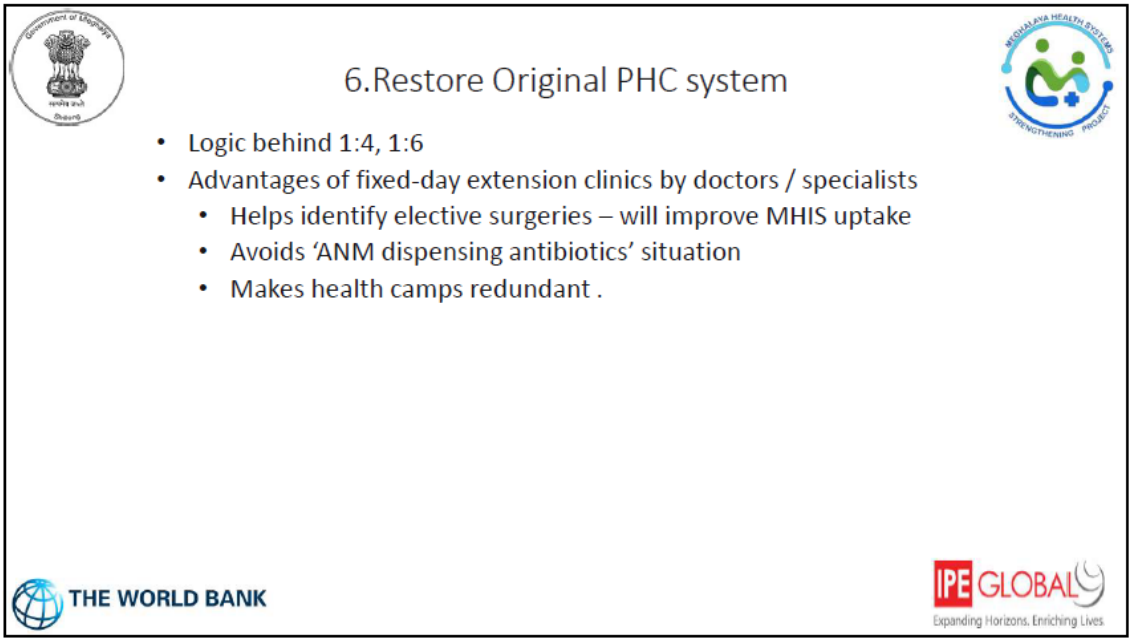
8


6.Restore Original PHC system
• Logic behind 1:4, 1:6
• Advantages of fixed-day extension clinics by doctors / specialists
• Helps identify elective surgeries – will improve MHIS uptake
• Avoids 'ANM dispensing antibiotics' situation
• Makes health camps redundant .
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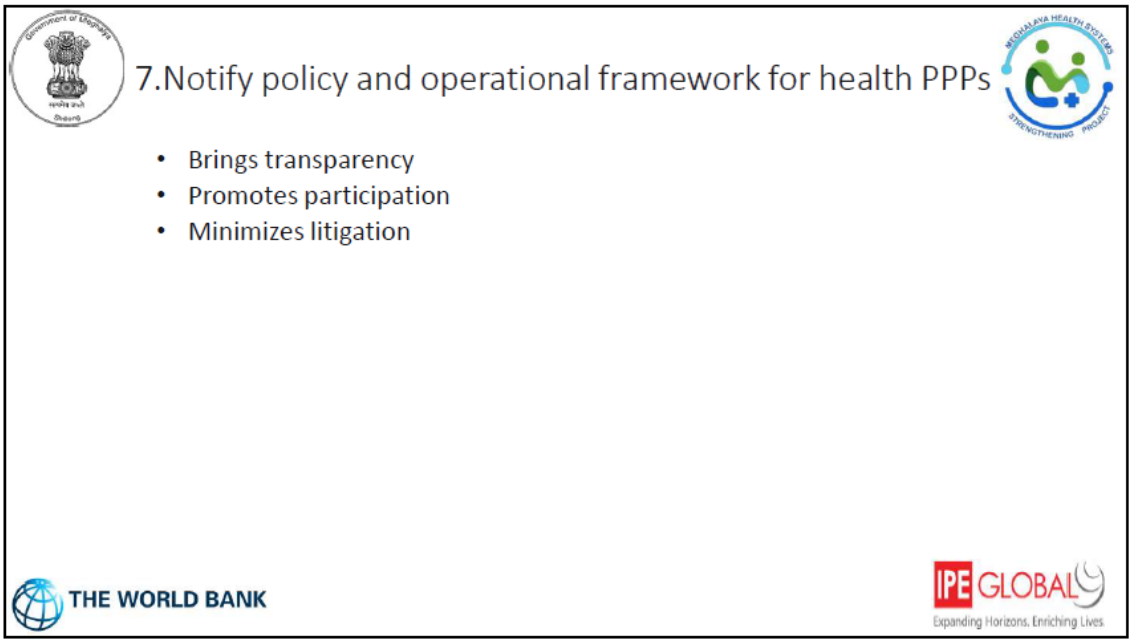
7.Notify policy and operational framework for health PPPs
• Brings transparency
• Promotes participation
• Minimizes litigation
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8.Use PPPs to Expand Network of ANM/Nursing Schools

- Co-develop design of PPP through consultations
  - training infrastructure created by private partner, within the civil hospital if possible
  - hospital allowed to be used for practice
  - fees structure jointly agreed
  - hospital technical staff allowed to be guest faculty on agreed honorarium
  - part of seats [e.g. 10 out of 30] sponsored by Government from the ASHA group [NHP para 11.6: preferential selection of ASHA into ANM, nursing and paramedical course]

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9. PPP Ideas worth Exploring /Replicating

- Pharmacies in public hospitals
  - Scale issue in replicating TNMSC
  - C&F agents could set up pharmacies at competitive terms
  - Discount at DPCO prices can be used as bidding parameter
  - Meghalaya can lead the way for all NE States
- Jharkhand PPP for pathology / radiology service
  - Hub and spoke model
  - Prices discounted w.r.t. CGHS rate
- CG BMWM outsourcing
  - Covers all hospitals
  - Built-in escalation clause
- CG 104 service
  - Help line for information and grievance / complaint registration
  - Triage driven information in several languages

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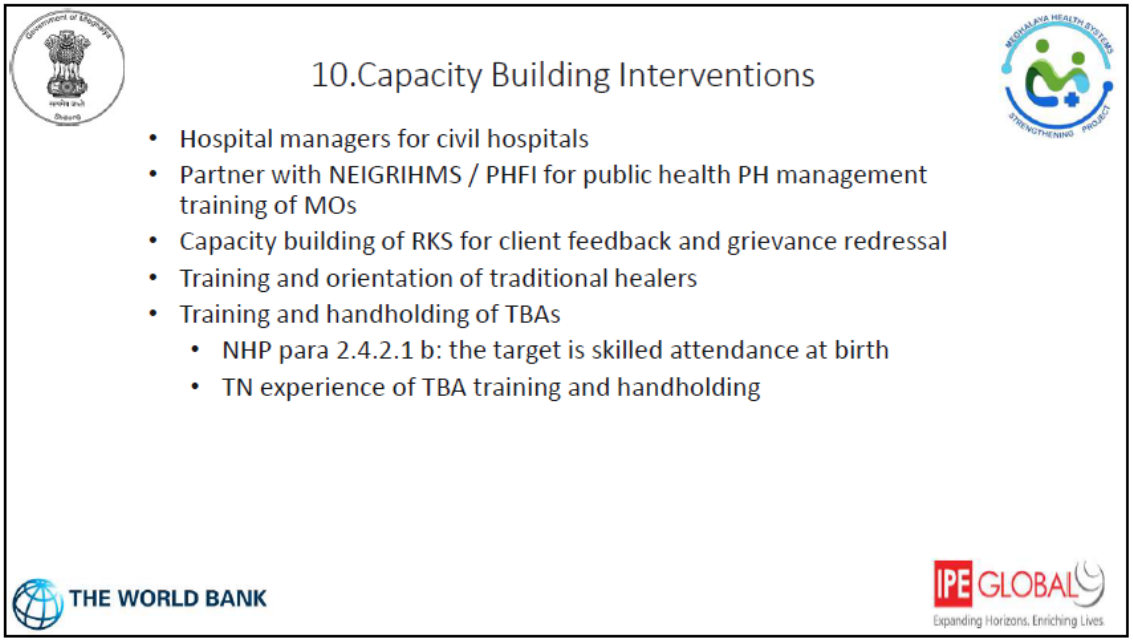
10.Capacity Building Interventions
Hospital managers for civil hospitals
Partner with NEIGRIHMS / PHFI for public health PH management training of MOs
Capacity building of RKS for client feedback and grievance redressal
Training and orientation of traditional healers
Training and handholding of TBAs
NHP para 2.4.2.1 b: the target is skilled attendance at birth
TN experience of TBA training and handholding
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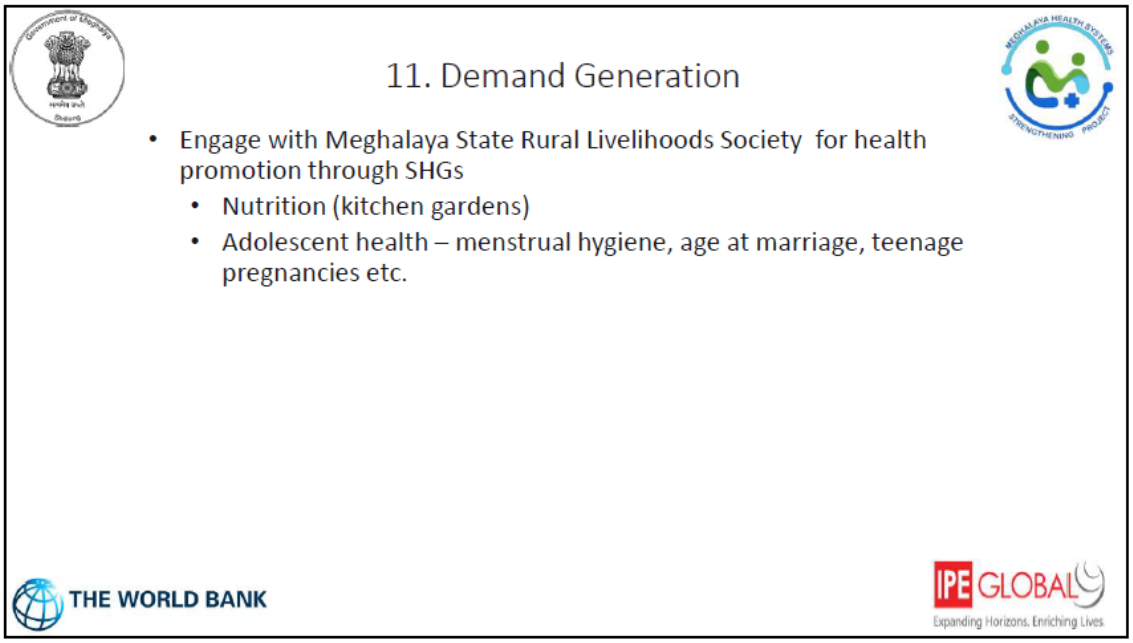
11. Demand Generation
Engage with Meghalaya State Rural Livelihoods Society for health promotion through SHGs
Nutrition (kitchen gardens)
Adolescent health – menstrual hygiene, age at marriage, teenage pregnancies etc.
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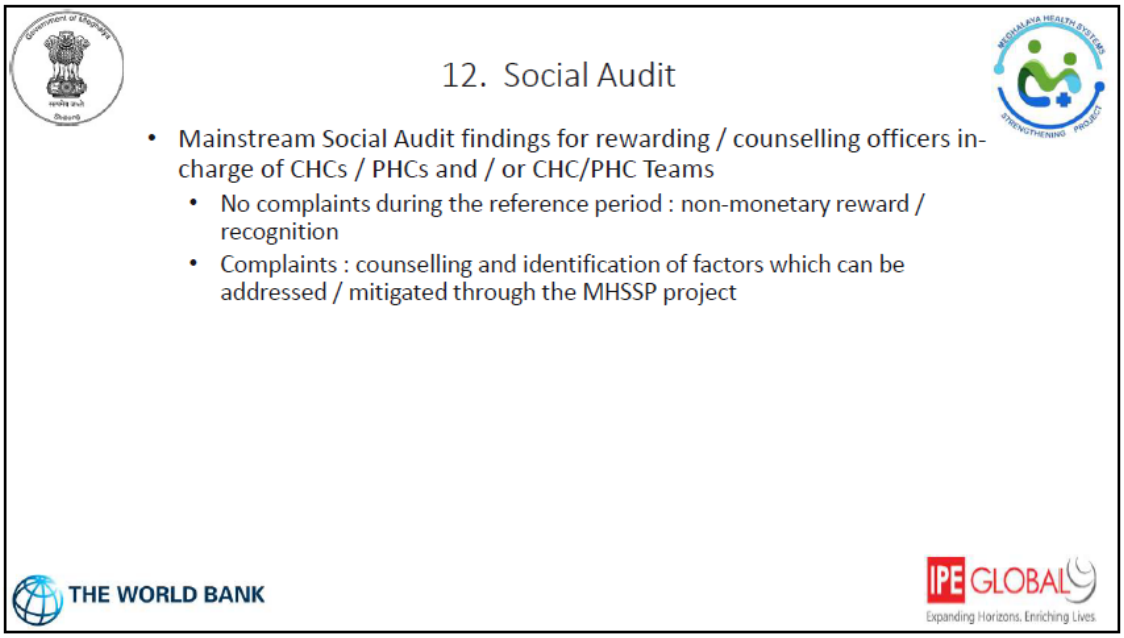
12. Social Audit
• Mainstream Social Audit findings for rewarding / counselling officers in-charge of CHCs / PHCs and / or CHC/PHC Teams
• No complaints during the reference period : non-monetary reward / recognition
• Complaints : counselling and identification of factors which can be addressed / mitigated through the MHSSP project
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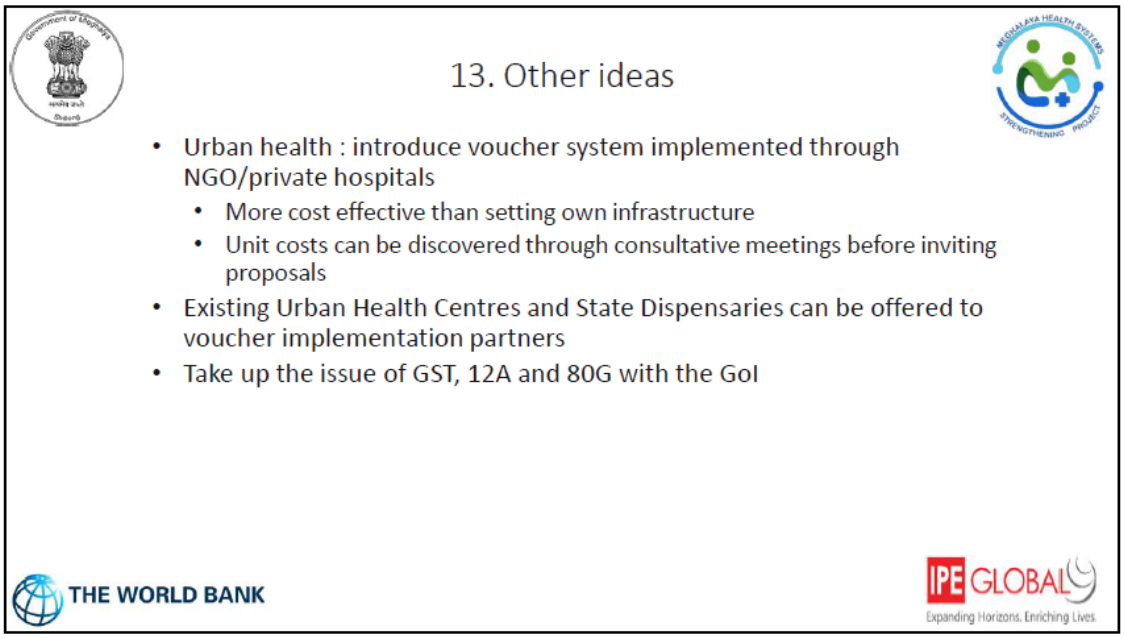
13. Other ideas
• Urban health : introduce voucher system implemented through NGO/private hospitals
• More cost effective than setting own infrastructure
• Unit costs can be discovered through consultative meetings before inviting proposals
• Existing Urban Health Centres and State Dispensaries can be offered to voucher implementation partners
• Take up the issue of GST, 12A and 80G with the GoI
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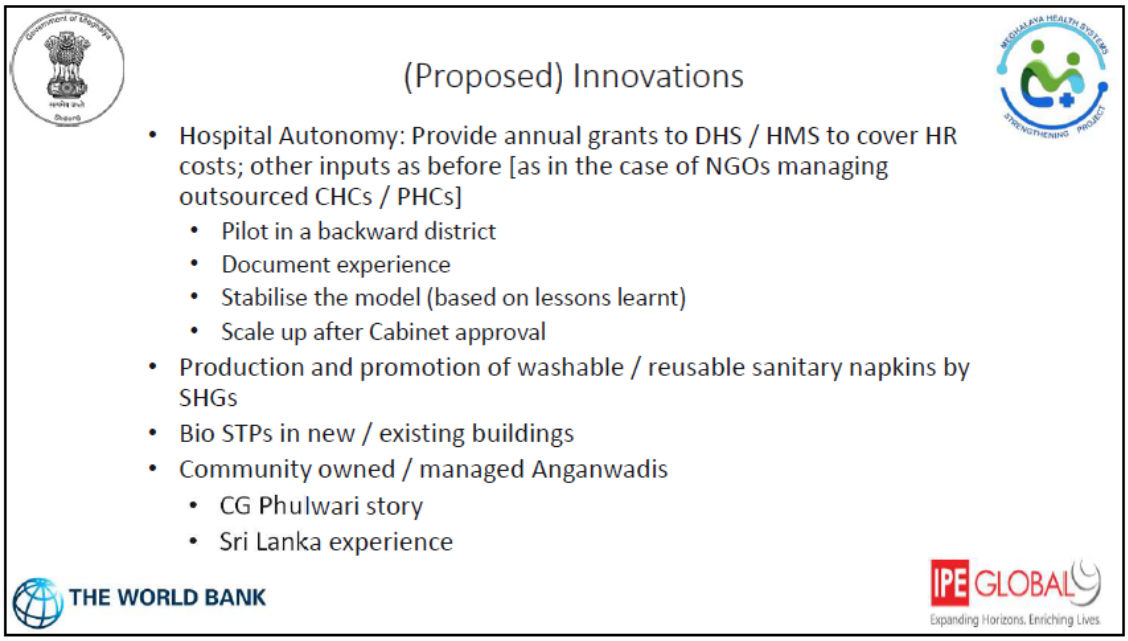
(Proposed) Innovations
• Hospital Autonomy: Provide annual grants to DHS / HMS to cover HR costs; other inputs as before [as in the case of NGOs managing outsourced CHCs / PHCs]
• Pilot in a backward district
• Document experience
• Stabilise the model (based on lessons learnt)
• Scale up after Cabinet approval
• Production and promotion of washable / reusable sanitary napkins by SHGs
• Bio STPs in new / existing buildings
• Community owned / managed Anganwadis
• CG Phulwari story
• Sri Lanka experience
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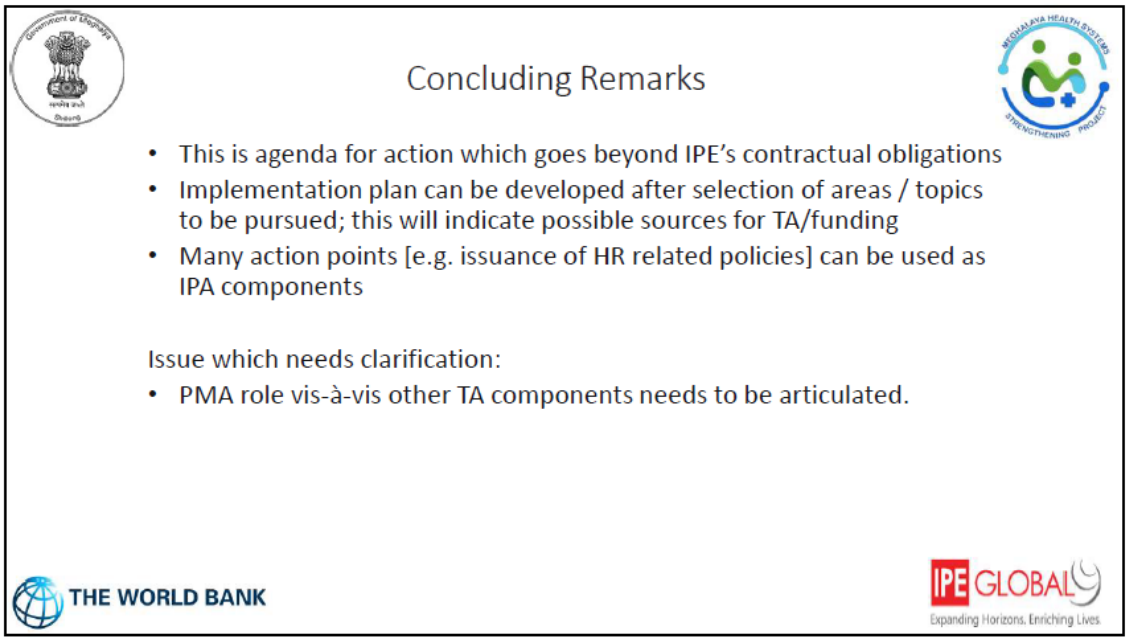
Concluding Remarks
• This is agenda for action which goes beyond IPE's contractual obligations
• Implementation plan can be developed after selection of areas / topics to be pursued; this will indicate possible sources for TA/funding
• Many action points [e.g. issuance of HR related policies] can be used as IPA components
Issue which needs clarification:
• PMA role vis-à-vis other TA components needs to be articulated.
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17-10-2021


Thank you for your attention…….
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14