MIZORAM

8TH COMMON REVIEW MISSION

CRM Dissemination Meeting

Feb 16th, 2015

CRM Team Members

Districts Covered:	**Aizawl West (Non HPD)**	**Lunglei (HPD)**
Team Leaders:	Dr. M.K. Aggarwal, MoHFW	Dr. Shailendra Kumar, Dir.(Drugs)
Team Members:	• Ms Renu Sobti, Jt Adv(HRD)-Planning Commission • Dr S N Sharma, Jt Director(NVBDCP) • Dr Pushpanjali Swain, NIHFW • Ms Shalini Nair, TSA • Dr. Sheema Chowdhary, CH&I Division • Dr Singh, Regional Director • Mr. Satyajit Sahoo, NHM-Finance • Ms Aastha, NHSRC	• Dr. Shahab Ali Siddiqui, NRHM-I • Dr. Ravinder Kaur, MH Division • Mr. Ajit Kumar Singh, NHSRC • Prof. Sandra Albert, PHFI • Shri Parijat Mishra, YP(SP)-Planning Commission • Ms Supriya Pattanayak, DFID • Dr Tulika Singh, SAATHI • Dr. Gautam Borgohain, RNTCP • Mr RLM Kima, RRC

Facilities visited

S.No	Facility	Aizwal- West	Lunglei	Total Number
1	Anganwadi Centre	-	2	2
3	Sub Centre	4	6	10
4	PHC	4	2	6
5	CHC	NA	1	1
6	District Hospital	1	1	2
7	Sub district Hospital	1	NA	1
8	Mobile Medical Unit	-	1	1
9	Ambulance Call centre	1 (state level)		1
10.	Others	Central Drugs Warehouse	TB Hospital	2
Total Facilities Visited				**26**

Innovations and Best Practices

- **DH Aizawl** is an ISO Certified hospital with Electronic Medical Record System, Functional Eye Bank and Cornea Transplantation facility, Tobacco cessation clinic, Cancer registry at pathology department
- Well functional **psychiatry unit at SDH** (Kulikawn) which is also providing treatment for drug de-addictions
- Concept of "**Sub Center Clinic**" based on time to care approach for scattered population
- **Motorcycle Ambulance** for first aid in hilly terrain
- Strong **community participation** in health activities, donations by NGOs and charitable organizations to health department
- **Telemedicine** in 3 districts for eye care in collaboration with Sathi NGO

Key Findings

Key Findings: Service Delivery

- Good range of services available in DH Aizawl including super specialty services such as cardiology and dialysis unit
- DH Aizawl also runs a well functioning Eye Bank with mobile unit for collection of cornea (Achievement 500 cornea collected since 2008 and 30% transplanted at DH whereas rest distributed in adjoining State)
- RRC – NE has conducted a QA assessment of DH (Aizawl) and found that it is complying 62% of QA indicators
- RSBY scheme has been implemented across the state since 2008
- Availability of Male and Female Health Workers in all Health Centers visited
- Underutilization of Ambulances & MMUs (2-5 visits per month) were observed. 102 was mostly engaged for drop-back through JSSK
- High Out of Pocket Expenditure on drugs, diagnostics & transport despite schemes like JSSK and RSBY

Key Findings: RMNCH+A & DCPs

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

Key Findings: HR, PM & Finance

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

Key Findings: Community processes, Medicine and technology

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

Recommendations

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

Recommendations

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

Thank You