Developing Strategy and Management Framework for Human Resources for Health (HRH) in Meghalaya

Meghalaya Health Systems Strengthening Project (MegHSSP)

PRELIMINARY REPORT

2022

Government of Meghalaya
सत्यमेव जयते
Shillong

IMS Health & Quintiles are now IQVIA™

CONTENTS

ACRONYMS

ACR	:	ANNUAL CONFIDENTIAL REPORT
ADARSH	:	**AD**OPTION OF **A**LTERNATE MODELS FOR **R**ESPONDING TO **SH**ORTAGE OF MEDICAL SPECIALISTS
AIDS	:	ACQUIRED IMMUNODEFICIENCY SYNDROME
ANM	:	AUXILIARY NURSING MIDWIFERY
AYUSH	:	AYURVEDA, YOGA AND NATUROPATHY, UNANI, SIDDHA AND HOMEOPATHY
BCG	:	BACILLE CALMETTE-GUERIN
C-DAC	:	CENTRE FOR DEVELOPMENT OF ADVANCED COMPUTING
CHC	:	COMMUNITY HEALTH CENTRE
COVID	:	CORONAVIRUS DISEASE
COVID-19	:	CORONAVIRUS DISEASE 2019
DHS	:	DIRECTORATE OF HEALTH SERVICES
DHS (MI)	:	DIRECTORATE OF HEALTH SERVICES, MEDICAL INSTITUTIONS
DHS (MCH&FW)	:	DIRECTORATE OF HEALTH SERVICES, MATERNAL, CHILD HEALTH & FAMILY WELFARE
DHS (R)	:	DIRECTORATE OF HEALTH SERVICES, RESEARCH
DM	:	DOCTOR OF MEDICINE
DOHFW	:	DEPARTMENT OF HEALTH & FAMILY WELFARE
EFMS	:	ELECTRONIC FUND MANAGEMENT SYSTEM
EIS	:	EMPLOYEE INFORMATION SYSTEM
EKH	:	EAST KHASI HILLS
GNM	:	GENERAL NURSING AND MIDWIFERY
GO	:	GOVERNMENT ORDER
GOI	:	GOVERNMENT OF INDIA
HEW	:	HEALTH ENGINEERING WING
HOD	:	HEAD OF DEPARTMENT
HR	:	HUMAN RESOURCES
HRH	:	HUMAN RESOURCES FOR HEALTH
HRMIS	:	HUMAN RESOURCES MANAGEMENT INFORMATION SYSTEM
HWC	:	HEALTH & WELLNESS CENTRE
IDSP	:	INTEGRATED DISEASE SURVEILLANCE PROJECT
IMR	:	INFANT MORTALITY RATE
INR	:	INDIAN RUPEE
IPHS	:	INDIAN PUBLIC HEALTH STANDARDS
IT	:	INFORMATION TECHNOLOGY
MBBS	:	BACHELOR OF MEDICINE, BACHELOR OF SURGERY
MCH	:	MASTER OF CHIRURGIAE
MEG EIS	:	MEGHALAYA EMPLOYEE INFORMATIO SYSTEM
MD	:	DOCTOR OF MEDICINE
MHAB	:	MEGHALAYA HEALTH ADVISORY BOARD
MI	:	MEDICAL INSTITUTIONS
MO	:	MEDICAL OFFICER

MPSC	:	MEGHALAYA PUBLIC SERVICE COMMISSION
MPW	:	MULTIPURPOSE WORKER
MS	:	MASTER OF SCIENCE
MSACS	:	MEGHALAYA STATE AIDS CONTROL SOCIETY
MSHS	:	MEGHALAYA STATE HEALTH SOCIETY
NACO	:	NATIONAL AIDS CONTROL. ORGANIZATION
NFHS	:	NATIONAL FAMILY HEALTH SURVEY
NGO	:	NON-GOVERNMENTAL ORGANIZATION
NHM	:	NATIONAL HEALTH MISSION
NHSRC	:	NATIONAL HEALTH SYSTEMS RESOURCE CENTRE
NHWA	:	NATIONAL HEALTH WORKFORCE ACCOUNTS
NIC	:	NATIONAL INFORMATICS CENTRE
NITI	:	NATIONAL INSTITUTION FOR TRANSFORMING INDIA
NNMR	:	NEO-NATAL MORTALITY RATE
NPA	:	NON PRACTICING ALLOWANCE
NRHM	:	NATIONAL RURAL HEALTH MISSION
OOPE	:	OUT OF POCKET EXPENDITURE
PFMS	:	PUBLIC FINANCIAL MANAGEMENT SYSTEM
PG	:	POST-GRADUATE/POST-GRADUATION
PHC	:	PRIMARY HEALTH CENTRE
PHFI	:	PUBLIC HEALTH FOUNDATION OF INDIA
PMU	:	PRIOJECT MANAGEMENT UNIT
PPP	:	PUBLIC PRIVATE PARTNERSHIP
RCH	:	REPRODUCTIVE AND CHILD HEALTH
RHFWTC	:	REGIONAL HEALTH AND FAMILY WELFARE TRAINING CENTRE
RMNCH	:	REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH
SACS	:	STATE AIDS PREVENTION AND CONTROL SOCIETY
SC	:	SUB-CENTRE
SDG	:	SUSTAINABLE DEVELOPMENT GOALS
TOT	:	TRAINING OF TRAINERS
U5MR	:	UNDER FIVE MORTALITY RATE
UHC	:	URBAN HEALTH CENTRE
UIP	:	UNIVERSAL IMMUNIZATION PROGRAMME
UN	:	UNITED NATIONS
US	:	UNITED STATES
UT	:	UNION TERRITORY
VHAM	:	VOLUNTARY HEALTH ASSOCIATION OF MEGHALAYA
WHO	:	WORLD HEALTH ORGANIZATION
WKH	:	WEST KHASI HILLS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

As per Census 2011, Meghalaya has a population of 29,64,007 of which females comprise 14,92,668 and males 14,71,339. The entire State is mountainous, hilly and the altitude ranges from 150 and 2000 meters above sea level. Due to its distinct topography, difficult and tough terrain, there is wide dispersed settlement pattern of the population, with average density of only 103 persons per sq. km of which 80% reside in rural areas. Prolonged rainfall, extreme cold in certain locations, roadblock due to landslides, narrow & difficult road, lack of electricity & telephone connectivity in most of the interior places makes Meghalaya as most challenging place for provision of health care services.

Rationale & objectives of conducting secondary desk review is to: -

- Gain contextual information about government's rules and regulations, transfer & posting and promotion policy, allowance, and incentive schemes in place for health personnel
- Review current job titles, description, and responsibilities, and staffing of Directorate of Health Services (Medical Institutions), Directorate of Health Services (Maternal Child Health & Family Welfare) and Directorate of Health Services (Research)
- Review capacity building at state training institutes and understand whether state training institutes are functioning to adequately address the requirements of the department
- Identify gaps in policies, documents & infrastructure to be addressed in the strategy document
- Identify some of the best practices on Human Resources for Health (HRH) globally & nationally to recommend to the state based on gaps identified

Approach for secondary desk review was based on development of checklists with close ended enquiry questions to get a snapshot of the existing HRH policies/ guidelines/ GOs, availability of training & education infrastructure, review of organizational structure in various directorates and the current set-up of state HRMIS structure. IQVIA tried to understand the organogram, staffing pattern, job descriptions & role and responsibilities of each cadre under Health & Family Welfare Department, Government of Meghalaya (staffing & responsibilities of staff at NHM, DHS (MI), DHS (MCH&FW), DHS (R), Directorate of AYUSH, MSACS, MSHS) along with information on current job titles and the job descriptions. Further, an attempt was made to comprehend the context around Government's rules, regulations, and documents on recruitment process, availability of segregation of the public health management cadre, transfer/posting and promotion policies, allowances, incentives & review of polices for in-service training for health personnel under various directorates. The findings from desk review have been analyzed to yield a comparison of HRH strategies to identify gaps and to highlight best practices in current HRH policies which can be adapted in Meghalaya & led to development of robust analytic HRH strategy framework for Meghalaya

TABLE 1: SECONDARY REVIEW OBSERVATIONS

THEMES	OBSERVATIONS FROM SECONDARY REVIEW OF DOCUMENTS AND WEBSITES[1]	
	REGULAR	**CONTRACTUAL**
Rules & Regulations	a) Most of the vital policies in relation to the health personnel in Meghalaya are found in the Meghalaya Health Service Rules, 1990 which applies to regular staff i.e., those on the State's regular payroll. b) Rules related to recruitment, promotion, inter-se seniority, allocation between general duty and specialist streams, probation & confirmation, time scale of pay, are available. c) The 1990 rules do not provide clarity on duration of compulsory rural posting and any allowances thereof. d) Rules related to transfer & posting, retirement & pension, leave rules, travel allowance, incentives & allowances, House Rent Allowance (HRA), in-service trainings/ further study etc. are not clarified nor mentioned. But it specifies that matters related to pay, allowances, increments, leave, pension, discipline and other conditions of service would be governed by general rules and orders made by the State.	a) Policies pertinent to the contractual staff under National Health Mission, Meghalaya State Programme Management Unit (SPMU), District Programme Management Unit (DPMU), Block Programme Management Unit (BPMU) and health facilities are covered in the HR Rules for NHM Meghalaya. b) Rules related to recruitment process, promotion process, increment eligibility, transfer and posting, office timings, leave and suspension and termination are available. c) Travel allowance, or any other benefits for employees are not covered under the NHM rules.
Organization Structure	a) The organograms of all three directorates and departments under them were received either through checklist administration or through the official website of Department of Health and Family Welfare (DoHFW). All the organograms were brought together to form a composite structure under the DoHFW. b) Organograms of Meghalaya State AIDS Control Society (MSACS) and Departmental Promotion Committee have been made by IQVIA team based on information gathered during the secondary review and placed in the report. c) Composition of Biomedical Waste Management Committee, Internal Committee Sexual Harassment of Women at Work Place and Internal Grievance Committee in redressal of employment/services related grievances are not available	a) The details on composition of State Health Mission and the State Health Society of NHM have been found on the official central and state websites and the same have been integrated within the report. Organogram of the former has been developed. The State Health Society and District Health Society's organograms are not available. b) Committees for selection of candidates, promotion, recruitment and disciplinary action are formed at both state and district levels and details of their composition are provided in the *HR Rules for NHM Meghalaya*. c) Rogi Kalyan Samiti (RKS)/Hospital Management Committees are also formed across the state details of which are also captured within the report. However, its composition in Meghalaya is not available. Suggested composition of RKS is available on the NHM website.
Job Descriptions	a) Instead of job descriptions, the work distribution document for DHS (MCH&FW) staff provides details on various programmes to be handled by each of the senior grade and grade I staff under it. b) The job description of Director of DHS (R) is unavailable. Some employees' job descriptions include one-liners on providing assistance to senior position. Some have detailed task segregations.	a) Detailed job descriptions available for SPMU, DPMU, BPMU staff are available b) Job description of health staff at various health facilities is not available

[1] **Detailed findings can be found in Annexures 1-7**

	c) Job descriptions of DHS (MI) staff is not available.	
Human Resource Management Information System	a) There is no system which is developed to capture comprehensive HRH information in terms of regular employees. b) During secondary review, it was found that Meghalaya Employee Information System (Meg EIS) used by the Directorate of Accounts and Treasury contains data related to regular and temporary health staff across the state working under the DoHFW which can be leveraged for the HRH enumeration exercise.	a) The current E-Human Resource Management Information System (E-HRMIS) captures various data points related to contractual employees within the health system under NHM. b) E-HRMIS is maintained by Centre for Development of Advanced Computing (C-DAC) and is a stable and strong web-based application that can be leveraged to aggregate all relevant details of health personnel on regular roll including 3F employees among others.
Training	a) The Regional Health & Family Welfare Training Centre's (RHFWTC) current capacity, functions and training curriculum were looked into. Issues or the lack of resources have been highlighted in the report within following categories: physical infrastructure, equipment and transport, human resources, accommodation for trainees, library and training materials, and budget. b) Training modules are developed on the following subjects: Adolescent Health, Capacity Building on Community Participation, Counselling Skills, Gender Based Violence & Health, Health Communication Behaviour Change, Immunization, Mental Health (Online) and Reproductive Maternal Neonatal Child Health & Adolescent	
Recruitment Process	a) From the information gathered from various departments, it has been ascertained that the recruitment process does not happen at regular frequencies. Based on the gaps identified, and through key discussions held with the Project Director, Meghalaya Health Systems Strengthening Project, IQVIA undertook development of case studies of certain states across the country on development of a recruitment board which will enable DoHFW to function independent of the current Meghalaya Public Service Commission to conduct recruitment at regular intervals (or go by the process specified under the Meghalaya Health Service Rules, 1990, i.e., bi-annually). Case studies covered include Tamil Nadu Medical Recruitment Board and West Bengal Recruitment Board.	a) From the information gathered through the HR Rule for NHM Meghalaya, an 11-step process is followed for recruitment of contractual staff under NHM. It includes notifying vacancies to MD, NHM who approves advertising/call for applications for vacancies in local newspaper, official NHM website and Office Notice Board followed by written test (questions made by three-member examination committee) with cut-off marks or percentile system to shortlist candidates. Further an interview panel led by MD, NHM, DC/DM along with the SPM and DPM, NHM, representatives from the Directorates and a subject expert is constituted. b) 1:3 ratio is followed for selection of interview candidates for a position. c) A selection committee is also instated at both state and district levels and includes immediate supervisor of the vacant position d) Verification of educational and other testimonials is undertaken e) Selection process includes display of selected candidate's details along with a waitlist on the NHM website and office notice board **f)** An appointment letter is then issued for selected candidate (or to candidate taken from waitlist in absence of the selected candidate) and a contract is provided based on ROP approval and renewed annually based on performance
Specialist Cadre	The central government mandate under the Public Health Management Cadre requires all states to divide the human resources for health in the following four categories: specialist cadre, public health cadre, health management cadre and teaching cadre. At present the Meghalaya Health Service Rules, 1990, in principle provides a segregation of the health staff into two categories, namely, General Duty Stream and Specialist Stream. However, the career progression for both streams remain the same along with their merging at the administrative level i.e., Senior Grade. To address current gaps in the movement of specialists within the state along with creating avenues for incentivizing such positions with the health department, Odisha and Haryana's cases have been studied with one having implemented the specialist cadre policy and logging positive results and the other in the process of implementation with expected positive outcomes.	

Overall Gap Analysis & Recommendations

From the secondary review analysis, the state needs to prioritize streamlining job descriptions, roles and responsibilities among others. Policy reforms for process streamlining are recommended in the following areas:

TABLE 2: OVERVIEW OF GAPS AND SCOPE FOR IMPROVEMENT

Theme	Gap	Scope of Improvement
Rules & Regulations	• A comprehensive HR handbook is not available. • At present the DHS has the Meghalaya Health Service Rules 1990 (which only covers doctors and specialists) and the Meghalaya Nursing Service Rules, 2008. • Neither of the above-mentioned rules or any other document reviewed, provide clarity on crucial rules/policies on transfer & posting, retirement & pension, leave rules, travel allowance, incentives & allowances, House Rent Allowance (HRA), Non-practicing allowance, in-service trainings/ further study etc.	• The state can consider developing a handbook if not available/revisit any available handbook at the DHS or Secretariat level and include all policies pertaining to HRH under one book. Sectionalizing them or redirecting cadres to their respective health service rules for detailed information can be undertaken. • The state can look at other service handbooks such as Handbook for Personnel Officers 2013 developed by Institute of Secretariat Training & Management (Department of Personnel & Training) Ministry of Personnel, Public Grievances and Pensions
Roles & Responsibilities	• There are no job descriptions available for all staff of DHS (MCHFW) except for work distribution. Job descriptions of JDHS (PI), DDHS (PI), ADHS (PI), SM&HO, M&HO, Government Analyst, Sr. Specialist, Specialist, Biochemist, and some administrative staff are vague or undefined. • The job descriptions of staff at DHS (MI) were not made available during the secondary review. • It is clear that the roles and responsibilities of staff members at the administrative sections need to be clarified, especially for DHS (MI).	• Where departments under the three Directorates and NHM have not provided the job descriptions, it is recommended that the state bring forth detailed roles and responsibilities as it is assumed that they are not available. • The state needs to revisit/provide job descriptions of core medical and paramedical staff along with key administrative staff at facilities and all three directorates to ensure better HRH management as well as enhanced health service delivery • Job descriptions should be clearly laid out to ensure guidelines and principles for healthcare personnel to work given the large number of workforce. • By comparing the job descriptions laid out by the private sector hospitals for healthcare delivery staff and NHM administrative staff, the state can develop and revise job descriptions for all core healthcare and administrative staff members
Organization structure	• While the composite organogram placed in the report is a result of information received from various departments and the directorates, clarifications and vetting needs to be done by the state. • Gap in the organogram for Health Engineering Wing was found where the Chief Engineer is instated but not incorporated in the current organogram. • Each of the directorates are formed for unique purposes. Overlaps or convergence, if any, do not come out through the organogram prepared. • The administrative roles and responsibilities of DHS (MCH&FW).	• Defining clear departments and sections across all verticals would help create a clearer picture. • Functional review of the Department of Health & Family Welfare needs to be undertaken which will enable further clarity in the structure and functions of departments. The organograms will be strengthened through the exercise. • Rationalized distribution of work among workforce and removal of archaic as well as redundant positions can be undertaken by the state. • Addition of new and resourceful positions to the advantage of better functioning of the three directorates. • Best practice models will be recommended post Functional review.
Human Resource Management Information System	• The state needs to have a strong HRMIS system to determine the total number of HRH in the state which is a challenge at present. • The state has an E-HRMIS for contractual NHM staff. A separate system covering the regular staff is available but data for the same has not been inputted.	• The state needs to complete the HRH enumeration and store the overall state data including that of regular staff, 3(f) contractual, other contractual staff • The composite HRMIS has to be designed in such a way to help course correction for programs/implementation, monitoring and troubleshooting on time.

	• It points to disjointed efforts for housing all pertinent HRH data. Although Meg EIS is an essential data source, it is only resourceful for aligning information that is stored for payment disbursement purposes.	• While the Delhi HRMIS system is a model the state can consider, further best practices can be explored.
Training	• Trainings are concentrated at the state headquarters and are not planned based on training needs but on mandates for completion of trainings attached to public health programs. • It was also ascertained that the Regional Health & Family Welfare Training Centre's current capacity needs to be built in terms of human resources, infrastructure, budget allocation among others. • Pre-service trainings are also missing in the current training curriculum collated in the report • Outdated training materials and no access to academic journals at the regional training centre was also taken into account during the secondary review along with paucity of budget and comprehensive training plan despite the existence of a training calendar	• The state needs to have a training needs assessment exercise to rationalize trainings and avoid duplication of efforts in training HRH. • Training of trainers to build capacity of trainers at district level needs to undertaken. This will also ensure creating a pool of trainers • A comprehensive training plan in association with assessment of current training calendars provided in the report, needs to be made. The plan should also include a curriculum, course modules and HRH cadre specific trainings with frequencies defined • The state should also explore more avenues with regards to e-learning, especially in the rural-remote areas. Simulation training should also be considered. • Availability of relevant and updated training materials and resources has to be undertaken as well • All the above should be undertaken systematically through a state HRH capacity building framework and a budget plan should also be made in alignment with the same
Recruitment	• The state does not have a comprehensive recruitment policy which governs the frequency of recruitment, spells out the duration for recruitment process, ensures regular recruitment. There are extreme delays in recruitment leading to overburdening the system to recruit HRH under contracts leading to stunting of growth for contractual staff	• Delinking of the current recruitment practice from the Meghalaya Public Service Commission, for instance, can be a step towards further streamlining the recruitment process and bringing for policy reforms which can be based on a rationale similar to that of Tamil Nadu or West Bengal would be more resourceful.
Public Health Management Cadre	• The state does not have a public health management cadre. But more importantly, the state does not have specialist and public health cadres which form a unit of the PHMC mandate released by the central government for states.	• Having specialist and public health cadres should be prioritized by the state. It will ensure better HRH management, retention and functioning of the health cadres. The same can be done through the amendment of the Meghalaya Health Service Rules, 1990 • Best practice models from Odisha, Haryana and Uttar Pradesh can be adopted by the state. These best practices can be found in the report as well.
Transfer Posting	• During secondary review, it was discovered that neither the Meghalaya Health Service Rules, 1990 nor any other service document pertaining to government service employees covers the transfers and postings of health personnel under the Health & Family Welfare Department. In a separate ongoing study for specialist cadre within the state, it was ascertained that the absence of such a policy has led to arbitrary postings for several key HRH staff under the department.	• The state needs to prioritize instating a transfer posting policy which rationalizes postings and transfers, ensures transparency by employing techniques such as computerized counselling among others. This require both policy as well as process development
Rural Retention (incentives, salary and benefits)	• Lack of incentives and performance-based recognition for healthcare staff, especially M&HOs posted in rural areas (and given the task of running PHCs entirely on their own). It was also evident that the rural posting allowance and other allowances were meagre and also happened to be a result of the low salary governed by the 5th pay commission. Acute shortage of HRH in rural areas	• Revision of 5th Pay Commission to 7th Pay Commission in consultation with Finance Department as well as Personnel Department • Introduction of a rural retention plan as part of the larger transfer policy and process • Compulsory rural posting has to be introduced • Place based incentives also need to be introduced as well as benefits for family of staff posted in difficult areas

	• The state has inadequate incentivization of rural posting. There are no guidelines or policy around this. • State doesn't have compulsory rural posting-there have to be proper defined guidelines for incentives for HRH staff and doctors working in rural areas,	• Reward and award schemes for outstanding effort in building capacities of peripheral facilities by in-charge, other staff members • Best practices from Chhattisgarh and Odisha are recommended for the state. The same have been briefly discussed in the report.

As has been illustrated above, several steps toward process and policy reforms are ongoing and many others planned through the current assignment for '**Developing Strategy and Management Framework for Human Resources for Health (HRH) in Meghalaya,**' undertaken by IQVIA for the state will lead to the development of a broad strategy and enable operationalization of key HRH policies. Some of the key activities and their current status are listed below:

- **HRH enumeration of all health facilities and staff across Meghalaya:** An ongoing exercise, HRH enumeration will enable the state to map total HRH, better plan recruitment, monitor transfers, among other HRH management aspects. Under the enumeration, the **human resource satisfaction survey** will also give the state a window into the current satisfaction levels of the employees across nine broad categories which will help shape policies in keeping with the operational barriers faced by HRH.
- **Functional review**, further, will help capture insights from multilevel stakeholders including policy makers to ensure a holistic approach towards development of policies which are well aligned to the situation in Meghalaya's health universe in terms of HRH as well as drive the ongoing aspirations of the state
- **Review of existing training programs, materials, and overall gaps in training process and systems**
- **HRH strategy paper** development for the state to implement for its health workforce

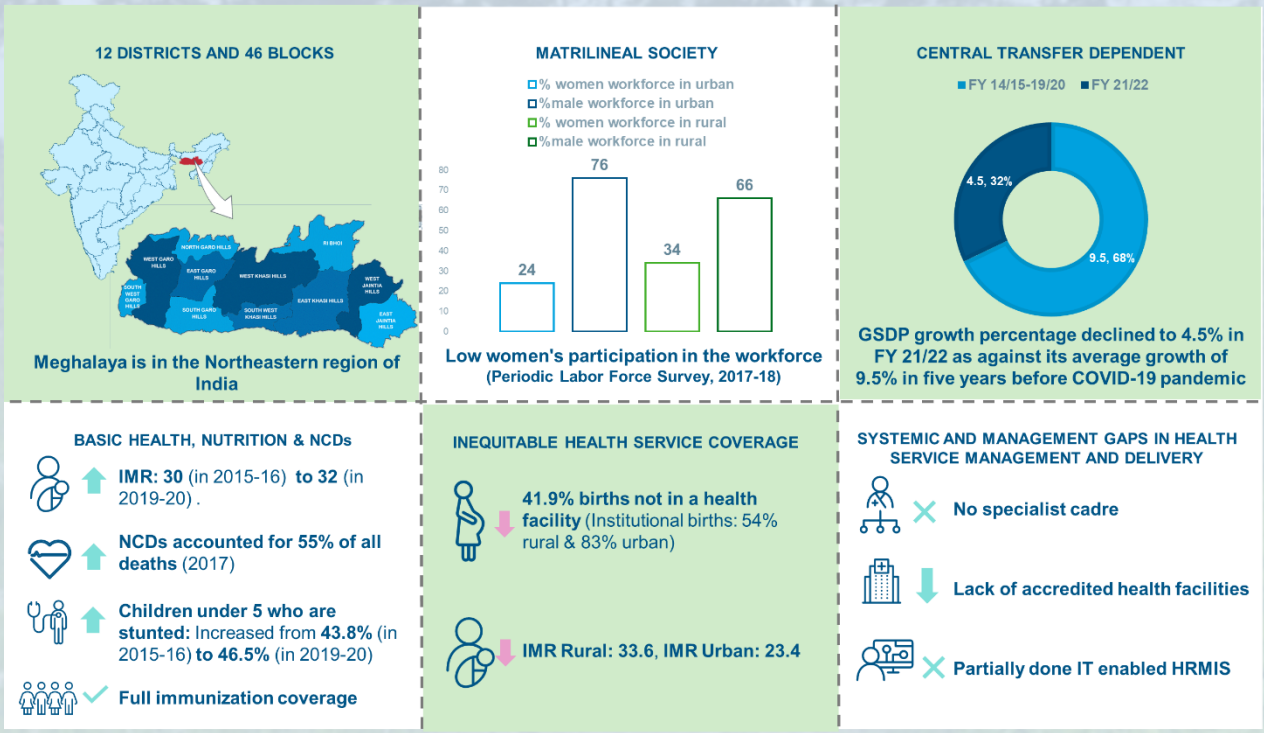
PART ONE: BACKGROUND

Source/Picture Credit: Department of Information & Public Relations, Government of Meghalaya

1. INRODUCTION

Meghalaya, one of the eight states in the North East Region of India, is predominantly rural and with a distinct tribal identity. Carved out of Assam in 1972, the state has a Legislative Assembly and three autonomous Hill Councils. The population is more dependent on government health services than elsewhere in India, although household out-of- pocket spending on health care is still a significant burden on the poor. Before we delve deeper into the human resources for health challenges in the state, it is imperative to understand the geographic and demographic profile along with certain other key facts about the state.

FIG 1: MEGHALAYA STATE SNAPSHOT



1.1. GEOGRAPHIC AND DEMOGRAPHIC PROFILE OF MEGHALAYA

Tucked away in the hills of eastern sub-Himalayas, Meghalaya (literal meaning: Abode of clouds) extends for about 300 kilometers in length and about 100 kilometers in breadth. Meghalaya became an Autonomous State on April 02, 1970, and a full-fledged State on January 21, 1972, which marked the beginning of a new era of the geo-political history of Northeastern India. Carved from the erstwhile State of Assam, Meghalaya became a full-fledged State on January 21, 1972. Bounded on the North and East by Assam and on the South and West by Bangladesh, Meghalaya is spread over an area of 22,429 Sq.Km. According to the 2011 census, Meghalaya has a population of 29,66,889 of which 1,475,057 are females and 1.491,832 are males. Divided into 12 districts (Table 2 below), the hills of Meghalaya are broadly divided under Khasi, Jaintia and Garo Hills.

As per the State of Forest Report, 2017 published by Forest survey of India, the Forest Cover of the State is 17,146 sq km (76.44 % of Geographical area) and Tree cover is 657 sq km (2.92% of Geographical area), which includes reserved Forest, protected forest, national park and unclassed forest. Six National Highways, namely NH 40, NH 40-E, NH 44, NH 44-E, NH 51, NH 62, NH127B pass through the State of

Meghalaya including Shillong and Jowai Bypass which covers a distance of 1124.92 Kilometers. The road density is 48.56 Sq.km.

TABLE 3: DISTRICTS OF MEGHALAYA (OFFICIAL WEBSITE, GoM)

Sl. No.	District	Headquarter
1	East Khasi Hills	Shillong
2	West Khasi Hills	Nongstoin
3	South West Khasi Hills	Mawkyrwat
4	Ri Bhoi	Nongpoh
5	West Jaintia Hills	Jowai
6	East Jaintia Hills	Khliehriat
7	East Garo Hills	Williamnagar
8	West Garo Hills	Tura
9	North Garo Hills	Resubelpara
10	South West Garo Hills	Ampati
11	South Garo Hills	Baghmara
12	Eastern West Khasi Hills	Mairang

TABLE 4: MEGHALAYA STATE OVERVIEW*

Total Population	29,66,889
No. of Districts	12
Sex Ratio	986
Population Density (per sq. km.)	132
Area	22,429 Sq. Km
Languages	Khasi, Pnar, Garo & English
Literacy rate	74.43%
Districts	12
Blocks**	46

*Census 2011

**Community & Rural Department. GoM

Like education, the foundation for health care system was laid by the Christian Missionaries as far back as the 19th century. The health services coverage in the State is much below the national average owing to the hilly terrain with its inadequate road network. To reduce Infant and Maternal Mortality (IMR), several family welfare programmes have been taken up under Central Government Sponsorship. There are at present 14 Government Hospitals, 27 Community Health Centres, 112 Primary Health Centres besides 450 Sub-Centres.[2]

1.2 HEALTH STATUS IN MEGHALAYA

Among the smaller states, Meghalaya is one of the leading states with almost all intermediate health outcomes indicators (25.3 percentage points) in the “Most Improved” category in terms of incremental change from base year (2018-19) to reference year (2019-20) as per the National Institution for Transforming India (NITI) Aayog’s Health Index Report 2019-20 Round IV. It appears that this distinction was achieved by Meghalaya through regular programme reviews, better governance, capacity building, use of Information Technology, creating awareness, line listing of beneficiaries and intensive follow ups.

Meghalaya recorded the highest progress from Base Year (2018-19) to the Reference Year (2019-20). Meghalaya also achieved 100.0 percent immunization coverage in 2019-20. Also, the highest increase in institutional deliveries was observed in Meghalaya (22.1 percent). The largest increase in Key Inputs and Processes domain from Base Year (2018-19) to Reference Year (2019-20) was observed by Meghalaya (10.40). [3]

[2] Statistics, Department of Health & Family Welfare, Government of Meghalaya

[3] Health Index Round IV- 2019-20 Healthy States Progressive India - Report on the Ranks of States and Union Territories, by NITI Aayog, WB & MoHFW. available at https://www.niti.gov.in/documents/reports

On the other hand, NFHS 5 (2019-20) data of the state reveals that urban rural disparity among several key health outcome indicators is evident. While comparing the outcomes between NFHS 4 and NFHS 5, it is seen that there have been minimal improvements in certain areas and though in comparison to national averages, the state fares better in terms of infant and child mortality rates, it is somewhat behind for other indicators. (Table 4 below)

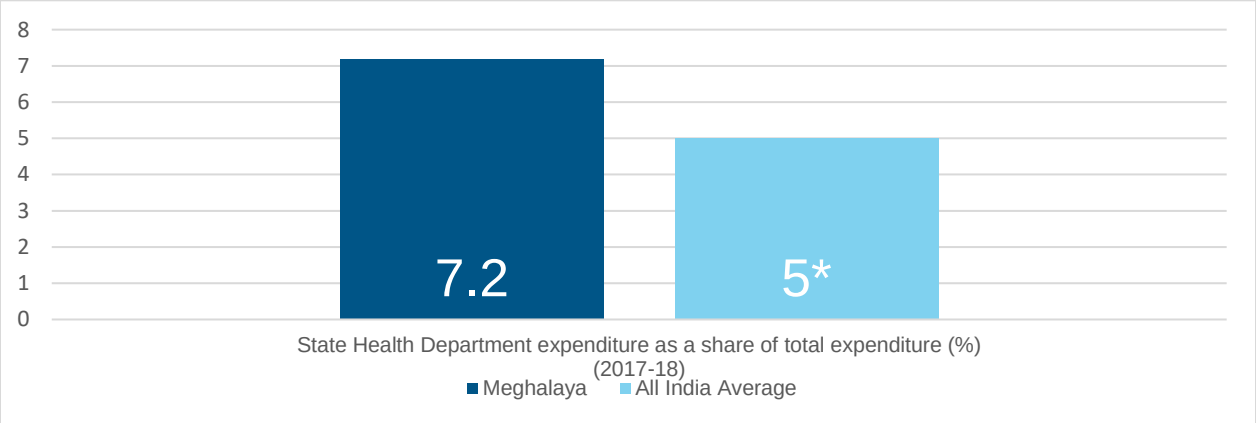
TABLE 5: COMPARING KEY HEALTH INDICATORS OF MEGHALAYA AND INDIA IN NFHS-4 AND NFHS-5

SL. NO.	INDICATORS	MEGHALAYA NFHS 5 (2019-20)			MEGHALAYA NFHS 4 (2015-16)	INDIA NFHS 5
		Urban	Rural	Total	Total	Total
Infant and Child Mortality Rates (per 1,000 live births)						
1	Neonatal mortality rate (NNMR)	14.2	20.6	19.8	18.3	24.9
2	Infant mortality rate (IMR)	23.4	33.6	**32.3**	**29.9**	35.2
3	Under-five mortality rate (U5MR)	23.4	42.6	40	39.6	41.9
Child Feeding Practices and Nutritional Status of Children						
4	Children under 5 years who are stunted (height-for-age) (%)	35.1	**48.2**	**46.5**	**43.8**	35.5
5	Children under 5 years who are wasted (weight-for-height) (%)	13	12	**12.1**	**15.3**	19.3
Child Vaccinations and Vitamin A Supplementation						
6	Children aged 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) as per vaccination card %	76	**80.5**	**80**	**81.3**	76.4
Maternal and Child Health						
7	Mothers who had at least 4 antenatal care visits (%)	67.5	49.6	**52.2**	**50**	58.1
Marriage and Fertility						
8	Total fertility rate (children per woman)	1.6	3.3	2.9	3	2

Budget allocation[4]:

The state budget for health in FY19/20 was US$155 million (INR 1,142 crores), or 7.4 percent of total public expenditure, which is significantly higher than the national average of 3.9 percent. Per capita government expenditure on health in FY15/16 was US$34 (INR 2,223) in Meghalaya, less than half compared to other small states in the North East region but double the national average of US$17 (INR 1,112). This is reflected by greater reliance on government health services than is evident elsewhere in India. In 2015–16, about 60 percent of institutional deliveries were in government facilities (compared to half nationally),[5] while in 2017–18, 85 percent of those who were hospitalized received care in a government hospital (compared to 42 percent nationally). In Meghalaya, in 2017, the average out-of-pocket expenditure (OOPE) incurred by patients for a hospitalization was US$35 (INR 2,385) at a public hospital and US$408 (INR 27,375) at a private hospital.[6] Also, there exist rural-urban differences, with OOPE in rural areas at INR 3,190 and INR 3,353 in urban public health facilities.

FIG 2: MEGHALAYA HEALTH BUDGET EXPENDITURE 2017-18 IN COMPARISON TO ALL INDIA AVERAGE (MEGHALAYA HEALTH DOSSIER 2021 BY NHSRC)



*Represents data for all states and 2 UTs with legislative assembly (Puducherry + Delhi)

Meghalaya State Health Policy 2021

Meghalaya has brought out a State Health Policy aligned with the National Health Bill 2009, National Health Policy 2017 and the National Public Health Act, 2018 (draft) which have provisions unique to the State's context. The policy follows a three-dimensional model with equal focus on preventive, curative and enabling dimensions of care. Aspects of the three dimensions within the State Health Policy 2021 are listed below:

[4] Meghalaya Project Appraisal Document 2020

[5] International Institute for Population Sciences (IIPS) and ICF. 2017. *National Family Health Survey (NFHS-4), 2015–16: India*.

[6] IIPS and ICF. 2017. *National Family Health Survey (NFHS-4), 2015–16: India*. http://rchiips.org/NFHS/factsheet_NFHS-4.shtml; Government of India (GoI). 2019. *Key Indicators of Social Consumption in India: Health - NSS 75th Round (July 2017–June 2018)*. Ministry of Statistics & Programme Implementation. National Statistical Office.

TABLE 6: MEGHALAYA STATE HEALTH POLICY DIMENSIONS

DIMENSION	ACTIVITIES
Preventive Care	• Focus on public health • Human resource development, capacity building, filling of all vacancies in health department • Strengthening role of communities • Mental health • Inter-departmental convergence • PPP models • Focus on nutrition and encouraging agro-ecological farming • Focus on physical fitness • Ensuring workplace safety
Curative Care	• IPHS driven quality healthcare services • Focus on CHCs as FRUs and availability of trauma centres • Focus on OOPE (invisible costs after exhaustion of MHIS caps) • Health seeking behavior • Lifecycle approach to address healthcare challenges starting from neonatal care to elderly care • Training of doctors on public health and all critical specialties
Enabling Dimension	• Maternal and Child health Protection Policy (clinical management, public health dimension, socio-economic dimension) • Awareness and capability building • Meghalaya Community Participation and Public Services Social Audit Act, 2017 • Early Childhood Development (ECD) Mission • Palliative and Rehabilitative Care

1.3 PURPOSE OF SECONDARY REVIEW

Under the Meghalaya Health Systems Strengthening Project, the Human Resources for Health (HRH) component is crucial to the state in terms of bringing forth impactful policy advocacy initiatives. IQVIA is engaging in various activities with the vision to develop a robust strategy and management framework for the department of Health and Family Welfare (DoHFW) by the end of the assignment in 2025. Key to the kickstarting of this assignment was to develop an understanding of the health universe within the DoHFW. This would require a close look into the available documents pertaining to key HRH policies, office memorandums, understanding the genesis of the Directorates of Health Services, mapping the roles and responsibilities of all persons within the department.

A) Rationale and Objectives

To conduct such an exercise in a swift manner, it was imperative for IQVIA to develop comprehensive checklists to conduct secondary review. The rationale & objectives of conducting the secondary desk review were to:

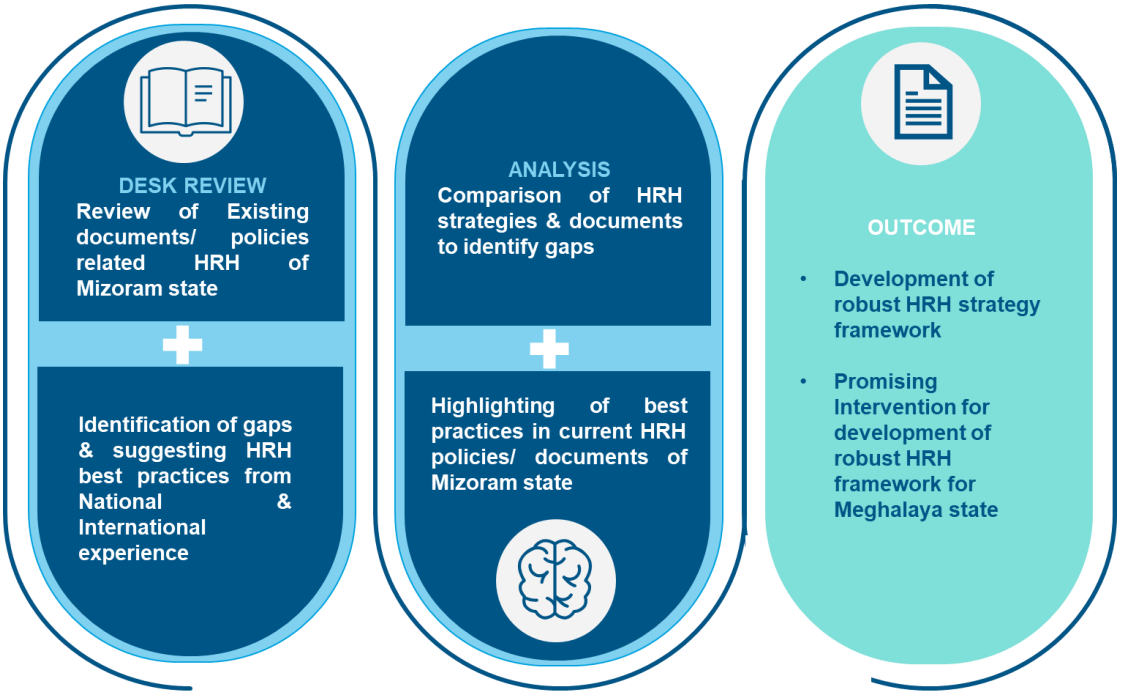
- Gain contextual information about government's rules and regulations, transfer & posting and promotion policy, and allowance and incentive scheme related to health workforce.
- Review current job title, description and responsibilities and staffing of DHS.

- Review capacity building at state training institute and understand whether state training institute is functioning for imparting training.
- Identify gaps in policies, documents & infrastructure to be addressed in the strategy document.
- Identify some of the best practices on HRH globally & nationally to recommend the state based on gaps identified.

B) Approach and Methodology

Approach for secondary desk review was based on development of checklists with close ended enquiry questions to get snapshot of the existing HRH Policies/ guidelines/ GOs, availability of training & education

FIG. 3: SECONDARY DESK REVIEW PROCESS



infrastructure with State, review of organization structure in various directorates, current set-up of State HRMIS structure.

Following checklists were developed by IQVIA: -

1. Organization Structure, Job Descriptions & Committees **(Annexure – 8)**
2. HRH Policies/ Guidelines/ GOs **(Annexure – 9)**
3. Training & Education **(Annexure – 10)**
4. Human Resource/Personnel Management Information System **(Annexure – 11)**

With the information made available by various departments, and through online sources (a mix of 24 documents, online and other sources) IQVIA tried to understand the organogram, staffing pattern, job descriptions & role and responsibilities of each cadre under Health & Family Welfare Department, Government of Meghalaya (staffing & responsibilities of staff at National Health Mission, Directorate of Health Services, Ayurveda, Yoga, Naturopathy, Unani, Siddha, Homoeopathy section, Meghalaya State Aids Control Society, Meghalaya State Health Society) along with information on current job titles and the job descriptions.

Further, IQVIA attempted to gain contextual information about Government of Meghalaya's (GoM) rules, regulations, and documents on transfer/posting and promotion policy, allowance, incentive schemes & review of polices for in-service training for health workforce under Directorate of Health Services (MI). The

findings from desk review have been analyzed to yield a comparison of HRH strategies to identify gaps and to highlight best practices in current HRH policies which can be adapted in Meghalaya and lead to development of robust HRH strategy framework for the state.

TABLE 7: LIST OF REFERENCE DOCUMENTS, WEBSITES & OTHER SOURCES FOR SECONDARY REVIEW

REFERENCE DOCUMENT	REFERENCE WEBSITE	REFERENCE SOURCE
• E.E. Office Structure Date of Issue: NA • Organizational Chart of Directorate of Health Services (MCH&FW) Meghalaya, Shillong Date of Issue: NA • Roles and Responsibilities of Faculty Members Date of issue: NA • Directorate of Health Services, (Research, Etc) Pasteur Institute Shillong, Meghalaya Date of Issue: NA • Directorate of Health Services, (Research, Etc) Pasteur Institute Shillong, Meghalaya Date of Issue: NA • Meghalaya Health Service Rules, 1990 (Annexure 13) Issue Date: Dec 05, 1990 • DHS (MCH&FW) Designation and Work Distribution Date of Issue: NA • Annexure B of document submitted BY DHS (R) with checklist Date of Issue: NA • Annexure C of document submitted BY DHS (R) with checklist Date of Issue: NA • EIS Employee List Health Department Date of Issue: 30 June 2022	• DoHFW website Webpage last updated on: Feb 24, 2021 • DoHFW website Organization chart as on: Feb 29, 2008 • Meghalaya SACS website Webpage last updated on: NA • SCSM Website Webpage last updated on: March 23, 2022 • MHIS Website Webpage last updated on: NA • Official Web Portal, GoM The Meghalaya Medical Council Act 1987 (passed by Meghalaya Legislative Assembly) Date of Issue: 3rd December, 1994 • Meghalaya Nursing Council official website Webpage last updated on: NA • Meghalaya Nursing Council Rules 2021 Date of issue: 9th March 2021 • State Pharmacy Council Meghalaya Webpage last updated on: NA • NHM Meghalaya website Webpage last updated on: September 4, 2020 • The Official web portal GoM Selected list of candidates for MBBS, BDS, BASLP 2020-21 Date of Issue: 6th December 2020 • Meghalaya Administrative Training Institute Meghalaya Fundamental Rules and Subsidiary Rules Date of Issue: 14th February 1984 • Printing and Stationery Department, GOM Gazette of Meghalaya Last Updated on: July 13, 2022	• Meghalaya State Health Policy 2021 Date of Issue: 9th March 2021

PART TWO: ASSESSING HUMAN RESOURCES FOR HEALTH (HRH) IN GLOBAL AND INDIAN CONTEXT

Source/Picture Credit: IQVIA (recreated from stock images)

2. HUMAN RESOURCES FOR HEALTH (HRH)-GLOBAL AND NATIONAL OVERVIEW

Health systems are complex and continually changing across a variety of contexts and health service levels. The capacities needed by health managers and leaders to respond to current and emerging issues are not yet well understood. There are several health workforce-related global and national level studies conducted by renowned healthcare bodies, organizations, independent public health researchers and institutions at both the international and national levels. To better elucidate the global and Indian context related to HRH, it is imperative to look at such landmark publications which provide insight into the status of healthcare human resource while simultaneously present a holistic picture. Additionally, these studies also act as guides for countries and help drive the formulation of government policies both at national and state levels.

2.1. SCENARIO AT GLOBAL LEVEL

Global strategy on Human Resources for Health: Workforce 2030 published by the World Health Organization in 2016 aims to improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate investments to strengthen health systems, and the implementation of effective policies at national, regional and global levels. Its objectives have been laid out below (Fig. 4):

FIG. 4: GLOBAL STRATEGY OBJECTIVES FOR HUMAN RESOURCES FOR HEALTH

Projections developed by WHO and the World Bank point to the need for creation of approximately 40 million new health and social care jobs globally to 2030 (14) and to the need for 18 million additional health workers, primarily in low-resource settings, to attain high and effective coverage of the broad range of health services necessary to ensure healthy lives for all.

In addition, the WHO World Health Statistics Report 2021 states that the pandemic poses critical challenges to the health systems in low-resource settings and is jeopardizing the hard-won health and development gains towards achieving the WHO Triple Billion targets and UN Sustainable Development Goals (SDGs). The second round of the WHO “pulse survey” of 135 countries and territories (April 2021) highlights persistent disruptions to health services at considerable scale over one year into the COVID-19 pandemic, with around 90% of countries reporting one or more disruptions to essential health services. Notably, health workforce-related reasons, including reassignment within the health system, remain the most common causes of service disruption, affecting two thirds of the surveyed countries.

The inequitable distribution of the health workforce – in terms of age, gender, place of employment – hinders national capacities to achieve UHC. The maldistribution of health workforces is central to the existing inequalities in health service coverage and burden of disease for populations in need. Striking variations in health worker availability are demonstrated by recent National Health Workforce Accounts (NHWA) (19). The inequity in distribution of health workers observed globally and regionally also exists within individual countries. Fifty-eight countries have reported subnational nursing personnel distribution data for the most recent years.[7]

Globally, 20–40% of all health spending is wasted[8] with health workforce inefficiencies and weaknesses in governance and oversight responsible for a significant proportion of that. The 'Global Strategy on Human Resources for Health: Workforce 2030' also states the need to modify and correct the configuration and supply of specialists and generalists, advanced practitioners, the nursing and midwifery workforce, and other mid-level and community-based cadres. While urbanization trends and the potential of telemedicine may, in some contexts, reduce the acute challenge of geographical maldistribution, in most of the settings access to health workers remains inequitable.

The 'decent employment' agenda entails strategies to improve both performance and equitable distribution of health workers. The WHO recommendations focus on strategies to increase the availability of health workers in remote and rural areas through improved attraction, recruitment and retention. Critical to ensuring equitable deployment of health workers are the selection of trainees from, and delivery of training in, rural and underserved areas, financial and non-financial incentives, and regulatory measures or service delivery reorganization. Also, the WHO recognizes that knowledge, skills and motivation among the workforce is critical for achieving universal health coverage (UHC) (WHO, 2020).

2.2 INDIA SITUATION ANALYSIS

Moving closer to home, India has a severe shortage of human resources for health – a shortage of qualified health workers, and the workforce is concentrated in urban areas. Bringing qualified health workers to rural, remote, and underserved areas is very challenging. Many Indians, especially those living in rural areas, receive care from unqualified providers. The migration of qualified allopathic doctors and nurses is substantial and further strains the system. Nurses do not have much authority or say within the health system, and the resources to train them are still inadequate.[9]

India continues to face challenges on the availability of health professionals. Its ratio of 0.96 doctors and 0.9 nurses per 1,000 population (Zopdey et al., 2019) is lower than the WHO-estimated global average of 1 doctor (Deo, 2016) and 3 nurses (WHO, 2018) per 1,000 population. This shortage of health professionals is coupled with the fact that capacity building needs to pick up pace to meet even the existent health needs of the Indian population.

For effective monitoring and strengthening of national health systems, identification of a set of HRH benchmarks and indicators is most crucial (WHO, 2008). Thus, there is a need for clear and updated staffing norms to link the HRH planning exercise to implementation and ensure equity in HRH distribution (Department of Health—South Africa, 2015).

[7] Who World Health Statistics 2021

[8] The World Health Report 2010 – Health Systems Financing: The Path To Universal Health Coverage. Geneva: World Health Organization; 2010 (Http://Www.Who.Int/Whr/2010/En/, Accessed 15 February 2015).

[9] Human Resources For Health In India Rao, Mohan Et Al. The Lancet, Volume 377, Issue 9765, 587 - 598

It is also necessary to understand the HRH situation in India through rural-urban distribution of healthcare workforce. In India, the rural population constitutes approximately 71% of the total population (2016), whereas only 36% of all health workers are in rural areas (Karan et al., 2019). People living in rural areas have lower access to health care compared to those who live in urban areas. If we analyse this from the health infrastructure perspective, among the 25,778 government hospitals in India (2019), 83% are in rural areas; however, these rural hospitals only hold 37% of the total government beds (Central Bureau of Health Intelligence, 2019).

Halving the current levels of disparity in health worker distribution between urban and rural areas would reduce disparity/inequity and would also contribute to reduction in out-of-pocket expenditure of poor, who spend most of it to travel to health facilities located in urban areas. [10]

A) NHM in India

Contrarily, the Indian health system witnessed rapid reforms after the launch of the National Health Mission (NHM erstwhile National Rural Health Mission [NRHM]). For instance, with the launch of the National Rural Health Mission in 2005, a serious effort to increase availability of community health workers was undertaken in the scheme for accredited social health activists. Local women (aged 25–45 years), married or widowed, with at least eight years of formal education were recruited and trained to serve the community.

NHM, India's flagship public health program, provides financial assistance to states, which includes assistance to recruit and retain staff for the delivery of health services. There is a provision to recruit contractual health professionals to supplement the work undertaken by the health department. These initiatives can provide efficient returns if they are part of a holistic HRH vision of the states. These contractual staff are deployed to overcome distributional imbalances and overcome skill mix gaps.

B) National Health Policy 2017

The primary aim of the National Health Policy 2017, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance.

The proposal of setting up a public health management cadre and the focus on strengthening of district hospitals for meeting the shortage of medical specialists are some Human Resources for Health (HRH) initiatives outlined in the National Health Policy 2017 to overcome the paucity of trained public health specialists and clinical specialists which are demonstrating progress.

The 2017 policy also states that there is a need to align decisions regarding judicious growth of professional and technical educational institutions in the health sector, better financing of professional and technical education, defining professional boundaries and skill sets, reshaping the pedagogy of professional and technical education, revisiting entry policies into educational institutions, ensuring quality of education and regulating the system to generate the right mix of skills at the right place. This policy recommends that medical and para-medical education be integrated with the service delivery system, so that the students learn in the real environment and not just in the confines of the medical school. The key principle around the policy on human resources for health is that workforce performance of the system would be best when

[10] Zodpey, Sanjay & Negandhi, Himanshu & Tiwari, Ritika. (2021). Human Resources For Health In India: Strategic Options For Transforming Health Systems Towards Improving Health Service Delivery And Public Health. Journal Of Health Management. 31-46.

we have the most appropriate person, in terms of both skills and motivation, for the right job in the right place, working within the right professional and incentive environment.

C) Current Scenario

Healthcare workforce to population ratio is one of the most important normative population-based indicators to measure the balance between demand for and supply of Human Resource for Health (HRH). Various Healthcare workforce ratios are mentioned in Table 7 below:

TABLE 8: HEALTH WORKFORCE DENSITY OF HEALTH WORKERS PER 10,000 POPULATION IN INDIA

HEALTHCARE WORKFORCE	WHO RECOMMENDED[11,12,13]	INDIA 2019[14]
Doctor	10	9.3
Dentist	1.3	2
Staff Nurse	30	24
Pharmacist	5	8.8

India is committed to achieving the Sustainable Development Goals (SDGs) and it is globally acknowledged that the success of the 2030 agenda is largely dependent on India. In that context, NITI Aayog Health Index Reports aim at encouraging healthy competition among states on their performance related to health outcomes, governance, and information as well as key inputs and processes.

As per the NITI Aayog Report 2019-2020 Round IV, five percent of the Larger States and 12 percent of Smaller States and none of the UTs performed best in Key Inputs and Processes domain (which includes indicators on shortfall of health care providers (regular + contractual) against required number of health care providers in public health facilities as well as on proportion of healthcare staff covered under an IT enabled HRMIS) compared to any other domain. To elaborate, vast majority of Larger States (15 of the 19), improved their performance in the Key Inputs and Processes, about half of the Larger States did not have any shortfall in positions of ANMs at SCs or that of MOs at PHCs, both in the Base Year (2018-19) and Reference Year (2019-20). All Larger States had shortage of required Specialists at the district hospitals. While, when we look at the smaller states, the report says that 50 percent of the Smaller States demonstrated better performance in Governance and Information domain as compared to the Key Inputs and Processes domain.

D) Snapshot of Human Resources for Health Challenges Overcome in Indian States

In many states, an important first step has been taken in identifying accredited social health activists (ASHA), and training and supporting them to provide basic health care and ease cooperation with the public health system by acting as a point of reference for people's health queries. These female health workers

[11] https://Www.Ncbi.Nlm.Nih.Gov/Pmc/Articles/Pmc6259525/

[12] https://Www.Ncbi.Nlm.Nih.Gov/Pmc/Articles/Pmc4385734/

[13] https://Www.Iomcworld.Org/Articles/Pharmacy-Teaching-And-Practices-Problems-In-Developing-Countries-Review.Pdf

[14] Https://Www.Who.Int/Data/Gho/Data/Themes/Topics/Indicator-Groups/Indicator-Group-Details/Gho/Sdg-Target-3.C-Health-Workforce

receive no pay but do receive incentivizes. Some states have recruited traditional birth attendants to be trained as accredited social health activists.

Several states in India have experimented with strategies to recruit and retain health workers in underserved areas. States such as **Tamil Nadu** have also made substantial efforts to augment human resources in health (Human Resources for Health in India). Part of their efforts was the establishment of the country's first ever health recruitment board in 2012. **Chhattisgarh** and **Assam** have created a new class of allopathic clinicians (with 3·5 years of medical training) to work in rural areas only. Physicians who are trained in Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy collectively termed as AYUSH, now work at primary health centres. The government is also considering a cadre of non-physician clinicians who will have a Bachelor of Rural Health Care degree to provide health care at rural sub centres. Other states have engaged in public–private partnerships to improve the availability of general and specialist health services in the public sector. The formation of a separate cadre of clinicians and public health experts in **Odisha** is also a replicable model for states like Meghalaya given similar HRH challenges.

Many states are now training general physicians to provide emergency obstetric services (e.g., caesarean sections) or to give anesthesia for emergency obstetric care. Close attention needs to be given to these efforts, which are local solutions to a national problem and are the templates for future strategies to bring qualified health workers and their services to the Indian population.

A LANCET REPORT PUBLISHED IN 2011 OBSERVES:

- **Higher salary for rural posting: Most states** in India offer a higher **salary** for public sector MOs in rural/remote areas, though the amount of the incentive varies between states.
- **Compulsory rural service bonds**: Introduced by some states, e.g., **Tamil Nadu, Assam** and **Kerala** for specialist doctors, **Meghalaya** for general doctors and **Assam** for graduated MBBS doctors in exchange for subsidized government-provided **medical education**. Other states have mandatory rural service for doctors aspiring for PG specialization. Some others such as Tamil Nadu, **Gujarat**, and **Andhra Pradesh**, reserve PG seats for or give preference to those who have completed a specific number of years of rural service.
- **Recruitment: Haryana** has adopted decentralized **recruitment process** with incentive packages as a way of filling MOs and specialists vacancies. **West Bengal** has also introduced location-specific recruitment of candidates from underserviced areas who undergo 18-month training course for nurse midwives after which they are posted in their respective local facilities.
- **Vacancies:** In **Chhattisgarh**, **Assam**, and **West Bengal**, a 3-year course for the provision of a rural medical practitioner with adequate skills for primary health care has been introduced and it has helped **fill** most **vacancies** in the public sector. In most Indian states, AYUSH physicians are **recruited** to PHCs, where they often serve as MOs. In Rajasthan, nurse practitioners are being used for primary health care in select areas.
- **PPP: Temporary employment** (from private hospitals) of physicians (and other staff) to fill vacancies is common. In **Karnataka** and **Arunachal Pradesh**, select PHCs have been contracted out to NGOs. In **Gujarat**, the government pays Gynecologists in private practice to increase institutional deliveries among individuals who are poor.

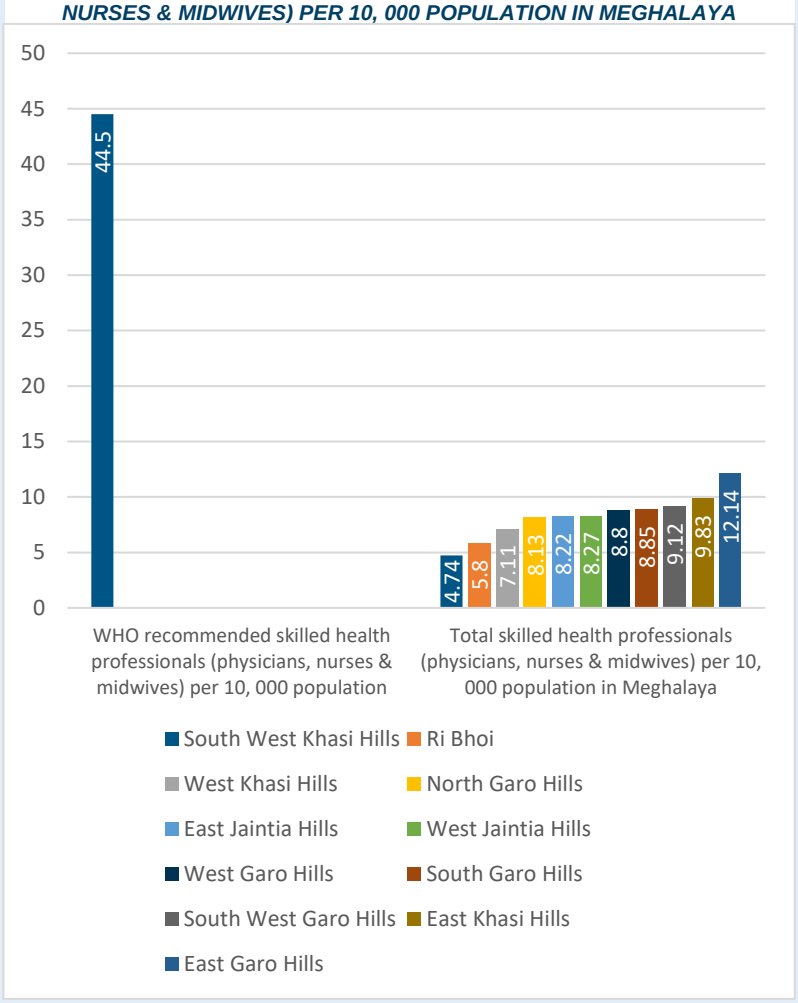
PART THREE: HRH SCENARIO IN MEGHALAYA

Source/Picture Credit: IQVIA

3. MEGHALAYA HRH DISTRIBUTION AND SITUATION ANALYSIS

Healthcare workforce to population ratio is one of the most important normative population-based indicators to measure the balance between demand for and supply of Human Resource for Health (HRH). The appropriate Healthcare workforce density implies that healthcare organizations have sufficient HRH staff to treat the patients with high quality medical services, and simultaneously, it ensures that healthcare workforce are not overloaded and have possibility to enjoy the balance between work and family life and opportunities to engage in further studies, trainings and capacity building.

FIG. 5: TOTAL SKILLED HEALTH PROFESSIONALS (PHYSICIANS, NURSES & MIDWIVES) PER 10, 000 POPULATION IN MEGHALAYA

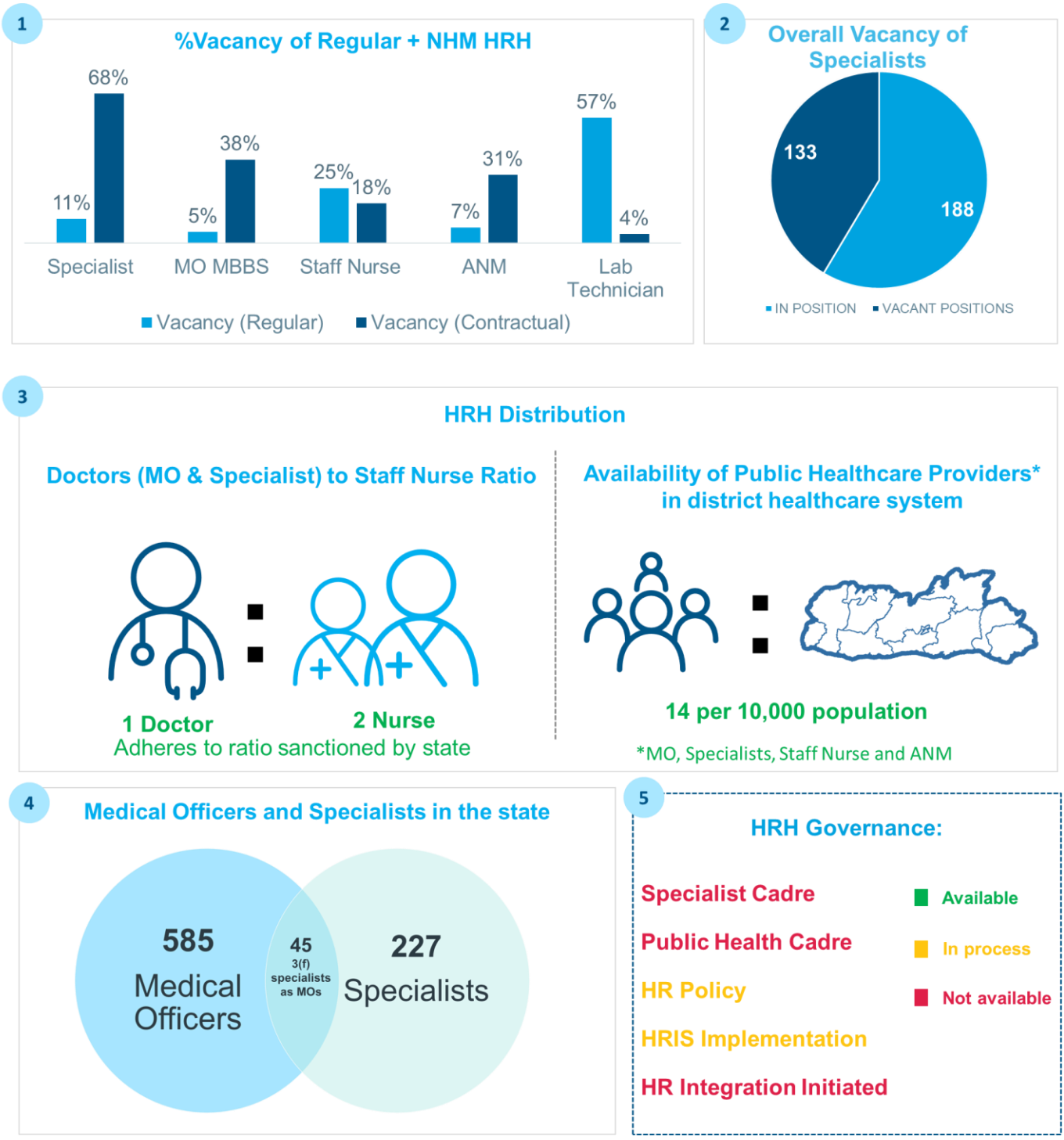


The WHO lays out a threshold of skilled health professionals' density (physicians/nurses/midwives per 10,000 population) of 44.5 per 10,000 population. In that context, the adjacent figure (Fig. 5) shows district wise information of skilled health professionals per 10,000 population.[15]

Although none of the districts in Meghalaya achieve the WHO benchmark, East Garo Hills comes to the forefront with 12 skilled health professionals per 10,000 population and South West Khasi Hills with the least number of skilled health professionals (4.74) per 10,000 population. Availability of HRH as per global guidelines and national guidelines such as the IPHS standards is only possible to an extent. A state's needs would often not be merely based on such standards but also other factors; one such key aspect being difficult terrain. Given the current geographical challenges, availability and accessibility of healthcare is affected from service delivery perspective in the context of availability of HRH in the difficult areas. Several reports of the NHSRC between 2017-18, 2018-19, and 2021 along with the most recent data collated by the state come together to provide the HRH scenario in Meghalaya below (Fig. 6):

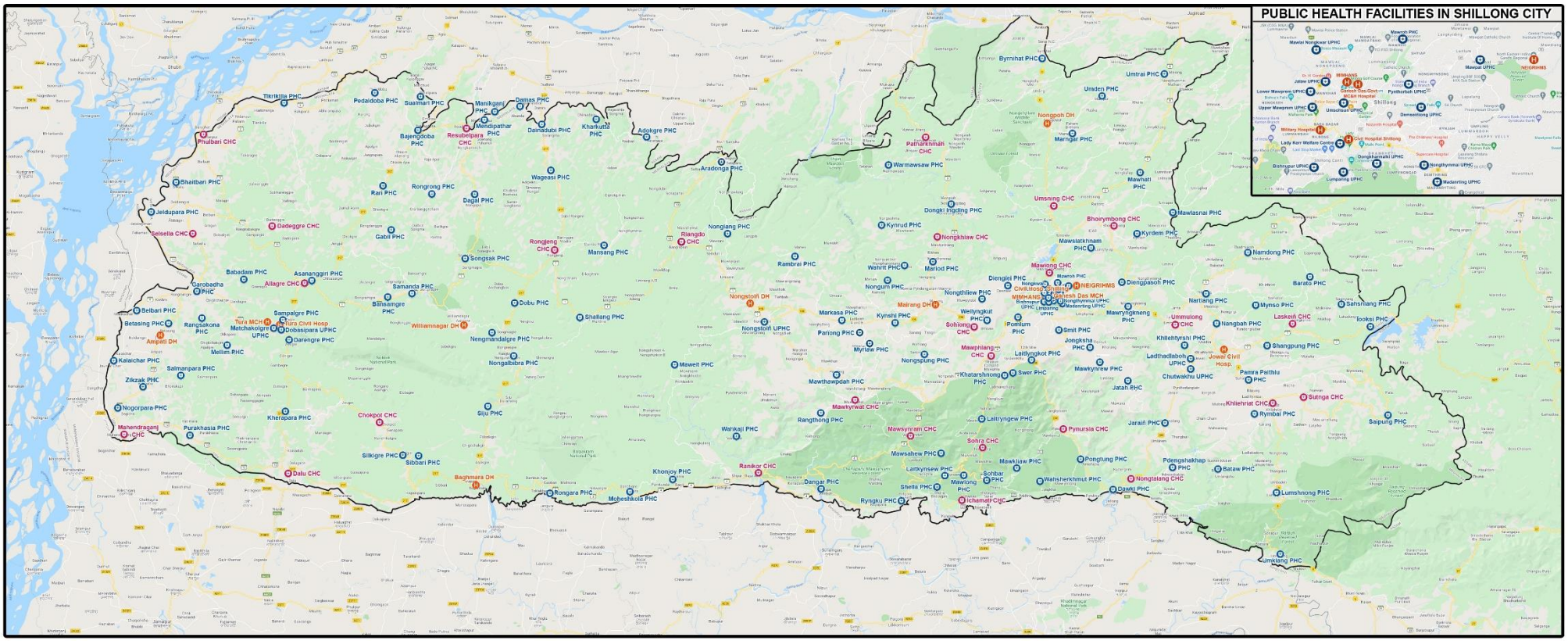
[15] North Eastern Region District SDG Index Report & Dashboard 2021-22

FIG 6: HRH SITUATION IN MEGHALAYA[16]



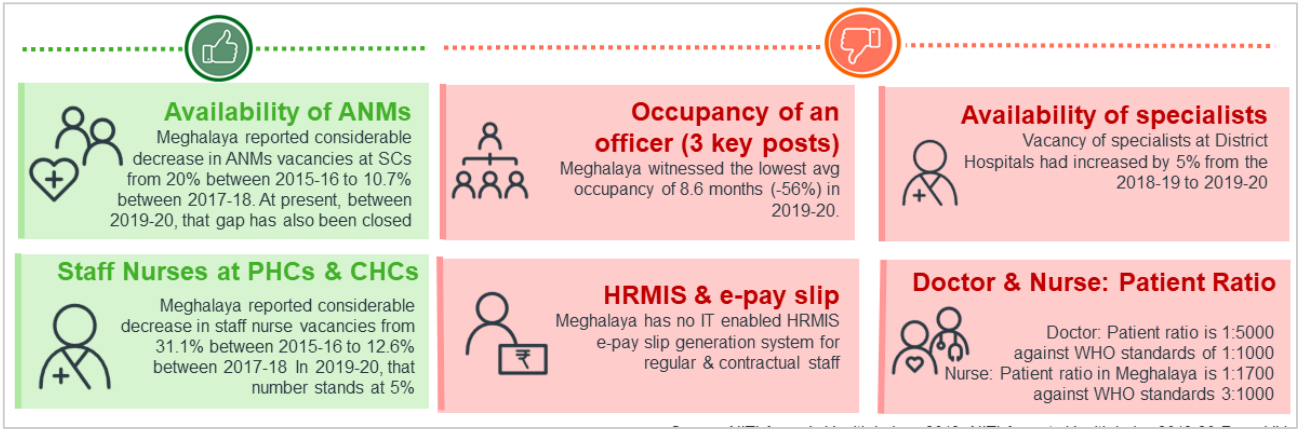
[16] 1, 3, 5, Meghalaya Health Dossier 2021 by NHSRC | 2 & 4 Data Collated by State

FIG. 7: PUBLIC HEALTH FACILITIES (DH, CHC, PHC) ACROSS MEGHALAYA (GOM)



As per NITI Aayog's Health Index Report 2019-20 Round IV, among the smaller states, Meghalaya is one of the leading states with almost all intermediate health outcomes indicators (25.3 percentage points) in the Most Improved category in terms of incremental change from Base Year (2018-19) to Reference Year (2019-20). It appears that this distinction was achieved by Meghalaya through regular programme reviews, better governance, capacity building, use of IT, creating awareness, line listing of beneficiaries and intensive follow ups. The state has also achieved 100.0 percent immunization coverage in 2019-20. Also, the highest increase in institutional deliveries was observed in Meghalaya (22.1 percent).

FIG. 8: HRH SITUATION IN MEGHALAYA (NITI AAYOG HEALTH INDEX 2019, NITI AAYOG HEALTH INDEX 2019-20 ROUND



The largest increase in Key Inputs and Processes domain from Base Year (2018-19) to Reference Year (2019-20) was observed by Meghalaya and Mizoram (10.40 and 10.32 points respectively) among Smaller States. The NITI Aayog's Health Index Report 2019 records Meghalaya's considerable positive decrease in Auxiliary Nurse Midwives' (ANMs') vacancies at SCs from 20% between 2015-16 to 10.7% between 2017-18. More importantly, between 2019-20, the NITI Aayog 2019-20 Round IV report shows that the remaining gap was also closed. Secondly, the state also reported decrease in staff nurse vacancies from 31.1% between 2015-16 to 12.6% between 2017-18 which further decreased to 5% in 2019-20. Finally, Meghalaya is one of the states in India which has achieved the target of one Community Health Centre (CHC) per 100,000 population. On the other hand, the report says that the state is notably facing a shortage of medical specialists at District Hospitals (5 percent increase in vacancies from 2018-19 to 2019-20)[5] and graduate medical doctors.

TABLE 9: SEATS FOR MBBS AND PG IN MEDICAL SPECIALTY BY STATE (2017)

SL. NO.	TYPE	NO. OF SEATS	SEATS PER LAKH POPULATION
1	Government	50	
2	Private	0	
3	Total MBBS Seats	50	1.77
4	Total PG seats*	22	0.78

** PG seats include seats for MD/MS, MCH, DM and Diploma*
Source: Ministry of Health and Family Welfare: Annual Report 2017-18

TABLE 10: NO. OF SEATS IN RECOGNIZED INSTITUTES FOR NURSES AND MIDWIVES (2019)

SL. NO.	TYPE	NO. OF SEATS
1	ANM	65
2	GNM	255
3	BSc	90
4	MSc	10
5	P BSc	30

Source: Indian Nursing Council website, 2019

[5] NITI Aayog's Health Index, 2019-20, Round IV

Studies conducted in the past as well as recent interactions between the IQVIA team and several specialists within the state point to the lack of education, training and career progression avenues available to medical aspirants in the state. The 2014 World Bank qualitative study conducted by PHFI recommended the establishment of teaching hospitals which is an ongoing endeavor of the state.

TABLE 11: LIST OF SPECIALISTS IN MEGHALAYA

SL NO.	SPECIALISTS	SANCTIONED	IN POSITION	VACANT POSITIONS
1	Anesthetist	35	17	18
2	Anatomy*		1	-1
3	Biochemist	13	7	6
4	Cardiologist	2	2	0
5	Cardiothoracic Surgeon	1	0	1
6	Community Medicine*		0	0
7	Dental		0	0
8	Dermatology	10	5	5
9	Diabetologist*		1	-1
10	DNB (Hospital Admin)*		1	-1
11	Endocrinologist	1	0	1
12	ENT	15	10	5
13	Gastro-enterologist	1	0	1
14	General Physician	40	19	21
15	General Surgeon	31	17	14
16	OBGY	33	18	15
17	Medical Oncologist	1	0	1
18	Microbiologist	3	3	0

19	Neurologist	2	0	2
20	Neuro Surgeon	2	0	2
21	Oncology	1	1	0
22	Ophthalmologist	27	7	20
23	Orthopedic Surgeon	14	8	6
24	Pediatric Surgeon	1	1	0
25	Pedaitrician	28	12	16
26	Pathologist	19	6	13
27	Pharmacology*		4	-4
28	Physiology*		7	-7
29	Physical Medicine and Rehabilitation		1	-1
30	Psychiatrist	16	6	10
31	Public Health*		17	-17
32	Radiologist	16	5	11
33	Radiotherapist	3	3	0
34	Radiation Oncologist	1	6	-5
35	Respiratory Medicine		1	-1
36	Rheumatologist	1	0	1
37	Surgical Oncologist	1	0	1
38	Thoracic Surgeon	1	0	1
39	Transfusion Medicine		2	-2
40	Urologist	1	0	1
Total**		**320**	**188**	**172**

***Data compilation: data received from state between June-Sept 2022*

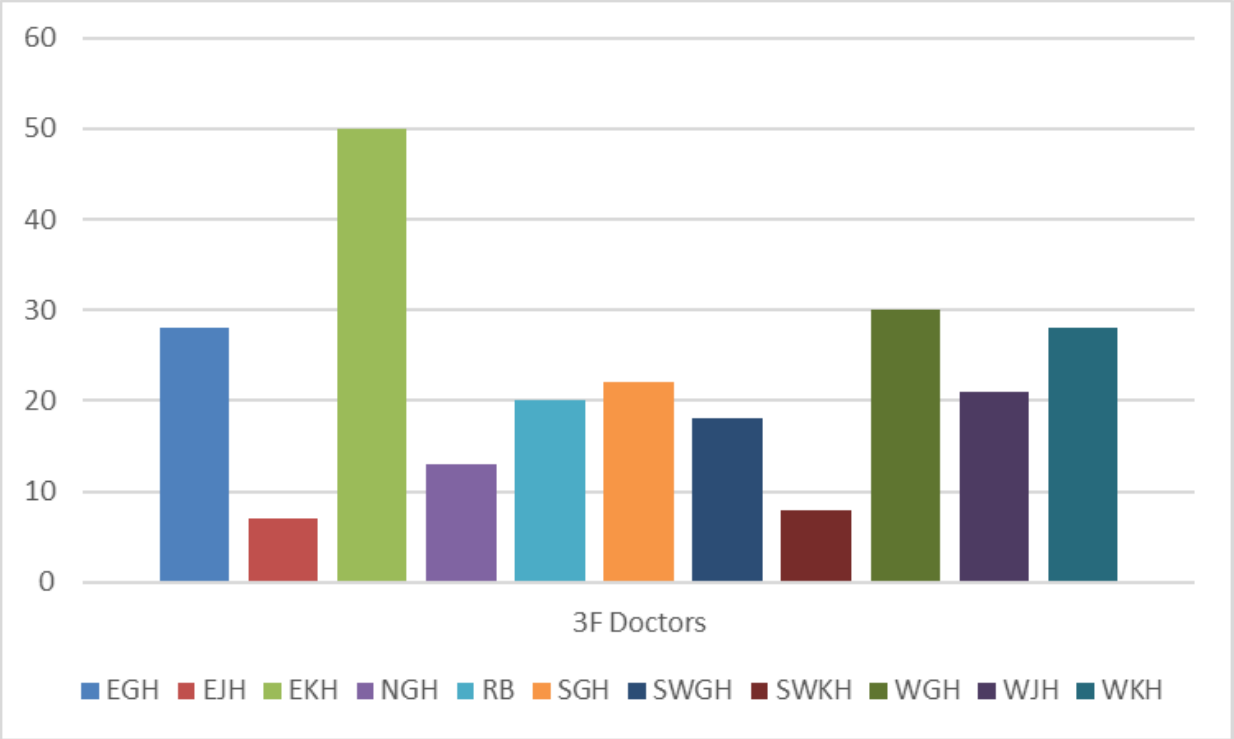
In position specialists without sanctioned posts

The Meghalaya Health Policy 2021 elaborates on the design and **AD**option of **A**lternate models for **R**esponding to **SH**ortage of medical specialists (ADARSH) project which will facilitate the training of specialists in district hospitals which will act as training institutes for post graduate courses.

The total number of specialists within the state at present stands at 188 (as per latest data collated by state in Table 10). Majority of the medical doctors in the state are general physicians (10%), closely followed by gynecologists (10%), general surgeons (9%), anesthetists (9%) and public health specialists (9%).

As per data collated by state, there are about 233 positions for doctors on 3F[17] (contractual staff who have their contracts renewed every three months and are onboarded on need basis). Available applications submitted at an erstwhile time by the DoHFW are reviewed and doctors are appointed on a first-cum-first-serve basis. Data on the current number of doctors employed under 3F is given below:

FIG. 9: DOCTORS EMPLOYED UNDER 3F CONTRACT IN MEGHALAYA



Source: Data compiled by state in June 2022

[17] Definition: The different appointing authorities within Assam State Government (which included Meghalaya at the time) made appointments for temporary periods by invoking the provision of clause (f) of Regulation 3 of the Assam Public Service Commission (Limitation of Functions) Regulations,195l. As per an Under Official Note dated March 1971, the regulation 3(f) has been retained within the Meghalaya Public Service Commission (Limitations of Functions) Regulations 1972 and it follows the same pattern of appointment as APSC for the temporary recruitment

Meghalaya doctors and specialists shortfall

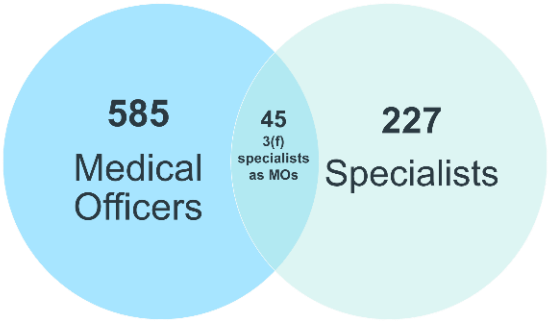
After evaluating several datasets collated for the state, it has been ascertained that no one dataset can be referred to due to inconsistent data presentation in terms of sanctioned, in position and vacant posts. However, as an aggregation, the Directorate of Health Services (MI) was able to present the following table which elucidates the current status of MOs and specialists in the state:

TABLE 12: STATUS OF DOCTORS IN THE STATE AS ON 13TH OCTOBER 2022

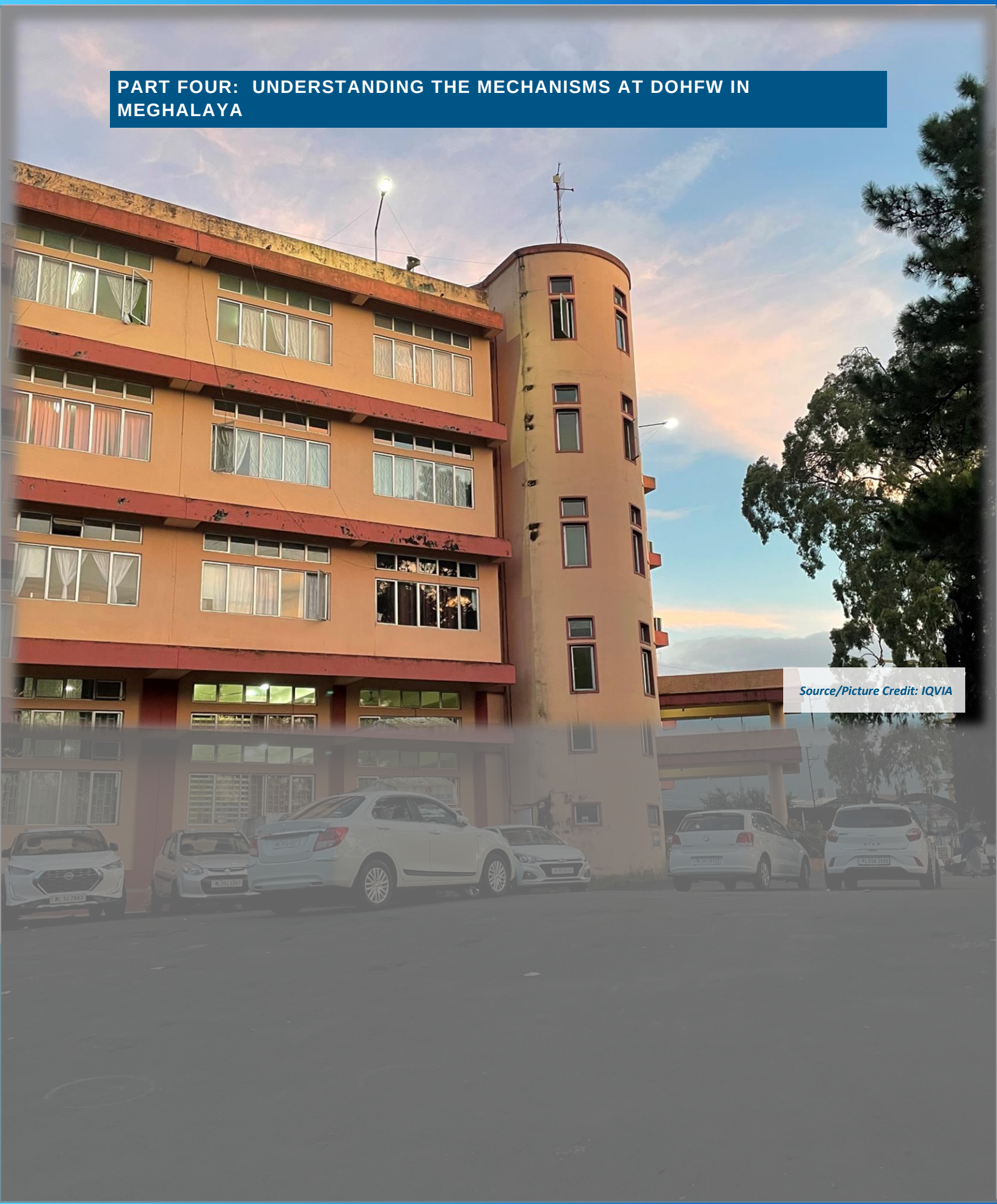
NAME OF POST	SANCTIONED POST	IN POSITION	VACANCY
Medical Officers	716	585*	97
Specialist	363	182**	182

*[includes 223 3(f) Doctors+ 45 specialists posted as MO under 3(F)]
**182 (Regular) + 45 [specialists posted as MO under 3(f)]

FIG. 10: TOTAL MEDICAL OFFICERS AND SPECIALISTS



PART FOUR: UNDERSTANDING THE MECHANISMS AT DOHFW IN MEGHALAYA



Source/Picture Credit: IQVIA

4. DEPARTMENT OF HEALTH AND FAMILY WELFARE-AN OVERVIEW

The State Department for Health and Family Welfare under the Minister for Health and Family Welfare is responsible for maintaining and developing the health care system in the State and guiding and supervising the Health and Family Welfare Programmes in the State. The services offered by the department are preventive health care services, promotive health care services, routine curative services, and rehabilitation services etc. The activities of the department include establishment and maintenance of medical institutions with necessary infrastructure, implementation of National Disease Control and Eradication Programmes, control of communicable as well as non-communicable diseases. The Health and Family Welfare Department, Government of Meghalaya is the Administrative Department. It is responsible for overseeing and coordinating the functions of the three Directorates:

- Directorate of Health Services, MI (Medical Institutions)
- Directorate of Health Services, MCH and FW (Maternal and Child Health and Family Welfare)
- Directorate of Health Services, R (Research)

The Department of Health and Family Welfare is mainly responsible for issue of statutory rules, notifications or orders pertaining to health care of all citizens and convey financial sanction order pertaining to schemes under health and family welfare programmes.[18]

4.1 ORGANIZATION STRUCTURE-DHS (MI), DHS (MCH&FW), DHS (R), HEW & RHFWTC

A) Directorate of Health Services (Medical Institutions)[19]

The Directorate of Health Services, Medical Institutions is responsible for establishment, administration, regulation and monitoring of Medical and Health Institutions (primary, secondary and tertiary) along with handling the necessary supporting infrastructure within the state, medical education, food safety and drug control and monitoring and implementation of various programmes related to public health and disease control.

TABLE 13: OBJECTIVES OF DHS (MI)

SL. NO.	OBJECTIVES	
1	Medical Institutions	• Administration and monitoring of medical services across the state • Providing medical services through a network of hospitals, Public Health Centres, Sub-Centres, Dispensaries from the District to the remotest villages in the state
2	Registration	• Registration of medical institutions, pharmacies and wholesalers • Registration of nurses, AYUSH doctors, etc
3	Food and Drugs Control	• Prevention of food adulteration • Control on availability of drugs • Price and quality Control on Drugs

[18] https://meghealth.gov.in/aboutus.html

[19] https://meghealth.gov.in/aboutus.html

4	Storage and Distribution	• Purchase or procurement of drugs, hospital equipment, surgical equipment etc., as also storage of drugs • Distribution of drugs, lifesaving medicines, surgical equipment, in Hospitals, PHCs, CHCs, Sub-Centres and Dispensaries across the state
5	Training and Education	• Training Programmes for nurses
6	Alternative System of Medicine	• Promotion and monitoring of alternative systems of medicine like Homoeopathy and Ayurvedic medicine through the state
7	Implementation and monitoring of various central programmes on public health and disease control	• IDSP (Integrated Disease Surveillance Project) and other central programmes for Leprosy, Malaria, Tuberculosis, Blindness Control, AIDS, etc.
8	Administrative Functions	• Controlling various medical institutions in the state. • Recruitment, Transfer and Posting of various health staffs. • Procurement of medical supplies, drugs and consumables. • Issue of rules, regulations and other orders from time to time • Maintenance of records and management of information system. • Other administrative functions

I) Health Engineering Wing (HEW)[20]: The main function of the Health Engineering Wing is to construct the Medical Buildings of the Health Department with the objectives to hand over the medical buildings of the Health Department to the Director of Health Services (Medical Institutions). [21]

TABLE 14: PROJECTS UNDERTAKEN BY THE HEALTH ENGINEERING WING

SL NO	HOSPITAL/HEALTHCARE FACILITY	DISTRICT	PROJECT UNDER	NUMBER
1	100 Bedded Hospitals	West Jaintia Hills	NRHM	1
2	State of the Art Diagnostic Centre at Pasteur Institute	East Khasi Hills	State Plan	1
3	Sub-centres	South West Khasi Hills	State Plan	1
		West Khasi Hills	State Plan	1
Total				4

II) AYUSH in Meghalaya: The AYUSH System of treatment was first introduced in the state Health Services in the year 1976 with only one Homoeopathic Dispensary in the Old Civil Hospital (Police Bazaar) Shillong, but now this system of treatment is available and collocated in all the eleven Districts of the State.

In 2002 Ayurvedic system of Medicine was implemented in our State (Meghalaya) at Sohra, Khlieh-shnong under East Khasi Hills District, this system has grown and is now collocated in all the District Hospitals. With the coming up of the NRHM from 2007, there is mainstreaming of AYUSH System, and it has paved way for all section of people by setting up of O.P.D centres collocated in DHs, CHCs, PHCs and Dispensaries providing their choice of treatment (Homoeopathy, Ayurveda and Yoga & Naturopathy).

[20] https://meghealth.gov.in/aboutus.html

[21] https://meghealth.gov.in/aboutus.html

III) Drugs Section: The drugs section is responsible for:

- Inspection for grant or renewal of licenses for the manufacture of allopathic drugs
- Inspection for grant or renewal of licenses for retail and wholesale of drugs
- Collection of samples of drugs and cosmetics from manufacturer, seller and pharmacist or from premises of warehouse for test or analysis to check their potency and originality.
- Inspections and raids with a view to detect offences under the Act specially movement and sale of spurious drugs or cosmetics.
- Investigations of cases of contraventions under the Act.
- Inspections of the premises licensed for manufacture and sale of drugs, with a view to ensure that conditions of the licenses are complied with.
- Launching of prosecutions against persons or firms found contravening the provisions of the Act.
- Control of prices of drugs under DPCO (Drugs Price Control Order) within the state.

B) Directorate of Health Services (Maternal Child Health & Family Welfare)[22]

The Directorate of Health Services, Maternal Child Health and Family Welfare is responsible for monitoring and implementation of the centrally sponsored schemes implemented in the State to cater to the health needs of women and children. The main objective of the programme is to seek stabilization of population in the shortest time at the level consistent with the needs of National Development as well as to seek improvement in the Reproductive and Child Health status.

To meet the objectives, several interventions are being attempted through various programmes brought under Reproductive Child Health (RCH)-II and Universal Immunization Programme (UIP) which are the major components of National Rural Health Mission (NRHM) launched by the Government of India.

TABLE 15: OBJECTIVES OF DHS (MCH&FW)

SL. NO.	OBJECTIVES	
1	Maternal Health	• Provision of safe motherhood care • Provision of safe abortion services • Prevention and treatment of nutritional anemia and promotion of maternal nutrition • Strengthening and improving quality of Obstetric care in the state • Prevention of maternal mortality and morbidity • Reduction of RTIs or STIs among women
2	Child Health	• Immunization of children against six killer diseases i.e., diphtheria, pertussis, tetanus, measles, tuberculosis and poliomyelitis • Prevention of childhood diseases including malaria, Tuberculosis, etc. • Promotion of child nutrition and prevention of malnutrition and anaemia • Provision of services for A.D.D. and A.R.I. among children • Prevention of neonatal, infant and childhood mortality
3	Family Planning	• Encouraging and promoting the use of various contraceptive methods • Provision of Family Planning and sterilisation services to eligible couples

[22] https://meghealth.gov.in/aboutus.html

4	Registration and Vital Statistic	• Registration of births and deaths • Registration and monitoring of P.N.D.T. facilities within the state 3) Maintenance and analysis of vital statistics like birth rate, death rate, T.F.R., etc.
5	Administrative and Training Functions	• Controlling various medical institutions in the state • Recruitment, Transfer, and Posting of various health staffs • Procurement of medical supplies, drugs and consumables • Issue of rules, regulations and other orders from time to time • Maintenance of records and management of information system • Other administrative functions • Time to time training of various health staff on various medical and health subjects related to Reproductive Child Health

I) Regional Health & Family Welfare Training Centre (RHFWTC)

The Regional Health & Family Welfare Training Centre was started in 1978 and was funded under the Centrally Sponsored Scheme (CSS). The center conducts trainings for health staff that include:

- HE/Block Extension Educator/Community Health Officer/Public Health Nurse
- Auxiliary Nurses & Midwives/Female Health Workers
- Health Assistant (M&F)/ Barangay Health Workers/Multi-Purpose Workers/ Vaccinators etc.,
- Lady Health Visitors,
- Medical & Health Officers

Management training for Medical and Health Officers is a relatively new addition to the center's training curriculum.

C) Directorate of Health Services (Research)[23]

The Directorate of Health Services, Research is responsible for the research and laboratory testing related activities for the Department of Health and Family Welfare apart from housing the regional blood bank and laboratory animal breeding facilities. It is based at Pasteur Institute, Shillong, which is one of the oldest vaccine production institutes in the country and is the only one of its kind in the entire North East Region. Pasteur Institute provides various laboratory services for diagnostic purposes, blood bank facilities with screening of HIV cases, training of laboratory technicians, laboratory assistance etc., besides the production of anti-rabies vaccine.

[23] https://meghealth.gov.in/aboutus.html

TABLE 16: OBJECTIVES OF DHS (R)

SL. NO.	OBJECTIVES	
A	Research & Investigation	• Providing laboratory facilities and investigations in all disciplines of pathology such as Histology, Bacteriology, Biochemistry, Haematology, and Parasitology to Government and Private Institutions • Serving as a State Government Drugs, Water and Food Testing Laboratories. The main objective of the combined Food and Drugs Laboratory is to carry out various tests and analysis of various food stuffs, water and drugs in case of adulteration of food and potency of various medicined drugs in conformity with P.F.A. Act and Drugs and Cosmetics Act • Maintaining an animal house for breeding different laboratory animals which are used for the biological standardization and quality control tests of vaccines. Some experimental animals such as Swiss Albino Mice are supplied to different institutions for their research works • Carrying out field and laboratory investigations during epidemics of diseases in the state
B	Training and Education	• Serving as a training centre for the North Eastern Region for medical, Paramedical personnel in laboratory techniques
C	Service Delivery (Diagnosis & Treatment)	• Running an outdoor centre for diagnosis and treatment and render expert advice on questions concerning animal and snake bites • Maintaining of regional blood bank for routine and emergency basis for all Government and Non-Government Hospitals. The regional blood bank is also a zonal screening centre for HIV antibodies
D	State Vaccines	• Pasteur Institute also plays a key role in maintaining Cold Chain system by providing storage facilities of EPI or UIP vaccines for the state of Meghalaya

The above three departments together form a composite whole of the Department of Health and Family Welfare in Meghalaya. Given the interactions with the state officials within the three departments and in consultation with the PMU in addition to the organogram documents received via the IQVIA checklist, the organizational structure of the DoHFW has been drawn up in the Fig. 11 below.

I) Pasteur Institute: Pasteur Institute, Shillong is the oldest and premier Institute erected to the Memory of His Majesty the King Emperor Edward VII by Public subscription in the then Bengal and Assam during the British Rule. The Foundation stone was laid by the then Chief Commissioner of Assam, Honorable Sir Archdale Earl K.C.I.E. on the 4th of November 1915.

The Institute was headed by successive Directors appointed by the British Authorities from Delhi and the first Director was appointed in 1917 and it was only after the year 1947 when our country attained its Independence that the appointments were made by the State Authorities of Assam until Meghalaya attained statehood in the year 1972. The Directorate of Health Services (Research) was created in the year 1987. The Institute has contributed to this purpose through research and production of Vaccines like Neural Anti Rabies Vaccines and the Cholera, Typhoid and Paratyphoid Vaccines from the year 1917-2005 and 1922-1996 respectively. Pasteur Institute since the past many years has been playing an important role as:

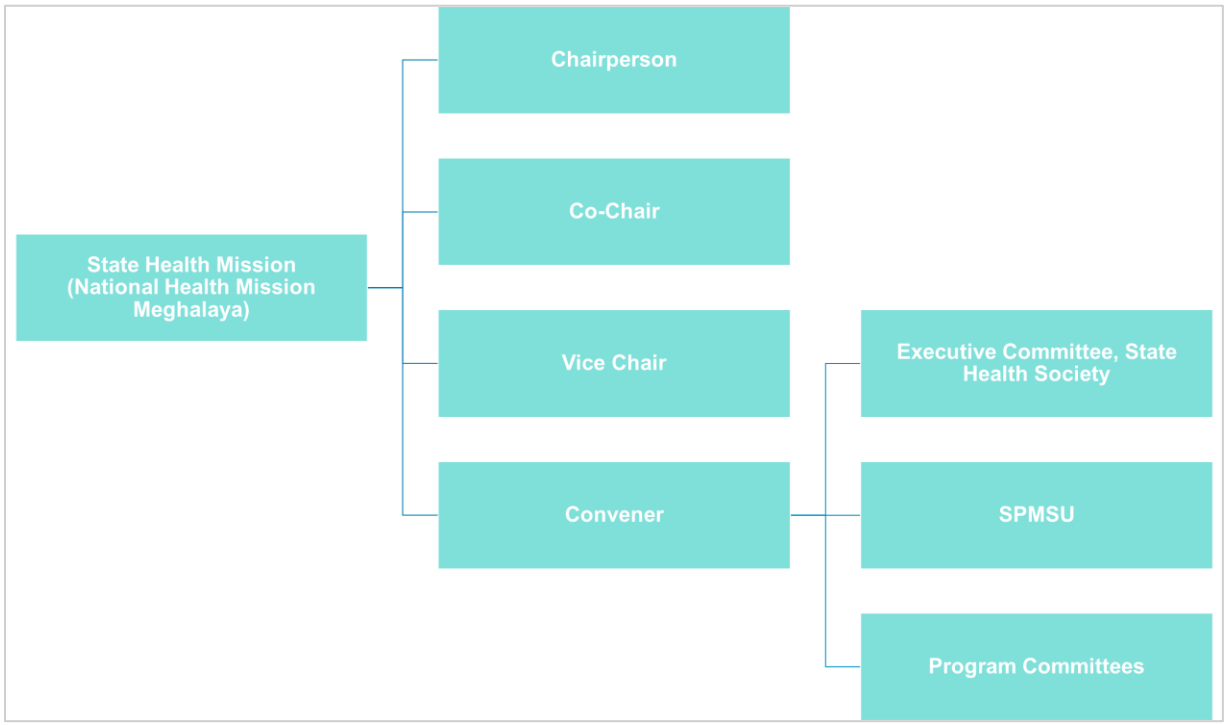
1. Laboratory Testing Centre
2. Centre for diagnosis, advice and treatment of rabies cases and other animal bites
3. Institute that maintains Cold Chain System for E.P.I. or U.I.P. Vaccines, AIDS and Vaccines for Meningococcal Meningitis, maintain Regional Blood Bank

D) National Health Mission (NHM) [24]

At the state level, the National Health Mission functions under the overall guidance of the State Health Mission headed by the Chief Minister of the State.

Structure of the State Health Mission is in Fig. 11 below.

FIG. 11: STATE HEALTH MISSION (NHM, MEGHALAYA WEBSITE)



E) Key findings of the current organizational structures within the Department of Health and Family Welfare

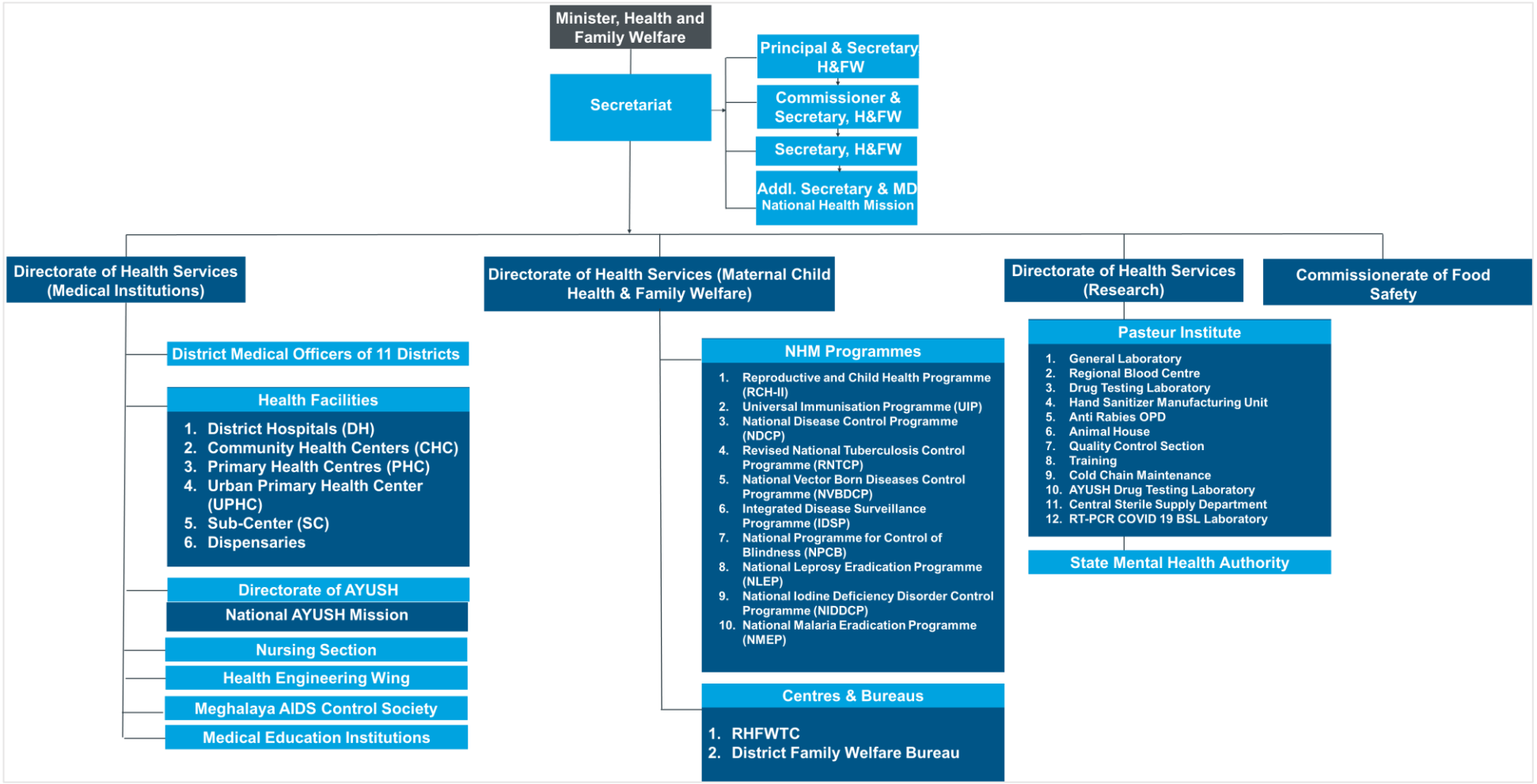
TABLE 17: KEY FINDINGS ON ORGANIZATION STRUCTURES

REGULAR	CONTRACTUAL
• The organograms of all three directorates and departments under them were received either through checklist administration or through the official website of DoHFW. After carefully studying the same, all the organograms were brought together to form a composite structure under the DoHFW (Fig. 12). The current organization structure below has been created	• The State Health Mission and the State Health Society of NHM have been found on the official central and state websites and the same have been attached as annexures (Annexure 14). • Details on the composition of the District Health Society have not been found either through the checklist or through online sources and requires

[24] http://nhmmeghalaya.nic.in/shm-shs.html

with existing information and needs to be vetted since some information on organization structure has been taken from the state's official website. • Although the Regional Health & Family Welfare Training Centre was initially instated through the efforts of the Central government, it is understood that in its current shape, it falls under the Directorate of Health Services (MCH&FW). • While the food safety section was erstwhile a part of the Directorate of Health Services (R), at present it is a section on its own called the Commissionerate of Food Safety which was brought forth in 2011. • Further, the organization structure provided by the Health Engineering Wing is not updated as the Chief Engineer's position seems to be unclear and is not incorporated in the current structure. The organogram created by IQVIA can be found in Annexure 8 • Each of the directorates are formed for unique purposes. Overlaps, if any, do not come out through the organogram prepared. However, it is unclear as to the administrative roles and responsibilities of DHS (MCH&FW). Defining clear departments and sections across all verticals would help create a clearer picture.	to be clarified by representatives of the NHM State Program Management Unit or District Program Management Unit

FIG. 12: OVERVIEW OF DEPARTMENT OF HEALTH AND FAMILY WELFARE IN MEGHALAYA



F) Key findings of the staff job descriptions

TABLE 18: KEY FINDINGS OF STAFF JOB DESCRIPTIONS

REGULAR	CONTRACTUAL
• Instead of job descriptions, the work distribution document for DHS (MCH&FW) staff provides details on various programmes to be handled by each of the senior grade and grade I staff under it • Certain job descriptions for staff under DHS (R) such as that of the Senior Medical & Health Officer needs to be detailed out. At present the SM&HO's job description states: Performs duty in their respective Sections as assigned to them. Job descriptions of JDHS (PI), DDHS (PI), ADHS (PI), SM&HO, M&HO, Government Analyst, Sr. Specialist, Specialist, Biochemist, and some administrative staff are vague or undefined. ▪ The responsibilities of JDHS (PI), DDHS (PI), ADHS (PI) are minimal. ▪ The job description of Director of Health Services (R) is unavailable. ▪ The job description of medical staff is a little more detailed. However, the work of a Chemist and an Assistant Chemist are the same. ▪ The Nursing Sister's position is responsible for both Anti-rabies OPD as well as being in-charge of Grade IV staff falling under administrative staff ▪ Three positions under the paramedical staff section have vague job description as under: To work in respective section as assigned to them • Job descriptions of DHS (MI) staff is not available	• Detailed job descriptions available for SPMU, DPMU and BPMU staff • Job description of health staff at various health facilities is not available

Gap analysis for job descriptions

- Given the above, it is clear that the roles and responsibilities of staff members at the administrative sections need to be clarified, especially for DHS (MI)
- Where departments under the three Directorates and NHM have not provided the job descriptions, it is recommended that the state bring forth detailed roles and responsibilities as it is assumed that they are not available

4.2. AVAILABLE POLICIES AND GUIDELINES

The IQVIA checklist on Policies and Guidelines was administered among the different departments within the Directorates of Health Services, namely, DHS (MI), DHS (MCH&FW) and DHS (R). One of the key documents received was the Meghalaya Service Rules, 1990.

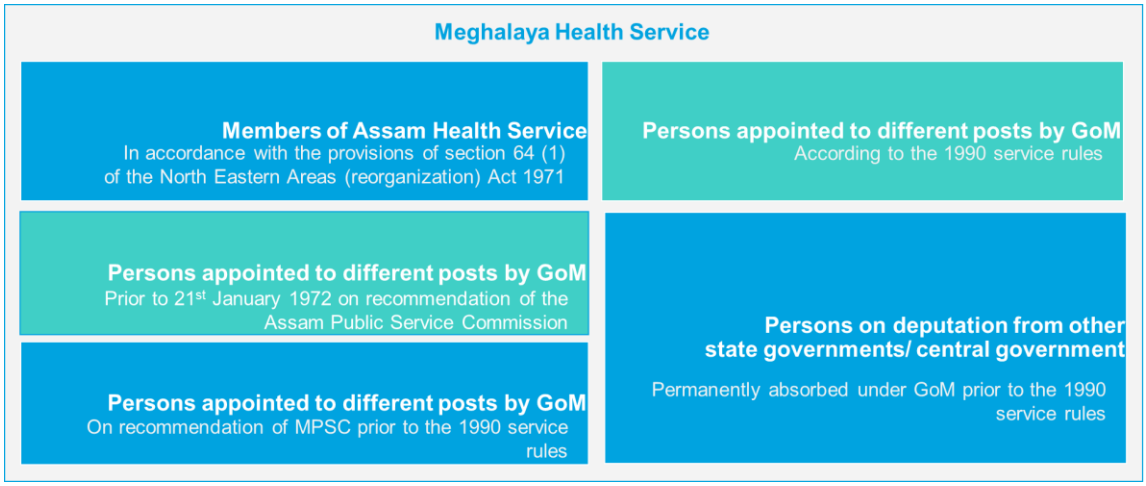
A) The Meghalaya Health Service Rules, 1990

Under the DHS (MI), IQVIA found the Meghalaya Health Service Rules 1990 and a list of 24 policies/rules were drawn from the document to understand the current HRH scenario.

I. Constitution of Meghalaya Health Services

The Meghalaya Health Service Rules, 1990 consists of five categories of members with gazette status. It includes members of the Assam Health Service, persons appointed to different posts by Government of Meghalaya prior to 21st January 1972 on recommendation of the Assam Public Service Commission, individuals appointed to different posts by GoM, On recommendation of MPSC prior to the 1990 service rules. Persons appointed according to the 1990 service rules and persons who received permanent positions while on deputation from other state governments or the central government within the state's DoHFW prior to the implementation of the 1990 service rules.

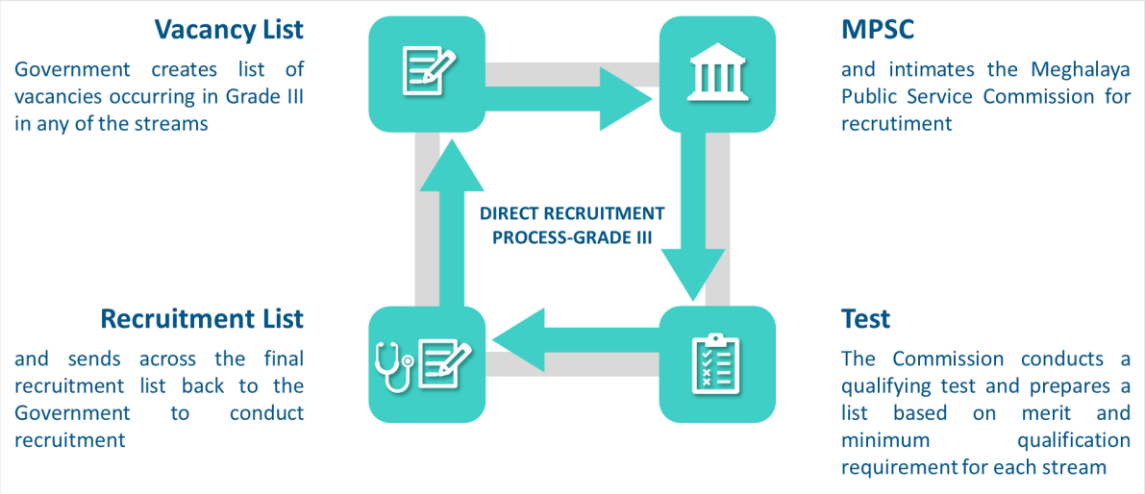
FIG. 13: MEGHALAYA HEALTH SERVICE COMPOSITION



II. Appointment & Recruitment

Direct recruitment at the Grade III level is undertaken by the Meghalaya Public Service Commission

FIG. 14: RECRUITMENT PROCESS



(MPSC) on receipt of vacancy list prepared by the government on bi-annual basis. The MPSC undertakes recruitment of Grade III staff bi-annually by conducting a test and preparing a merit list which it then passes back to the government for final recruitment.

Gap analysis for direct recruitment policy of regular staff (doctors & specialists)

- Although a recruitment process exists in the Meghalaya Health Service Rules, 1990, during several discussions, it was determined that the process of holding recruitments twice a year was not being followed by the MPSC
- The document does not provide crucial information on when the recruitment process should be held in a year and duration taken to complete the hiring process

III. Promotion

Through the development of a select list for members eligible for promotion from both General and Specialist streams, Grade III members receive promotions to Grade II based on pre-requisites related to years of service in Grade III. The promotions are not dependent on availability of posts as per the 1990 rules. Although the 1990 rules specified clear demarcation of years of service in each grade for the general and specialists. During a 2018 amendment, the years of service were made uniform for both streams (Table 17). Actual progression within the 1990 rules has been provided in Fig. 17.

However, as per the rules, the government at its discretion can also conduct direct recruitment of Senior specialists in Grade I through the MPSC but such enrolled specialists would not be encadred. Notably for promotions to fall through in both streams, the staff is expected to have completed compulsory rural posting (details of number of years is missing). Vacancies in Senior Grade or Grade I of either General Duty or Specialist stream, are referred to the Departmental Promotion Committee. Details of the current career progression is available in the table below:

TABLE 19: GENERAL DUTY AND SPECIALIST STREAMS' PROGRESSION

GRADE	DUTY STREAMS		PROGRESSION**
	GENERAL	SPECIALIST	
III	Medical Officer	Junior Specialist	Direct
II	Sub-divisional Health Officer/Zonal Leprosy Officer/DTO	Specialist	9 years of service in Grade III (should include compulsory rural posting)
I	DDHS/ DD/DM&HO/Principal-RHFWTC	Senior Specialist/MS/Addl. MS	18 years of service in Grade III and II (minimum two years in Grade II)
Senior Grade	JDHS/SH/JD-PI/STO		4 years of service in Grade I
Senior Grade	DHS/DHS (R)/ADHS		3 years as JDHS/SH/JD Pasteur Institute/STO (or aggregate)/22 years of continuous service
Senior Grade	DHS/DHS (R)/ADHS		2 years as ADHS or Director of Pasteur Institute OR 4 years as JDHS/SH/JD Pasteur Institute/STO (or aggregate)/25 years of continuous service

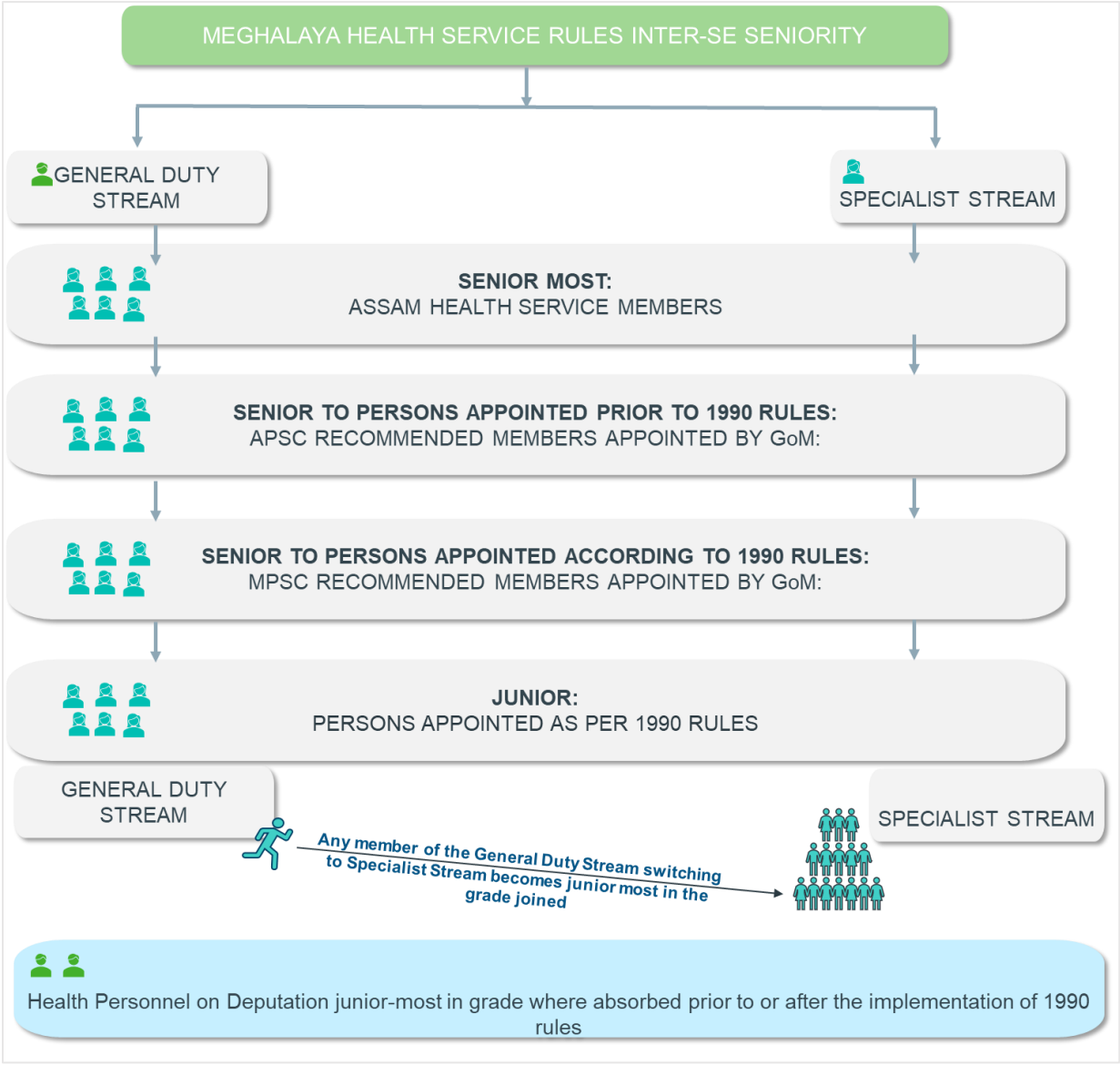
**promotion depends on total qualifying length of service and not availability of posts

Gap analysis for promotion policy of regular staff (doctors & specialists)

- While the Meghalaya Health Service Rules, 1990, earlier stated that the progression of a specialist with a post graduate degree would be within six years and a diploma holder's would be within 8 years, at present an amendment has revised the duration for promotion to coincide with that of MBBS doctors. The amendment has not been made available although it exists
- Although the document does provide the existence of two different streams, i.e., General Duty Stream and Specialist Duty Stream, a specific policy for either the Specialist Cadre or the Public Health Cadre are not available

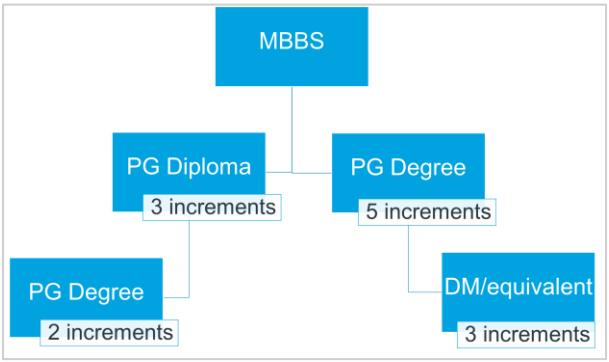
Apart from that, the inter-se seniority of persons within the health services is ascertained through various parameters. It is all-encompassing and ensures that members of Assam health service and persons appointed by the GoM prior to 1990 rules are incorporated within the system. There are three junior categories, namely, all health personnel appointed post the implementation of the Meghalaya Health Service Rules, 1990; persons on deputation by other state or central government and persons who switch from general to specialist duty stream after gaining a post-graduate diploma or degree. A snapshot of the same has been presented in Fig. 15 below.

FIG. 15: MEGHALAYA HEALTH SERVICE INTER-SE SENIORITY



IV. Time Scale of Pay

FIG. 16: TIME SCALE OF PAY



Time scale of pay Members of the services in the state acquiring additional qualifications become eligible for advance increments in the following order (Fig. 15):

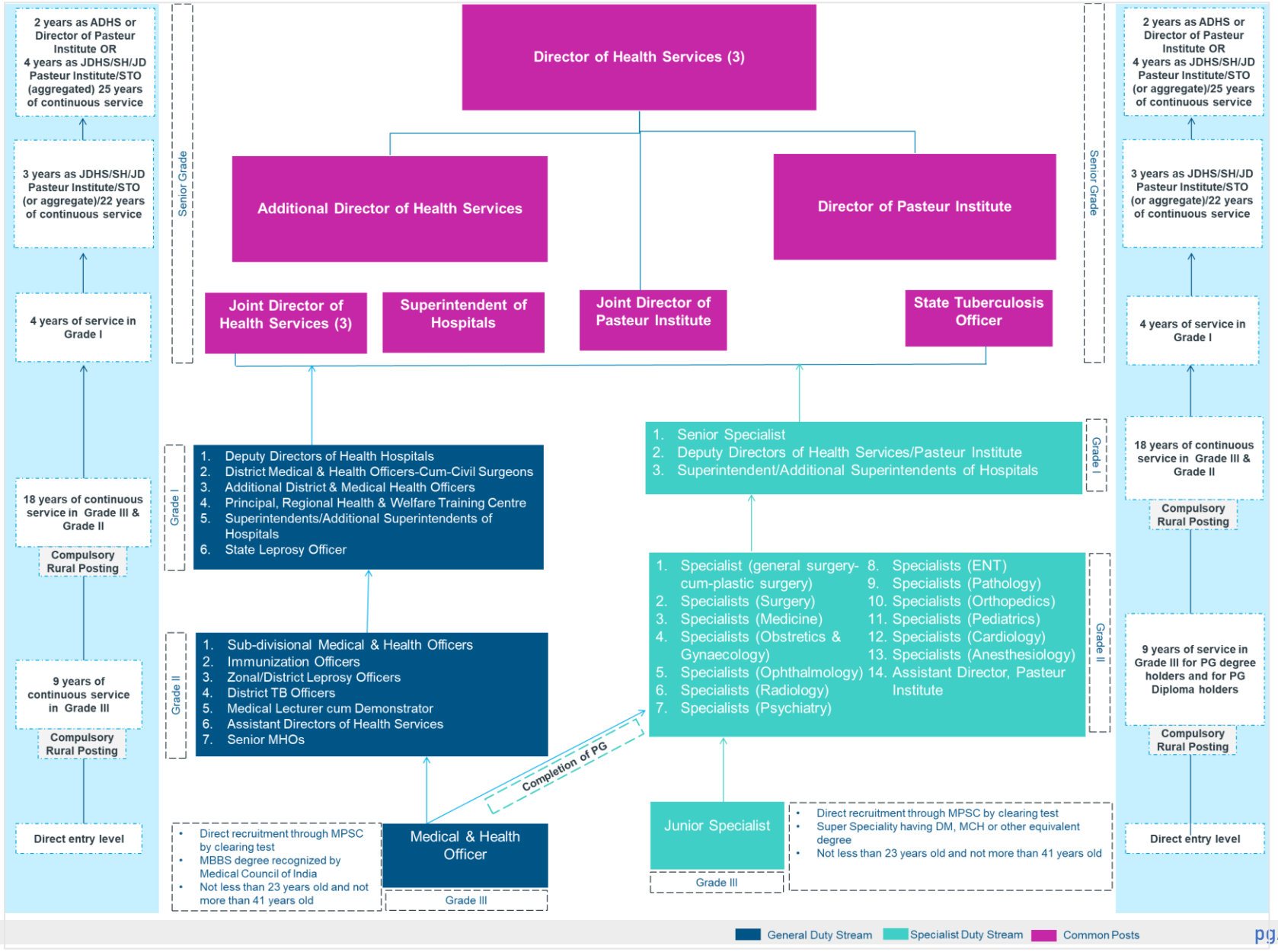
- An MBBS degree holder acquiring PG Diploma is entitled to 3 increments and subsequently pursuing PG degree will lead to 2 increments
- An MBBS degree holder acquiring PG Degree is entitled to 5 increments

- A PG degree holder acquiring DM/equivalent would be entitled to 3 increments

Gap analysis for increments & incentives policies

- The time scale of pay in the Meghalaya Health Service Rules spells out the number of increments one is eligible for depending on the qualification one has attained. However, during interactions with doctors and specialists, it was ascertained that the amount given to doctors/especially specialists is:
  a. Meagre due to the lag in the pay commission within the state since Meghalaya is on 5th pay commission
  b. During their in-service study leave for post-graduation, doctors are not entitled to any increments which are then provided to them once they come back to serve the state. So, the five increments translate, essentially to two increments after joining.
- Revision of increments provided to MBBS doctors as well as specialists is recommended
- The document also does not cover any place-based incentives

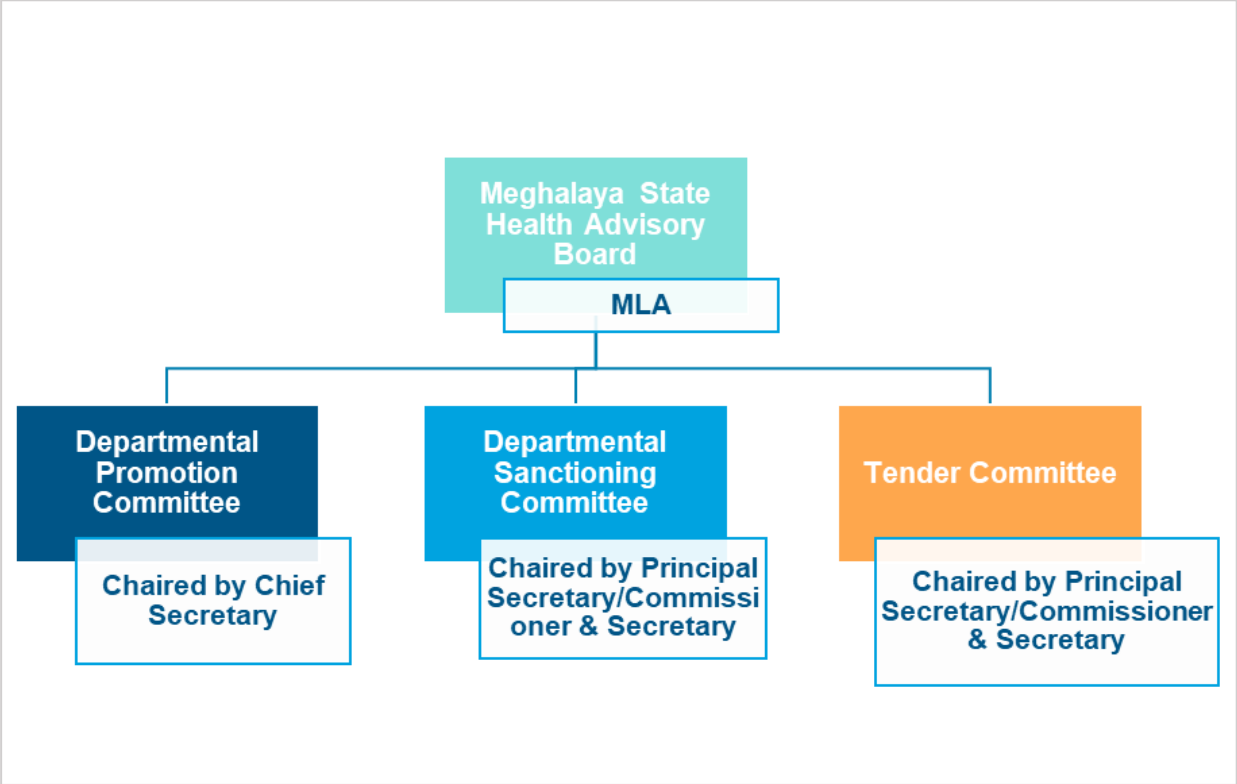
FIG. 17: CAREER PROGRESSION CHART AS PER MEGHALAYA HEALTH SERVICE RULES, 1990



B) Meghalaya State Health Advisory Board (MHAB)

The Meghalaya State Health Advisory Board (MHAB) is led by an MLA and has three committees under it, namely, Departmental Promotion Committee, Departmental Sanctioning Committee and Tender Committee.

FIG. 18: MEGHALAYA STATE HEALTH ADVISIORY BOARD COMPOSITION



C) MBBS and PG Education under state quota[25]

The availability of a bond-cum-agreement for students who want to go for medical education are provided with financial aid which can range between INR 10,00,000-25,00,000. By signing such a bond, a medical student makes an agreement with the government that once the education is completed, the graduate/post-graduate candidate will provide her/his services to the state for a stipulated period of five years in the form of compulsory rural posting. Students who do not serve the State government after completion of education are expected to pay out their bonds (Annexure 15).

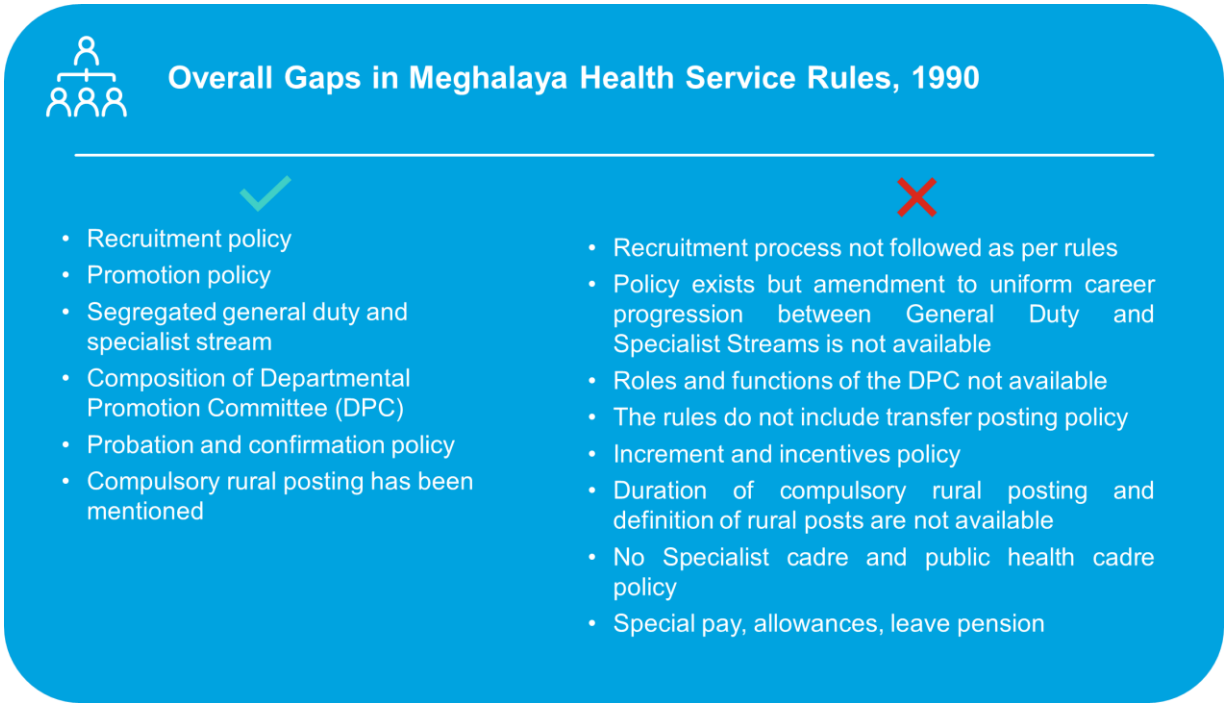
[25] https://meghalaya.gov.in/sites/default/files/forms/Bond_Cum_Agreement_MBBS.pdf

D) Key findings of the current available policies and guidelines

TABLE 20: KEY FINDINGS OF CURRENT POLICIES & GUIDELINES

REGULAR	CONTRACTUAL
• Most of the vital policies in relation to the health personnel in Meghalaya are found in the Meghalaya Health Service Rules, 1990 which applies to regular staff i.e., those on the State's regular payroll. • Rules related to recruitment process, promotion process, inter-se seniority, allocation and between general duty and specialist streams, probation & confirmation, time scale of pay, are available. • Although the rules provide a systematic approach to instating and movement of different streams of personnel, it does not provide clarity on duration of compulsory rural posting and any allowances thereof. • Rules related to transfer & posting, retirement & pension, leave rules, travel allowance, incentives & allowances, HRA, in-service trainings/further study etc. are not clarified or mentioned. • The rules further specify that matters related to pay, allowances, increments, leave, pension, discipline and other conditions of service would be governed by general rules and orders made by the State. • Applicability of the Meghalaya Fundamental and Subsidiary Rules 1984 needs to be ascertained which encompasses the leave, travel and other HR rules for government employees across the State.	• HR rules vital to the contractual staff under NHM SPMU, DPMU, BPMU and health facilities are covered in the HR Rules for NHM Meghalaya. • Rules related to recruitment process, promotion process, increment eligibility, transfer and posting, office timings, leave and suspension and termination are available. • Travel allowance, or any other benefits for employees are not covered under the NHM rules.

FIG. 19: OVERALL GAPS IN MEGHALAYA HEALTH SERVICE RULES, 1990



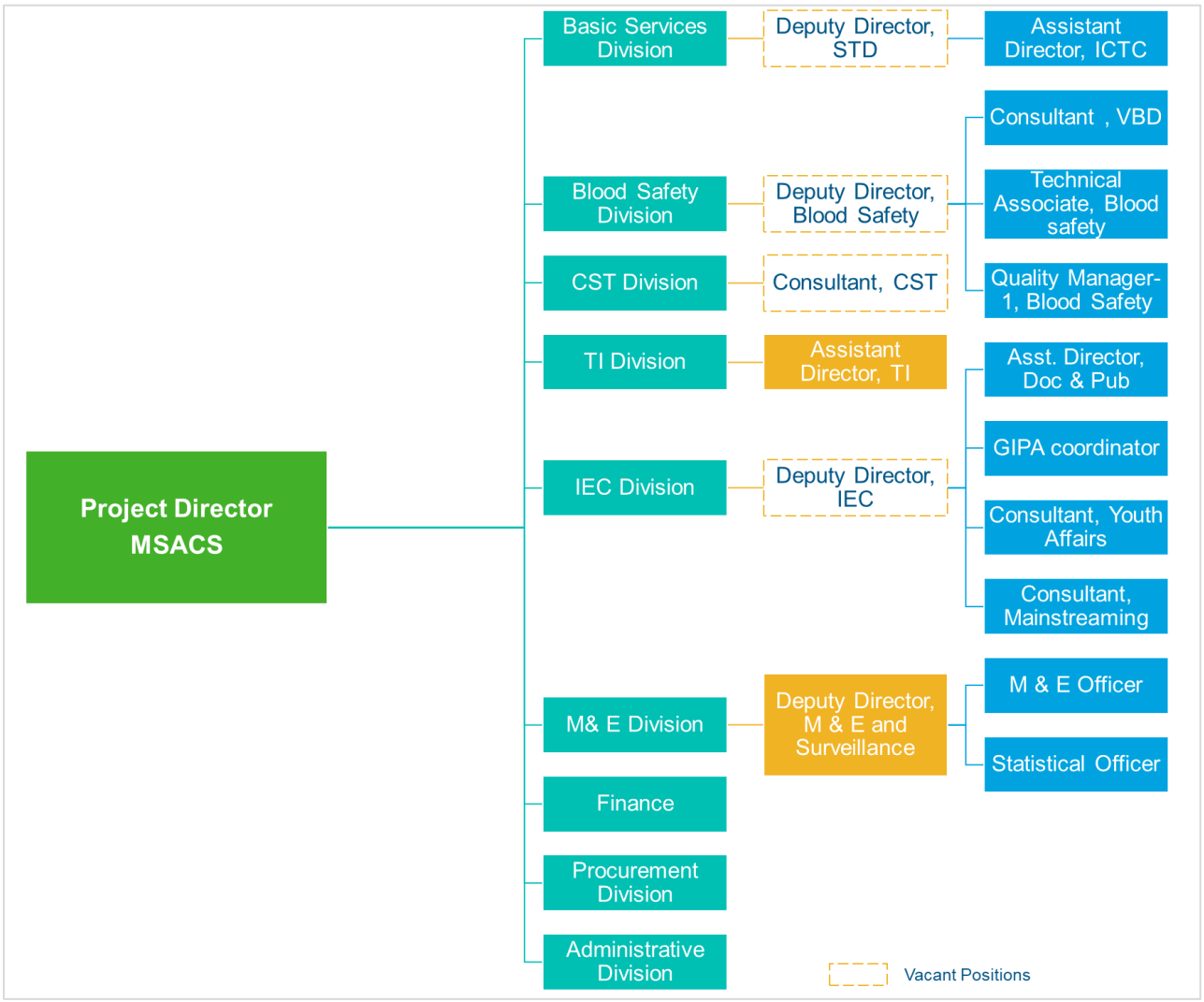
4.3. HEALTHCARE SOCIETIES AND COMMITTEES

A) Societies

I) Meghalaya State AIDS Control Society (MSACS)

National AIDS Control Organization provides leadership to HIV/AIDS Control Programme in India, implementing one National Plan within one monitoring system. State AIDS Prevention and Control Societies (SACS) implement NACO programme at state level but have functional independence to upscale and innovate.

FIG. 20: HUMAN RESOURCES UNDER MEGHALAYA SACS



II) State Cancer Society of Meghalaya

The State Cancer Society of Meghalaya was notified by the Government of Meghalaya on the 16th of July 2003. On the 13th of January 2004 it was registered with the Meghalaya Societies Registration Act 12, 1983. Chaired by the Additional Chief Secretary/Principal Secretary/ Commissioner and Secretary /Secretary, Health & Family Welfare Department, it has 10 members which includes members of the DoHFW, DHS (MI), DHS (MCH&FW), DHS (R), Finance Department, GoM and representatives from the NGO sector. The Member Secretary is HOD Oncology Department, Civil Hospital Shillong.

III) Meghalaya State Health Mission and State Health Society[26]

Functions under the State Health Mission are carried out through the State Health Society. The State Health Mission led by the Chief Minister and Minister of Health & Family Welfare, Meghalaya (co-chairperson) includes different departments' in-charge from NHM, nominated public representatives, Chief Secretary/Development Commissioners and Principal Secretaries/Secretaries in-charge of relevant departments who are identified as official representatives. Nominated non-official members include health experts, representatives of medical associations, NGOs, etc. and representatives of any development partners. The State Health Mission provides health system oversight, consideration of policy matters related with health sector (including determinants of good health), review of progress in implementation of NHM; inter-sectoral coordination, advocacy measures required to promote NHM visibility, among others.

The State Health Society led by Chief Secretary/Development Commissioner provides approval / endorsement of Annual State Action Plan for the NHM. It considers proposals for institutional reforms in the H&FW sector, reviews implementation of the Annual Action Plan, provides inter-sectoral co-ordination: all NHM related sectors and beyond (e.g., administrative reforms across the State). It also oversees status of follow up action on decisions of the State Health Mission and co-ordinates with NGOs/Donors/other agencies/organizations.

IV) Regional Health & Family Welfare Training Centre Management Society

As per information provided by the Training centre, the RFWTC management society is yet to be constituted. More details were not received during the IQVIA checklist document collection exercise.

B) Councils

I) State Medical Council of Meghalaya

The State Medical Council of Meghalaya was instated through the Meghalaya Medical Council Act, 1987. It has two members nominated by the state government, two members elected by registered practitioners, one member nominated by the Director General of Health Services, Government of India (GoI), two members nominated by the Medical Council of India and the DHS (ex-officio). Members of the Council hold office for five years. The council includes a registrar who is responsible for logging all information of medical practitioners across the state. Details logged include address, appointments, qualifications/titles of medical practitioners. The state council comes under the Medical Council of India (now known as National Medical Commission).

II) Meghalaya Nursing Council[27]

The Meghalaya Nursing Council was established on May 4th, 1992, by the Government of Meghalaya. The first council was nominated by Government with different members representing various constituencies under section 4 (1) of the act, all together consisting of 14 members. The council is an Autonomous Statutory Registration body for qualified Nurses and ANMs. The council aims:

- to prepare nurses with a sound educational programme in Nursing to enable them to function as efficient members of the Health Team beginning with the competencies for first level positions in all kinds of Health care settings.
- to prepare them in personal and professional development so that they can make their maximum contribution to the society as useful and productive individuals and citizens, as well as efficient nurses.

[26] https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1137&lid=143

[27] https://web.archive.org/web/20190330225317/http://meghanursingcouncil.org:80/Default.aspx

Its functions include:

- Register person qualified to practice as Nurses and to grant certificate of Registration.
- Recognize Schools and colleges of Nursing in the State.
- Hold and conduct Examination of Nursing schools in the state.
- Arrange periodical inspection of all Schools and Colleges of Nursing.
- Tender advice on training and maintenance of standard by the Schools and Colleges of Nursing.
- Make regulations for the conduct, practice and professional ethics for the Nurses.
- De-recognize Schools and Colleges of Nursing in the state when the training standards have fallen short of the requirement.

III) State Pharmacy Council, Meghalaya[28]

The State Pharmacy Council, Meghalaya is a statutory body constituted by the Government of Meghalaya under the provisions of the Pharmacy Act 1948, Government of India to regulate the profession and practice of Pharmacy in the State of Meghalaya. The prime function of the State Pharmacy Council, Meghalaya is to grant registration and renewal thereof to the eligible candidate possessing requisite qualifications as per the provisions of section 32(2) of the Pharmacy Act & to enforce the necessary provisions of the Pharmacy act 1948. Continuous Pharmacist Education Programme, Refresher courses are regularly conducting by the Council to the working Registered Pharmacists to update their knowledge and to have update drug information to enable them to serve better to the community.

C) Committees

I) Social Audit Committees

The Meghalaya State Health Policy 2021 states that under the Meghalaya Community Participation and Public Services Social Audit Act, 2017, Social Audit Committees (SACs) have been formed to bring about transparency and accountability in healthcare. The policy further elaborates that the SAC will monitor and evaluate healthcare related programs which can lead to better performance. Social audits shall be conducted at village and institutional levels including the PHCs/CHCs to improve the quality of services and to increase the awareness and uptake of services by the communities with special focus on helping the poor and marginalized in accessing their due health entitlements. This social audit mechanism would enable the public and various groups and organizations to give free and independent feedback about health care services. The Social Audit body would record the issues and where possible immediately recommend actions regarding cases of denial of health care or violation of rights enumerated herein or suggest follow-up actions by the parties; similarly, it would recognize service providers acknowledged for providing exemplary good services. The concept of Granular Performance Monitoring may be used to ensure accountability by clearly identifying roles, responsibilities and deliverables for every duty holder.

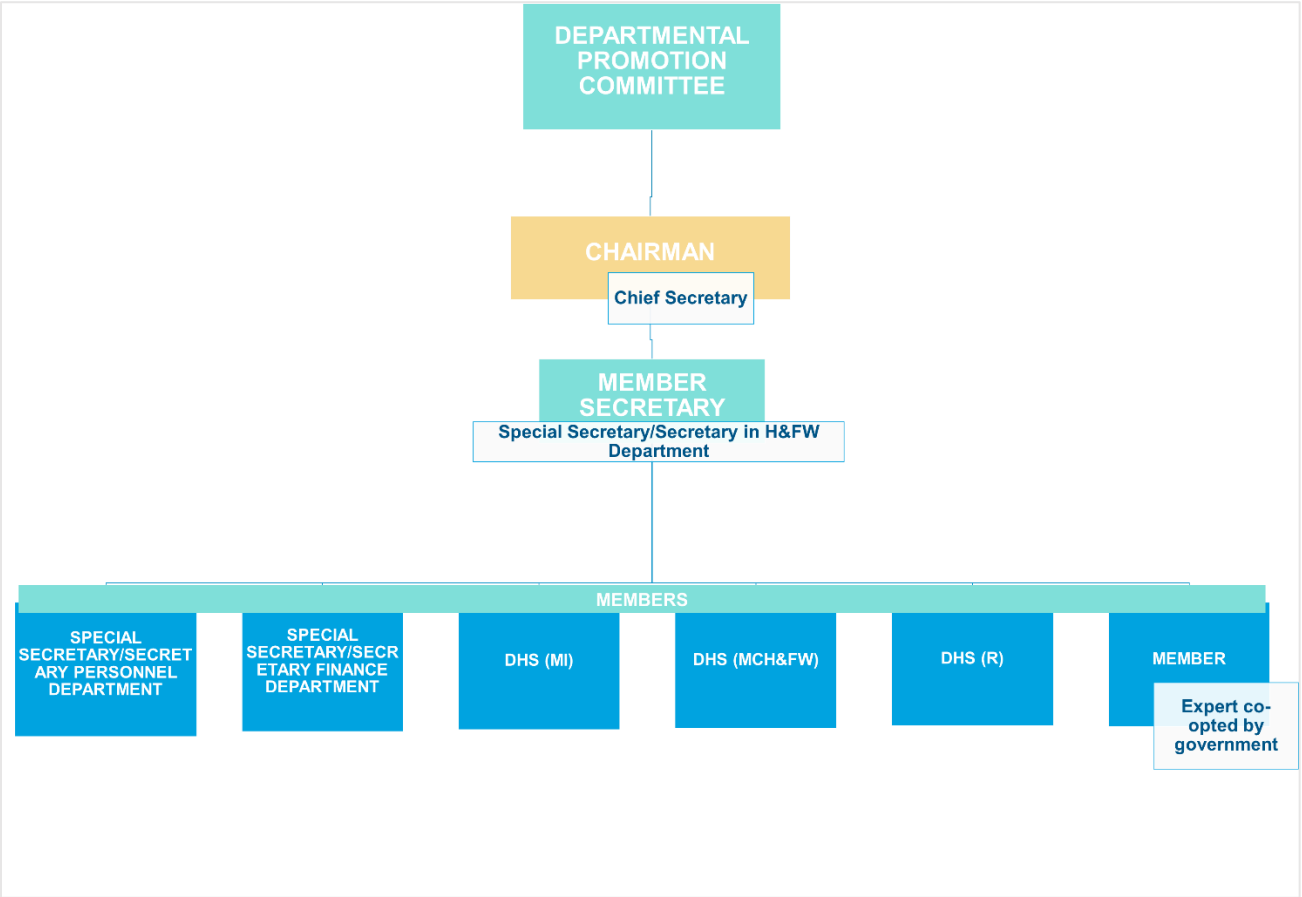
II) Departmental Promotion Committee

The Meghalaya Health Service Rules, 1990 provides details of the constitution of the committee (Fig. 19). It also provides insight into its function as a committee that is referred vacancies at various grades by the State. Based on character rolls, service records, and any other relevant document, the Committee prepares select lists for each of the grades where vacancies are available. The 1990 rules assert the need for the list to be three times the number of vacancies and is governed by staff seniority with ‘due regard to individual merit and

[28] http://www.mgpharmacycouncil.com/

suitability of members for promotion'. On occasions where junior members are preferred for promotion over senior members in the list, the Committee provides justification for the same.

FIG. 21: DEPARTMENTAL PROMOTION COMMITTEE COMPOSITION



III) Medical Waste Management (Biomedical Waste) under DHS (R)

Through the IQVIA checklist exercise, it was found that the DHS (R) has a Biomedical Waste Management Committee. It is responsible for:

- Compliance with regards to Bio Medical Waste Management.
- Submit Quarterly reports of Bio Medical Waste.
- Any other matter that may arise relating to Bio Medical Waste.

However, the constitution of the committee is not available.

IV) Internal Committee Sexual Harassment of Women at Work Place

The constitution of the committee is unknown. Its purpose as mentioned by DHS (R) is to oversee the implementation strategy of the Sexual Harassment of Women at Workplace (Prevention, Prohibition & Redressal) Act 2013.

V) Internal Grievance Committee in redressal of employment/services related grievances

The Committee examines the complaints of individuals belonging to Schedule Tribe on matters.

- Non-maintenance of reservation roster and filling up of reserved vacancies.
- Discrimination in promotion/MACP/ACP.
- Non-appointment on compassionate grounds.
- Adverse/downgrading of APARs
- Termination/dismissal from services.
- Discrimination in transfer/posting.
- Denial of pensioner benefits etc.

The Committee also prepares quarterly reports and submits to the Social Welfare Department if any grievances are registered.

VI) Rogi Kalyan Samiti (RKS)/ Hospital Management Committee (HMC)[29]

Rogi Kalyan Samiti (RKS)/ Hospital Management Society is a registered society, which acts as a group of trustees for the hospitals to manage the affairs of the hospital. It consists of members from local Village councils, NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs. RKS has been set up in the various districts in the District Hospitals, CHCs and PHCs. Details of the same are below:

TABLE 21: ROGI KALYAN SAMITIS AT DH, CHC AND PHC LEVELS

DISTRICT	DISTRICT HOSPITAL	CHC	PHC
East Khasi Hills	1	6	23
West Khasi Hills	1	5	19
Ri Bhoi	1	5	8
Jaintia Hills	1	3	18
West Garo Hills	1	7	18
East Garo Hills	1	2	16
South Garo Hills	1	1	7
Total	7	29	109

D) Public Private Partnerships-Organizations working with the state[30]

Considering the state's unique challenges in terms of health care service delivery, and with an aim to ensure that the health care delivery services are also given to these remotest parts of the State, in the year 2008, Health & Family Welfare Department, Government of Meghalaya through National Health Mission (erstwhile National Rural Health Mission) decided to implement Public Private Partnership (PPP) as a pilot project, by outsourcing management of 22 hard-to-reach health facilities including its Sub Centres to selected Non-Government Organizations (NGOs).

These two health facilities include -- 2 CHCs and 19 PHCs and one state dispensary from nine districts of the State and had been handed over to 5 non-profit organizations namely --Karuna Trust, Voluntary Health Association of Meghalaya (VHAM), Citizens Foundation, Jaintia Development Society and Bakdil. The strategic objective of the PPP project is to provide quality clinical and preventive health services to the people residing in the Primary Health Centre area at the same time effectively implementing NHM and other National programs

[29] http://nhmmeghalaya.nic.in/programmes/rks-hms/status.html

[30] Information provided by state

(E.g., Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram, Rashtriya Bal Swasthya Karyakram, Rashtriya Kishor Swasthya Karyakram, etc) including IEC activities.

TABLE 22: NGOS THE STATE HAS ENGAGED UNDER PPP MODE ACROSS THE STATE

SL. NO	DISTRICT	HEALTH BLOCKS	NAME OF NGOS	NAME OF HEALTH FACILITY
1	East Khasi Hills	Mawkynrew	Voluntary Association of Meghalaya	Jatah PHC
2		Mawsynram		Dangar PHC
3		Shella Bholaganj	Karuna Trust	Mawsahew PHC
4				Mawlong PHC
5			Citizens Foundation	Ichamati CHC
6	West Khasi Hills	Mairang	Citizens Foundation	Nongkhlaw CHC
7			Karuna Trust	Kynrud PHC
8		Mawthadraishan		Myriaw PHC
9		Nongstoin		Maweit PHC
10		Mawshynrut		Aradonga PHC
11	West Jaintia Hills	Laskein	Jaintia Hills Development Society	Sahsniang PHC
12				Barato PHC
13	East Jaintia Hills	Khliehriat	Karuna Trust	Umkiang PHC
14		Saipung		Saipung PHC
15	Ri Bhoi District	Umsning	Karuna Trust	Umtrai PHC
16		Jirang		Warmawsaw PHC
17				Jirang St. Dispy
18	West Garo Hills	Rongram	Bakdil	Babadam PHC
19	North Garo Hills	Kharkutta		Wageasi PHC
20		Resubelpara		Gabil PHC
21	South West Garo Hills	Zikzak		Salmanpara PHC
22	South Garo Hills	Baghmara		Siju PHC

E) Key findings of available committees and societies

TABLE 23: KEY FINDINGS ON COMMITTEES & SOCIEITES

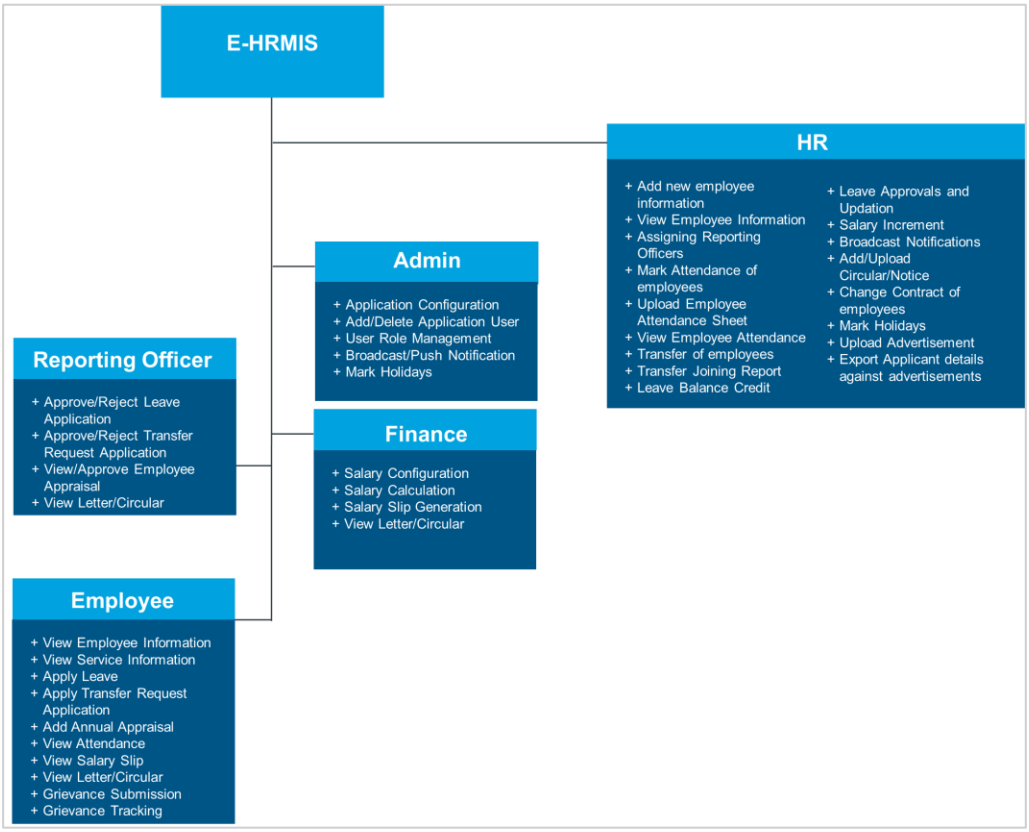
Regular	Contractual
• Organograms of some societies, committees and councils have been made by IQVIA team based on information gathered during the secondary review through various sources: ▪ Three societies have been identified of which Meghalaya State AIDS Control Society's organogram was developed based on details available on its website. Information has been	• Committees for selection of candidates, promotion, recruitment and disciplinary action are formed at both state and district levels • Rogi Kalyan Samiti/Hospital Management Committees are also formed across the state details of which are also captured within the report

collated for all societies except for Regional Health and Family Welfare Training Centre Management Society's. Organograms of other societies with details available from documents and other sources are available as annexures. ▪ The three councils identified above, and their functions are available. However, little clarity on the organograms of the councils have been found and would need to be further clarified by the councils or the state. ▪ Of the five committees identified above, organogram of the Departmental Promotion Committee was developed by IQVIA through the Meghalaya Health Service Rules, 1990. Details of its functions are also provided. However, the current role of the committee along with the details of the Meghalaya Health Advisory Board are necessary to better placed for recommendations on the development of a health recruitment board. ▪ Social Audit Committees and their current role needs to be clarified by the state which has been mentioned within the State Health Policy 2021	

4.4. HUMAN RESOURCE MANAGEMENT INFORMATION SYSTEM (HRMIS)

A) HRMIS

FIG. 22: E-HRMIS FUNCTIONS

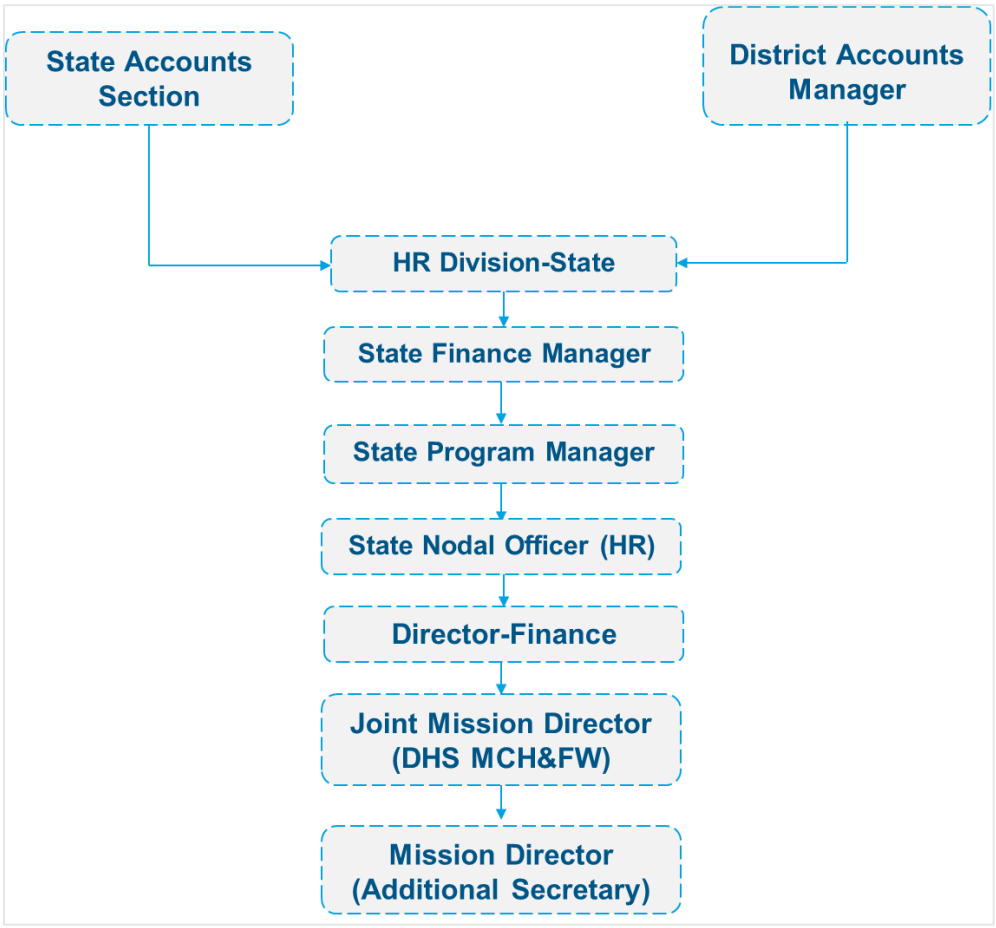


The Government of India (GOI) has included establishing a human resources management information system (HRMIS) for health workers as an important priority in its 12th five-year plan. The GOI's reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCH+A) strategy also emphasized the mandatory disclosure of all facility-level deployment of human resources on the state NHM website. Further, MoHFW, GOI has issued letter

to Mission Director, NHM of all the States & UTs to implement HRMIS and the application should be designed in such a way that it is integrated with process of appointment, transfer, promotion, salary disbursement etc. so, that HR database always remains updated. Accordingly, NHM Meghalaya prepared E-HRMIS portal designed by C-DAC, Silchar, Assam with its management undertaken by the NIC team in Himachal Pradesh.

Payments management:

FIG. 23: E-HRMIS PAYROLL MANAGEMENT



The information delivered by the E-HRMIS to the state covers major data points for HRH and is the preferred platform for the state to monitor and manage HRH data related to the NHM contractual staff.

B. Electronic Fund Management System (eFMS)

Payment process for unskilled health workers. To address the delay in payment of wages, avoid parking of funds at various levels and ensure transparency Government of India decided to go in for Electronic Fund Management System.

Objectives of eFMS:

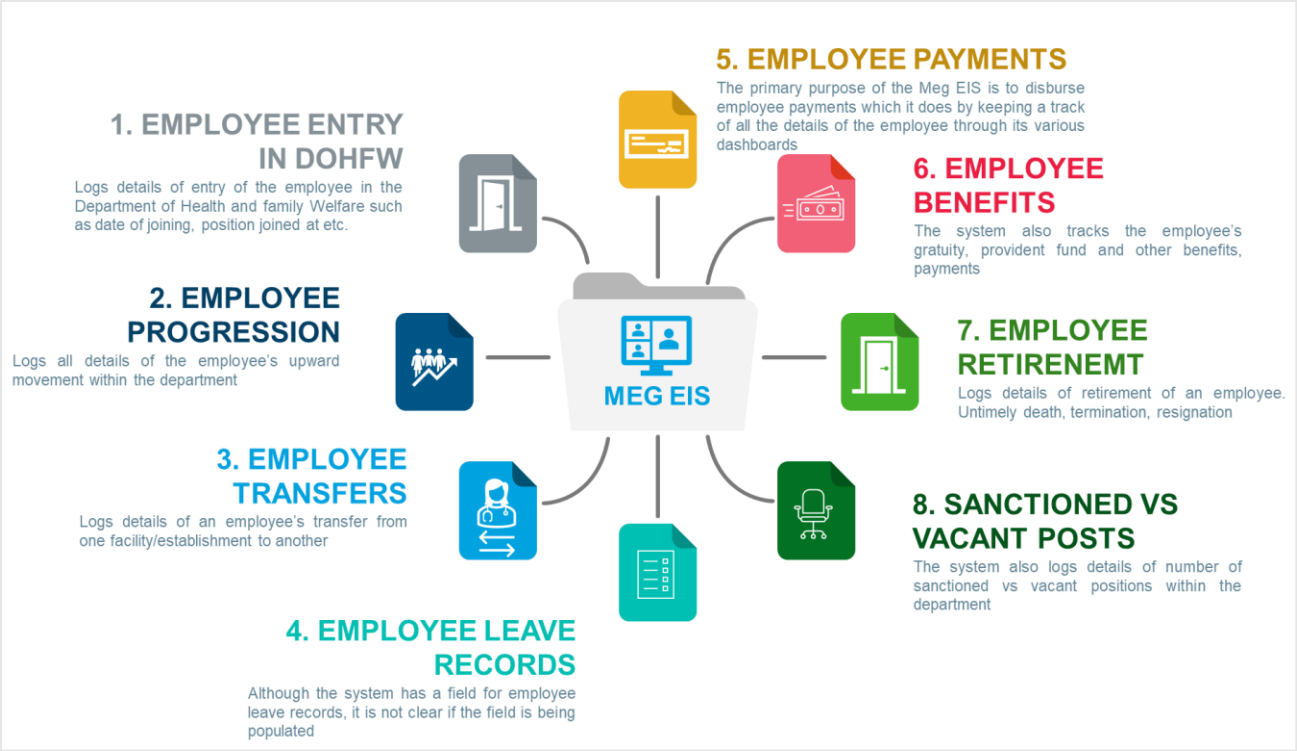
1. e-FMS solution will automate all processes involved in crediting the accounts of the beneficiaries.
2. Reduction in the turn-around time required for wage processing and payments

3. Automation of processes will eventually lead to real-time availability of data at all levels of governance for strategic decision making.
4. e-FMS will act as seamless payment mechanism which will automatically ensure fund transfer and crediting of beneficiaries accounts leveraging the Core Banking infrastructure (NEFT/RTGS) of banks.
5. The system ensures right amount in right accounts in time.
6. Successful implementation of the project across the country would do away with large number of bank accounts that are currently being operated by the Gram Panchayats all over the State as payments would be credited to the accounts of beneficiaries from an e-FMS Account.
7. This would also take care of the problem of large unspent opening balances.

C) Meg EIS[31]

Meghalaya Employee DB is an integrated package of Personnel Information which includes Basic Information, Leave Record, Salary, Loan, HR/Service Book), Payroll etc.

FIG. 24: MEG EIS DATA POINTS ON EMPLOYEE RECORDS FROM 2014 ONWARDS



The system is the payroll management of regular staff under DoHFW and is hosted by National Informatics Centre (NIC).

D) Key findings of human resource information systems within the state

[31] http://megfinance.gov.in/Employee-Information-System.html#:~:text=Meghalaya%20Employee%20DB%20is%20an,is%20903%20out%20of%20960.

TABLE 24: KEY FINDINGS ON HRMIS IN MEGHALAYA

REGULAR	CONTRACTUAL
• There is no system which is developed to capture HRH information in terms of regular employees • During the secondary review, through various discussions with WB TT and PMU, the Meghalaya Employee Information System (Meg EIS) used by the Directorate of Accounts and Treasury was brought forth. It contains data related to regular and temporary health staff across the state working under the DoHFW • Meg EIS has been developed and maintained by National Informatics Centre (NIC) captures crucial data points on regular roll staff including that of 3F	• The current E-Human Resource Management Information System (E-HRMIS) captures various data points related to contractual employees within the health system under NHM. • E-HRMIS is maintained by Centre for Development of Advanced Computing (C-DAC) and is a stable and strong web-based application that can be leveraged to aggregate all relevant details of health personnel on regular roll including 3F employees among others. • The system has eight different modules for employees to input their information with all 11 districts' NHM contractual staff mapped under the E-HRMIS. It is a real time data entry & web-based portal software (including Android and iOS). Further, data centrally managed and maintained by C-DAC and stored in their server. • Does not capture comprehensive information of all health staff now which means that regular staff, 3F and muster roll staff are excluded from the system

Gap analysis for HRMIS

- Even with the existence of an E-HRMIS system for the contractual staff, it has been determined that the collection of information for regular staff was a challenge during the HRH data collection for NHM staff.
- The state needs to complete the HRH enumeration and store the overall state data including that of regular staff. Although Meg EIS is an essential data source, it is only resourceful for aligning information that is stored for payment disbursement purposes.

4.5. TRAINING

The Regional Health and Family Welfare Training Centre (RHFWTC) was brought forth by the Central government to serve as a regional centre that imparts trainings to health workers in Meghalaya and its neighboring states.

A) Training capacity at the Regional Health & Family Welfare Centre

There are about 10 broad categories of trainings offered by RHFWTC.

FIG. 25: CURRENT COMPOSITION OF THE RHFWTC

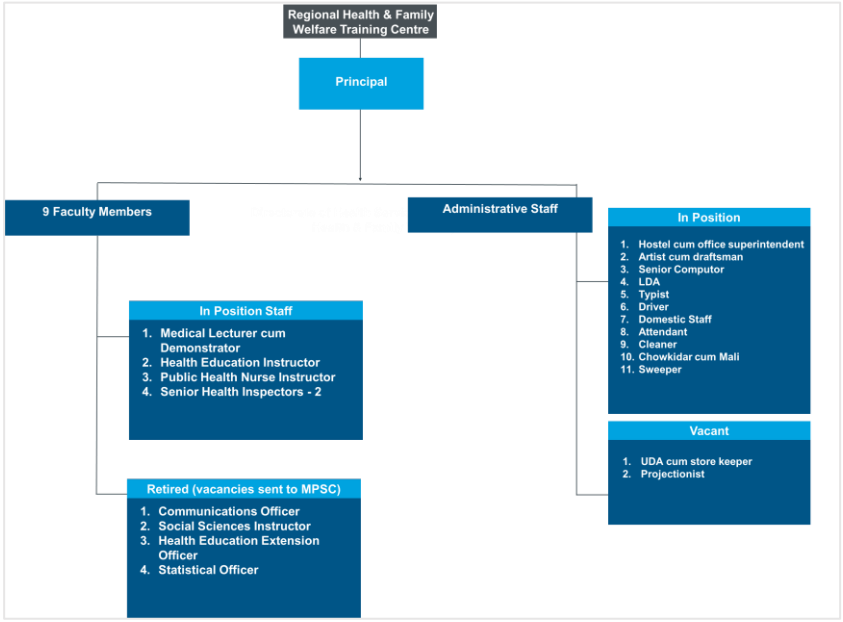


TABLE 25: LIST OF TRAININGS CONDUCTED BY RHFWTC ANNUALLY

SL. NO.	NAME OF THE COURSE	CATEGORY OF TRAINEES	NO. OF DAYS	SESSIONS PER YEAR
1	Adolescent Health	HE/Block Extension Educator/Community Health Officer/Public Health Nurse Auxiliary Nurses & Midwives/Female Health Workers Health Assistant (M&F)/ Barangay Health Workers/Multi-Purpose Workers/ Vaccinators etc. Lady Health Visitors	3	7
2	Capacity Building on Community Participation	Health Assistant (M&F)/ Barangay Health Workers/Multi-Purpose Workers/ Vaccinators etc. Auxiliary Nurses & Midwives/Female Health Workers Medical & Health Officers HE/Block Extension Educator/Community Health Officer/Public Health Nurse Lady Health Visitors	3	6
3	Counselling Skills	HE/Block Extension Educator/Community Health Officer/Public Health Nurse Lady Health Visitors Auxiliary Nurses & Midwives/Female Health Workers Health Assistant (M&F)/ Barangay Health Workers/Multi-Purpose Workers/ Vaccinators etc. Medical & Health Officers	3	7
4	Gender Based Violence & Health	Auxiliary Nurses & Midwives/Female Health Workers Medical & Health Officers HE/Block Extension Educator/Community Health Officer/Public Health Nurse Lady Health Visitors Health Assistant (M&F)/ Barangay Health Workers/Multi-Purpose Workers/ Vaccinators etc.	3	6
5	Health Communication Behaviour Change	Auxiliary Nurses & Midwives/Female Health Workers HE/Block Extension Educator/Community Health Officer/Public Health Nurse Lady Health Visitors Health Assistant (M&F)/ Barangay Health Workers/Multi-Purpose Workers/ Vaccinators etc.	5	9
6	Immunization	Health Assistant (M&F)/ Barangay Health Workers/Multi-Purpose Workers/ Vaccinators etc.	2	3
7	Mental Health (Online)	Auxiliary Nurses & Midwives/Female Health Workers Medical & Health Officers Supervisors	1	5
8	Reproductive Maternal Neonatal Child Health & Adolescent	Lady Health Visitors HE/Block Extension Educator/Community Health Officer/Public Health Nurse Auxiliary Nurses & Midwives/Female Health Workers	5	9

9	MSACS Trainings	ASHA and ANMs	6	2
		Counsellors (STI/RTI Trainings	3	1
10	Management Training	Medical Officers	5	2

As the centre continues to function on insufficient funds allocated by the DHS (MCH&FW) under which it functions at present, table 23 above is an overview of the courses (taken from the Annual Calendar 2022 of the RHFWTC) available at the training centre per calendar year.

B) Overall trainings undertaken across Meghalaya

Further data collated by state on skill development-based trainings conducted for regular and contractual NHM staff across the state provides insight into the current trainings that doctors, nurses, pharmacists and lab technicians have access to at present. Details of the same are provided in Table # below:

TABLE 26: TRAININGS AVAILABLE TO REGULAR AND NHM CONTRACTUAL STAFF ACROSS MEGHALAYA

SL. NO	SKILL DEVELOPMENT BASED TRAININGS	HRH CATEGORY
1	Maternal health - Antenatal, delivery and postnatal care	**Doctors and Nurses**
2	Child Health	
3	Reproductive: Medical Termination of Pregnancy (MTP)/ Family Planning Services/ Intra-Uterine Contraceptive Device (IUCD)	
4	Communicable disease/Infectious diseases	
5	Non-communicable disease: Hypertension, Hearth Attack, Diabetes, Cervical Cancer, Breast Cancer & Oral Cancer	
6	Integrated Disease Surveillance Project (IDSP) & Information Technology (IT)	
7	Mental Health/ Counselling skills	
8	Palliative Care & Elder Care	
9	Blood and Lab Services	
10	Medical legal examination & reporting	
11	HIV & AIDS detection and management	
12	Blood bank services	
13	Administration & Finance management at health facility	
14	Biomedical waste management	
15	Life Saving Anesthesia Skills (LSAS)	
16	Basic Emergency Obstetric Care (Bemoc)	
17	Quality Assurance	
18	**Drug store and inventory management**	**Pharmacist**
19	Procurement Management	
20	Quality Assurance	**Lab**
21	Special training on detection of infectious disease	
22	Special training on detection of HIV & other disease. New diseases	
23	Blood bank services	

C) Key findings of the current trainings, resources and equipment available to the RHFWTC below:

TABLE 27: KEY FINDINGS ON TRAINING CAPACITY OF RHFWTC IN MEGHALAYA

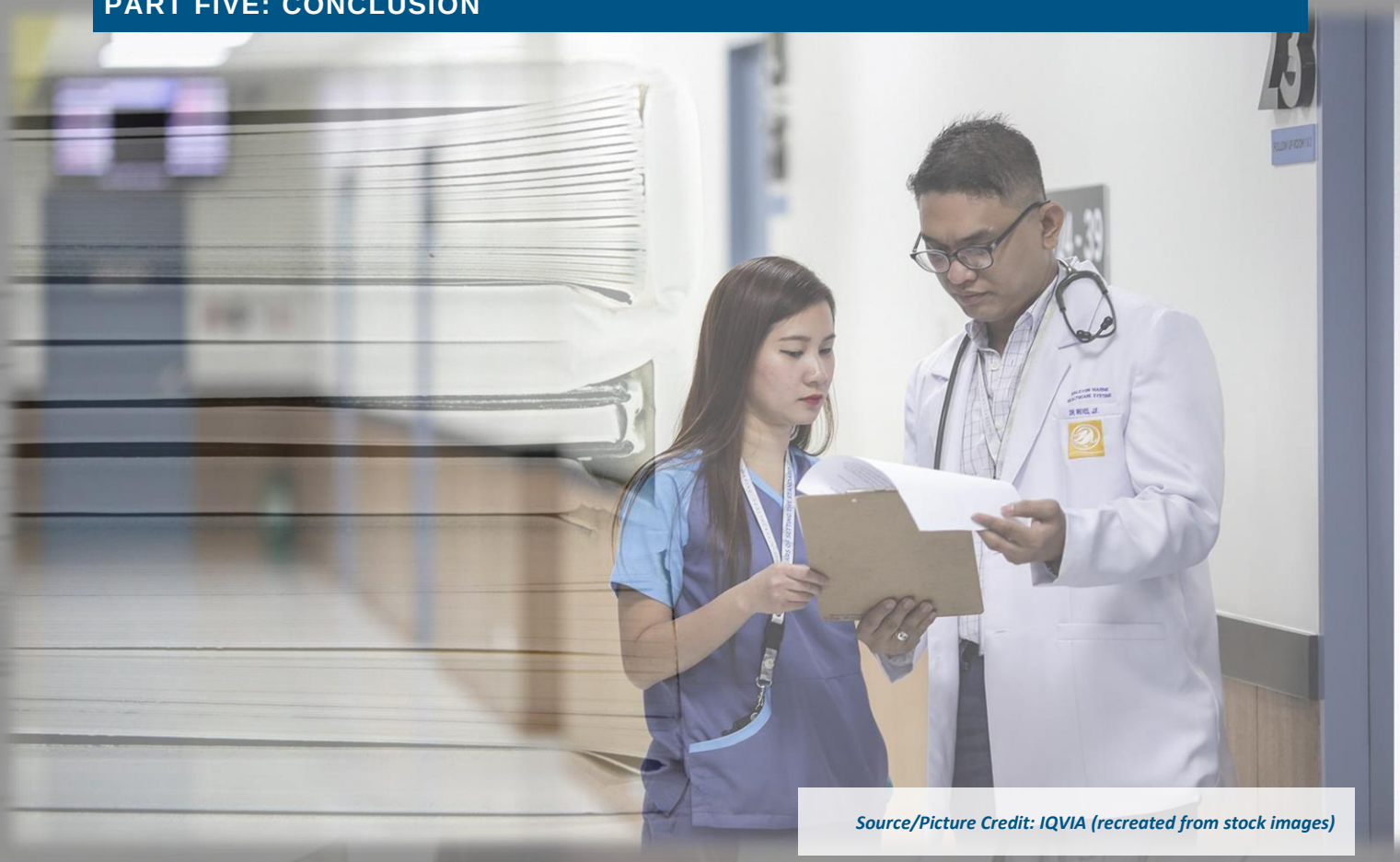
TRAINING CAPACITY
Through the training checklist developed and administered by IQVIA, the Regional Health & Family Welfare Training Centre's (RHFWTC) current capacity, functions and training curriculum were reviewed. Issues or the lack of resources have been highlighted as under:

- **Physical infrastructure:**
  - The training institute has a mini training hall, resource centre, hostel accommodation, internet services and parking
  - It lacks a main training hall, board room, records room, computer lab, power back up, cafeteria, emergency fire exit and is not structured with accessibility for disabled in mind
- **Equipment and transport:**
  - Outdated laptops/computers. The centre has only one laptop and a basic functioning printer which requires updating
  - Second-hand transport facilities from 30 years ago are in use
  - A video conferencing subscription (such as Zoom) for online trainings is not available and the centre depends on NHM for the same
- **Human resources:**
  - The training centre has expert visiting faculty filling in the gaps for the existing vacant faculty members' training courses. At present, positions remain vacant for following positions: Communications Officer, Social Sciences Instructor, Health Education Extension Officer and Statistical Officer, Projectionist and UDA
  - Training of Trainers (ToT) for Faculty is not available impeding the capacity of existing trainers to take up new subjects for training. Where the need is felt for a new subject, an expert is brought in for such cases.
  - Filling the vacant positions is priority for the training centre at present
- **Accommodation for trainees (Hostel):**
  - Power backup is available with 3-6 bedded rooms (bed, mattress, clean linen, geyser and heater)
  - Does not have funds for running the kitchen
  - Does not have a security guard, no AC, cooler
- **Library & training materials:**
  - Training calendar and training materials are outdated
  - Library in-charge, budget and subscription to national and international journals are not available to the centre
  - Indexed resources are put in a manual register
- **Budget:**
  - The training centre is used by the directorates and NHM. The NHM trainings are dependent on NHM budget. While budget for trainings from Directorate are managed through the training centre's self-generated resources
  - The training centre does not have a dedicated budget
  - Does not have funds for running the kitchen for visiting trainees from other districts accommodated at the hostel

Gap analysis for state's training capacity

- The Regional Health & Family Welfare Training Centre functions and provides all trainings from Shillong which is the state headquarter. This limits the ability of healthcare staff to take time and days out to travel and visit the centre to undergo the trainings. In consultation with the MCH training representatives of the PMU, a rough estimate was made, for instance, that a doctor/healthcare staff posted in Garo Hills and in need of training will have to spend two days to travel to and from Shillong and three days to attend a training which will lead to loss of five days of work. Travel time can be reduced if the doctor/healthcare staff has training avenues within her/his district of posting
- The state needs to strategically rationalize healthcare workforce trainings. With proper budget allocation and a training projection plan (which can be born out the training needs assessment exercise), the state will be better equipped to have clear and relevant trainings for all healthcare staff. It is also recommended that the state undertake mechanisms to build capacities of trainers at the district level so that training opportunities are uniform district wise
- Outdated training materials and no access to academic journals at the regional training centre was also taken into account during the secondary review along with paucity of budget and comprehensive training plan despite the existence of a training calendar
- Pre-service training is missing in the training schedule or any other training curriculum
- Budget and capacity building of the RHFWTC in terms of infrastructure, training resources, human resources, equipment among others has to be streamlined

PART FIVE: CONCLUSION



Source/Picture Credit: IQVIA (recreated from stock images)

5. NEED FOR POLICY REFORMS

A recent study on HRH gaps in India states that the various possible reasons behind the existing shortfalls in HRH in public facilities could be attributed to requirement of state specific domicile, language barrier, slow, and cumbersome process for recruitments by public service commissions, rural postings requirement, lack of incentives, migration of HRH, and non-availability of adequate fund[32]. Based on similar gaps identified from secondary review of the policies/guidelines/GOs in Meghalaya, IQVIA understands that the state's Health & Family Welfare Department would benefit from some key policy reforms for better functioning as illustrated in the Fig. 25 below:

FIG. 26: POLICIES TO BE REFORMED OR INTRODUCED IN THE STATE

5.1 BEST PRACTICES IDENTIFIED FOR POLICY REFORMS

In the above context IQVIA is proposing some of the HRH best practices from various states across the country that are described below.

Recruitment: Knowing that the shortfall in HRH is more in rural areas compared to the urban areas, an urban bias in the distribution of HRH is visible. Regular recruitment based on a rationale similar to that of Tamil Nadu or West Bengal would be more resourceful.

TABLE. 28: RECRUITMENT GAPS IN MEGHALAYA AND BEST PRACTICE MODELS

CURRENT GAPS	BEST PRACTICE MODELS	INTERVENTION
• Unavailability of a comprehensive recruitment policy that covers all aspects of the recruitment process • Irregular recruitment • Delay in recruitment (backlog of recruitment of healthcare workforce since 2017 which was when the last MPSC was held)	• Tamil Nadu Medical Recruitment Board • Medical & Health Recruitment Board of Assam • West Bengal Health Recruitment Board	• Government of Tamil Nadu established Medical Services Recruitment Board (MRB) in 2012 to make direct recruitment to various categories of staff in the Health & Family Welfare Department. • Similarly, the Medical and Health Recruitment Board in Assam was established to recruit Human Resources in public health facilities, medical colleges and AYUSH colleges. • Another example is the West Bengal Health Recruitment Board (WBHRB) which also delinked

[32] Kumar, Shobhit; Sarwal, Rakesh. Closing human resources gap in health: Moving beyond production to proactive recruitments. Journal of Family Medicine and Primary Care: August 2022 - Volume 11 - Issue 8 - p 4190-4194 doi: 10.4103/jfmpc.jfmpc_2463_21

• Contractual recruitments with low to no guarantee of recruitment on regular roll • Low clarity in recruitment process under the Meghalaya Health Service Rules, 1990	• Haryana Recruitment Process	the health department's recruitment process to ensure speedy on-boarding of health staff hence speedy service delivery. The WBHRB oversees selection and recommendation of candidates for direct recruitment to permanent or temporary positions. • Further the Haryana government, while defining the specialist cadre policy, also laid out a simple recruitment process which was attached to strict timelines. Recruitment season began between November to January with one month taken for calculation of vacancies, one month for vacancy advertisement, one month for scrutiny of applications and selection and finally for issuing of appointment letter and on-boarding

The above best practice models have been successful as a result of the availability of requisite information such as availability of data for total number of vacancies and a strong mechanism to ensure timely recruitment. Meghalaya's recruitment process can be successful if all factors are considered. The same have been listed below:

- **Availability of accurate data** on sanctioned and vacant posts (this should also include total number of staff on contract holding sanctioned posts). Instating a central HRMIS system to capture and monitor this data would be instrumental in providing accurate data and enable the state to have better projections as well as be better prepared in terms of not just recruitment but also for promotions
- **Determining frequency for recruitment** is necessary to ensure timely and well planned recruitment. It is recommended that the state undertake recruitment more than twice a year initially, consider repurposing the recruitment season from the Haryana model and incorporate the same

Transfer Posting: During secondary review, it was discovered that neither the Meghalaya Health Service Rules, 1990 nor any other service document pertaining to government service employees covers the transfers and postings of health personnel under the Health & Family Welfare Department. In a separate ongoing study for specialist cadre within the state, it was ascertained that the absence of such a policy has led to arbitrary postings for several key HRH staff under the department. The state needs to prioritize instating a transfer posting policy

TABLE. 29: TRANSFER & POSTING GAPS IN MEGHALAYA AND BEST PRACTICE MODELS

CURRENT GAPS	BEST PRACTICE MODELS	INTERVENTION
• No transfer posting policy • Arbitrary transfers • No regular and rotatory transfers • Undefined rural posting duration in the Meghalaya Health Service Rules, 1990 • No mechanism to monitor transfer and postings of health staff to	• Karnataka Transfer Policy • Himachal Pradesh Difficult Area and Compulsory Rural Posting	• To rationalize transfers and to address long standing requirement for structural framework for transfer and posting, the Karnataka government launched the 'Counselling Act'. It led to computerized transparent counselling for transfers. It led to rational deployment of highly skilled care providers/specialists at the facilities. Real-time update on vacancies with all substitutions reflected on the HR database are displayed on the website

ensure transparency and fair transfers		instantly after the transfer. Counseling and priority listing have helped greatly in limiting favoritism, bribery and muscle power • Himachal Pradesh came up with "Guiding Principles for effecting transfers of State Government employees" in 2008 consequent to several litigations by government employees. It defined maximum limit of stay at one place for H&FW dept employees to be two years extendable depending on performance and administrative exigencies. It also defined frequency for difficult area posting to be just once during entire service period. Duration of stay in rural posting is for three years and is attached to promotions. All transfer and postings

The above best practice models have been successful as a result of the policy reformation by state governments, availability of requisite information such as availability of data for total number of transfers for each staff member, instating mechanism to monitor transfers as well as providing ample information to employees for their regular and rotatory transfers and postings:

- **Availability of accurate data** on number of transfers undertaken for staff members. If all transfers are logged into a central system such an HRMIS, it would enable the state to better manage and monitor the fair transfer of staff. Maintaining index cards for transferred staff such as that done in Himachal Pradesh would help keep a track of each employee transfers
- **Defining the duration** of posting as well as frequency would also help curb arbitrary transfers
- **Computerized counselling process** taken from the Karnataka counselling process can enable the state to ensure transparent transfers
- **Introduction of an airtight transfer policy** with all components from the best practices listed above would help the state ensure the right HRH mix

Rural Retention, Salary and Incentives: During secondary review, it was ascertained that there was a lack of incentives and performance-based recognition for healthcare staff, especially M&HOs posted in rural areas and given the task of running PHCs entirely on their own. Apart from that, during several discussions with key staff within the Health & Family Welfare Department, **it was evident that the rural posting allowance and other allowances were meagre and also happened to be a result of the low salary governed by the 5th pay commission.**

TABLE 30: RURAL RETENTION, SALARY & INCENTIVES GAPS IN MEGHALAYA AND BEST PRACTICE MODELS

CURRENT GAPS	BEST PRACTICE MODELS	INTERVENTION

• No rural retention plan • No incentives for rural or difficult area posting • No recognition for management of PHCs/facilities by doctors • Low salary and allowances	• Chhattisgarh Rural Medical Corps (CRMC) • Odisha Difficult Area Posting	• Chhattisgarh, with one of the lowest health human resource densities in the country and non-aligned staffing to IPHS norms or other global standards, took an initiative to retain and motivate the service providers to work in difficult and remote areas under the scheme "Chhattisgarh Rural Medical Corp (CRMC)". objective of improving the health services especially at difficult and remote areas by taking the services of current and retired employees of Department of Health & Family Welfare as well as from private sector such as doctors, specialists and staff nurses in those identified health facilities. It had four key components: o Attractive monthly incentives (doubled from previous incentive plan) o Priority in PG admission where bonus marks were awarded to staff serving under CRMC o Retention of government accommodations for families of CRMC staff o Assurance of posting in general area after tenure completion (regular transfer policy of the govt not applicable to CRMC staff) • Odisha Difficult Area Posting was done to source and retain Human Resource in difficult and hard to reach areas. The key criteria for identification of difficult areas included Difficult & backward location, tribal dominance, LWE affected, communication & transport, social infrastructure, distance from State hq. Odisha also implemented the corpus fund, management of which was decentralized and was capped at Rs. 1 crore per district. Place based incentives were provided to a GMO at Rs. 40K for most difficult V4 institutions and Rs. 80K for specialists.

The above states' best practices incorporated in this report can be successfully implemented by Meghalaya state if all possible actions are taken prior to implementation. The same have been listed below:

- **Segregation of state into most difficult, difficult and normal zones** to conduct both transfers and difficult area posting and then determining place-based incentives. The Odisha (11 districts) and Himachal Pradesh (12 districts) models can be reference points for the state
- **Revisiting the 5th Pay Commission along with the Finance and Personnel Department.** From the policy perspective and as a finding from a separate study undertaken among specialists, a key observation was that the state is two commissions behind other states. Policy reformation in this case is required. In the event that the same cannot be easily or immediately reformed, place-based

incentives as well as revision of allowances such as winter allowance, risk allowance among others need to be revisited and kept on the higher side (budget implications need to be factored in for the same)

- **Award and recognition mechanism for doctors with outstanding performance at PHCs.** During several discussions with doctors and specialists, it was found that the institutional and functional capacity of some non-functional facilities and departments have been undertaken with no incentives or even recognition. The recommendation would be to instate within the HRH retention policy, the provision to award and reward HRH staff/teams in the peripheral areas as well as facilities and departments. A mechanism to monitor the performance of staff through ACRs or through logging of information on HRMIS can be undertaken. Some parameters through which the same can be measured would be availability of infrastructure during the tenure of a facility/department in-charge and the staff members, drastic change in patient footfall, among others

Specialist and Public Health Cadre Policy: During secondary review, it was discovered that the Meghalaya Health Service Rules, 1990 does segregate the health personnel into General Duty Stream and Specialist Stream. However, a specific specialist cadre and public health cadre policy does not govern their career progression. Other than that, the specialists progress at slow pace. In a separate ongoing study for specialist cadre within the state, it was also further noted that the irregular recruitment subjected a considerable number of specialists to the position of an M&HO under the 3(f) contract with no retention or regularization plan. The state needs to prioritize instating a transfer posting policy.

TABLE 31: SPECIALIST AND PUBLIC HEALTH CADRE GAP IN MEGHALAYA AND BEST PRACTICE MODELS

CURRENT GAPS	BEST PRACTICE MODELS	INTERVENTION
• No specialist cadre and public health cadre policy • Specialists often posted to facilities lacking infrastructure, equipment and key supporting staff • Specialists interested in pursuing clinical practice can only do so by foregoing their promotions •	• Odisha Medical & Health Services (OMHS) • Uttar Pradesh Medical and Health Services (UPMHS) • Haryana Civil Medical Services (HCMS)	• Restructuring of Odisha Medical & Health Service Cadre (OMHS) was done (2016-17) with creation of 1330 new posts of doctors. New posts created for four posts of specialists (O&G, Peds, Medicine & Surgery).The restructuring also came with a strong recruitment drive, rural retention plan, annual financial increments and most importantly attractive incentives (qualification based as well as difficult area posting based). • In Uttar Pradesh, specialists were not motivated to join government services since all doctors (with or without specialization) were hired as medical officers. But with the restructure one of the welcome changes was that specialists recruited directly till level 3 were able to practice in their home district which was not allowed earlier. As opposed to specialists being promoted in nine years in Meghalaya from Grade III to Grade II, a specialist in UP is promoted in a span of seven years and so on. Consultant positions were created instead between L3 to L5 to ensure clinical practice with senior, i.e., director level positions with ample scope for practicing beginning at L6 • In Haryana, apart from the restructuring and segregation of public health cadre and specialist cadre, there were changes in pay grade, and promotions were given out after every five years

		with the development of additional posts. The policy also laid focus on better working condition for specialists which included: ○ Enhanced infrastructure (e.g. OT) machinery, equipment and support staff, (Technicians, Paramedics, OT Assistant etc.) for ensuring that patients can be treated optimally by Specialists. ○ Removal of emergency or postmortem or administrative duties for specialists ○ Non-duties given due to administrative exigency, it would exempt specialists of Gynecology, Medicine, Surgery, Orthopedics, Paediatrics and Anesthesia

As discussed earlier, a holistic change in the streamlining of cadres can be undertaken in alignment with the central mandate to instate a Public Health Management Cadre which segregates the HRH into four specific cadres allowing for independent functioning as well as progression within the health state's health system. The state can initially focus on streamlining the Specialist and Public Health Cadre Policy. The rest of the cadres' policy reforms can be undertaken over time. Again, the success of the amendment of the Meghalaya Health Service Rules, 1990 to restructure the health services, is dependent on the following factors:

- **Budget allocation and relative feasibility for developing more positions** to ensure shorter period of time taken for promotions
- **Revision of pay structure** needs to be explored via revision of 5th pay commission to 7th Pay Commission with the Personnel Department as well as the Finance Department
- **Budget and infrastructure availability** for incentives and strategies implemented for rural retention need to be ensured. All incentives and revision of allowances are planned in alignment with the availability of budget
- **Availability of right HRH mix and reducing work burden** at facilities to support specialists as well as the right HR to manage emergencies, postmortems or other administrative duties.

Other recommended measures that the state can undertake:

- Creation of a common state level web portal for displaying vacancies and job opportunities for medical and paramedical staff members in different facilities (from primary healthcare to district level). This will provide information to aspirants regarding notified vacancies and provide a platform to apply for work in particular regions/areas as per their choices. Going by the corporate job portal models, the state can also consider developing a portal/mini site routed via the current Health & Family Welfare Department's official website which provides all notifications, houses an application form for compulsory notification of vacancies as is the case in Karnataka. Provision for registration of various healthcare professionals with basic information can also be made. District-wise vacancies can be uploaded on this portal for information of aspirant candidates. This may result in improved availability of HRH in public health facilities especially in rural, remote, and underserved areas.
- The state should consider creating avenues for paid internships, fellowships, observership, and apprenticeships, in facilities after completion of respective degree courses.
- Eligible professionals returning to state after completion of course should have the flexibility of further choosing to study to pursue a teaching career. Provision for assured career progression can be made,

as also promotion of eligible professionals as teaching faculty at either teaching hospitals in the state (as and when they become functional) or central institutes (such as NEIGRIHMS). The state can refer to the practice followed in Armed Force Medical Colleges.

5.2 SPECIALIST CADRE STUDY-PRELIMINARY FINDINGS

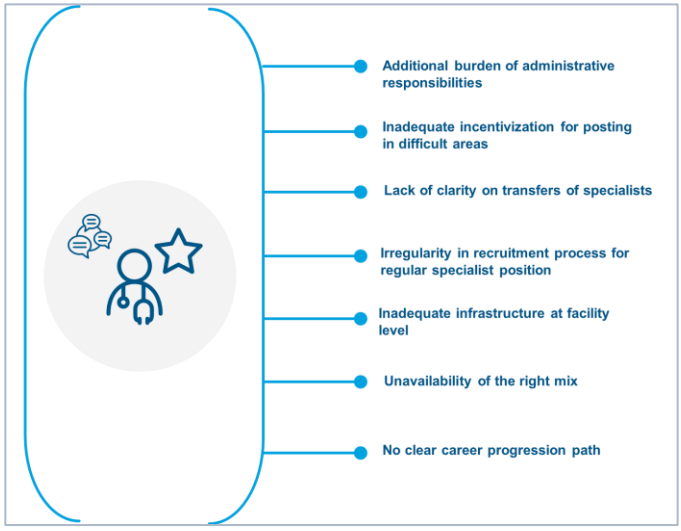
Based on the availability of specialists within the state, their deployment and initial interaction with a few of them, IQVIA developed an understanding of the current scenario. Although a more comprehensive approach will be undertaken to get qualitative information from the specialists, the following findings from the initial interaction are notable:

TABLE 32: KEY CONCERNS SHARED BY SPECIALISTS

1	**Inadequate infrastructure**	Inadequate physical structure of the health facilities, drugs and supplies, equipment, diagnostics and staff, staff quarter for specialist to function optimally.
2	**Unavailability of right mix**	• Unavailability of combination of gynae, pediatrician and anesthetist, at health facilities for effective service delivery. • Lack of certain specialists such as anesthetists
3	**Unclear career progression path**	• Career progression is slow; the rationale of promotions is based on seniority rather than performance; no equivalent clinical position at senior grade level. • Unclear career progression and regularization of 3F category of doctors/staff
4	**Burden of administrative responsibilities**	Specialists are being pulled into administrative work due to lack of Hospital managers.
5	**Inadequate incentivization for difficult areas**	Although an amount is set aside as an allowance for rural posting, there is no lucrative allowance/benefits for difficult areas
6	**Lack of clarity on transfers**	Lack of clarity on transfer and posting for specialists. Posting is done on need basis
7	**Irregularity in recruitment process**	Irregular recruitment process through MPSC
Note: Clarity required in no. of posts created/sanctioned by state for specialists under regular and contractual, specialization and health facility wise.		

It has been ascertained that the state does not have a specialist cadre and so does not have a clear progression plan for its health staff. To address the same, a specialist cadre policy would be imperative which would help streamline the current rules available in terms of specialists' roles and responsibilities, incentive packages, availability of posts to be filled by specialists among others.

FIG. 27: HIGHLIGHTS FROM PRELIMINARY DISCUSSIONS WITH SPECIALISTS IN MEGHALAYA



Given below are case studies undertaken by the IQVIA team on the specialist cadre policy designed and developed by the Odisha, Haryana and Uttar Pradesh governments in the recent past.

5.3. CASE STUDIES ON FORMATION OF SPECIALIST CADRE

Before delving into the formation of specialist cadre in the state, a fundamental understanding of the structural framework of the public health management cadre is necessary. As we are aware, multiple cadres exist in the

state (as is the case with several states). Creating a specialist cadre helps the streamlining of clinical and non-clinical activities among health staff. As per the Booklet for Public Health Management Cadre, Guidance for Implementation 2022 published by the Ministry of Health and Family Welfare, the Public Health Management Cadre consists of four cadres, namely, specialist cadre, public health cadre, health management cadre and teaching cadre. In the context of Meghalaya, IQVIA looked at the specialist cadre models in various parts of India and some key states' case studies have been listed below:

HARYANA SPECIALIST CADRE POLICY

Background

Health Department of Haryana has been facing shortage of specialists at District Hospital, Sub-District Hospital & Community Health Center due to a smaller number of specialists joining in Haryana Civil Medical Services (HCMS) and higher number of specialists leaving government sector due to lucrative job offers in private sector.

In view of this, Government of Haryana has drafted a policy with an objective of creating a specialist cadre within the existing cadre to make available secondary care specialist services & to retain the specialists in Haryana Civil Medical Services (HCMS).

Key interventions

Recruitment Drive

Separate recruitment process to be followed for General & Specialist cadre.

Annual recruitment at the level of DGHS through Departmental High Powered Selection Committee & removing it from purview of Haryana Public Service Commission.

Timelines for recruitment process

October	Calculation of vacancies
November	Vacancy advertisement
December	Scrutiny of applications & selection
January	Issuance of appointment letter

Post recruitment **if further vacancies exist, Civil surgeons are authorized to hire the services of MBBS/ Specialist doctors purely on contract basis**, by constituting a Committee consisting of Civil surgeon, one senior surgeon & in-charge of health institution concerned as per vacancy position for one year or till the regular incumbents joins or whichever earlier.

No Specialist are allowed to join the general cadre except mentioned otherwise or on medical ground certifying that the doctor is unable to perform specialist services by board of PGMIS Rohtak or any Government medical college

Better working conditions for specialists

To provide ample opportunity for specialist to do clinical/surgical work related to the specialty. Haryana government shall take necessary steps on following:-

1. **Enhance Infrastructure (e.g., OT) machinery, equipment and support staff, (Technicians, Paramedics, OT Assistant etc.) for ensuring that patients can be treated optimally by Specialists.**
2. Specialists shall not be given any **emergency or postmortem or administrative duties**, which are not related to their specialty.

Wherever such non-duties need to be given because of **administrative exigency**, the specialists of Gynecology, Medicine, Surgery, Orthopedics, Paediatrics and Anesthesia shall **be exempted**, and other options be explored.

In-charge of the concerned health facility shall make all efforts that specialists perform only clinical duties. related to their respective specialty; however, it shall also be ensured that other duties are not suffered

Source: Letter issued by Additional Chief Secretary, Health Department, Government Haryana to DGHS, Haryana dated 6th Sept 2021

Existing Designation	Existing structure as equivalence of designation	
	Length service	Pay Structure
Medical Officer	Entry	GP Rs 5400 (FPL-10)
Medical Officer	After 5 years	GP Rs 6600 (FPL-11)
Additional SMO/ SMO	After 10 years	GP Rs 7600 (FPL-12)
ASMO/ Civil Surgeon	After 15 years (as per seniority)	GP Rs 8700 (FPL-14)
DHS (Medical)	As per seniority	GP Rs 9500 (FPL-17)
ADHS		GP Rs 9800 (FPL-18)
NIL		
DGHS	As per seniority	HOD Scale (FPL-20)

Proposed Designation	Proposed Structure	
	Length service	Pay Structure
Junior Specialist	Entry	GP Rs 6600 (FPL-11)
Additional Specialist	After 5 years	GP Rs 7600 (FPL-12)
Specialist	After 10 years	GP Rs 8700 (FPL-14)
Senior Specialist	After 15 years	GP Rs 9500 (FPL-17)
NIL		
Principal Specialist	After 20 years	GP Rs 9800 (FPL-18)
Chief Specialist (Single post)	As per seniority	GP Rs 10000 (FPL-19)
Specialist-in-chief (Single post)	As per seniority	HOD Scale (FPL-20)

Existing Designation	Proposed Designation (Specialist)	Present Strength	Proposed Strength	
			General Cadre	Specialist Cadre
Medical Officer	Junior/Additional Specialist	**3641**	**2356**	**2064**
SMO/DD/ Dy. CS	Specialist	526	425	
MO/SMO (At De-addiction Centre of all the District Civil Hospitals)		22	0	
CS/ DDSS	Senior Specialist	48	29	
DHS	NIL	6	6	
ADGHS	Principal/Chief Specialist	1	1	
DGHS	Specialist-in-chief	2	1	
Sr. Consultants (At TCCC Ambala Cantt.)	-	6	0	6
Deputation/ PG/ Leave/ Reserve	-	350	330	20
Total		**4664**	**3148**	**2090**
			5238	

Key consideration under specialist cadre

- The specialties mentioned in the PG policy applicable at that time, would be considered for selection in specialist cadre. However, the **specialists of Hospital Administration. Public health and Community Medicine would be posted on administrative side but their seniority/pay structure would be as per the Specialist**
- The **existing specialists** (PG) in the cadre would have the option to opt specialist cadre. This option would be one and would not be changed, except on medical grounds. However, those who have done PG as in-service candidate shall have to opt the Specialist Cadre.
- The additional increments granted in lieu of the PG qualification, would be withdrawn for **the existing specialists who do not opt for Specialist Cadre.**
- If a doctor acquires PG degree during the service. S/he shall be designated as junior specialist.

Expected result

This proposal shall **increase the post for specialist cadre** to overcome the shortage of specialists at District Hospital, Sub-District Hospital & Community Health Center as mentioned below:

- **1516 posts of General Cadre are proposed to be shifted to Specialist Cadre (4664 - 3148 = 1516)**
- **Number of additional posts proposed for specialist cadre i.e. HCMS: 574 (2090 - 1516)**

Source: Letter issued by Additional Chief Secretary, Health Department, Government Haryana to DGHS, Haryana dated 6th Sept 2021

5.2. CASE STUDIES ON APPOINTMENT AND RETENTION OF HRH

ODISHA PUBLIC HEALTH & SPECIALIST CADRE RETENTION

Background

Department of Health & Family Welfare, Govt. of Odisha has taken concrete steps for augmentation of Human Resources in Odisha which includes not only creation of new posts or increasing seats in medical colleges, but also appointment of regular/ad-hoc/contractual Medical Officers & Specialists H&FW Department and further taken measures for retaining them as well.

Intervention

Recruitment Drive:

- Engagement of contractual doctors through walk-in interviews done monthly at district & state level
- Restructuring of Odisha Medical & Health Service Cadre (OMHS) was done (2016-17) with creation of 1330 new posts of doctors. New posts created for four posts of specialists (O&G, Peds, Medicine & Surgery).
- Increasing the promotional avenues. number of posts in Pay Band-IV from 35 to 433 thereby, increasing promotional avenues.

Incentives for rural posting:

- Categorization of 1,751 peripheral Government Health Institutions based on intensity of vulnerability (difficult and backwardness of the location, tribal dominance, left wing extremism, train communication, road and transport facilities, social infrastructure and distance from state head quarter etc.) was done.
- Incentives given to specialists and MOs based on the above categorization. E.g. a specialist working in V4 CHC gets Rs 80,000/- p.m. as per incentive.
- Corpus fund has been created in KBK and KBK plus for recruitment of HR including doctors and specialists allowing negotiable remuneration under this scheme

Incentives for Specialists:

Incentives have been provisioned for motivating Specialist doctors of Odisha Medical & Health Services (OMHS) cadre.

- Incentive for Doctors with Super Specialization: Rs.30,000/- p.m.
- Incentive for Doctors with Post-graduation: Rs.20,000/- p.m.
- Incentive for Doctors with Post- graduate Diploma: Rs.10,000/- p.m.

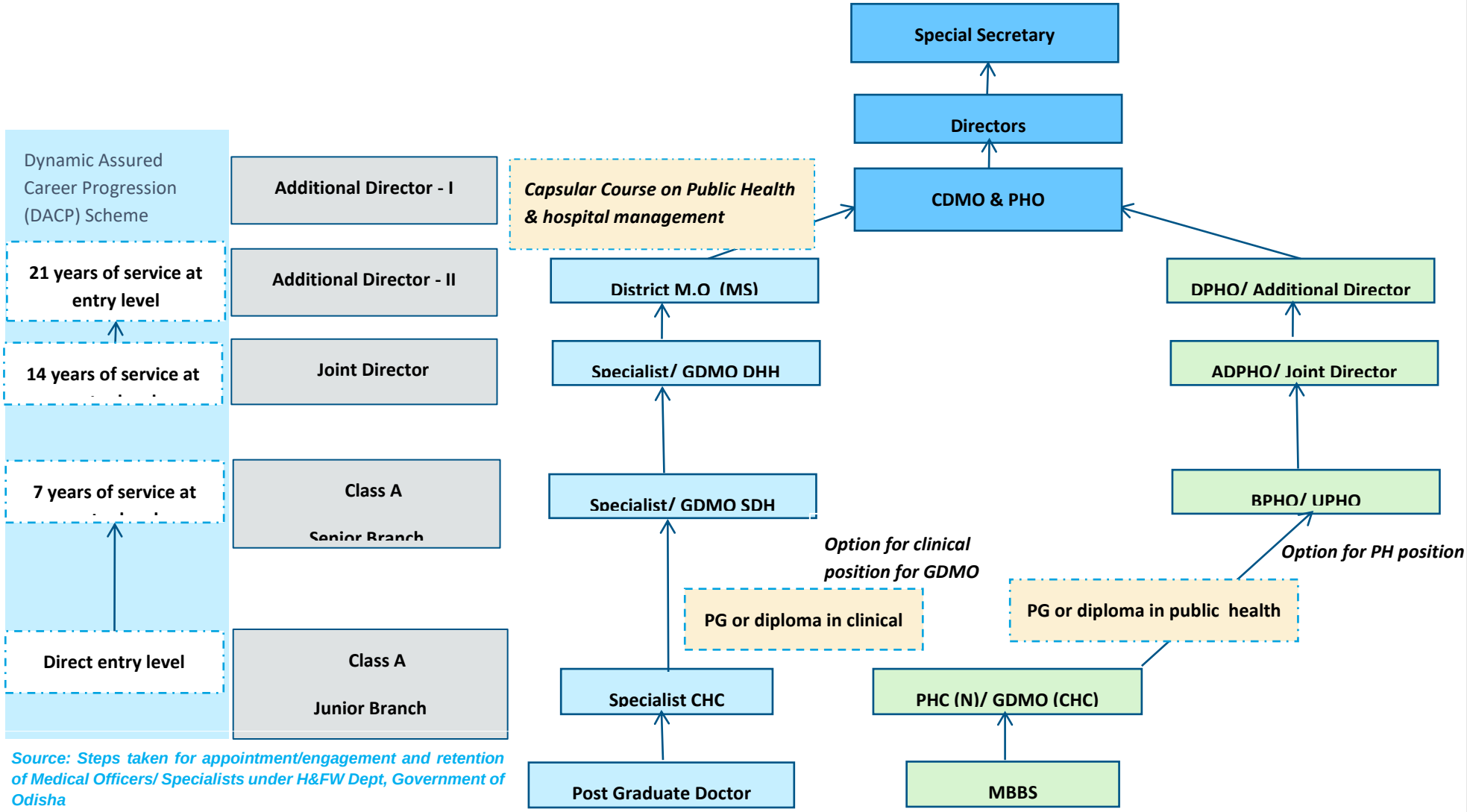
Annual financial increments:

The remuneration of contractual doctors have been enhanced to:

- 55,000/- for MBBS doctors
- 60,000/- for Specialists
- Provision for a hike of 3% every year on satisfactory completion of one year of contractual service has been made

Source: Steps taken for appointment/engagement and retention of Medical Officers/ Specialists under H&FW Dept, Government of Odisha

Career Progression for Public Health & Specialist Cadres under OMHS



Source: Steps taken for appointment/engagement and retention of Medical Officers/ Specialists under H&FW Dept, Government of Odisha

Outcome

1. **Addressing shortage of doctors by enhancement of MBBS seats:** Before the introduction of the new attraction and retention norms there were about 850 MBBS seats (450 government MBBS seats and 400 private college seats). Under the new cadre norms, the government augmented the number of MBBS seats in government institutes by 600 leading to a total of 1,050 seats.
2. **Reduction in vacancies in OMHS Cadre:** In 2014, there were 4,805 doctors in position. After the reforms were implemented, 5.643 doctors were in position in 2018. Vacancy of doctors against sanctioned posts in peripheral institutions is 29%. It reduces further to 16% when overall vacancy is counted after considering ad-hoc, contractual, & Corpus fund.
3. **Increased availability of doctors at rural/difficult areas**: In 2014, there were 786 doctors posted in KBK/KBK+ districts with no incentivization schemes/funds. However, after the introduction of incentives and new norms related to rural posting, the number saw a rise. By 2018, there were 1072 doctors posted in KBK/KBK+ districts with incentivization schemes/funds

Source: Steps taken for appointment/engagement and retention of Medical Officers/ Specialists under H&FW Dept, Government of Odisha

5.3. CASE STUDIES ON DELINKING RECRUITMENT FROM STATE

CONSTITUTION OF WEST BENGAL HEALTH RECRUITMENT BOARD (WBHRB)

Background

- Acute shortage of medical/para medical personnel and other staff belonging to various categories in the health department
- High turnaround time for new recruitment and filling vacant posts for the DoHFW through the Public Service Commission, West Bengal.

In year 2012, DoHFW constituted separate statutory body as recruitment board i.e. **West Bengal Health Recruitment Board (WBHRB)** which is responsible for selecting and recruitment of temporary & permanent posts under the Health department

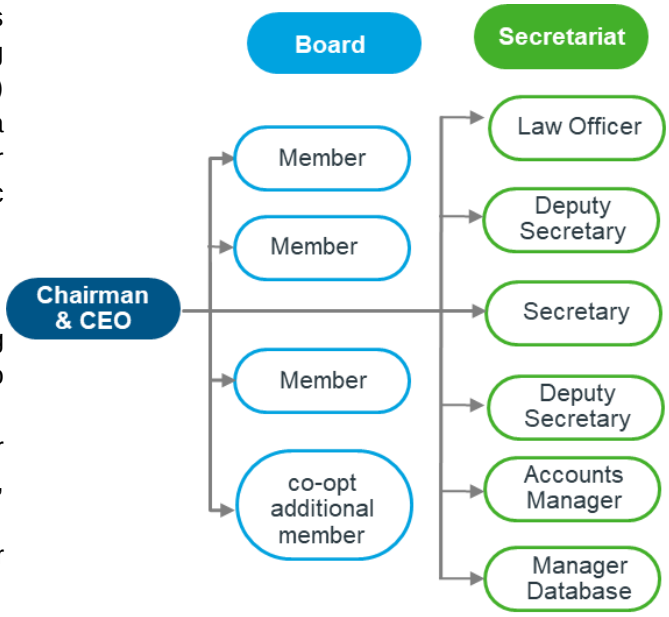
Approach

Sanction to constitution of WBHRB was accorded by Governor by way of making regulations under the proviso to clause (3) of Article 320 of the Constitution of India by delinking recruitment of posts under DoHFW from the purview of Public Service Commission

Functions

- Selecting and recommending candidates for direct recruitment to permanent or temporary posts.
- Generating online applications for various posts (GDMO, Staff Nurse, Lab technician etc.)
- Notifications of vacancy of posts under DoHFW.
- Preparations of merit list for various posts as per recruitment criteria
- Online generation of interview call letters of successful candidates.

Composition of WBHRB



Results

- Significant reduction in the number of vacancies of medical/para-medical posts at public health facilities of state
- Effective & timely filling of the vacancies in various healthcare levels.

CONSTITUTION OF MEDICAL SERVICES RECRUITMENT BOARD (MRB)

Background

- Tamil Nadu Health System comprises of ten directorates and over one lakh posts exists across the 200 categories of posts under health department
- Recruitment was done through the Tamil Nadu Public Service Commission which led to delay in filling up vacancies in Health and Family Welfare Department

In 2012, Government of Tamil Nadu constituted **a separate Medical Recruitment Board** with aim to achieve **zero vacancy situation** in various medical and para medical posts in the government medical institutions in the State.

Functions

- Conducting recruitment by way of open advertisement in the newspapers
- Receiving the application on-line and selecting candidates either by conducting competitive examination (or) by giving suitable weightage to relevant academic performance of the candidates in various examinations.
- Conducting walk-in selection process for Assistant Surgeons in every quarter of the year to invite competent candidates

Composition of WBHRB

Chairman

Additional Secretary, Health and Family Welfare department

Member

Cadre equal to that of Medical department Deputy Director

Member-Secretary

An officer equal to the ranks of District Revenue Officer will

Results

- Reduction in the number of vacancies of medical/para-medical posts at public health facilities of state
- Effective & timely filling of the vacancies in various healthcare levels- medical institutions comprising of the Government Medical college Hospitals, the Government District / Taluk Head Quarters Hospitals / Non Taluk Hospitals / Dispensary / ESI Medical institutions / Primary Health Centres/ Health Sub Centres etc.
- A more systematic and calendarized way of conducting recruitment

DISCLAIMER

- The analyses, their interpretation, and related information contained herein are made and provided subject to the assumptions, methodologies, caveats, and variables described in this report and are based on third party sources and data reasonably believed to be reliable. No warranty is made as to the completeness or accuracy of such third-party sources or data.
- As with any attempt to estimate future events, the forecasts, projections, conclusions, and other information included herein are subject to certain risks and uncertainties and are not to be considered guarantees of any particular outcome.
- It should neither be regarded as comprehensive nor enough for making decisions, nor should it be used in place of professional advice. IQVIA accepts no responsibility for any loss arising from any action taken or not taken by anyone using this material.
- All reproduction rights, quotations, broadcasting, publications reserved. No part of this presentation may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without express written consent of IQVIA.