



MEGHALAYA HEALTH SYSTEMS STRENGTHENING PROJECT
(MHSSP)

INCEPTION REPORT

SUTRA CONSULTING PVT. LTD.

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Abbreviations

| | |
|-------|---|
| AC | Air Conditioning |
| ADC | Average Daily Census |
| ADMO | Additional District Medical Officer |
| AHPI | Association of Healthcare Providers (India) |
| AHU | Air Handling Unit |
| ANC | Antenatal Care |
| ANM | Auxiliary Nursing Midwifery |
| APH | Antepartum Hemorrhage |
| ART | Anti-Retroviral Therapy |
| ASHA | Accredited Social Health Activist |
| AV | Audio Visual |
| AYUSH | Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy |
| BMW | Biomedical Waste |
| BMWM | Biomedical Waste Management |
| CBO | Community-Based Organization |
| CHC | Community Health Center |
| CMO | Chief Medical Officer |
| DEIC | District Early Intervention Center |
| DH | District Hospital |
| DLI | Disbursement Linked Indicators |
| DoHFW | Department of Health & Family Welfare |
| ECG | Electrocardiogram |
| ECHO | Echocardiogram |
| ENT | Ear-Nose-Throat |
| HEPA | High-efficiency Particulate Absorbing |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health-Management Information System |
| HRMIS | Human Resources Management Information System |
| ICT | Information Communication Technology |
| IDSP | Integrated Disease Surveillance Program |
| IEC | Information Education Communication |
| IMR | Infant Mortality Rate |
| IPA | Internal Performance Agreement |
| IPF | Investment Project Financing |
| ISO | International Organization for Standardization |
| ISQua | International Society for Quality in Health Care |
| IT | Information Technology |
| JSSK | Janani Shishu Suraksha Karyakaram |
| JSY | Janani Suraksha Yojana |
| LBW | Low Birth Weight |
| MCTS | Mother and Child Tracking System |
| MHIS | Megha Health Insurance Scheme |

| | |
|-------|---|
| MHSSP | Meghalaya Health Systems Strengthening Project |
| NABH | National Accreditation Board for Hospitals & Healthcare Providers |
| NCD | Non-Communicable Diseases |
| NFHS | National Family Health Survey |
| NGO | Non-Government Organization |
| NHM | National Health Mission |
| NHSRC | National Health Systems Resource Centre |
| NMR | Neonatal Mortality Rate |
| NQAS | National Quality Assurance Standards |
| OPD | Out-Patient Department |
| OT | Operation Theatre |
| PAD | Project Appraisal Document |
| PDO | Project Development Objective |
| PEC | Project Executive Committee |
| PHC | Primary Health Center |
| PID | Project Information Document |
| PIH | Pregnancy-induced Hypertension |
| PLHIV | People Living with HIV |
| PMJAY | Pradhan Mantri Jan Arogya Yojana |
| PMU | Project Management Unit |
| PPE | Personal Protective Equipment |
| PSC | Project Steering Committee |
| RBF | Result-based Financing |
| RSBY | Rashtriya Swasthya Bima Yojana |
| SC | Sub-Center |
| SC | Scheduled Castes |
| SEP | Stakeholder Engagement Plan |
| SNCU | Special Newborn Care Units |
| ST | Scheduled Tribes |
| TB | Tuberculosis |
| ToR | Terms of Reference |
| UHID | Unique Health Identification |
| UHS | Universal Health Insurance Scheme |
| VHSNC | Village Health Sanitation and Nutrition Committee |

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Chapter I: Overview of the Assignment

1. Background of the Assignment

Meghalaya is a Schedule-VI state under the constitution of India and more than 86 per cent of the population is scheduled tribe with three main ethnic communities; the Khasis, the Jaintias, and the Garo tribe. The state has eleven administrative districts spread across a total area of 24,548 sq. km; bound by Assam on the north and the east, and the south and west by Bangladesh. The state has approximately 2.9 million people and it recorded the highest decennial population growth of 27.8 percent among all the states of the region¹. It is estimated that the population of the state has increased to about 3.3 million² in 2020. Nearly 80 percent of the population of Meghalaya reside in rural areas and given the difficult geographic terrain, many parts of the rural areas are inaccessible. The Tendulkar Committee estimated in 2011-12 that 21.92 percent of the Indian population lives below poverty line. Against this national average, Meghalaya has recorded 11.87 percent as people who are living below poverty line. More recently, Meghalaya has been listed as the fifth poorest state in India and the poorest in the Northeastern region, as per NITI Aayog's first Multidimensional Poverty Index (MPI) report released in Nov 2021. The district-wise analysis of the report shows that Ri Bhoi is the poorest district in Meghalaya with 46.31% of its population regarded as multi-dimensionally poor. Meghalaya with 37.05% also has the tenth-highest percentage of malnourished people among all the states in the country.

As per the NITI Aayog state health index study (2019) the state was ranked 3rd among the group of 8 smaller states for performance in the reference year (2017-18) with an overall health index score of 55.95, the incremental performance over the base year has not improved and has marginally fallen from a health index score of 56.83 in 2015-16. The ranking was a result of the state's performance under indicators such as Neonatal Mortality Rate (NMR), Under-five Mortality Rate (U5MR), full immunization coverage, institutional deliveries, and People Living with HIV (PLHIV) on Anti-Retroviral Therapy (ART). Meghalaya fared below the national average in almost all of these parameters. The main reasons for low health coverage, especially in rural areas, are,

- i. Religious differences leading to lack of faith and acceptance of modern healthcare facilities
- ii. Lack of availability of healthcare facilities in the near vicinity
- iii. Poor levels of awareness and understanding of disease symptoms and preventive measures leading to delay in seeking treatment
- iv. Poor connectivity to remote areas thus posing limitations to service providers in providing quality healthcare

The recent Covid-19 pandemic was an eye-opener for the state to focus on strengthening its health systems and addressing the key health requirements of the population by creating a positive healthcare model that would touch upon the socio-economic determinants of its residents. The Meghalaya Health Systems Strengthening Project (MHSSP) with support from the World Bank intends to strengthen the management capacity and quality of health services in Meghalaya over five years.

1.1. Overview of Public Health System in Meghalaya

Meghalaya faces continuing challenges in basic health and nutrition outcomes along with a growing burden of non-communicable diseases (NCDs). The status of key health indicators is also significantly poorer than the national averages as can be seen from the following table.

¹ Census 2011

| Health Indicator | Meghalaya | National average |
|---|-----------|------------------|
| Infant Mortality Rate (IMR) (per 1000 live births) | 32 | 30 |
| Maternal Mortality Rate (per 1,00,000 deliveries) | 197 | 154 |
| Institutional deliveries | 51.4% | 78.9% |
| Immunization | 44 % | 62% |
| Deaths due to NCDs (including hypertension, diabetes, cardiac conditions, and cancers) out of total deaths recorded | 55% | 61% |
| Average life expectancy rate | 62.3 yrs. | 68.8 yrs. |

The Department of Health and Family Welfare (DoHFW) is the administrative department responsible for the health sector and oversees and coordinates the functions of three Directorates namely, Directorate of Medical Institutions, Directorate of Maternal and Child Health, and Family Welfare and Directorate of Research. The public health infrastructure in the state is structured in a three-tier system as prevalent in most states, comprising of Sub-Centers (SC), Primary Health Centers (PHCs), and Community Health Centers (CHCs). Higher-level institutions include District Hospitals (DHs). The classification of the facilities is based on the expanse of area and population that they serve.

A Sub-Centre is the grassroots level facility that serves a population of 3,000 is the bridge contact point between the Primary Health Care system and the community. It is manned by one Multi-Purpose Worker (Male) and one ANM. Sub-centers are responsible to bring about behavioral change and provide services concerning maternal and child health, family welfare, nutrition, immunization, diarrhea control, and control of communicable diseases programs. The Sub-Centers are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women, and children.

A Primary Health Centre (PHC) caters to a population of 20,000 serves as the first contact point between the village community and a medical officer. It acts as a referral unit for 6 or so Sub-centers. It has 10 beds for indoor patients and a general OPD for consultation. The activities of PHC involve curative, preventive, promotive, and Family Welfare Services.

A Community Health Centre (CHC) caters to a population of approximately 80,000 and serves as a referral center for 4 PHCs. As per minimum norms, a CHC is required to be manned by four medical specialists i.e., Surgeon, Physician, Gynecologist, and Pediatrician supported by 21 paramedical and other staff. It is supposed to have 30 beds for indoor patients with an operation theatre, X-ray, labor room and laboratory facilities, and OPD facilities as per availability of specialists.

A district hospital is the major health care delivery system in a certain district or region. It is staffed by medical officers, physicians, surgeons, and other specialists, nurses, and paramedical personnel. A district hospital is supposed to have beds for indoor patients and patients requiring intensive care and long-term care. It is also required to be equipped with an operation theatre, X-ray, labor room, and laboratory facilities. All district hospitals are supposed to have a minimum of 100 beds with larger hospitals like the civil hospital having higher bed strength.

1.2. Findings of NITI Aayog State Health Index Study

The NITI Aayog state health index study (2019) covering relevant indicators in the domain of Health outcomes; Governance and information; and key Inputs / Processes in public health indicated mixed performance for Meghalaya. The state was ranked 3rd among the group of 8 smaller states for performance in the reference year (2017-18) with Mizoram and Manipur ranking 1st and second respectively. Meghalaya's overall health index score was 55.95, marginally lower from the health index score of 56.83 in the base year (2015-16). The study recognized Meghalaya under the category of "Achievers" since it has shown relatively better performance, but there is still huge scope for improvement.

Among the various health outcome indicators, Meghalaya was rated relatively low among the smaller states particularly on the following indicators, and also showed a fall from base year (2015-16) performance:

| Indicator | Reference Year performance | Base Year performance |
|--|----------------------------|-----------------------|
| Full immunization coverage among infants between 9 to 11 months (%) | 77.6 | 93.3 |
| Proportion of Low Birth Weight (LBW) among newborns (%) | 7.7 | 7.6 |
| Proportion of Institutional Deliveries (%) | 62.6 | 62.1 |
| Total case notification rate of tuberculosis (TB) (per 1,00,000 population) | 116 | 137 |
| Treatment success rate of new microbiologically confirmed tuberculosis cases | 79.7 | 85.8 |

In the domain of Governance and Information, the performance of Meghalaya was found to be mixed among smaller states on Data Integrity measures based on the deviation of HMIS reported data and data from the NFHS-4 survey:

| Indicator | Reference Year performance | Base Year performance |
|---|----------------------------|-----------------------|
| Data integrity measure- ANC registered within the first trimester (%) | 10.6 | - |
| Data Integrity Measure – institutional deliveries (%) | 13.4 | - |
| Average occupancy of an officer for three key posts at State level for last three years (in months) | 10.0 | 19.3 |
| Average occupancy of a District Chief Medical Officer (CMO) or equivalent post (heading District Health Services full-time) in last three years (in months) | 22.7 | 14.8 |

Among health indicators where the performance of Meghalaya was relatively better among smaller states includes;

- i) Treatment success rate of new microbiologically confirmed tuberculosis cases (ranked 2nd) though there was a drop in performance as compared to base year;
- ii) The proportion of people living with HIV (PLHIV) on antiretroviral therapy (ART) in which Meghalaya was one of the three states in India which have achieved the target of 90% as set in The National Health Policy (2017).

The indicators where Meghalaya needs to focus include LBW, TB treatment success rate, average occupancy of State-level key positions, functional 24x7 PHCs, first trimester ANC registration, and IDSP reporting.

In the domain of Key Inputs and Processes of health systems, Meghalaya ranked 4th among smaller states with marginal improvement in index scores from 38.38 to 39.80. Meghalaya's performance under key indicators in this domain is listed below:

| Indicator | Reference Year performance | Base Year performance |
|--|----------------------------|-----------------------|
| Vacancy of ANMs at sub-centers (%) | 10.7 | 20.0 |
| Vacancy of Staff Nurse at PHCs and CHCs (%) | 13.4 | - |
| Vacancy of Medical Officers at PHCs (%) | 30.9 | 35.7 |
| Vacancy of Specialists at district hospitals (%) | 41.5 | 29.7 |

The study shows that vacancies of health care providers such as ANMs at Sub-Centers, Staff nurses at PHCs and CHCs, and medical officers at PHCs have reduced in Meghalaya, while the vacancies of Specialists at district hospitals has increased. However, the level of vacancies particularly of medical officers at PHCs (31%) and of Specialists at district hospitals (41%) is still very high in Meghalaya.

While the number of functional 24x7 PHCs in the state is double the target based on 1 PHC per lakh population norm, the number of medical facilities/institutions functioning as First Referral Units (FRUs) is only 66.7% of the targeted number in the state⁸. The district hospitals in the state also do not have any Cardiac Care Units (CCUs). The study also shows that only 10% of CHCs in Meghalaya have a score of four points or higher (out of 5 points) as per MoHFW's grading system using data on service utilization and availability of infrastructure and resources and less than 10 percent of district/sub-district hospitals are accredited as per standard quality assurance system of NQAS / NABH / ISO / AHPI. Among other indicators in this domain, the proportion of ANC registered within the first trimester against total registrations is low at 34.4% in the state and IT-enabled Human Resources Management Information System (HRMIS) for generating e-pay slip is yet to be implemented. Registration of birth, surveillance reporting under the Integrated Disease Surveillance Program, and the time taken for transferring NHM funds to implementing agencies were however found to be better in Meghalaya.

Data from the NFHS-5 (2019-20) shows that the most critical health service delivery issues in Meghalaya relate to Institutional Deliveries and deliveries assisted by health personnel; Antenatal and Immediate Post Natal care; universal vaccination of infants (in particular, second dose of measles); use of modern family planning methods; etc. Access to financial assistance under Janani Suraksha Yojana (JSY) was also found to be low in the state. The gap in health services between urban and rural areas is also evident, given the difficult geographic terrain and inaccessibility of some regions of rural areas in Meghalaya.

1.3. About the Meghalaya Health Systems Strengthening Project (MHSSP)

The Department of Health and Family Welfare (DoHFW), Government of Meghalaya is implementing the Meghalaya Health Systems Strengthening Project (MHSSP) with support from the World Bank. The project intends to strengthen the management capacity and quality of health services in Meghalaya. The project to be implemented from 2021-2024 will adopt a systems approach and will combine results-based financing and input-based financing to achieve enhanced performance management in the public sector. The project is supported by an IBRD loan of US\$40 million using an Investment Project Financing (IPF) instrument structured in four components. It uses a system's approach and is broken down into three individual parts which need to be appreciated as forming part of a whole system's approach complimenting each other – the first component is a performance-based financing approach, while the second and third components are designed for input-based financing and these three parts together work complementary and are critical for achieving the project objectives. In addition, strengthening the management and organization of the health insurance program is expected to boost health insurance utilization and a swifter reimbursement to providers.

Project Development Objective (PDO)

To improve the utilization and quality of health services in Meghalaya.

The project has four components each of which targets various areas of focus.

Component 1: Improving accountability, management and strengthening governance

- This component provides performance incentive grants to health agencies and health facilities with an overarching aim to improve governance and management structures and delivery of quality health services.
- The project envisages the IPA as a tool to introduce new ways of operations by moving from input-based financing to RBF which will strengthen the management, governance, and accountability relationships between the state- and the sub-state-level implementing units.
- Grants to health agencies and health facilities would be made available based on the achievement of results, as measured by performance indicators specified in the IPA to enhance efficiency and effectiveness of performance of institutions and facilities
- The component would cover 15 administrative units (4 state level units and 1 district level unit in each of the 11 districts) and 95 health facilities (11 District Hospitals, 18 CHCs and 66 PHCs of which 64 PHCs are in rural area). The PHCs would be selected based on factors such as travel time to the state capital, human resources density, poverty scores and immunization coverage.

Component 2: Strengthening systems to improve the quality of health services

- Aims to strengthen systems and processes in order to improve quality of health services.
- Interventions under this component will support developing capacities and focus on improving the quality of care through a comprehensive quality assurance for health service; augmenting systems related to human resource management, bio-medical waste management, procurement and supply chain, and project management capacity.
- Provision of support for the design, development, and piloting of innovative models for outreach and in-service delivery
- Development of tools and provision of TA including training and outsourcing to improve (i) HR supply, planning, and management, (ii) in-service capacity building, and (iii) pre-service education and to the administrative structures responsible for health system management in planning, management, and monitoring.
- Provision of support for information and communication technology (ICT) activities to improve overall efficiency and develop pilot innovative ICT solutions.

Component 3: Increasing coverage and utilization of health services

- Targeting increasing coverage and utilization of quality health services.
- Assessment and strengthening of the MHIS, including its organization and operation systems to improve coverage. Expansion and universalization of the Megha Health Insurance Scheme (MHIS) by focusing on improving scheme coverage and utilization, reduce disparities, develop institutional capacities and evaluate processes, utilization, benefit packaging and prices.
- Pilot innovations would be undertaken in 20 HWCs in two districts⁹, while pilot on community-led interventions would be implemented in 100 HWCs for integrated development of women and children.

Component 4: Contingent Emergency Response Component

- Provide contingency emergency response to any eligible crisis or emergency that takes place.

Project Beneficiaries

The project will benefit the entire state of Meghalaya as it aims to strengthen the state's public health system. The primary focus will be on strengthening the 12 district hospitals, 23 CHCs, and 70 PHCs across the state including coverage of the Megha Health Insurance Scheme (MHIS) which is currently at only 56 percent.

Increasing coverage of the Megha Health Insurance Scheme (MHIS)

The Megha Health Insurance Scheme (MHIS) intends to cover and provide insurance services to the total population of the state for inpatient services in government and private hospitals. However, the scheme has so far covered only 56 percent of households in the state. In Meghalaya, the MHIS has merged with the national PMJAY program, leading to a more comprehensive benefits package. In 2017–18, the MHIS reimbursed claims totaling US\$4.2 million (INR 269 million) for services delivered by the government system and US\$9.1 million (INR 58.7 crore) for private sector services. The payments made by the scheme for services provided by government hospitals are managed at the facility level. Primary challenges are related to poor coverage of households and underutilization of funds mobilized by government hospitals through medical claims reimbursement, resulting in missed opportunities for facility upgrades and improvement of services in hospitals. This is also indicative of weak management capacity at the facility level and poor oversight and monitoring capacity at the state level.

The project will also benefit over 10,000 of the health sector staff, specifically those at the secondary and primary levels such as ASHA workers, ANMs, village-level health workers, etc., by strengthening their capacity and providing them with skills training. The investment at the health facility level to improve infrastructure, private sector partnerships, technology solutions, and improved working conditions will improve their efficiency and satisfaction level and provide better quality care.

The community-level interventions that follow the integrated approach for child development also provide focused health and nutrition services for mothers. This will benefit the women and children through focused intervention.

Institutional and Implementation Arrangements

The DoHFW is the institution responsible for the governance and management of health systems in the state and its directorates are used for MHSSP implementation. A Project Steering Committee (PSC) under the Chairmanship of the Chief Secretary and including Principal Secretary, Health and Family Welfare, and Secretaries of other relevant departments has been set up to oversee the project. The Committee is responsible for the supervision of the implementation and overseeing the project results, approval and monitoring of the annual project plans and budgets, and approving amendments to the Project Operations Manual. The Commissioner and Secretary, Health and Family Welfare, heads the Project Executive Committee (PEC) and provides regular monitoring and necessary approvals for the day-to-day implementation of project activities. Given the results-based focus of the project, which requires coordinated action by directorates within the DoHFW, the designation of the Commissioner and Secretary, DoHFW, the senior-most official within the department is critical for effective implementation.

The Mission Director, National Health Mission (NHM) has been appointed as the Project Director to lead the Project Management Unit (PMU). The PMU is the unit responsible for the project implementation, including its regular monitoring and supervision with staff deputed from all three directorates. The staff consists of approximately 10 staff and consultants including a team leader and other members responsible for procurement, financial management, data analytics, and IT as well as technical areas including health engineering, community mobilization, quality assurance, human resource development, and capacity building. Recruitment of a few more consultants under specific technical areas is underway. Technical and knowledge partnerships, as well as multi-stakeholder engagements, have been established to augment the technical capacity of the department and support Village Health Sanitation and Nutrition Committees (VHSNC), including women's groups.

Additionally, the state and PMU are being supported with adequate capacity-building efforts especially in the areas of fiduciary, procurement, environment, and safeguards.

Key Stakeholders

The key stakeholders in the MHSSP project can be categorized into three parties:

| Affected parties | Interested parties | Vulnerable groups |
|--|---|--|
| Those who are directly or indirectly impacted or likely to be impacted by the Project | Those who have interests in the outcomes of the project and may also have the potential to influence the Project outcomes | Those who, due to their vulnerable status, may be disproportionately impacted by the project and that may require special engagement efforts to ensure equal address to their needs |
| <ul style="list-style-type: none"> - Communities residing in the target areas of the project - Community institutions such as Village Health and Sanitation Committees (VHSCs), and frontline workers such as ASHAs, ANMs in the villages that coordinate with target health facilities - District Hospitals, CHCs, PHCs, and SCs which are the target facilities under the project - Health care workers in the target health facilities including those providing peripheral services such as BMW, procurement of supplies and medicines, sanitation services, consultants, etc. - Department of Health and Family Welfare and all its Directorates | <ul style="list-style-type: none"> - Other line departments and agencies such as State pollution control board, Social Welfare, and Tribal Development Department, Women and Child Development Department, Education Department, Autonomous development Councils (Khasi Hills ADC, Garo Hills ADC, Jaintia Hills ADC), etc. - Elected representatives - NGOs and CBOs including women groups, elderly groups, etc. - INGOs supporting NGOs/ CBOs in Meghalaya on health care, disability, gender, and other such issues - Media groups and academia - The public at large | <ul style="list-style-type: none"> - Elderly - People with disabilities - Women, especially young women and girls at heightened risk of gender-based violence - Scheduled tribes (ST), scheduled castes (SC), and communities living in remote and hilly locations - Illiterate and poor population especially in rural and remote areas - Female-headed households, especially single mothers with underage children - Tribal/ ethnic/ gender minority groups and migrant workers from other states etc. |

The Result Chain

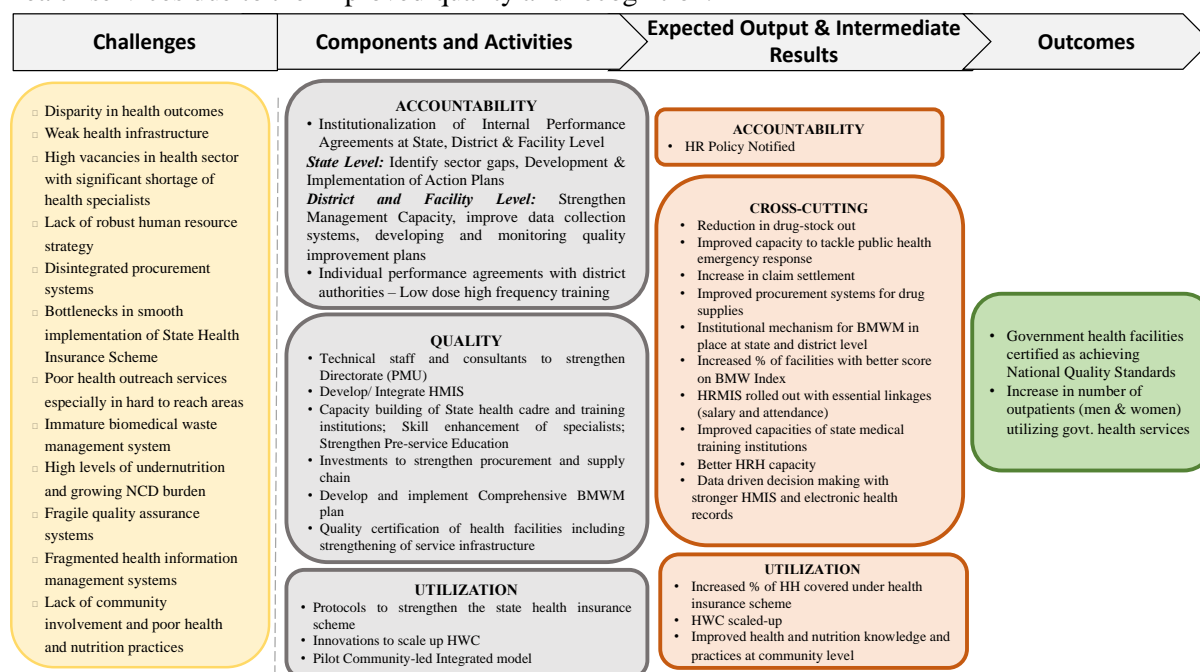
A results chain is an exhibit outlining the action, reaction, and expected outcomes of project intervention. It depicts how a particular action undertaken as part of the project will lead to the desired result. Results chains diagrams map out a series of statements that link short-, medium-, and long-term results in three basic components: a strategy, expected outcomes, and desired impact.

The Results chain for the MHSSP is depicted in the exhibit below. The first part of the chain highlights the challenges the project may have to face both internally and externally. These challenges highlight the factors that need to be inherited into the project planning and implementation to mitigate circumstances that may hinder the project's progress. Some of the main challenges that the project may face include:

- Disparity in health outcomes
- Weak health infrastructure
- High vacancies in the health sector with a significant shortage of health specialists
- Disintegrated procurement systems

- Bottlenecks in smooth implementation of State Health Insurance Scheme
- Poor health outreach services especially in hard to reach areas

The activities of the project have been classified into three categories, namely, Accountability, Quality, and Utilization focusing on the area that the activities will improve on. Similarly, the expected outcomes i.e., the intermediate results of these activities have also been envisaged under the same areas of focus. The outcome of the project is highlighted as Government health facilities being certified as achieving National Quality Standards and an increase in the number of outpatients (men & women) utilizing govt. health services due to the improved quality and recognition.



2. Scope of Work

The main objective of the assignment is to undertake a third-party verification of the 1st project Component (Improve accountability and strengthen governance through Internal performance Agreements) under the Meghalaya Health System Strengthening Project. The verification would focus on evaluating the achievement of the targets for Disbursement Linked Indicators (DLIs), set in the Internal Performance Agreements (IPAs) for the Administrative Units and Health Facilities, enabling them to receive financial disbursement from the World Bank.

The supplementary objective of the assignment is to verify the quantitative and qualitative DLIs set in IPAs and to validate the same through patient feedback data indicating that the services are indeed meeting the desired effectiveness, efficiency, and quality as expected due to reforms in governance, management and service delivery as per the IPAs.

The scope of work for the third-party verification under MHSSP includes;

- Verifying the progress of the implementation of IPAs in the 15 administrative units (4 state-level units and 1 district level unit in each of the 11 districts)- IPAs as agreed with World Bank
- Verifying the progress of the implementation of IPAs in 95 health facilities (11 District Hospitals, 18 CHCs, and 66 PHCs of which 64 PHCs are in rural area) – IPAs as approved by DoHFW, Meghalaya, and World Bank
- Gather and check the validity of patient feedback data (20 patients at PHCs / CHCs and 30 patients at DHs) during each round of the verification. The verification would be used to triangulate the achievement of the IPAs

The coverage of administrative units and health facilities to be covered during the various rounds of verification are as follows;

- The baseline assessment of IPAs would cover all the 15 administrative units and 95 health facilities as mentioned above.
- The 1st round of IPA verification would cover all the 15 administrative units and 95 health facilities.
- The subsequent rounds of IPA verification i.e., from the 2nd round to the 16th round the coverage would be 50% of administrative units and 50% of the health facilities.
- The patient feedback data that would be collected at health facilities covered in each round would be 20 patients at PHCs / CHCs and 30 patients at DHs in each round of the verification.

The scope of the consultancy does not include reviewing the performance of other components of the project (Component 2, 3, and 4) or the results or impacts related to it, since it was not specified in the Terms of Reference (ToR) for the assignment.

3. About this Report

This inception report outlines the current status of health systems in the state, an overview of the MHSSP, scope of work for the ‘Third Party Verification’ and methodology, and the work plan that would be adopted. The Inception report is being submitted to MHSSP and comments, feedback, and suggestions received from the project team would be duly incorporated in the same.

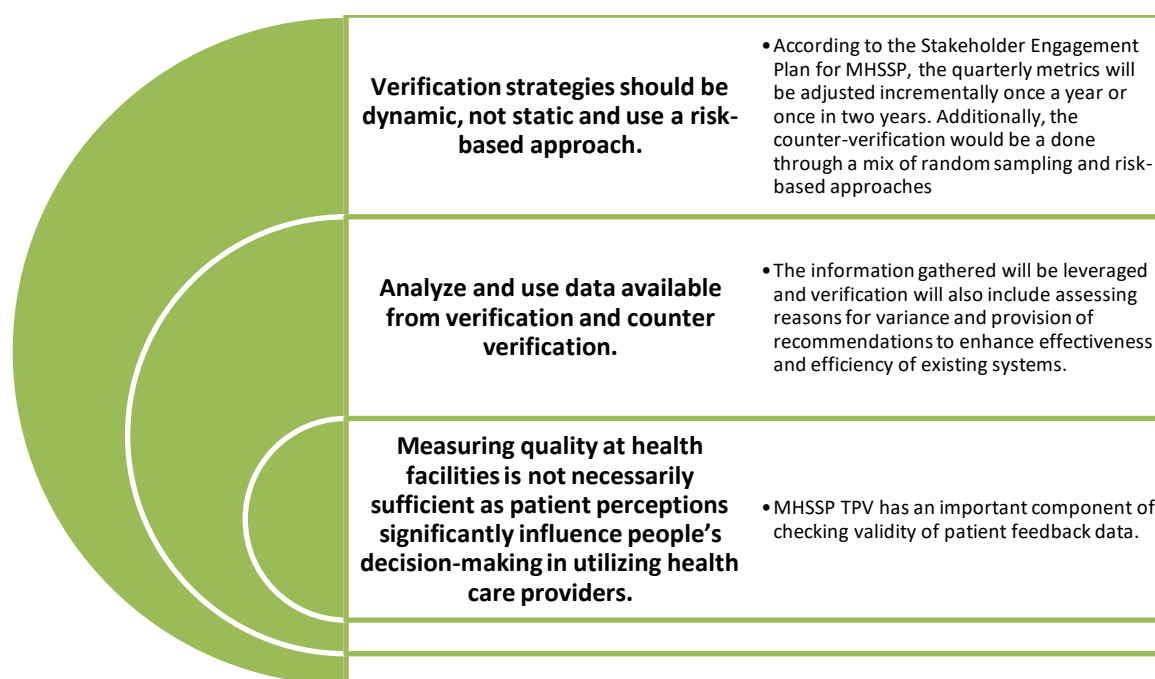
Chapter II: Methodology for the Assignment

1. Introduction to Chapter

This chapter outlines the approach and methodology that will be adopted for conducting various tasks under the assignment. The approach has been designed based on the consultant's expertise and experience carrying out large scale Disbursement Linked Indicator (DLI) verification / Results-based Verification for Financing assignments in various sectors, Performance Assessment for performance-based grant disbursement; and end-to-end large Monitoring & Evaluation assignment across sectors for Results-based Management of projects.

2. Overview of World Bank Program-for-Results and IPAs

The MHSSP is being implemented in a P4R model which refers to the World Bank Program-for-Results (PforR). It is a Results-Based Financing (RBF) instrument that is based on the delivery of verified results which ensures enhanced accountability and value for money in public budget/expenditure. A key provision of this model is a performance-based incentive payment to implementation units that motivates them to focus on achieving the desired targets of the program. Verification of target achievements is an important part of the RBF program implementation and key to maintaining transparency, fairness, and viability of the programs. The World Bank Group makes the following recommendations for Results-Based Financing for Health¹¹ which have been duly incorporated in the MHSSP:



2.1. About IPAs

IPAs are 'Internal Performance Agreements', made in a system that aims to boost performance throughout, by strengthening management, accountability, and quality performance. An IPA includes objectives, key results, and indicators reflecting those results, as well as financing tied to the composite performance score.

Based on the results, verified appropriately, incentive funds are transferred to the project unit. The IPAs will be verified internally by a team of quality assessors as well as externally by the agency.

The project is in the process of finalization of IPAs. The IPAs designed will be such that they align with the objectives of the participating entities. The performance of the project units under the IPAs will be done through internal verification mechanisms and regular assessments. The external counter-verification mechanism will be established to validate internal verification results. In the first stage, internal quality assessors from the health department at different levels would verify compliance with IPAs. At the next stage, an external verification on a sample basis will be undertaken to confirm the findings from the internal performance verification processes. The IPAs would be monitored through quarterly metrics generated through the certified internal assessors from district and state levels. Some of the metrics would measure progress on NQAS accreditation planning and implementation. The IPAs will be implemented at the state, district, and health facility levels in a phased manner. The state and the World Bank will jointly identify local institutions and build their capacity that will be retained in the state to support the implementation of the IPA.

A mixed-method approach would be adopted for the external verification of IPAs using both quantitative and qualitative techniques for data/information collection in each quarterly verification round depending on the requirement. The qualitative methods would complement the quantitative methods in validating the results, identifying process-related changes, capture best practices and lessons that would emerge from the implementation of MHSSP. The verification process of IPAs will be evidence-based, to confirm the findings of the internal performance verification conducted by internal quality assessors of the project and include documents, M&E reports, Government Orders, Office Orders, data recorded in HMIS, data records in facilities, quality certification, physical verification for facilities, feedback and information from patients, officials, health practitioners, other stakeholders, etc. as evidence.

2.2. IPAs for MHSSP

MHSSP is in the process of finalization of IPAs in consultation with the Bank. The IPAs will be different for administrative units and Health facilities, but the broad thematic areas that would be covered in IPAs would be aligned with the project design and sector reforms/changes suggested under various project components. The thematic focus in this project is on Quality performance, accountability, utilization. Performance agreements will be signed between government institutions, which will receive a one-time grant on the signing of the contract. The performance will be measured transparently and regularly with self-assessments, internal assessments, and external verifications. The financing will be based on the levels of performance achieved, after verification of results at a fixed interval.

Some of the potential thematic areas that could be covered under the IPAs for improving Accountability and Governance under Component 1 of the projects are:

- i. Resource allocation to Health Facilities
- ii. Quality Improvement and Accreditation of Health Facilities
- iii. Human Resource Policy, Deployment and Capacity Development
- iv. Clinical and managerial skills of medical staff
- v. Procurement (Equipment and Drugs) and Supply Chain Management
- vi. Bio-Medical Waste Management
- vii. Energy-efficient Resources
- viii. Quality of Health Service Delivery (Patient Satisfaction in particular Women)

| |
|--|
| Health System Improvement for Public Health Services |
| <ol style="list-style-type: none"> 1. Health facilities adopting health facility improvement plan; 2. Improvement in Physical & ICT infrastructure of facilities (Cleanliness of the medical facility; Demarcation of rooms for each specialty services; Increase in functional and emergency rooms; Availability of computers/ laptops, printers, scanners, and functioning; Availability of internet connection and devices connected with it; Functional HMIS node at the facility, etc.) 3. Improvement in the biomedical waste management system 4. Increase in Public health facilities receiving NQAS certification |
| Human Resource and Capacity Development for Public Health Services |
| <ol style="list-style-type: none"> 5. Availability of medical specialists (Hospital Superintendent, Surgery Specialists, Psychiatrists, Dermatologist / Venereologist, Pediatrician, Anesthetist, ENT Surgeon, Orthopedician, Radiologist, etc.) 6. Availability of Paramedical staff - Staff Nurse, Hospital worker, Sanitary Worker, Social Worker / Counsellor, ECG Technician, ECHO Technician, Laboratory Technician, etc. 7. Improved knowledge, skills, and capacity for service delivery (In major specialization area/department; Knowledge of staff about roles and responsibilities, services and reporting, etc.; Use of HMIS for decision making; Improved usage and upkeep of medical equipment; etc. |
| Procurement Process and Supply Chain Management for Public Health Services |
| <ol style="list-style-type: none"> 1. Procurement of Goods with improved Procurement norms (Evidence of NITs released as per prescribed norms; Review of Supplier credentials; Availability of comparative statement of quotations from bidders; Availability of signed contracts, work order/supply order, etc.) 2. Timely supply of resources and drugs and reduced stockout of essential medicines 3. Improved Storage infrastructure and management of stores |
| Accounting and Financial Management System for Public Health Services |
| <ol style="list-style-type: none"> 1. Timely disbursement of funds to stakeholders and Local fund utilization to health facilities including performance grants and insurance reimbursements 2. Record keeping and accounting practices 3. Regularity of Financial Audit conducted and Action taken against any adverse observation from Auditors 4. HMIS upgradation and generation of e-salary slips 5. Compliance with Anti-Corruption guidelines |
| Infection Prevention & Control and Biomedical Waste Management for Public Health Services |
| <ol style="list-style-type: none"> 1. Process and mechanism for infection prevention and control 2. Improved knowledge and awareness on biomedical waste management 3. Improved process of biomedical waste disposal and controls |
| Quality of Public Health Services |
| <ol style="list-style-type: none"> 1. Growth in the number of outpatients utilizing public health services (gender-disaggregated) 2. Increase usage of Health Helpline to receive health information or lodge grievances 3. Increase in Referral cases 4. Universalization of Health Insurance Schemes 5. Enhanced universal Immunization of infants and children 6. Increase usage of mobile health vans and emergency services 7. HMIS integrated with a spectrum of dashboards covering clinical, hospital, patient's records, etc. |
| Patient Feedback and Health seeking behavior |
| <ol style="list-style-type: none"> 1. Perception of patients on the quality and quantity of health care services 2. Satisfaction level of patients on public health services (Availability of medical and paramedical staffs; Ease of registration for appointment; Time required for the discharge of medical services; Ease of referrals for complicated medical cases; Availability of prescribed medicines; Improved knowledge and access to health insurance; etc.) |

The IPAs will have indicator definitions and reporting procedures based on HMIS and other documentation systems. Although the IPAs would be prepared keeping a holistic point of view, the same will be reviewed by the external verification agency to ensure any ambiguities, inconsistencies, unclear definition and interpretation of indicators or means of verification or measurement method are reported back to the PMU with suggestions for changes before finalization.

Level and Nature of Entity

The counter verification protocol would need to be defined clearly for the different levels of entities under assessment i.e., state, district, or primary as well as its nature, whether it is an administrative entity or a health facility.

Performance Metrics

The IPA verification protocol would have to include specific performance metrics or indicators to be counter verified at the different levels of assessment which has not been specified in the ToR. The IPAs once finalized would be expected to have been agreed upon with all units (administrative and health facility) before the start of the counter verification process. It is also assumed that key aspects of the counter-verification protocols would also have been laid down.

Counter-verification Period

The first round of counter-verification would be undertaken six months from the commencement of the assignment and subsequent rounds would be undertaken every quarter throughout the project. The timelines would have to be modified keeping in mind the finalization of the IPAs. Decisions would also need to be made on which performance indicators or metrics would have to be counter-verified in each round as per project stage and type of indicator.

Source of Information or Means of Verification

A specific source of information would have to be assigned for each performance indicator in the counter-verification protocol of the IPAs. For instance, certain indicators may be counter-verified through reports and registers whereas others may be counter-verified through discussions with officials, service providers, or end-users.

Counter Verification Procedure

Finally, the IPA counter-verification protocol would also have to notify the process to be followed and the methods to be utilized for the verification e.g., in-depth interviews, surveys, review of reports and registers, etc. This would also include staff who would be responsible for the activity, the required authorizations that would be required, the number of hours that would be dedicated for the activity, and the specific methods that would be adopted.

3. Key Methodological Steps

The DLI based verification assignments require close coordination with various stakeholders of the project; and therefore, a participative and consultative approach for various engagements such as for designing the verification framework, undertaking verification, sharing of findings and results, etc. would be one of the critical aspects of our approach.

The third-party counter-verification will be carried out periodically during the project implementation until the end of the project timeline. The assignment includes three main components:

1. Baseline study
2. Quarterly verification of IPAs covering administrative units, health facilities as well as patients' feedback.
3. Process Documentation

3.1. Baseline Assessment of IPAs

Upon finalization of the IPA framework, a detailed facility-level baseline study including process and output level data will be undertaken in the first six months of the assignment. The baseline assessment

provides information on the situation the project aims to change. It provides a critical reference point for assessing changes and impact and establishes a basis for comparing the situation at the quarterly counter-verification rounds. The comparison of before and after an intervention is utilized for making inferences to the effectiveness of the project strategies and implementation.

The baseline IPA assessment would be conducted subsequent to the finalization of the IPAs by the project and sharing of the IPA-based indicators with the agency. The baseline assessment of IPAs would cover all the 15 administrative units and 95 health facilities that fall under the ambit of the project as well as patients' feedback. The sampling plan for the Baseline IPA assessment including coverage of the patients' feedback survey is presented below.

| Baseline of IPAs | Sampling Plan |
|-----------------------------|--|
| Administrative Units | State Level – 4 District Level – 11 Total Administrative Units – 15 |
| Health Facility | District Hospitals – 11 Community Health Centers – 18 Primary Health Centers – 66 Total Health Facility – 95 |
| Patients Feedback | District Hospitals – 330 (30 patients per Hospital) Community Health Centers – 360 (20 patients per CHC) Primary Health Centers – 1320 (20 patients per PHC) Total Patients Feedback – 2010 |

The data collection tools for the Baseline assessment would be designed keeping in mind the indicators finalized as part of IPA verification protocol in order to ascertain the required information that would help in the future counter verification of the IPAs. These tools would be suitably translated as required and field testing will be undertaken to ensure seamless usability of the tools, identify and discrepancies, and roll out and gaps in the tools. Appropriate training would be provided to data collection teams prior to the fieldwork. The survey would be closely monitored to ensure good quality and accuracy. The subsequent analysis would reveal the as-is state for IPA-based indicators and report drafting would be undertaken based on a table of contents agreed with the project.

3.2. Quarterly Verification of IPAs

As per the terms of reference, the 1st round of counter verification of IPAs would cover all administrative units and health facilities while subsequent rounds of counter verification would be done on 50% of administrative IPAs and 50% of health facility IPAs. The sample for patient feedback data has been arrived at based on clarification provided by the project on pre-bid queries. In total there would be 16 quarterly rounds of counter verification of IPAs during the project duration from 2021-24.

Finalization of Counter-Verification Methodology

The process would commence following the finalization of the counter-verification protocol that would have to be followed for each type of unit (administrative, health facility). The protocol would include the indicators that would need to be counter-verified, period of counter-verification, source of information, and procedure. A methodology will be developed in consultation with the PMU based on the protocol and the requirements of the counter-verification.

The stakeholders covered in the counter-verification would include officials of the Project Management Unit of MHSSP, officials of the State and District level administrative units, officials of public health institutions (CDMO, ADMO, Medical Officers / Doctors, paramedical staffs, administrative and support function staffs, etc.) and patients/users of health facilities.

The sampling methodology would be a mix of random sampling and a risk-based approach. Simple random sampling is a technique where units in the population have an even chance or an equal probability of being selected in the sample. Risk-based sampling on the other hand is an approach in which a sub-set of units are selected purposively because of their expected or observed status being outliers relative to the overall / State level averages. The criteria to select institutions would include

those that have the volume of services and/or trends/indicators that differ significantly from the state average.

The sampling strategy proposed for MHSSP is as follows:

- i. First, select samples purposively using a risk-based approach based on observed outliers of performance in consultation with MHSSP.
- ii. Second, select the remaining samples randomly using a random number generator.
- iii. Sampling would be disaggregated by categories of institutions (administrative and health facility at different levels)
- iv. Patients' feedback samples would be selected at the health institutions randomly using a systematic random sampling method depending on patient load.

Design of Tools, Pre-Testing, And Finalization

The counter-verification will be undertaken using customized tools developed for each type of indicator and unit/facility in consultation with the PMU. Prior to data collection in the field, the tools would be pre-tested at select units/facilities in order to assess the practicality of usage, identify gaps or areas requiring improvements and also estimate the time required for the collection of information.

The Terms of Reference indicate that counter-verification of each facility would take three hours. As per the preliminary visits to the facilities, it is estimated that the PHC and CHC would require 3-5 hours for the collection of information at each facility and the district hospitals would require 7-8 hours. However, the pre-testing would help assess the actual time required.

Finalization of Sampling Plan

A mix of random sampling and risk-based approaches would be adopted for the counter verification rounds. The parameters that may be included while designing risk-based approaches could include the volume of load at facilities, the criticality of functions performed and remoteness of facilities, outliers with low or high value of indicators as compared to the state average, etc.

The sampling plan for the 1st and subsequent rounds of Counter Verification of IPAs including coverage of patient's feedback data is given in the tables below.

| Verification of IPAs | Sampling Plan (1 st Round) |
|-----------------------------|--|
| Administrative Units | State Level – 4 District Level – 11 Total Administrative Units – 15 |
| Health Facility | District Hospitals – 11 Community Health Centers – 18 Primary Health Centers – 66 Total Health Facility – 95 |
| Patients Feedback | District Hospitals – 330 (30 patients per Hospital) Community Health Centers – 360 (20 patients per CHC) Primary Health Centers – 1320 (20 patients per PHC) Total Patients Feedback – 2010 |

| Verification of IPAs | Sampling Plan (2 nd Round to 16 th Round) |
|-----------------------------|---|
| Administrative Units | State Level – 2 District Level – 6 Total Administrative Units – 8 |
| Health Facility | District Hospitals – 6 Community Health Centers – 9 Primary Health Centers – 33 Total Health Facility – 48 |
| Patients Feedback | District Hospitals – 180 (30 patients per Hospital) Community Health Centers – 180 (20 patients per CHC) Primary Health Centers – 660 (20 patients per PHC) Total Patients Feedback – 1020 |

Development of Field Plan

Subsequent to the finalization of sampling plans, detailed field movement and operational plans would be developed. These would lay down the composition of the verification teams, the timelines for the process, routes that would be followed, daily schedules and facilities/units that would be visited, etc. The field plan will be prepared by the third-party verification agency and approved by the PMU.

Training of Field Teams

The teams involved in counter-verification would be provided intensive training prior to each round. The training would focus on developing a clear understanding of the verification protocols including indicators that are to be counter-verified, key stakeholders who are to be met, tools and methodologies that need to be used, etc. The training would ensure that the field teams are aware of the information to be collected and the protocol for the collection of information. Given the current pandemic situation, the teams will also be given instructions on following go Covid-10 appropriate behaviors during the field movement and data collection, along with interpersonal skills and other soft skills that would be required while interacting with various stakeholders, etc.

Data Collection and Quality Assurance

The actual process of data collection would take place as per specified timelines. Additionally, a stringent quality assurance mechanism would be instituted and implemented to ensure the authenticity of the data collected as well as ensure that the most effective and efficient approach has been adopted by the field team for the counter-verification process.

Reporting

Reporting processes would be critical to the success of the assignment and these would be undertaken as per the requirements of the project. Each round of counter-verification would result in the submission of a draft counter-verification report followed by the submission of a final report based on feedback provided by the MHSSP.

3.3. Video Documentation

Video documentation of the project would be undertaken once every year. The thematic areas to be documented in the video have not been specified in the ToR. However, it is proposed to use the videos to document the good practices being undertaken by the health facilities to strengthen their operation, increase patient coverage, innovations arising out of the novel practices, and pilot interventions being implemented as part of the project. HD Quality Videos of 5 minutes duration with English narration will be produced 1 per year or a total of 5 videos during the project duration.

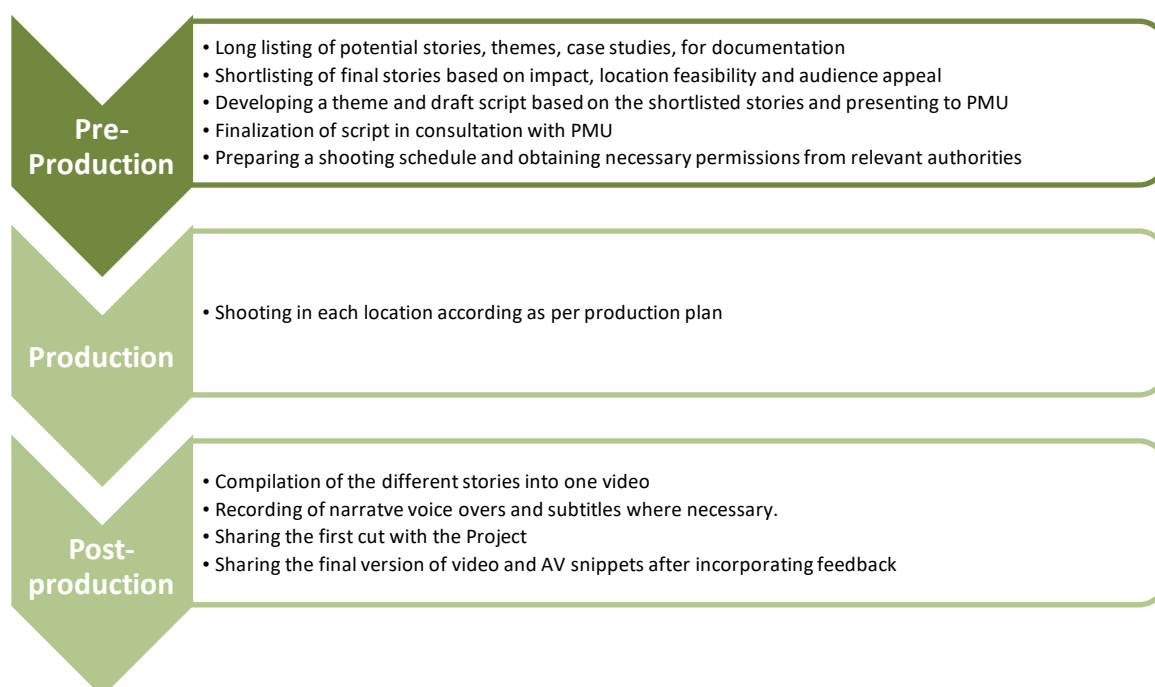
| | Description |
|------------------|--|
| Formats | Short length video of 5 minutes AV snippets meant for Social Media dissemination of 45 sec -1 min |
| Potential Themes | <ul style="list-style-type: none"> Improvement in Health Infrastructure, availability of medical staff Better access to Healthcare Services, increase in patient coverage Innovations and pilots initiated under the project Improved process for training, health care services, services for women, etc. |
| Audience | Policymakers, Planners and Stakeholders for Development State Departments, Officials and Public Health professionals General Population / Public in Meghalaya Donors, Central Government, Outside State Institutions |
| Dissemination | Public Screening in Events, Health Institutions, Fairs, etc. Social Media sites such as Facebook, Twitter, YouTube, etc. Use of Photographs in State-Wide Publication and Reports Workshop, Conclave, Official Events, Presentation by Government Officials both inside and outside the State |

Video Documentation Plan

The video documentation would be done over an approximate period of three months starting with a pre-production stage which would include identifying potential stories/case studies/interventions in consultation with the client and relevant service providers. The stories/case studies/interventions that have the highest impact, are scalable and replicable, and have a visual appeal to the target audiences would be shortlisted through consultations with the client. Further, a script would be developed for the video highlighting the narrative for each story to be documented and the key messages that should emerge from the videos. A field plan for the shooting would be developed including identification of equipment, shooting dates, shooting locations, availability of key stakeholders, etc.

The second stage is the production state which includes the actual video documentation of the stories in the identified locations. This would include the video documentation of the activities, impacts achieved interviews with relevant stakeholders including beneficiaries

The third stage is the post-production stage wherein the documented video footage would be edited to create a short-length video. This would also include adding before intervention scenarios where applicable, adding narrative voiceovers and subtitles for easy viewing and dissemination.



An indicative list of themes for the video documentation component of the contract are listed below.

- Improvement in health infrastructure, availability of medical staff
- Better access to healthcare services, increase in patient coverage
- Innovations and pilots initiated under the project
- Improved process for training, health care services, services for women etc.

The list of topics/ themes will be finalised on approaching the milestone after consultation with the PMU. The videos will be available in local languages as well.

3.4. Process Documentation

Process documentation intends to document factual and measurable outcomes and compile the positive impacts of an intervention to be shared with third-party organizations for reporting as well as learning. It looks at the change process through the eyes of those involved in it and seeks to monitor the process of change and development by focusing on the “how” of the implementation processes to build a story of change. In particular, it aims at:

- Capturing the perceptions of stakeholders involved in the process
- Using this information to support reflection and learning so as to improve the process.
- Helping those looking at the process from outside to understand the changes in knowledge, attitudes, and behaviors that were necessary to achieve results.

Process documentation is also beneficial to the process itself as it records the activities through the eyes of the implementors and documents a chain of events, making it possible to identify gaps, overlaps, and/or linkages which can potentially increase the efficiency and effectiveness of the processes.

As part of the assignment, five process documentation exercises would be undertaken during the assignment period. The process documentation will showcase the implementation of the IPAs and the changes that have occurred subsequently. The output of this assignment will be a Process Document / Brochure of length 4 pages in English depicting the changes due to the Internal Performance Agreements (1 per year or a total of 5 Process Documents)

Process Documentation Plan

Process documentation would commence by identifying the specific ‘themes’ or ‘processes’ that are to be documented within the context of the IPAs in consultation with the PMU officials. The IPA process under observation would be studied and described to capture key aspects such as the context of the implementation area, institutional structures, stakeholders involved, activities undertaken, implementation and monitoring systems, capacity building, awareness generation, outputs and outcomes achieved; sustainability and way forward.

A field plan would be prepared which will allow the documentation team to witness the identified process/es and document the same. The team would attend specific events or activities which form a part of the relevant IPA implementation. In-depth interviews, stakeholder consultations, and key informant interviews would be held with relevant stakeholders, community representatives, users of health facilities, etc. The process documentation would be completed with necessary photographs and imagery as necessary for the depiction of the process.

| | Description |
|-------------------------|---|
| Potential Themes | Improvement in Health Infrastructure, Availability of medical staff better access to Healthcare Services Innovations and pilots initiated under the project Improved process for training, health care services, services for women, etc. |
| Audience | Policymakers, Planners and Stakeholders for Development State Departments, Officials and Public Health professionals General Population / Public in Meghalaya Donors, Central Government, Outside State Institutions |
| Dissemination | Sharing of the printed version with audience of interest, Social Media sites such as Facebook, Twitter, YouTube, etc. Use as cross-referencing in State-Wide Publication and Reports Workshop, Official Events, Presentation by Government Officials both inside and outside the State |

Plan for Process Documentation



Chapter III: Status of the Assignment

1. Introduction to the Chapter

This chapter outlines the activities undertaken subsequent to the commencement of the assignment and the status of activities at the time of documenting this inception report. The chapter also outlines preliminary findings of the third-party verification team during the visit to the health facilities during the commencement meeting.

2. Status of the Assignment

2.1. Team Mobilization

The team of experts as enlisted in the ToR has been onboarded. This includes,

- Team Leader/ Leader/ Principal Investigator
- Qualitative Research Expert
- Hospital Quality Assessment Expert
- Survey Manager
- Information Technology Expert

All team members excluding the Information Technology Expert, along with representatives from Sutra Consulting visited the PMU in Shillong from 9th to 13th November for a commencement meeting and also visited three health facilities nearby Shillong. The team was also accompanied by the technical backstopping team from the agency.

2.2. Commencement Meetings

A commencement meeting was organized at the PMU in Shillong on 9th November 2021. The PMU team was present at this meeting along with representatives on World Bank. The purpose of this meeting was to develop a common understanding of the work plan, proposed methodology, identify nodal persons for contact. Along with introductions of all those present, each person's role in the project was also discussed. The project team also provided a background of health systems in Meghalaya and the geography of the state, especially in terms of the provision of health services.

An introductory meeting was also organized with the Project Director to ensure clarity in the scope of work, outline the expectations of the assignment and provide a background for commencement.

2.3. Field Visits

A field visit was organized for the team members and representatives from Sutra Consulting ahead of the compilation of the inception report. This preliminary field visit was made to three facilities, as detailed below.

| Name of Facility | Name of Personnel Interacted | Date of Visit |
|---|------------------------------|--------------------------------|
| CHC, Mawphlang | Dr. H Lyngdoh | 11 th November 2021 |
| PHC, Pomlum | Dr. D P Syiem | 11 th November 2021 |
| Ganesh Das Govt Maternal & Child Health Hospital, Shillong | | 12 th November 2021 |

The purpose of the visit was to observe the status of the facilities in terms of operations, maintenance of records, provision of health services, and their performance against different National Quality Standards (NQAS) on a preliminary basis. The observations of the team have been summarized in Annexure 1

2.4. Desk Review

Ahead of the compilation of the inception report, the team has collected and reviewed relevant literature concerning the project. These include,

- i. Terms of Reference (ToR)
- ii. Project Information Document (PID)
- iii. Stakeholder Engagement Plan (SEP) MHSSP
- iv. Concept Environmental and Social Review Summary (ESRS) MHSSP
- v. Key Performance Indicators (approved on 15 Nov 2021)
- vi. Project Appraisal Document (PAD) (approved on 15 Nov 2021)

Additionally, secondary data has been collected through various reports such as,

- i. Meghalaya Health Policy, 2021
- ii. NITI Aayog Health Index Report 2018-19
- iii. NITI Aayog National Multidimensional Poverty Index 2021

Websites of government departments including the DoHFW have also been referred to for the compilation of the inception report.

3. Work Plan and Deliverables

| Deliverables | Month | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|-------|-----|-----|-----|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|----|
| | 1-2 | 3-4 | 5-6 | 7-8 | 9-10 | 11-12 | 13-14 | 15-16 | 17-18 | 19-20 | 21-22 | 23-24 | 25-26 | 27-28 | 29-30 | 31-32 | 33-34 | 35-36 | 37-38 | 39-40 | 41-42 | 43-44 | 45-46 | 47-48 | 49-50 | 51-52 | 53-54 | 55 |
| Inception Report | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Verification survey and draft survey tools, pretesting, final template | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Completion of Baseline IPA assessment | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Completion of Quarterly Counter Verification | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fieldwork plan for each round of verification | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Video and Process documentation | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Annexure 1: Field Observations

A field visit was organized for team members and representatives from Sutra Consulting ahead of the drafting of the inception report. This preliminary field visit was made to three facilities, as detailed below.

| Name of Facility | Name of Personnel Interacted | Date of Visit |
|---|------------------------------|--------------------------------|
| CHC Mawphlang | Dr. H Lyngdoh | 11 th November 2021 |
| PHC Pomlum | Dr. D P Syiem | 11 th November 2021 |
| Ganesh Das Govt Maternal & Child Health Hospital | | 12 th November 2021 |

The following were some of the key observations on the overall functioning of health facilities at different levels.

All the three facilities visited have a satisfactory infrastructure for the provision of necessary services at their respective levels. The PHC and CHC were short-staffed, however in the first impression, adequate equipment seemed to be available to serve the available patient load. A summary of the health services functionality is provided below for each of the facilities:

Functionality Of Health Services & Infrastructure

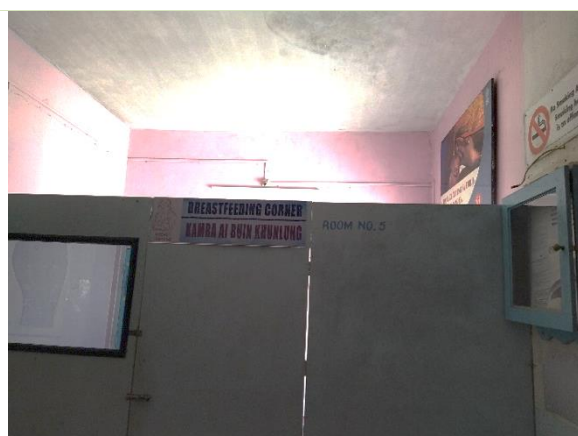
Pomlum Primary Health Centre (PHC), Pomlum

- PHC Pomlum has 10 in-patient beds with basic health services for preventive, promotive, and curative services. It also supports national health programs as per the applicability. The main building is located in a Semi-pucca type construction.
- IEC materials concerning health as well as services are visible and available in English and local language.
- A decent waiting area for patients was available along with the provision of drinking water and a public toilet.
- The facility was well maintained and clean.
- There were proper demarcated areas. Well demarcated OPD services.
- Specialized areas visited were the labor room, maternity ward, and female ward. All the areas visited have good functionality
- Infection prevention and control- All measures are adopted for infection prevention and control.
- There is a provision for foot-operated handwashing and hand sanitizing stations.
- Lack of specialist doctors has been observed and the facility is providing care to high-risk obstetric cases (e.g., APH, Eclampsia, PIH, etc.) despite the absence of OT and in-house service for surgery.
- A blood bank/blood storage unit is also not available.



Mawphlang Community Health Centre (CHC), Mawphlang

- Mawphlang CHC is located in the Mawphlang division of East Khasi Hills District at about 30 Km from the Shillong. This was a PHC and has been converted to CHC in the recent past. A new building has been constructed for the CHC.
- CHC Mawphlang has 30 in-patient beds with preventive promotive and curative services.
- Clinical services available are general medicine, obstetrics & gynecology, pediatrics, dentistry, and AYUSH. But few important services are missing like surgery, anesthesiology, blood storage, etc.
- It has a well-constructed and maintained building and good infrastructure.
- Proper demarcated areas. Well demarcated OPD services.
- Display of IEC and signages in English and local language.
- There is a screening Kiosk for referring the patients to the ILI/SARI cases clinic and general OPD service.
- The waiting area is well lit, enough chairs are available for seating patients. There is the availability of drinking water, public toilets, and a small tea/coffee kiosk.
- Specialized areas visited were the labor room, maternity ward, and female ward. All the areas visited have a good functionality
- All measures are adopted for infection prevention control.
- There is provision for foot-operated handwashing and hand sanitizing stations inside and outside the building
- Lack of specialist doctors has been observed and the facility is providing care to high-risk obstetric cases (e.g., APH, Eclampsia, PIH, etc.) despite the absence of OT and in-house service for surgery.



Breastfeeding room



OPD waiting hall



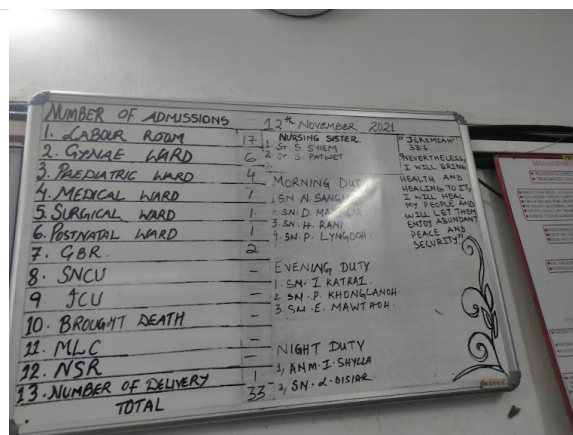
Public Toilet

Ganesh Das Hospital for Women and Children, Shillong

- Ganesh Das hospital is a mother and child care hospital with clinical specialties also available to support patients. The hospital is assigned as a district hospital of West Khasi Hills district and is a state referral hospital.
- This hospital has 200 in-patient beds and clinical services available are Obstetrics & Gynecology, General Medicine, General Surgery, Pediatrics, Pediatric Surgery, and Anesthesiology. Diagnostic and laboratory services are available almost as per the need of available specialties. Though there is no blood bank available in this hospital there is a govt blood bank adjacent to the hospital campus which suffices the need.
- All the units and departments are well defined and well-functioning since it is the most visited hospital as a part of supportive supervision by state and central monitors.
- The SNCU was found functioning quite systematically. Relevant formats are routinely used to capture important data and information. All the formats of registers are maintained and updated. However; there is a shortage of space and the number of radiant warmers is less than required as per the caseload. Multiple newborns have been accommodated at most of the radiant warmers.
- Labor room- All the records randomly selected were found to be in order.



OPD waiting area



Information Board



MHIS information center



Public Toilets

Status of Quality Assurance in the Facilities

National Quality Assurance Standards (NQAS) have been developed keeping in the specific requirements for public health facilities as well global best practices. NQAS are currently available for District Hospitals, CHCs, PHCs, and Urban PHCs. Standards are primarily meant for providers to assess their own quality for improvement through pre-defined standards and to bring up their facilities for certification. The National Quality Assurance Standards are broadly arranged under 8 "Areas of Concern"—Service Provision, Patient Rights, Inputs, Support Services, Clinical Care, Infection Control, Quality Management, and Outcome. These standards are ISQUA accredited and meet global benchmarks in terms of comprehensiveness, objectivity, evidence, and rigor of development.

Govt of Meghalaya took the initiative for adherence of quality systems to its public health facilities. The number of qualified Internal assessors in the state is 86 (out of which some have retired and few have resigned) (as per State Quality Assurance Consultant). Following this, public health facilities have been assigned to adhere to NQAS as per the applicability. At present, there are about 175 public health facilities (PHC, UPHC, CHC, and DH or equivalent) exist in the state and only 02 (1. PHC Umden of Ri-Bhoi district and 2. PHC Nartiang of West Jaintia Hills district) are certified by NQAS.

As reviewed from the state NHM website, it appears that the state has put enough focus on quality assurance. As per the NHSRC portal, (<http://qi.nhsrindia.org/meghalaya>), Nodal officers (Quality Assurance) have been appointed and there is a quality assurance committee constituted at the state level. The website also mentions the number of facilities earmarked for quality assurance work. However, the details of the state and district quality assurance committee meetings have not been updated.

Infection Prevention and Control

The facilities are trying to maintain better infection control and also trying to take preventive actions against future recurrence. However; in all the facilities, some anomalies were observed such as improper storage of waste items, not maintaining the appropriate distance between beds, etc. The possible reasons for these were observed to be lack of knowledge and high patient load in hospitals.

Pomlum PHC

Service providers of this hospital are well trained to provide clinical service safely. The majority of the staff observed at the facility adhered to the standard precautions during their clinical practice at the hospital. Medical, nursing, and paramedical staff were wearing PPE, following the aseptic procedure, maintaining hygiene, handling BMW safely, keeping the work environment non-contaminated as far as possible, keeping the patients & visitors educated regarding safe activities in the hospital. Foot/elbow operated taps are not available at handwash stations at every nursing station; however, foot-operated hand wash and hand hygiene stations are available for visitors near the entrance of the building.

Mawphlang CHC

Service providers of this hospital are well trained to provide clinical service safely. The majority of the staff observed adhered to the standard precautions during their clinical practice at the hospital. Medical, nursing, and paramedical staff were wearing PPE, following the aseptic procedure, maintaining hygiene, handling BMW safely, keeping the work environment non-contaminated as far as possible, keeping the patients & visitors educated regarding safe activities in the hospital. Foot/elbow operated taps are available at the hand wash station inside and outside the hospital.

Ganesh Das Hospital for Women and Children, Shillong, Shillong

Service providers of this hospital are also well trained to provide clinical service in a safe manner. Almost all staff observed have adhered to the standard precautions during their clinical practice at the hospital. Medical, nursing, and paramedical staff were wearing PPE, following the aseptic procedure, maintaining hygiene, handling BMW safely, keeping the work environment non-contaminated as far as possible, keeping the patients & visitors educated regarding safe activities in the hospital. Even in case of overload or failure, the staffs work in complementary to others to maintain a clean environment and always try to minimize the infections in the hospital. It has been observed that a foot/elbow operated tap is not available at every nursing station.

The OT complex was very clean and tidy, zones have been demarcated and in practice as well, sufficient space for movement and operating two operating together. To check the sterility, environment samples are tested and corrective actions are also taken in case of any growth found. The OT complex is maintained by split units of AC hence, there is no scope to install any AHU or HEPA filter.

There is a separate sterilization unit with two functional autoclaves having sufficient capacity of sterilization for the need of the hospital. This unit runs round the clock as well. A register is maintained to keep records of sterilization also. However; only one piece of Sygnolac tape is used in every load and the same is later affixed on the register. So, there is no way to check the sterility of any individual pack/drum. No biological indicator is used to confirm sterility.

SNCU is well equipped and excellently maintained in terms of cleanliness, aseptic practice, and maintaining all required data & information. However; due to the overflow of patients, multiple babies are kept in many warmers. Safety is compromised this way.



Mawphlang CHC

Use Of Energy Efficiency Measures

Solar-powered Street lights were observed in all the three facilities visited. Furthermore, there is a wide scope for integrating energy-efficient measures and adopting alternative resources of energy at the facilities for other operations such as solar-powered cold rooms, use of solar power in indoor lighting, use of biogas for managing kitchen waste, etc. During a discussion with the project team, it was also found that a parallel project has been initiated with 100 facilities in the state to utilize solar energy for their power needs.



Mawphlang CHC



Pomlum PHC



Ganesh Das Hospital, Shillong

Biomedical Waste Management

Except for Ganesh Das Hospital, the other two facilities have a satisfactory process of managing their biomedical waste on-site. However, there is scope for improvement and adopting a more scientific and appropriate practice for the management of biomedical waste. Major sites for waste generation such as Emergency Room, Labor Room, Wards, Immunization room were visited and it was observed that they have the provision of segregating waste at source with the presence of color-coded bins. Both facilities have a designated storage area for the temporary storage of biomedical waste. However, the different types of waste are not properly segregated in these areas. Disposal of biomedical waste is done on-site. Recommended practices for disposal are observed to be followed such as the presence of sharp pit, the deep burial of red and yellow bins' waste, and collection and disposal of blue bin waste i.e., recyclable rubber, plastic and glass items. Mutilation of plastic waste is not practiced at any of the three facilities.

Pomlum PHC also has a treatment chamber for liquid waste. Liquid wastes are drained directly to this chamber from the laboratory, emergency, and labor room. Wastes are mixed with sodium hypochlorite in this chamber and after the recommended holding period, it is drained to the sewer and flushed with fresh water. The entire practice is appreciable.

At the Ganesh Das Hospital, bio-medical waste is picked up by the Municipal waste collector along with other waste. Segregation of waste at source is done. However, in the temporary storage, it was found that BMW is not stored separately. The storage area is far from the hospital building and there is poor accessibility for trolleys. The waste is also not stored separately and mixed with regular wet and dry waste from the hospital.



Mawphlang CHC



Pomlum PHC



Ganesh Das Hospital, Shillong

Safety Measures

Significant actions have been taken to ensure safety and precautions in all three hospitals especially Ganesh Das hospital.

The **Mawphlang CHC** building is newly constructed. The facility also consists of an adjacent building that houses some of the departments such as radiology, etc. which is a Semi-Pucca type building made in the Assam style of architecture. However, disaster preparedness plans were not found despite the fact that Shillong and surrounding areas are earthquake-prone.

Pomlum PHC is a Semi-Pucca type building made in the Assam style of architecture which is considered to be an earthquake-resistant structure. A newer section of pucca construction is built adjacent to the old structure. Here too disaster preparedness plan was not found.




In **Ganesh Das Hospital**, part of the facility is housed in an old building-a semi-pucca-type building, which would be demolished shortly and all departments would be transferred to the new building. Currently, some of the departments are housed in the new building and some renovation has also been undertaken in the old building for updating of infrastructure. The corridor, ramp, and staircase have been constructed with proper planning. As a safety precaution, antiskid measures on the floor, grab bars on walls, safety guard and directional signage are available at all such areas of the new building.



Signage at Ganesh Das Hospital, also written in Braille for the visually challenged



Pomlum PHC semi-Pucca type building made in the Assam style of architecture

| | |
|---|---|
| <p>Most of the fire extinguishers have been found expired at all three facilities.</p> |  |
| <p>At CHC Mawphlang, the patient transportation trolley and wheelchairs do not have safety belts.</p> |  |
| <p>The X-ray room at CHC Mawphlang is located in the old PHC building facility adjacent to the main building and is not connected with a weather-proof way for transportation of in-patients.</p> |  |

Documentation and Records

All three hospitals are trying their best to maintain the documentation better as far as possible. However; a few observations are as below.

- UHID is generated but not mentioned in the clinical record part of the patients' files at all three facilities.
- There is no system in situ for auditing medical records at any of these three facilities
- Medical records are kept well organized but there is no defined process/practice for the retrieval of medical records.
- Informed consent is not taken for all surgical cases at Ganesh Das Hospital.
- Partograph is not maintained for every case at CHC Mawphlang
- Delivery notes and baby notes are scanty in most of the cases at all three facilities.
- There is a standardized format for BHT at Ganesh Das hospital, but it is not used uniformly across the departments.
- Personnel records could not be reviewed as the visit was undertaken on a holiday.

Mawphlang CHC

- A UHID is generated for every patient who comes here. There is a printed BHT with sets of all required forms in it. This is used uniformly for all patients but as per applicability. Staff maintains all required forms in the course of treatment. Medical records are kept well organized and stored securely. The missing part is that there is no defined process and practice for the retrieval of the medical record from the store.
- Record keeping for labor room registers is done properly. This is an L2 facility and performs assisted vaginal deliveries. Records for the same were also available and well maintained.
- Randomly checked obstetric Bed Head tickets were all properly completed and partographs are being filled up.
- The immunization record is being kept properly in a tickler bag.

Pomlum PHC

- A UHID is generated for every patient who comes here. BHT is used for every patient with a few pre-printed forms. Staff maintains all required forms in the course of treatment. All data and information are captured on several registers.
- Many records such as Labor room registers and Obstetric Bed Head tickets are not well maintained in comparison to the CHCs visited
- MCTS records were found to be vacant in the registers.
- In obstetric, bed head tickets partograph was not filled up properly.

Ganesh Das Hospital for Women and Children, Shillong

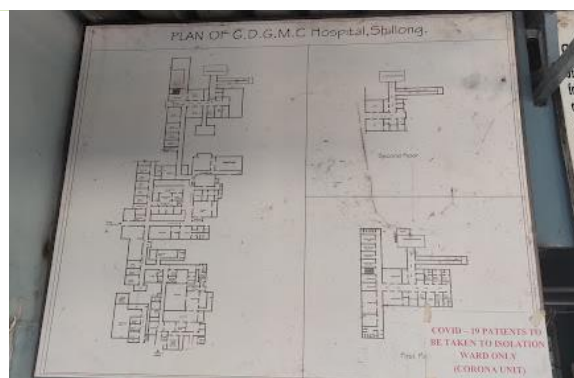
All records are well documented specifically clinical activities.

Accessibility To Services

All three facilities are easily accessible and well connected by road.

Almost all services are easily accessible to patients and visitors, however; few observations are as below

- The newly installed X-ray room in the old building of CHC Mawphlang is a little difficult to access from the main building. This is accessible through an open-air route and high-gradient narrow stone stairs.
- Signage is not prominent and sufficient at the entry point of Ganesh Das hospital to guide patients and visitors to their targeted department /unit.



Building plan displayed at Ganesh Das Hospital



Mawphlang CHC

Supportive Services

Mawphlang CHC

OPD waiting services are quite suitably arranged. Laboratory services are well arranged with charges specifically mentioned. There was no mention of free services available under JSSK. Toilets are clean and have no issues with water availability. There is a kitchen garden and composting pit maintained on the premise. Other services like baby care rooms, immunization services are available



Handwashing station at Mawphlang PHC



Liquid waste treatment unit at Pomlum PHC



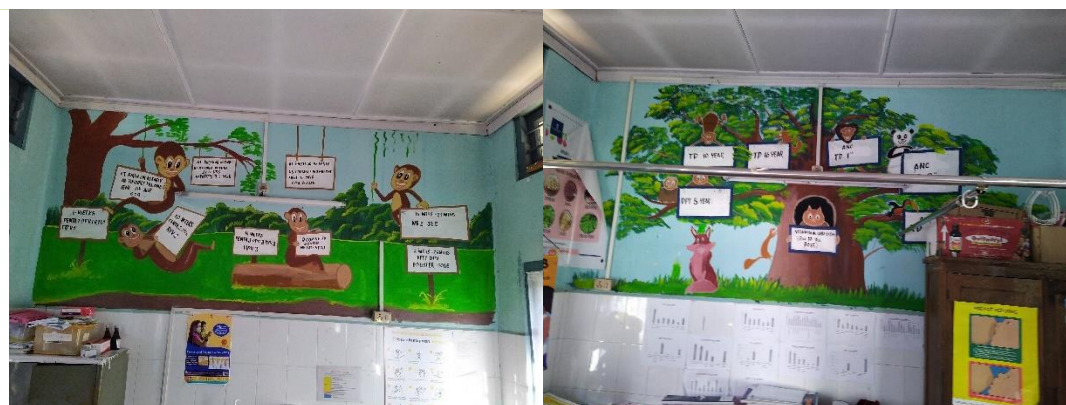
Kitchen garden and vermicompost pit at Mawphlang PHC



Corridor in Ganesh Das Hospital

Pomlum PHC

Laboratory services are available in the facility with charges are mentioned at the center. However, free services under JSSK were found to be missing here also. The immunization room is clearly demarcated.



Baby-friendly immunization room at Pomlum services

Ganesh Das Hospital for Women and Children, Shillong

It is a state hospital with well-demarcated signages and IEC information services.

All the information is clearly demarcated. DEIC has good signage services. Also, within the Child Health Section there is a playground

IEC For Patients and Staff

All three hospitals have well-defined, clear, and visible signages in both English and local languages.



Display of IEC Materials and signages at Mawphlang CHC



Various notices on display at the nursing station at Ganesh Das Hospital

Information regarding respectful maternity care in Ganesh Das Hospital

Resource Supply

As per the information given by staff at **Mawphlang CHC**, medicines are indented from the central store as per the requirement. The medicines are supplied as per the availability in the central medical store. Hence even after submitting the indent at the appropriate time, medicines are not received before ending the stock at the hospital. Thus stock-out of some medicines are evidenced in different frequencies.

However; as the facility in-charge has the authority to purchase medicine from the local market in this situation, so, things are being managed and the patient's vital needs are fulfilled. The same procedure is followed at **Pomlum PHC**.

At **Ganesh Das Hospital**, Medicines are supplied from the central medical store mainly and a few from the NHM store. There is a clearly defined process of indenting the medicines from the store and the hospital follows the same. The hospital places its indent as per the notification received from the respective govt. offices (Usually this notification comes once in three months and for selected medicines only). There is variance in the time in which the supply is received and the volume of medicines. Due to this the hospital store faces stock-out of many medicines from time to time. Sometimes the stock-out

was recorded for a long duration of up to 8-10 months. However; the in-charge of the facility has the authority to purchase those medicines in such situations. Hence the hospital store is managing the balance between the supplied stock and locally purchased stock per the requirement of patients.

State Health Insurance Program

Megha Health Insurance Scheme (MHIS) is a Universal Health Insurance Scheme (UHS) in the State of Meghalaya, using the RSBY framework to provide health insurance to all persons that are residents in the State excluding state and central government employees. The Megha Health Insurance Scheme (RSBY + UHS) was launched on 15th December 2012 with an objective to provide financial aid to all the citizens of the state at the time of hospitalization. The scheme progressed in phases and is now working in convergence with AB-PMJAY. It is called Megha Health Insurance Scheme (AB-PMJAY + Universal Health Insurance Scheme). Together, they cover all the families in the state, and the benefits provided are the same as those under PM-JAY. Improvement and amendments have been made to the scheme as the insurance coverage has been increased to 5 Lakhs with an enrolment fee of Rs.31. Meghalaya state have a total household of 5,48,059 as per the 2011 census. As per Megha IV, the total number of households enrolled in the scheme were 4,61,702 which is about 84 percent of the target coverage.

The project document indicates a few challenges in the scheme such as underutilization of funds mobilized by government hospitals through medical claims reimbursement, resulting in missed opportunities for facility upgrades and improvement of services in hospitals. This is also indicative of weak management capacity at the facility level and poor oversight and monitoring capacity at the state level. During interaction with chief medical officers of the hospital, it was indicated that more than 70 percent of the inpatients are pursuing the scheme benefits. The benefits of the scheme are also appropriately displayed on the hospital premises.



Any grievances related to claim disbursement are mostly taken to ASHA (health worker) first and then people approach the facilities.

During a discussion with the facility staff, it was noted that the insurance scheme is well accepted and is used by more than 80% of the patients that avail of treatment at the facilities.

Public Health Emergency Response

Though Meghalaya is an earthquake-prone zone, preparedness for earthquakes has been found to be lacking. However, the PHC and CHC reported having training on Emergency Response last year.