INDIA COUNTRY COORDINATING MECHANISM

OVERSIGHT COMMITTEE VISIT TO GUWAHATI (KAMRUP DISTRICT), ASSAM

REPORT

7th-9th August 2018

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Oversight Committee Visit to Guwahati (Kamrup District), Assam (7-9 August, 2018)

Background

An Oversight Committee of India Country Coordinating Mechanism (I-CCM) functions to oversee implementation of the Global Fund grant in India. As part of oversight activities, a team was constituted to undertake field visit to Guwahati (Kamrup District) from 7th -9th August 2018.

Objectives of the visit:

a) To oversee HIV grant and its implementation in Guwahati, Assam by Principal Recipients/ Sub Recipients under the Global Fund.
b) To oversee TB grant and its implementation in Guwahati, Assam by Principal Recipients/ Sub Recipients under the Global Fund.
c) To oversee Malaria grant and its implementation in Guwahati, Assam by Principal Recipients/ Sub Recipients under the Global Fund.

Composition of team for the visit:

1. Dr. Inder Prakash, Advisor (PH), Oversight Committee Member
2. Dr. Sangeeta Kaul, Team Leader (A), HIV/AIDS Division, Health Office, USAID/India, Oversight Committee Member
3. Ms. Sanghamitra Iyengar, Trustee, Samraksha, Oversight Committee Member
4. Dr. Shampa Nag, Oversight Committee Member
5. Mr. S A Khan, General Manager (Procurement), CMSS, Oversight Committee Member
6. Mr. Bobby Singh Jayanta, Oversight Committee Member
7. Ms. T. Mercy Annapoorani, Director, Blossom Trust, Oversight Committee Member
8. Mr. Veeraiah S Hiremath, National Consultant PDC, WHO RNTCP
9. Mr. Mrigen Deka, Consultant, NVBDCP
10. Ms. Neha Garg, Consultant, CST, NACO

The team was accompanied by India CCM Secretariat staff – Dr. Sandhya Gupta, India CCM Coordinator and Dr. Benu Bhatia (Programme Officer, India CCM).

PRs/ SRs under GFATM in Assam

The Global Fund grant is supporting six Principle Recipients –NACO, India HIV Alliance, Plan India, CTD, CHRI and NVBDCP for HIV, TB and Malaria programmes in Assam for the period January, 2018- March, 2018 which are implementing projects through their SRs and SSRs.

PR	SR
NACO	Assam State AIDS Control Society
India HIV/AIDS Alliance	Northeast Region implemented by Alliance India (NERO)

Plan India	Piramal Swasthya
CTD	Assam RNTCP
CHRI	World Vision India
NVBDCP	Assam VBD

Activities undertaken by Oversight team during visit:

The Oversight team undertook following meetings and activities during its three days visit in Guwahati (Kamrup District), Assam:-

Day 1:

a) Meeting with Sub Recipients to understand project implementation activities undertaken by them
b) Visit to State SACS Store
c) Visit to State TB Store
d) Visit to CMSS Drug store

Day 2:

HIV Team:

a) Visit to Guwahati Medical College and Hospital – ART, ICTC , PPPTCT centre
b) Visit to Hajo CHC
c) Visit to Satribari Christian Hospital
d) Visit to Kamrup CSC under NERO (Assam Network of Positive People)

TB/ Malaria Team:

a) CHC Azara, PHC Uparhali and Sub Centre Puv. Dharampur, Kamrup Rural to oversee TB and Malaria activities
b) Intermediate Reference Laboratory, Guwahati

Day 3:

e) Meeting with Principal Secretary (Health)

Day 1: Sub Recipient-level meeting (7th August, 2018)

Oversight Committee held a meeting with Sub Recipients implementing Global Fund grant in Guwhati, Assam on 7th August, 2018 at Assam SACS Committee room to understand activities undertaken, targets achieved, fund disbursement, expenditure status and challenges encountered in program implementation. List of participants is placed at *Annexure 1*. Representatives from Assam SACS, Alliance India and NERO, Plan India and Piramal Swasthya, Assam RNTCP, CHRI and WVI and Assam VBD made brief presentation. Following are the highlights of the projects presented by SRs:

A. Assam SACS:

Assistant Director ICTC, Assam SACS, Dr. Rashmi made a brief presentation on state programme activities, achievements and challenges.

She highlighted that the prevalence of HIV in Assam is only 0.06% (yr. 2016) and fares better than national average of 0.25. A total of 37 lakh persons were tested for HIV in Assam till 31st March 2018 of which 14,586 were found to be positive. The route of transmission observed in HIV positive in Assam is mostly heterosexual, and majority of the PLHIV have been detected in Kamrup Metropolitan followed by Cachar and Dibrugarh district.

The state is providing HIV prevention, testing and treatment services through the following facilities:

Facilities under Assam SACS	
Name of the Facilities	**No. of Facilities**
Integrated Counseling Testing Centre (ICTC)	97
Facility Integrated ICTC	203
Mobile ICTC	2
Public Pvt. Partnership (PPP) ICTCs	44
ART centres	3
ART Plus centres	2
Link ART centers	2
CD4 testing centre	5
Designated STI/ RTI Clinics	2
Targeted Intervention (TI)	50
Blood Banks	68

HIV testing Efforts: For year 2017-18, of the 1,98,383 persons tested in general population, 1419 were found to be positive, of which 1259 were put on treatment. Of the 6,84,407 women registered for ANC, 4,60,100 were tested for HIV. 195 of these were found to be HIV positive, of which 188 have initiated ART. Of the 1419 found positive in the general population, 1303 (92%) spouse were tested, and of the 195 HIV positive pregnant women, only 124 (64%) spouse were tested. There are 5 functional EID centres in Assam

PLHIV-ART Linkage System (PALS): Around 70% of the HIV positive persons reported in General population were reported through PALS in 2017-18 and only 110 are reported to be taking ART in PALS, as compared to 1259 persons as per SIMS data. Similarly, only 45% of the HIV positive pregnant women were reported through PALS, of which only 20 are reported to be on treatment, as compared to the figure of 188 in SIMS.

Cold Chain structure was reported to be inadequate for the state. Two Walk-In-Cooler (Blue star) with capacity of 8' X 8' are available at Store ASACS which is not sufficient to accommodate test kits supplied by NACO. Further, there is no permanent mechanism for transportation of HIV test kits from District and Sub-District level by maintaining cold chain. Stocks for WBFPT, NVP Syp and AZT/ZDV Syp were reported to be deficient with ASACS. Additional budget is required for maintenance of existing equipments like Refrigerator, Centrifuge Machine, Computer and Printers etc.

Three positions at the Assam SACS level (DD ICTC, AD ICTC and Divisional Assistant) are lying vacant and hence the provision of supervision to the staff is low. 22 ICTC Counselors and 30 ICTC- LTs are also yet to be recruited at various facilities. PD Assam SACS has been appointed recently, and it is an additional charge for him.

B. Northeast Region implemented by Alliance India-NERO

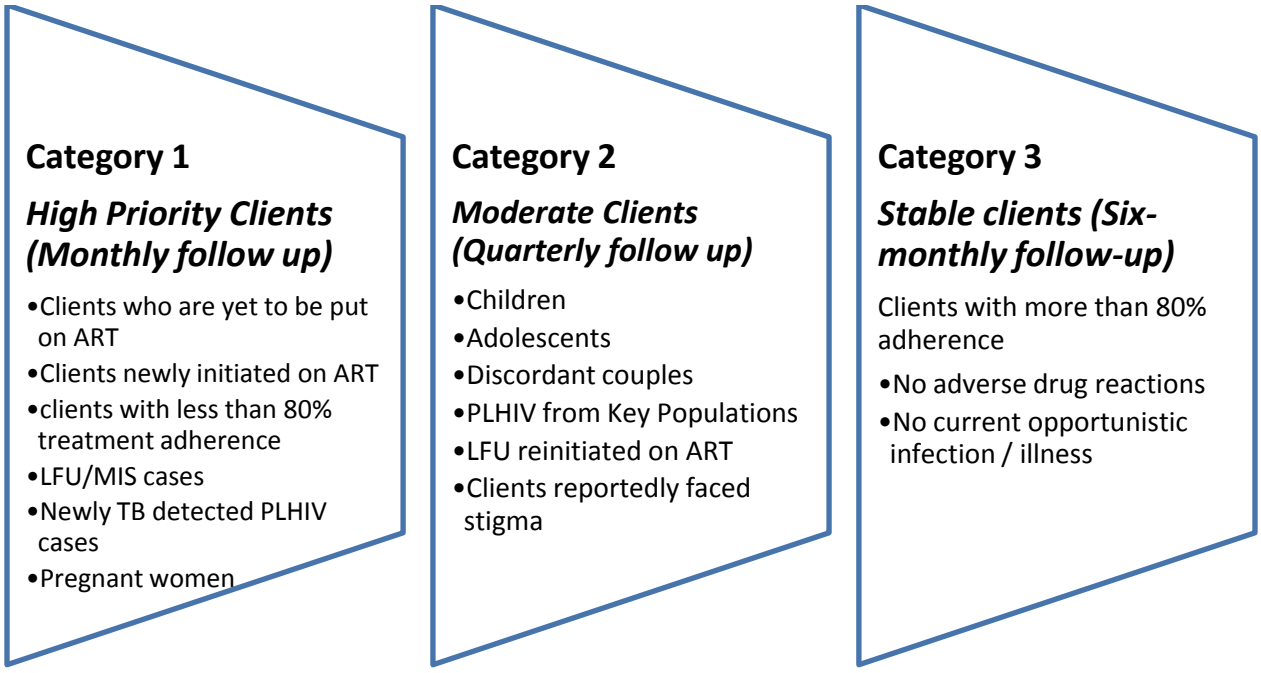
India HIV Alliance is the Principal Recipient under the Global Fund grant to implement Vihaan project to improve the survival and quality of life of PLHIV by fulfilling their Care, support and treatment needs. In Assam, India HIV AIDS Alliance operates through its North East Region Office (NERO) which is an SR. The SSR working with NERO in the region is Assam Network of Positive People (ANP+), whose staff operates through Kamrup CSC for 4 districts in Assam and 1 in Arunachal Pradesh and Dibrugarh CSC. Deshabandhu Club is a SSR working in Assam for Cachar CSC in Cachar district.
NERO has been set up by India HIV AIDS Alliance for 6 NE states – Assam, Manipur, Mizoram, Meghalaya, Nagaland, and Tripura.

CSCs in Assam	**ART centres covered**	**No. of Outreach Workers**
Kamrup (Assam Network of PLHIV- ANP+)	Barpeta, Kamrup, Jorhat, Nagaon, Papumpare	8
Dibrugarh (ANP+)	Dibrugarh	2
Cachar (Desha-bandhu Club)	Silchar	3
3	**7**	**13**

Human Resources of NERO in Assam: All sanctioned positions under NERO are filled up in Assam. The posts of Project Director, Project Coordinator and Accountant form the NERO (SR) and Peer Counselors and Outreach workers are from SSR.

State	**Project Director**	**Project Coordinator**	**Peer Counsellor**	**Outreach Worker**	**Accountant**	**Total**
Assam	3	3	3	11	3	**23**

The Oversight Committee members were also informed that the model of Differentiated Care is being implemented since January 2018, where the patients are sorted into 3 categories depending upon few criteria which determine the different level of care they will receive.



The PR/SR reported that from January to June 2018, a line list of 460 was provided which were to be initiated in ART. Of this, only 9.75% clients have been initiated on ART. The list of patients who have been initiated on ART, ANP+ has been able to channel 71% of patients to complete 3 services. Of the total 337 patients LFU in Assam from January to June 2018, the organization was able to bring back 55 patients to treatment.

63% of the budget issued to Assam project of Vihaan has been expensed till June 2018 for various activities.

NERO has monthly coordination meetings with HIV Alliance, NACO and Plan India.

C. Plan India

The objectives of AHANA project are

- To improve HIV testing among pregnant women and effective reporting system both Public in Private sector
- To ensure effective linkages and retention to ART treatment to HIV positive pregnant women (PPW) and their children through Intensified Case Finding (ICF) approach
- To provide comprehensive care and support services to HIV positive pregnant women and their families through community based outreach activities

As per the implementation strategy entire North East has been divided into 2 clusters – NE I (Assam, Arunachal Pradesh, Meghalaya & Sikkim) & NE 2 (Manipur, Mizoram, Nagaland & Tripura) and NE Cluster I is managed by Piramal Swasthya.

Only fourteen districts of Assam were being covered in the previous grant. From January 2018, all districts of Assam will be covered under Piramal Swasthya for the current grant. The implementation at

Kamrup Metro and Rural has started from April 2018. For 33 districts of Assam, 8 Programme Officers and 36 Field officers have been appointed.

Till June 2018, the following activities have been completed by the PR/SR:

1. State level Action Plan has been prepared in collaboration with SACS
2. Sub Recipient Partner Selection has been completed
3. State and District level SR staff recruitment has been completed
4. Induction training for the project staff has been completed
5. Engagement with SACS and NHM to roll out the project has begun
6. Supported state level NHM in PIP preparations to ensure the EMTCT interests are addressed
7. Mapping, Assessment and Engagement process for private sector has been initiated
8. Orientation of Private Medical Associations has been done for Guwahati, Tinsukia, Jorhat, Cachar and Nagaon
9. Situational Assessment (Public Sector)is being conducted for preparation of the Baseline
10. Training of District Resource Team has been conducted (Sensitization of BPM, LT NHM, SR ANM on PPTCT)

Indicator	Target	Achievement till June'18	Percentage Achievement till June'18	Global Fund Target (Till September, 18)
Percentage of pregnant women who know their HIV status	188729	92050	48.8	60
Percentage of HIV-positive pregnant women who received ART during pregnancy	41	34	82.9	90
Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	21	12	57.1	75
Number of people who were tested for HIV and received their results during the reporting period (Spouse of PPW)	41	33	80.5	80

D. Assam RNTCP programme:

State TB Officer, Assam made a brief presentation on RNTCP programme implementation in Assam and shared the following highlights/achievements:

1. Assam is the first state in the country to launch Bedaquiline on 6th June 2018.
2. TB case notification has increased, with Annualized TB case notification of 110 in year 2017. As per Nikshay data in year 2017, 101% (37036) cases have been notified by public sector compared to 18% (3591) notification from Private sector. During Jan-June 2018, Public sector has reported 16739 (89%) cases against private sector reporting of 2392 (14%) cases.
3. Treatment outcome of 85% in new patients has been achieved consistently since 2014.
4. MDR TB case detection has increased (from 313 cases in 2016 to 404 cases in 2017) because of universal Drug susceptibility testing (DST) and majority of the MDR cases are put on treatment.

5. CBNAAT machines have been successfully installed in 27 districts for decentralized diagnosis for Multi-Drug Resistant TB cases. Additional 3 CBNAAT machines has been installed, one each in Majuli, South Salmara and Biswanath Chariali. Average monthly utilization of CBNAAT is 100 tests per machine. Sufficient stock of Cartridges to last for three months is available with the state.

Status of utilization of CBNAAT machines by 2nd Quarter of 2018	
No. of tests per month	No. of CBNAAT labs performing tests
<150	25
150-250	4
>250	1
Total	**30**

6. TB- HIV collaboration activities are taking places. Up to year 2017, around 72% of DMC were collocated with ICTC in the state and 51% of registered TB patients knew their HIV Status.
7. Under Nikshay Poshan Yojana, 157 patients received DBT incentives against 2313 total eligible patients since Apr, 2018 till July, 2018.
8. All 27 districts have established district DR-TB Centre with all facilities as per PMDT guidelines.
9. Under Active case finding carried out in 2017, 93562 people at risk were screened for TB and 5499 presumptive cases were tested, of which 40 TB positive cases were found.

Key challenges:

1. Case notification in private sector is progressing but not at required pace (only 14% private sector notification achieved in 2018).
2. There is backlog in NIKSHAY real-time data entry with huge gap between the actual number of TB patients notified in the districts and numbers registered in NIKSHAY. Tablets have been distributed to all concerned staffs for real-time entries and re-fresher training has also been conducted. All relevant staffs has been allotted the tablets provided by Got of India, however real-time NIKSHAY data entry is yet to pick up.
3. State Coordination Committee (SCC) meeting for TB-HIV collaborative activities has not been conducted in the state for more than 3 years.
4. Active case finding component needs to be strengthened to increase target population and identify more cases.
5. Fund utilization in year 2017-18 has been only 45 % (Rs. 13.6 crores) against the disbursement of Rs. 30 Crores to the state.

E. Joint Effort for Elimination of TB (JEET) Project under TB grant

- World vision India is implementing JEET project in Assam as sub recipient (SR) to Centre for Health Research and Innovation (CHRI) which is a non –government principal recipient under the current Global Fund grant (2019-2021).
- The project aims for Intensive engagement with the private sector in Assam to achieve universal access to quality diagnosis and treatment for TB through Patient provider support agency (PPSA) model. Project has 1 PPSA site and 11 PPSA lite sites (with limited HR) in Assam.
- MoU between CHRI (PR) and WVI (SR) has been signed
- On field implementation has not started yet. So far, key state staff (State program lead, Operations manager, data analyst, field officers etc) and 82% of SR team have been hired in July 2018.
- Training of PPSA team completed on 31st July 2018 by World Vision India with support from CHRI.
- Preliminary discussion for engagement with JEET project has been initiated with Satribari Christian Hospital and Health City Hospital.

F. Assam NVBDCP programme:

Joint Director of Health Services cum State Program Officer, NVBDCP presented following achievements and issues related to programme implementation in Assam:

Achievements:

1. State has been successful in reducing malaria annual parasite incidence across its various districts.

Over the years, the malaria situation has shown progressive improvement. The Annual Parasite Incidence (API) has declined from 0.46 per thousand population in 2015 to 0.15 per thousand population in 2017. In 2017, no deaths were reported as compared to previous years (Table 1). However, it is significant to note that the ABER (Annual blood examination rate) has shown steady decline over the years with 7.96 per cent reported in 2017, although the state mentioned about the need for strengthening of surveillance of fever by ASHAs. Male Health Volunteers are also being proposed for remote villages. District Kamrup has also progressive decline in malaria cases from 195 in 2015 to 45 in 2017. In 2018 (until July), the number of cases reported was 13. No deaths were reported during this period.

Table 1:

Indicator	2012	2013	2014	2015	2016	2017
ABER	12.76	11.83	11.08	10.03	9.14	7.96
API	0.92	0.59	0,43	0.46	0.23	0.15
Malaria Deaths	13	7	11	4	6	0

According to the NSP 2017-2022 categorization, Assam falls in category 2. The district-wise stratification showed that 5 districts in high endemic category of API 2-5 in 2015 have shown progress with two districts in category API<1 and three districts in category API 1-2 in 2017. The latter three districts are: Karbi Anglong, Kokrajhar and Udalguri (Table 2).

API stratification in 27 districts of Assam				
Year	API<1	API 1-2	API 2-5	API >5
2014	22	0	1	4
2015	22	0	5	0
2016	23	0	4	0
2017	24	3(KarbiAnglong, Kokrajhar) Udalguri	0	0

2. Under Intensified Malaria Control Programme (IMCP) with funding support from the Global following malaria control, capacity building and monitoring activities have been undertaken in the state since 2015:
   i) 28.5 lakhs LLIN distributed to malaria endemic SCs of state during 2015- 16
   ii) Trainings of ASHAs (N-30654), LTs (N-202), all MTS, Medical Officers (N~70) and Practitioners under IMA N(~150 in 5 districts) and staff for Public Financial management system (PFMS) were conducted.
   iii) 28 bolero vehicles for (27 districts + ST HQ) for supervision & monitoring support at state level and motor bikes for MTS for block level monitoring
   iv) 393 Compound Microscope received and distributed to the CHC& PHC
   v) HR support for DMO (27), state consultant (5), district consultants (27), MTS (149) and LTs (54)

Key challenges:

1. Malaria elimination campaign has not been launched in the State. State has yet to initiate developing own strategic plan for malaria elimination in line with national NSP 2017-2022 and has yet to launch malaria elimination campaign, although the state aims to progress to elimination phase. Efforts have been initiated to stratify districts, CHC/PHC, Sub centers by API. However, all reported data are collated from the public health facilities only (includes community level data reported by ASHAs) and reports from private sector, especially hospitals, clinics, tea estates, private practitioners (trained under NVBDCP) and NGO etc. are not collated and integrated under HMIS. Malaria is yet to be declared as a notifiable disease. Moreover, state malaria elimination task force is yet to be constituted and is in process.
2. More than 40% sanctioned positions(65 out of 149) of Malaria Technical Supervisor (MTS) and 100% (54) sanctioned position of Lab Technician under GFATM are lying vacant resulting in improper implementation of anti malaria interventions at periphery level. The sanctioned LT positions are required to be correctly proposed in PIP by the state to get approval from NHM before initiating recruitment for LT positions.
3. Remuneration of contractual manpower (Malaria Technical Supervisor and Data Entry Operator) is very less in comparison to other GFATM states due to proposal of less salary by the state in its PIP. This results in unavailability of qualified staff for these positions in the state.
4. Timely logistic supply is a continuing issue. There is shortage of ACT-AL (6 month-3 years) and ACT-AL (14 years + Adult dose) with requirement of around 5000 units of each age, while ACT-AL (3-9

years) and ACT-AL (9-14 years) drugs are not available in the state. Shortage of Rapid Diagnostic Kits (RDT) and Microscope slides was informed. State expressed additional requirement of 12 lakh RDT kits and around 20 lakh slides for year 2018-19. Besides, state informed complete stock out of drug Primaquine 2.5 and swabs.

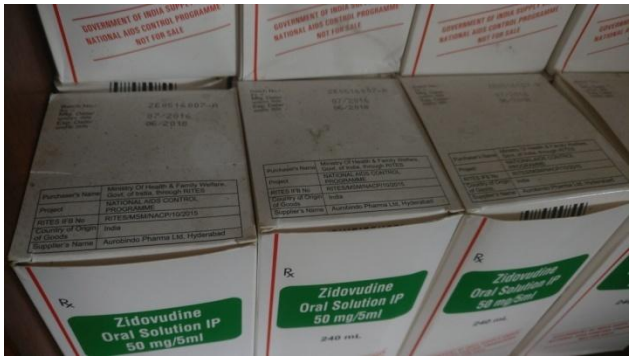
Site Visit by Oversight Team

Subsequent the meeting with Sub- Recipients, Oversight Team members planned its visits to review activities related to HIV, Tuberculosis and Malaria programme in Guwahati, Assam in Kamrup Metropolitan and Kamrup Rural districts.

Visit to SACS drug store (7th August, 2018)

The team visited the SACS drug store on 7th August to assess the condition on the facility and availability of the medicines. The store was a 4 room space. The plot area was being shared with a family living in a kutcha house, and also reared livestock.

At the store, the committee found that stocks of consumables were kept out in open which have the tendency of getting damaged as monsoon season was prevailing. On close inspection of the racks where required drugs were placed, the committee found expired and damaged drugs. Expired stock of Zidovudine oral sol. 50mg/5ml were found in store racks



The committee also observed the condition of walk in coolers at the SACS store. There was presence of 2 walk in coolers, one of which was in a poor condition, water dripping and stocks getting visibly damaged. The walk in cooler requires urgent maintenance.

For maintaining stock records, the committee observed that the staff is using MARG software instead of IMS. It was also observed that the staff employed as store keeper also has been given additional charge as there is gross HR shortage in Assam SACS.

Stock of Abacavir+Lamuvidin paediatric drug was available for < 1 month.

The committee felt that the installation of the appropriate software to track requirements at the click of a button is critical. Having a dedicated person managing stocks and inventories will help to maintain better conditions of storage.

Visit to CMSS Warehouse (7th August, 2018)

Team visited CMSS warehouse and found stock of essential drugs for TB, HIV and Malaria drugs. Some of the drugs were found in quarantine including ACT-AL (all age groups) which was not available at field.

On Day 2, Oversight members formed two teams, of which one team reviewed implementation of HIV/AIDS activities and other team reviewed TB/Malaria activities in kamrup district.

Visit to Guwahati Medical College and Hospital (8th August, 2018)

At the Guwahati Medical College, the team visited the ICTC centre, ART centre and PPTCT centre.

ICTC centre

The ICTC centre receives close to 100 patients a day, with referrals from STI Clinic, from RNTCP, TI NGOs, Blood Banks and few are self-referred.

	Number of referrals for the month of July 2018 at GMCH ICTC
STI	163
RNTCP	105
TI NGO	21
Blood bank	3
Govt	1674
Self and Others	59
TOTAL	**2025**

Referral of Inpatients is more than outpatients

Of the 2025 people tested for HIV, 28 were found to be positive for HIV. A low referral to the centre by TI NGOs was observed as only 1 IDU TI is referring to this centre.

The ICTC centre is manned by 2 counselors – one male (working since past 3 months) and one female (working since 2 years) and 2 lab technicians.

CD4 lab was also visited in the vicinity. It was informed that there is no shortage of kits. However, the UPS attached to CD4 machine is not working well. As the cost of service is similar to cost of a new machine, a request for a new UPS has been issued. Viral Load test is not conducted in this lab, and has been outsourced to Metropolis. The infrastructure for installation of Viral Load machine is ready at GMCH.

It was checked through registers that for the month of July 2018, 35.6% of the patients had CD4 less than 350 which presumes that the patients are not getting tested at an early stage. The team suggested that the SACS should keep this information into account for future.

The team also found that the ICTC registers were not revised as per latest format. The SACS representative was informed regarding the same. PALS entry is made at the ICTC centre as the computer has been installed here. However, internet speed is often seen as a challenge for updation of data.

The counselors were interviewed. One counselor counsels around 50 patients in a day. Due to heavy patient load, it becomes difficult for one counselor to manage work in case the other counselor is on leave. There is thus a need of an additional counselor at the centre.

The committee felt that the load of the patients is high as compared to the periphery, and the number of counselors is not adequate for proper post test counseling. The committee also suggested that a better waiting area would also help to provide the privacy for the post test and ensure that the post test sessions are not continuously disturbed by others waiting to meet the counselor. A good post test session will go a long way in strengthening linkage to ART and subsequent follow up.

<u>ART Centre</u>

The ART Centre located at GMCH is manned by 1 MO (1 position of MO lying vacant), 3 counselors (1 position of Counselor lying vacant), 2 Data Managers, 1 Pharmacist, 1 staff nurse (1 position of Staff nurse and 1 care coordinator lying vacant) and 1 support staff.

There are more than 7000 registered cases at GMCH ART and 2700 are currently on ART. Around 100 patients are on 2nd line ART.

GMCH provides 1st line and 2nd line ART and as it was the first ART centre opened in Assam due to which the number of registered patients is more. Later when other centers opened up in Assam, the patients shifted to them citing convenience. Any patients requiring third line ART are referred to Calcutta at a Centre for Excellence. The travel cost of the patient is borne by the Government.

On a single day, 60-70 patients attend OPD of ART to manage side effects of ART medication.

The team attempted to elicit the drop out from ICTC to ART. In the month of July 2018, of the 28 positive cases, 20 patients reached the ART centre. Two of the total positive cases were outstation, but yet the team was not able to bring 6 cases to the ART centre for treatment from the ICTC centre situated in the same building. The ART staff complained that they get minimal support from the Vihaan Programme.

The ART staff reported of Paediatric drug shortage at the centre. The drugs are collected from the SACS store by the ART staff.

A patient, 40 yrs/ female was interviewed by the committee. She has been on ART since 10 years. She has two children who stay in Chandigarh, one child (23 years) on ART and the second child has not been tested yet. She mentioned that she receives proper care and treatment from the ART centre. However, she claimed that she hasn't been approached by any CSC staff ever.

PPTCT Centre

The PPTCT centre situated in GMCH is manned by 2 counselors. 40-50 patients are attended by the counselors daily. In the month of July, only four women were found to be positive during ANC Check. All underwent miscarriages/ MTP.

The staff of PPTCT explained that once a week Field Officer from Ahana Project visits the centre to take latest report. In case any positive ANC is detected, the field officer takes consent for home visit and attempts to prepare the entire family for a safe institutional delivery. The field officer also reminds the ANC patient to keep taking ART for her health.

Visit to Hajo CHC (8th August, 2018)

Hajo CHC caters to a population of 25,000 people. The centre acts as CHC, PHC and FRU.

Stand Alone ICTC is located at Hajo CHC. Both ANC and general patients visit the centre. HIV positivity rate at this centre is very low with reporting of approximately 2-3 cases annually. In the month of July, 240 ANC and 74 General clients were tested, and none was found to be reactive. Any positive cases are referred to GMCH ART centre. The staff informed than only one migrant TI refers to this CHC. The counselor mentioned that she believes that as the presence of Non Government organizations is low in the area, the High risk populations are not catered, and it often becomes difficult to counsel such cases.

HIV testing lab was also visited by the team and all consumables were found to be available and kept in order.

The HLL Lab carrying out all tests including Hepatitis and VDRL at the Hajo CHC was inefficient in documenting the tests conducted. The team of Ahana project was requested to conduct a training for the staff at HLL lab to improve documentation.

The RNTCP Lab, located in the vicinity was also visited by the team. The HIV-TB referral was found to be very low. The staff was requested to send TB patients for HIV testing.

Visit to Satribadi Christian Hospital (8th August, 2018)

Satribadi Christian Hospital is a private hospital and acts as standalone PPTCT under the Ahana Programme of Plan India implemented by Piramal Swasthya in Kamrup Metropolitan district.

It is a 120 bedded hospital. The stand alone PPTCT is manned by one GNM, 1 Lab technician and 1 Incharge ICTC. One field officer has been appointed from Piramal Swasthya for Kamrup Metropolitan who caters to all PPTCTs and FICTCs under the district, Satribadi Christian Hospital being one such centre.

A low positivity rate was reported by the PPTCT staff. The counselor mentioned that around 15-20 patients are counseled every day, including patients from IPD and OPD. The ICTC incharge mentioned that only screening tests are conducted in the centre and for confirmatory tests the patients are referred. The test kits are supplied by Assam SACS.

The committee felt that a Closer touch with the hospital by the PLAN team may be necessary to ensure that no positive pregnant woman is lost to follow up. This will apply to all in the list of hospitals undertaking institutional deliveries. The project should conduct a mapping exercise of all the private hospitals conducting deliveries in each of the implementation districts, especially for HIV positive pregnant women.

Visit to Kamrup CSC (8th August, 2018)

Assam Network of Positive People (ANP+) Care and Support Centre is an SSR under the SR - North East Regional Office (NERO) of India HIV AIDS Alliance (PR).

The NERO office at Kamrup Metropolitan is manned by 1 Project Director, 1 Project Coordinator and 1 Accountant. 1 Peer Counselor and 4 Out Reach Workers (ORWs) are working under the SSR- ANP+.

The ORWs conduct home visits (1-2 households per day) and the Peer Counselor visits the ART centre for coordination. Home visits are conducted for patients newly initiated on ART and to track LFU. Others are tracked via phone. Registration letters are also sent to persons who are irregular in attending ART centre. Once the patients come to the Care and Support cnetres, client registration forms are filled up taking all necessary information and they are then counseled.

The Oversight Committee observed that the number of ORWs is low as compared to the patient load (4 ORWs for one ART centre- GMCH which has patient load of ~2800). Given the geographical spread, travel allowance for home visits is also low for ORWs (Rs. 1000/ month).

The committee also felt that the roles and responsibility of each ORW are not clearly defined. No work plans or micro plan have been made for each ORW to carry out their functions effectively. Presence of inadequate training, supportive supervision and hand holding of ORWs/ implementation staff by Project Coordinator was observed. The committee also noticed that technical support by SR to the CSC project team is missing.

The staff was not able to provide accurate data on the number of patients registered, LFU etc. It was previously told to the committee that accurate data will be available in the E- Mpower tablets; however they were also found to be non functional due to a technical defect.

The committee also felt that even though the model of differentiated care was described in the presentation made on 7th August 2018 by the PR, the actual implementation of the model by outreach workers was not observed during the visit to the CSC. There was no training conducted for the outreach workers on the differentiated care approach, hence they were totally ignorant of this concept.

The staff complained that as the CSC is located 11 kms away from ART (GMCH). It is difficult to bring the patients to CSC for a detailed counseling. A person has to take a rikshaw and bus to reach the CSC from ART centre.

The committee felt on meeting the ART staff and CSC staff that while the presence of a peer counselor/ outreach worker is critical at the ART centre, there is no designated place for the peer counselor to do any testimonial counseling. Talking in the corridor cannot lead to effective motivation building. A review is needed to examine the role of the peer counselor and outreach worker positioned at the ART centre in the context of the differentiated care strategy of the new phase of the Vihaan programme. The success rates of ART LFU and Pre-ART LFU tracking should also be analyzed across the country.

To oversee implementation of Malaria and TB activities, of the teams of oversight committee visited CHC Azara, PHC Uparhali, SC Pub Dharampur and IRL, Guwahati. Team interacted with facility staff, reviewed programmatic records/reports and available laboratory services. Team had following observations related to each of the facility:

Visit to CHC Azara (8th September 2018):

It is a 30-bedded CHC in the Kamrup Rural district of Assam, covering population of around 1 lakh. CHC Azara is also serving as First Referral Unit (FRU). It has three PHCs and 26 Sub Centers associated with it. It is one of the designated Tuberculosis units (TU) under RNTCP with three DMCs (Azara, Mirzapur and Rampur) under it.

A) Malaria Program:

- CHC Azara falls within category API 0-1. Malaria caseload at CHC has declined since 2015 from 48 cases to 6 in 2017 due to distribution of LLIN and other malaria control activities.
- In current year (2018), from Jan-June 7cases were reported (5 cases of Plasmodium falciparum and 2 case of P. vivax) by government facilities. Reporting of malaria cases from private sector was not initiated. Four Pf cases seemed to be from same family belonging to village Nomolipathar under Sub centre Garbhanga, which has challenging settings. Strategies regarding identification & response for such hot spots were not very clear.
    - In district Kamrup, whilst the declining trend is seen in most CHC/PHC during rapid comparison of epidemiological situation for the year 2017 & 2018 (until July), reverse trend was noted in CHCs Azara (2 cases in 2017 and 6 cases in 2018) and Bihdia (nil case in 2017 and 1 case in 2018). Further, whilst the district is progressing towards malaria elimination, the surveillance is yet to evolve to detect, notify, investigate, classify and respond to all cases and foci to move towards malaria elimination. Efforts are initiated for line listing of cases although yet to capture important information like travel history for all cases. In some cases, there are separate narratives. Also, as malaria elimination is aimed at, data quality audit needs to be carried out regularly and further strengthening of supervision & monitoring is needed, since in CHC Azara (quite accessible from the state capital-Guwahati) mismatch of figures as well as absence of important information in various forms & registers, amongst others were noted.
- Team found that diagnosis of malaria at the facility is mainly done by RDT kits instead of Gold standard method of Microscopic diagnosis. It was noted that numbers of RDTs performed were higher by facilities (Sub centers/PHC/CHC) than by ASHAs.
- LT was not found to be thorough in his testing skills as well as recording/reporting. Two slides taken on the day of the visit were poor in quality (both thick & thin smears). The place for washing slides was quite unclean. Laboratory did not have any display charts on required information relating to malaria microscopy.
- Stock status of Malaria diagnostics and medicines:
    - ACT-AL Pediatric dose (6month-3 yrs) and adult dose (14+) were available at the facility, however ACT-AL 3-8 yrs age group and ACT-AL 8-14 years age group were out of stock. Staff informed that adult dose (ACT-AL 14+) is being used to treat cases of 3 to 14 years age group after breaking the adult dose into smaller dose. Team raised the concern that this practice may lead to difficult stock tracking and may be misinterpreted as increase in adult cases due to higher consumption of adult dose.
    - Primaquine 7.5 was available while Primaquine 2.5 was out of stock
    - RDT kits stock of 1-2 months was available. Distribution of new RDT packages has been initiated. However, orientation on changes in RDT cassettes is yet to done at all health facilities & for ASHAs.
    - CHC Azara received and distributed 14,800 LLIN through its SCs during year 2015 under GFATM grant.
    - The emergency malaria medicine box was found deficient & not kept properly. It was mentioned to the team that since cases are on the decline, the same is not required.

- Stock records need to reconcile with one another. Also, appropriate stock recording needs to be followed. In CHC Azara, monthly closing & opening balances are not reconciled. Additional stock of different batch number & expiry date were seen added to the following month stock without disaggregation, although the VBDCP team agreed that such recording was needed.

- IEC/BCC activities and Coordination efforts:
  - Efforts are made through IEC/BCC activities to promote use of LLINs. The district seemed to have observed LLIN fortnight in May 2018. It was mentioned by the State/District/CHC officials, MTS that LLIN use was noted quite high and IEC/BCC messages were also disseminated. However, no report was available at any level. Also, IEC/BCC materials especially for promoting LLIN use was not seen at facility or community levels, although 1-2 banners were shown that depicted picture of LLIN use & message along with many other illustrations & messages on EDCT & other components. Information scroll on national treatment guidelines were seen at CHC & PHC levels.
  - No inter-departmental meeting for malaria has happened at CHC level.
  - Staff informed that monthly MTS meetings happen but no minutes were found.
  - Team did not find adequate IEC material related to standard operating procedures (SOP) for diagnosis and treatment in the facility. Besides epidemiological data was also not displayed at the facility, which indicates data is not being used for local planning.
  - Staff informed that for IEC activities limited funds are allocated to the CHC. Mostly IEC materials are to be purchased at facility level from other heads.
  - Malaria awareness through 1-2 School/village level meetings and use of mike were done by programme staff. However, NGO/private sector were not involved in such activities.
  - Appropriate planning for IEC/BCC for calendar month/quarter etc. needs to be done at District/CHC/PHC/Sub centre levels. Sample activities need to be supervised regularly. Leaflets were distributed, although no sample was shown to the visiting team.
- Visit to few households in East Dharampur village revealed LLIN use by beneficiaries.
- Record maintenance at facility was deficient especially under malaria programme. The Lab technician (LT) had not maintained patient and diagnostic supply record properly.
  - Rapid checks of different M forms, registers at CHC, PHC levels showed deficient data quality in terms of completeness, correctness especially in Azara CHC (example, M2 forms received by labs included RDT related information in place of results, copies of M2 forms did not include results and sent to patients, patient's age related information on M2 form & M3 registers showed mismatch, M3 registers did not include the dates of slide examination & other information or incorrect information is included, columns were not filled for Pf RT done, comments like 'outside of PHC' were written for one case, M4 summation of slides & RDT numbers mismatch with totals & in few instances totals were not mentioned, M4 mentioned number under stock out column, none of M4 had stock related information for reconciliation of stock consumption related data.
- Key staff for malaria programme - LT, pharmacist, Data entry operator (DEO) and malaria treatment supervisor (MTS) was in place. MTS and DEO raised concern of their low salaries

compared to their counterparts in other neighboring states, which is quite demotivating for such field staff who are key link between programme and community and hence many such positions often remain vacant.

B) TB Program:

- CHC Azara is one of the 8 Tuberculosis units of Kamrup District with three DMCs-Azara, Mirza and Rampur under it.
- TB diagnosis activities:

Year	**Number of TB Suspects/sputum samples examined**	**Number of smear positive patients diagnosed**	**Number of cases put on treatment within TU**
2017	913	83	83
Jan-June, 2018	487	55	55

- 6 MDR cases were detected during 2016-2018 at the Azara TU of the total 26 MDR cases of the entire district. All cases are on treatment.
- CBNAAT lab functioning was observed. At the facility, CBNAAT machine was installed in March, 2018. Around 312 cases were performed from March till July, 2018, with an average 62 tests per month. Total 71 Rifampicin sensitive cases and 9 Rifampicin resistance cases were detected.
    - As per stock register records, 486 cartridges were available at the facility. Team found that it was not matching with the physical stock of cartridges (220) available at the facility. There was difference of about 266 cartridges. LT explained that initial stock of cartridges was probably wrongly entered in the stock register and while some cartridges were shifted to other facility, this information was not entered in the register.
    - Stock register was not maintained properly (Opening –Closing balance).
    - STLS and LT at CBNAAT trained did not receive training since 2012.
    - No diagnostic algorithm or SoP was found in the lab.
- Stock status :
    - Sufficient stock of 4 FDC (60 courses) and 3 FDC (404) for up to 3 months was available. Stock of around 2 months of medicines for MDR cases (67 boxes for all categories) was available at district level.
- Around 5000 cases were screened in the entire Kamrup district in 2017, require more focus.
- Under Nikshay Poshan Yojana, there were 43 eligible cases under the facility, whose bank details were not updated in Nikshay and were not linked to PFMS. Hence, beneficiary could not receive benefit so far. STS agreed to complete this by 15th August 2018.
- Supervision and leadership of TB Programme was found to be lacking. District TB Officer was not present at the facility. M.O with additional charge of DTO was not updated about programme status.

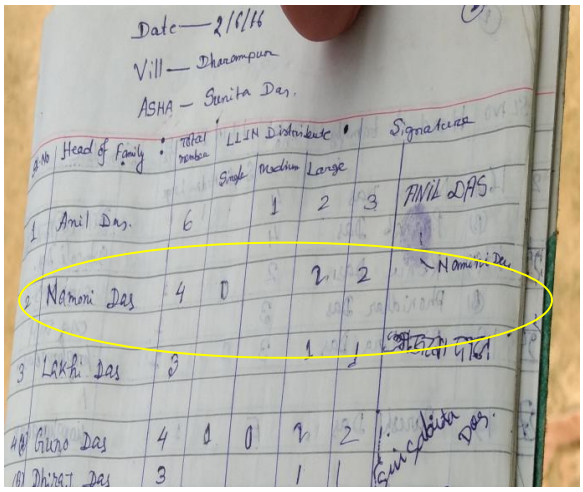
- Team interacted with two TB patients to enquire about quality of services provided at the facility. Patients were satisfied with the diagnostic and treatment facilities available at the facility.


CBNAAT at CHC Azara

Visit to PHC Uparhali (8th August 2018)

- Team found that incorrect stock of ACT-AL (14 years + adult age group) was recorded in the stock register. Physical stock of ACT-TL tablets was 300 tablets while recorded 500 tablets. Pharmacist acknowledged the error and assured to correct the stock record.
- LT under malaria programme was not trained since 2014. New microscope was kept in almirah and was not being used.
- As mentioned above, recording/reporting and M&E showed deficiencies and absence of regular scrutiny/data quality audit by higher levels, which needed improvement.

Team visited **Sub Centre Pub Dharampur** to review LLIN utilization status by beneficiaries in the surrounding areas of the sub centre. Two households in village Rangapara were visited, where LLINs were provided by SC. The LLIN utilization was observed.




LLIN use by beneficiary at SC Dharampur

Visit to Intermediate Reference Laboratory, Guwahati (8th August 2018)

- Intermediate Reference Laboratory (IRL), Guwahati was started in 2012 under RNTCP and is the first laboratory in the Eastern Region to be certified for all technologies (Solid / Liquid / LPA / CBNAAT).
- IRL Guwahati is the first lab in the region to be certified for 2nd Line Drug Sensitivity Testing and also1st IRL under RNTCP to get NABL certification.
- TB laboratory activities for period Arp-Dec, 2017 and Quarter 1 of 2018 are as follows:

Period	CBNAAT		LPA (1st line)			LPA (2nd line)			
	Total	Resistant	Total	Susceptible	Resistant (HR/R/H)	Total	Susceptible	Resistant (FQ/SLID/KM)	XDR
April-Dec, 2017	3989	152	419	182	111	-	-	-	
Jan-March,2018	1239	43	174	136	37	99	60	30	2

Period	MGIT Culture (Follow up)		Liquid DST (2nd line)		
	Total	Culture +	Total	Susceptible	Resistant (All MDR inc. XDR)
April-Dec, 2017	1974	447	105	22	45
Jan-March,2018	612	143	-	-	

- IRL had sufficient stock of cartridges available for at least three months (stock as on 31st July, 2018 was 1098).
- Challenge: IRL Guwahati , Laboratory Head explained that facility has 2 technical officers, 4 laboratory technicians and 1 data entry operator who have been supported by FIND till Dec, 2018. Beyond 2018, IRL has got approval for only3 technical staff under domestic funding from MoHFW. IRL Guwahati being top notch laboratory for the north eastern region has high work load and requires highly trained and experienced staff to manage its activities. Laboratory Head, IRL Guwahati expressed need to retain all existing trained staff (2 T.O, 4 LT and 1 DEO) beyond Dec 2018 through domestic budget and include it in state PIP for 2018-19.

Key challenges identified by team related to Malaria and TB programme at the field (CHC Azara, PHC Uparhali and IRL, Guwahati):

1. Malaria diagnosis at the CHC/PHC is mainly done through RDT kits instead of Microscopic diagnosis.

2. ACT-AL 3-8 yrs age group and ACT-AL 8-14 were out of stock and ACT-AL adult blister dose were being used as replacement. Appropriate & efficient stock monitoring & record maintenance are needed.
3. SOP for diagnosis/treatment, IEC material and epidemiological data were not displayed at the facility, which indicates data is not being used for local planning.
4. Laboratory facilities need trained LTs, emphasizing microscopy in facilities, use of new microscope etc.
5. Record preparation and maintenance at facilities was deficient under both Malaria and TB programmes. Data quality audit needs to be carried out regularly and further strengthening of supervision & monitoring is needed. The data need to be analyzed & used for local planning.
6. The surveillance is yet to evolve to detect, notify, investigate, classify and respond to all cases and foci to move towards malaria elimination. Efforts are initiated for line listing of cases although yet to capture important information like travel history for all cases.
7. Inter-sectoral coordination meetings are needed. Reporting from tea estates, private hospitals needs to be initiated.
8. IEC/BCC strategy and activities need to be structured in regular & campaign modes and need improvement.
9. At CBNAAT lab, Kamrup rural- stock of cartridges was not maintained properly. Around 266 cartridges were not physically available though were recorded in the stock register. Stock up keep need to be improved and monitored properly.
10. Active Case Finding for TB cases -campaigns/activities need to be strengthened.
11. Under Nikshay Poshan Yojana, bank details of 43 eligible cases were not updated in Nikshay and not linked to PFMS. Hence DBT was not initiated for these cases.
12. Supervision and leadership of Malaria and TB Programmes need to strengthened.
13. Require capacity building of LTs at field level.
14. At IRL Guwahati, need to retain existing trained technical staff (2 T.O, 4 LT and 1 DEO) beyond Dec 2018 for effectively managing laboratory functioning. These positions are required to be included in state PIP 2018-19.

Debrief meeting of oversight team with Principal Secretary (Health), Assam (9th August, 2018)

Oversight Team met and shared brief observations from the visit with Principal Secretary (Health), Assam, Sh. Samir Kumar Sinha on 9th August 2018 in presence of state officials-Regional Director (Health), Project Director (Assam SACS), State TB Officer, Joint DHS (Malaria) and programme consultants.

Principal Secretary (Health) assured to take note of the findings of Oversight team and recommended concerned state officials to resolve issues/challenges in the field highlighted by the team.

Annexure – 1

Attendance – Oversight Committee Visit to Guwahati, Assam

S.No.	Name	Designation/ Organisation
1	Mr. Umesh Phaseha	Jt. DHS
2	Dr. Inder Prakash	Advisor, PH/ Oversight Committee member
3	Dr. Sangeeta Koul	USAID / Oversight Committee member
4	Ms. Sanghamitra Iyenger	Samraksha/ Oversight Committee member
5	Mr. Kh. Jayanta Kumar Singh	SPYM / Oversight Committee member
6	Dr. Shampa Nag	Oversight Committee member
7	Mr. S. A. Khan	CMSS/ Oversight Committee member
8	Ms. T. Mercy Annapoorani	Rainbow TB Forum/ Oversight Committee member
9	Mr. Veeraiah S	CTD
10	Dr. Mrigen Deka	NVBDCP
11	Dr. Neha Garg	NACO
12	Dr. Sandhya Gupta	Coordinator, CCM
13	Dr. Benu Bhatia	PO, I-CCM
14	Dr. Parashee Chaoudhary	Sr. Medical and Health Officer, NVBDCP, Assam
15	Mr. Mohit Maskara	Finance And Accounts, NVBDCP, Assam
16	Mr. N. Madan	Program Manager, IHAA
17	Mr. Pardha Pratim	M& E , PSMRI
18	Mr. Khanindan Kalita	Project Manager, PSMRI (AHANA)
19	Ms. Marium Chaoudhary	Procurement Consultant, NVBDCP, Assam
20	Ms. Sangita Dasgupta	Sr. Manager, Plan India
21	Mr. Gauri Nandan Saika	State Project manager, Plan India
22	Mr. Litsaba T Y Sanysaka	M& E Officer (NE Region), India HIV Alliance
23	Mr. Manab Das	I/c CST, ASACS
24	Mr. Ratanjyoti Deka	M& E Officer, ASACS
25	Mr. Mukul Borah	Sr. Manager, World Vision
26	Mr. Palash Takdar	WHO RNTCP Consultant
27	Mr. Mehboob Rehman Saleem	AD (LS), ASACS
28	Dr. Randeep Neog	State PPM Lead, CHRI
29	Dr. Simanka Borah	TB/ HIV Coordinator, RNTCP, STC Assam
30	Dr. P Boretelor	State IEC, STC Assam
31	Ms. Rashmi Rekha Bhuyan	Assistant Director (ICTC) & Nodal Officer, DAPCU (K), ASACS