Third

Common Review Mission

State Report

Uttarakhand

3RD COMMON REVIEW MISSION REPORT FOR UTTARAKHAND

DRAFT

3RD COMMON REVIEW MISSION VISIT			
NAME OF THE STATE: UTTARAKHAND			
NAMES OF THE DISTRICTS VISITED			
SL NO	**NAME OF THE DISTRICT**	**DISTRICT HEADQUARTER**	**NAME OF THE C.M.O.**
1	Almora	Almora	Dr. B. K. Verma
2	Tehri Garhwal	Baurari	Dr. B. C. Pathak
3RD C.R.M. TEAM MEMBERS			
1	Almora	• Dr. Anil Kumar, CMO (NFSG), Ministry of Health & Family Welfare, Govt. of India • Ms. Deepika Shrivastava, Communication Specialist, Unicef, India • Dr. Abhijit Das, Director, Centre for Health & Social Justice	
2	Tehri Garhwal	• Dr. Manisha Malhotra, Assistant Commissioner (Maternal Health), Ministry of Health & Family Welfare, Govt. of India • Ms. Shagun Mehrotra, Programme Officer, European Commission Delegation to India • Dr. Ravish Behal, Consultant, RCH II Technical & Management Support Agency	
NAME OF THE HEALTH FACILITIES VISITED			
1	Almora	▪ District Hospital Almora –Male and Female ▪ Sub-district hospital- Civil Hospital Ramnagar, Nainital ▪ CHC: Dwarahaat, Almora ▪ Additional PHCs: Hawalbagh, Barechina, Binta ▪ 24x7 Block PHCs: Takula, Bailparao ▪ State Allopathic Dispensary Takula ▪ Sub-centres: Dinapani, Hawalbagh, Takula, Binta, Bailparao ▪ VHNDs: Tatik ▪ AWCs: Pilkha, Tatik, Matena, Basera ▪ MMU: Bailparao ▪ EMRI: Ramnagar, Takula ▪ Schools: Pilkha, Matena, Basera ▪ ANMTC : Almora	
2	Tehri Garhwal	• District Hospital, Baurari • Sub-district/ Combined Hospital, Narendra Nagar • CHC / FRU: Bileshwar • 24x7 Block PHCs: Pilkhi, Nandgaon • SAD:Chopriyal • Sub-centres: Chopriyal, Jhajal, Duadhar • AWCs:Chopriyal and Chopriyali • VHNDs: Thangdhar, Jharipani • MMU run by Jain Video (Sachal Chikitsa Vahan) • EMRI: Bhilangana	
MEETINGS WITH STAKEHOLDERS			
▪ Meetings with District team, health functionaries ▪ Meeting with groups of ANMs ▪ Meeting with groups of ASHAs ▪ Meeting with voucher scheme functionaries ▪ Meetings with JSY beneficiaries ▪ Meetings with mothers and community members ▪ Meetings with other sectors- ICDS, Swajal ▪ Meetings with MNGO and FNGOs			

INTRODUCTION

The following table shows the health infrastructure in the state:

Sn.	Health Facility	Number
1	District Hospitals – Male and Female	18
2	Sub districts Hospitals	18
3	CHC	55
4	PHC	239
5	Sub centers	1765
6	SAD	322
7	Blood Banks (13 in govt sector)	24
8	Aryuvedic Hospitals	477
9	Unani Hospitals	03
10	Homeopathic Hospitals	96

The human resource position in Uttarakhand is:

Sn.	Resource	Sanctioned	In Position	Regular	Contractual	Vacant
1	MO including Specialists	1296	1046	684	362	250
2	MO	1389	883	777	106	506
3	LMO	280	169	135	34	111
4	Staff Nurses	862	1006	862	144	-
5	Lab Technicians	286	131			155
6	ANM	2039	2008	1925	83	31
7	ASHA		9923			

Indicators

Goals

Uttarakhand's (including UP) MMR at 440 (SRS 04-06) has improved from 517 in SRS 01-03, but still way above the national average of 254. The IMR is at 44 (SRS 2006-08), a decrease from 48 (SRS 2005-07), but an increase from 41 in SRS 2001-03; however it's lower than the national average of 55. TFR has remained static at 2.6 between NFHS-2 (1998-99) and NFH-3 (2005-06) and is higher than the target of 2.1 for the year 2012.

Outcomes

Uttarakhand's progress during the four year period between DLHS 2 (2002-04) to DLHS 3 (2007-08) is encouraging:

S. No.	OUTCOME INDICATOR	UTTARAKHAND		INDIA*	
		DLHS–2 (2002–04)	DLHS–3 (2007–08)	DLHS–2 (2002–04)	DLHS–3 (2007–08)
1.	Mothers who received 3 or more antenatal care checkups (%)	21.2	33.8	50.4	51.0

S. No.	OUTCOME INDICATOR	UTTARAKHAND		INDIA*	
		DLHS–2 (2002–04)	DLHS–3 (2007–08)	DLHS–2 (2002–04)	DLHS–3 (2007–08)
2.	Mothers who had full antenatal check-up (%)	8.0	15.6	16.5	19.1
3.	Institutional deliveries (%)	24.0	30.0	40.9	47.0
4.	Children 12-23 months age fully immunised (%)	44.5	62.9	45.9	54.1
5.	Children age 6-35 months exclusively breastfed for at least 6 months (%)	61.3	37.1	22.7	24.9
6.	Children with diarrhoea in the last 2 weeks who received ORS (%)	21.6	44.0	30.3	33.7
7.	Use of any modern contraceptive method (%)	44.0	57.7	45.2	47.3
8.	Total unmet need for family planning - both spacing methods and terminal methods (%)	26.9	20.8	21.4	21.5

FINDINGS OF THE 3RD COMMON REVIEW MISSION

PART I

1. INFRASTRUCTURE UPGRADATION

Overall infrastructure of the health facilities in the state is good, and NRHM has contributed to infrastructure improvement and maintenance. However, plans for development of infrastructure development need to be firmed up. Facility planning / upgradation and location of new facilities was affected by land availability and other consideration, than overall accessibility or need. There is also co-location (e.g. PHC / SC and CHC / SC) & some clustering.

Overall, facilities were found to be clean and power backup was available. However, shortage of water posed some limitations on the level of cleanliness of toilets.

Residential accommodation for providers was by and large available at CHCs and PHCs (although sometimes not occupied[1]), but was inadequate as sub-centres. Temporary arrangements for attendants were not available, and they usually were accommodated in available space in the wards.

Equipments was largely available, however inadequately utilised. Maintenance of equipments is hampered by lack of technical knowhow (e.g. operating eye microscope, lift, inverter) and lack of AMC arrangements.

2. HUMAN RESOURCES PLANNING

Availability of Human Resources & Gap

There is an overall shortage of doctors [2] (especially anaesthetists), staff nurses [3] and lab technicians (although LTs have recently been recruited). Remuneration package not attractive for hard to reach areas and lower than neighbouring states [4].

Norms of staffing are not as per Govt. of India norms, e.g. the CHCs have 09 doctors; staff nurse not sanctioned for PHCs; pharmacists posted at sub-centres to provide basic curative care.

Despite the large human resource gaps, even the available resources are not being used rationally / optimally, with several instances of mismatch seen in the two districts

[1] DH Almora does not have doctors quarters, while DH Baurari (Tehri) has quarters but only two doctors stay on campus - leading to delays in emergency response
[2] District Almora – 204 MOs sanctioned; 67 posts filled (including specialists); 137 posts vacant, of which 36 filled by contractual appointment (11 allopathic and 26 ayurvedic, on Rs. 24,000 per month).
[3] One staff Nurse per 6 beds was available at civil Hospital, Ram Nagar. A total of 16 out of 84 posts of staff nurse were vacant in District Almora.
[4] The neighbouring state of Uttar Pradesh is offering a much higher salary to contractual doctors (Rs. 24K in UA)

visited[5]. A facility-wise HR mapping is yet to be done, to analyse the extent of such mismatch across the state.

Pre-service Training capacity

The availability of medical colleges in the state (one private medical college, 2 new have started functioning) is insufficient to meet the demand. ANM Training Centres were closed down in Almora District in the year 1990 as the state felt there was no more requirement of ANMs at that time. ANM training centres have been reopened in the year 2005. These ANM centres are just sufficient to meet the requirement of one ANM per sub-centre. However, once the plan of 2 ANMs per sub-centre (as envisaged under IPHS) is implemented in the state, there will be acute shortage of ANMs.

The ANM Training Centre Almora has good training and residential facilities, is following the curriculum as per Indian Nursing Council and so far 177 candidates have passed out since it was reopened in the year 2005.

ANM training methodology can be improved by using modern computer/film/DVD based methodology. There needs to be a review of curriculum of the BHW female in line with the current job responsibilities of the Female Health worker in consultation with the Nursing Council. The state may consider possibilities of training local women (including ASHAs), who do not have Inter Science, as Basic Health Worker Female.

Recruitment and cadre management

The State Public Service Commission takes about 2-3 year to fill vacancies. Both cadre of General duty medical officer and Specialists are available. Medical officers in hard-to-reach areas, get posted for long durations, and hence do not get opportunities for in-service training. Additionally, inadequate promotion and professional growth avenues exist for ANMs.

State has recently recruited ANMs and lab technicians, however there were delays in the recruitment process.

Posts of Block Level Manager were advertised only on state health website but that may not be accessed by all the eligible candidates, especially local candidates.

Plan for Augmentation of Health Human Resources

New / renovated ANMTC is coming up in Dehradun. Similarly, a medical college is proposed to be set up in Doon Hospital, and a SIHFW is under construction in Haldwani.

[5] No Ob/Gyn in Tehri DH; 2 Ob/gyn in SDH Narendranagar but not providing C-section/ EmOC services (OT under-construction / non-functional since past 3 years,); LSAS trained MO posted in a CHC without complementary services (Ob/ Gyn and Paed), and low utilisation (due to poor location); Post training deployment does not adequately utilise newly acquired skills, e.g. No Anaesthetist available in District Male and Mahila Hospital Almora, while MO trained in anaesthesia posted in Tarikhet PHC; Doctors without LT and LTs without Doctors – Barechina; AYUSH doctors posted in SAD without Ayurvedic dispensary/drugs; X-Ray machine available but no technician in PHC Bailparao

Additionally, the State has done a tie up with a nursing college in Bhopal for a 2-year post-basic nursing diploma.

State is considering ANM training for qualified ASHAs, either through reservation of seats in existing ANMTCs, or setting aside the seats in the new ANMTC in Dehradun for this purpose.

Skill quality of Health Human Resources

Skill-based training for MCH has been initiated. Service providers, particularly MOs, have reasonable knowledge and core skills, especially in basic obstetric care. Doctors have received different types of trainings like DOTS, Leprosy, Vector Borne Diseases, Quality assurance, IMNCI. Similarly ANMs have also received trainings. However, the thematic refresher trainings, especially on maternal and child health, have been inadequate.

Trained Staff Nurses for specific health care services like ICU, Sick New Born Units are insufficient. Moreover postings of trained staff are not rationalized.

In-service training takes place at a limited number of institutions, that are overstretched, e.g. several in-service skill trainings are conducted at Dehradun DH. Quality of skill training eg SBA needs focus, eg the single SBA trained nurse at Baurari District Hospital at Tehri did not know what a partograph was.

3. ASSESSMENT OF THE CASE LOAD BEING HANDLED BY THE PUBLIC SYSTEM

NRHM, JSY and ASHA are contributing to an increase in the case load at OPD, in-patient, institutional delivery [6], and immunisation, and a reduction in DOTS defaulters. Community expectation for service delivery has increased, 108 Services are being universally used and appreciated [7], publicising of mobile phone numbers has led to easy communication for service delivery, and JSY payment has been very useful. Prominent signages (citizens charter, drug availability, JSY provisions, other IEC) were on display at all facilities.

However, utilization in some of the higher order facilities in the districts has been sub-optimal, e.g. in Tehri district, nearly 130 institutional deliveries in 2008-09 in SDH Narendranagar, compared to 250 in DH Baurari and 430 in PHC Pilkhi. Similarly, District Female Hospital in Almora is inadequately utilized.

No patients were seen in any of the wards at the two PHCs or one CHC visited in the hills. The OPD was thinly attended. While this may be in keeping with the low density of population in the hills, this is also a problem of dispersing valuable resources (e.g. doctors) very thinly.

[6] 53% increase in OPD at DH Almora; Institutional deliveries increased from 24 per year in 2003-04 to 196 in 2008-09 in CHC Dwarahat, and from 7 in 2005-06 to 192 in 2008-09 in PHC Belparao.
[7] Although, 108 services were bypassing 24x7 PHCs at Hawalbag and Barechina because of proximity to Almora

4. PREPAREDNESS OF FACILITIES FOR PATIENT CARE SERVICES

Preparedness of designated FRUs to provide emergency care / comprehensive emergency obstetric care is quite poor. The reasons identified are:

a) Shortage of doctors, both general and specialists.
b) Irrational posting of available / trained Staff.
c) Poor Blood Bank facilities: Blood storage facilities were not available in most of FRU at CHC and PHC [8] [9].
d) Indian Public Health standards were not found to be implemented for any level of facilities. Posts sanctioned at most levels of facilities are not as per norms
e) Poor System for maintenance of equipments [10].
f) Patient load is increasing in general in all the facilities but number of staff is not increasing in the same proportion [11].
g) Poor availability of Residential accommodation in the campus of health facilities especially for Doctors in District Almora was observed. In odd hours it is difficult to call doctors from their residence because of difficult terrain.
h) Less budget being given to Health Facilities from state Government side e.g. Civil Hospital Ram Nagar tackling an annual load of OPD of 150000 patients and 100 beds in-patient was provided a annual budget of Rs. 40 lakh which was grossly insufficient.
i) Location of sub-centres buildings was found in isolated areas; which makes it difficult for ANM to stay there at night. In most of sub-centres, ANM was not staying.
j) Poor Lab facilities in PHC and CHCs. At most of the places, lab technicians were not available and no lab work was being done.
k) Mobility support (Vehicle, POL) for Medical Officer in-charge not available at most PHCs/ CHCs. So the monitoring of peripheral centres is poor.

5. OUTREACH ACTIVITIES OF SUB-CENTRE

State has made intensive efforts to strengthen the sub-centres and improve the performance of all outreach programmes especially the utilization of Village Health and Nutrition Days and immunization coverage. Session microplanning for Fixed Monthly Village

[8] Both DHs and SDHs visited, did not have functioning blood storage units/ blood banks: DH Almora has a blood bank (the only blood bank in Almora district and catering to the neighbouring Bageshwar district) but its licence is expired for some time now, and it does not have any sanctioned posts; while DH Baurari (Tehri) does not have a BB/ BSU; Civil Hospital Ramnagar – 100 bedded without blood storage; while SDH Narendranagar has blood bank whose refrigerators have been moved to Haridwar and DDN.
[9] Even in Civil Hospital Ram Nagar, a 100 bedded hospital, BB / BSU facilities were not available. Doctor on duty at this hospital refused to admit one delivery case brought by 108 ambulance at the time of visit of team. The reason given was that it was not a booked case and they do not have facilities for emergency caesarian section which may be needed. This happened despite the availability of a Gynaecologist at that time.
[10] Eye Microscope was found to be not working for last 4 months and the administration failed to get it repaired. Similar problem for maintenance of Lift was observed at District Hospital Almora.
[11] e.g. in DH Almora, while OPD load had increased by 53% as compared to last year, while the total number of doctors decreased by 2

Health Days is working effectively and has also been well publicized and made known to the community. Villages have been classified into 3 types- sugam, durgam, ati durgam and intensive efforts are made to reach durgam and ati durgam areas[12].

VHND activities include largely immunisation, ANC, breastfeeding counselling, post natal advice, child health checkups and referrals, and family planning counselling. In the community perception, management of ARI requires more attention. Disruption in Kit A supplies over last two years had adversely affected IFA and Vitamin A supplementation through VHNDs/ bi annual sessions. .However the range of VHND activities can be expanded to include nutrition counselling, including growth monitoring of children, using the WHO child growth standards. Availability of weighing scales, growth cards and charts would need to be ensured. Available IEC material is being used- but this is not comprehensive. It would also be useful to strengthen the monitoring of VHNDs.

There was good teamwork between ASHAs AWWs and ANMs, as reflected in their planning for VHNDs. The use of ASHAs mobile phones to inform pregnant mothers regarding VHND timing- so as to reduce waiting time and unnecessary walking/climbing was another local response which the community appreciated in durgam areas. Support from panchayats was also evident – especially women pancahayat members who are contributing panchayat resources in some cases. They particularly expressed the need for women's health counselling /camps, inadequate pre-post pregnancy recoupment, cultural taboos, and a women's centre at AWC for counselling and vocational training. Additionally, there was a felt need to empower women to change traditional patterns where women bear the larger burden of productive work, load bearing, fetching fuel, fodder and looking after cattle, household tasks, in addition to their reproductive roles as mothers and child care givers.

Community members and mothers also expressed the need to have mini AWC in durgam hamlets, which would further strengthen and sustain health outreach activities. Joint microplanning with ICDS would be useful in this regard, as new population norms have come in with ICDS Universalisation with quality, with special provisions for hilly and difficult terrains.

Mobile Medical Units are operational in all districts in the state. One MMU was seen in operation in Nainital district. 13 camps are being held in a month with 6 in the Hills. Some of the Terai camps are not in the hard-to-reach areas, e.g. Kaladhungi, Belparao etc. Tehri district has 3 MMUs with a systematically planned operation to provide maximum coverage of under-served areas. Operated by Jain Video, the MMU has good OPD coverage (average attendance of 100 patients per day), with availability of specialists and diagnostic facilities (X-ray, USG, etc.).

The 108 EMRI ambulances were very well equipped. This has transformed the concept of access to health care, especially for remote hilly areas. Additionally, linkage of expected date of delivery (EDD) of the pregnant women has been done with EMRI, through ASHAs. What needs to be worked out is transporting pregnant women from the inaccessible

[12] It was heartening to note that in Valta, while the AWC was accessible , being located in the school premises on the road side- at the request of the panchayat, the VHND was organized closer to the community, in the unserved habitation in the valley, where mothers and infants had been mobilized jointly by AWWs, ASHAs.

hills/valleys to the roadside, from where 108 takes over. Palkis, a traditional transport mode are preferred by the community, as against stretchers, to provide privacy, comfort and safety. Another suggestion was the use of 108 to transport sick children, given the difficulties of transportation.

Good cross sectoral linkages were also seen with Sarva Shiksha Abhiyan and the school health programme in schools, with fixed health check up days and referral advice. Some teachers also recommended the introduction of a school health card and strengthening of nutrition and health education in the school curriculum.

6. UTILISATION OF UNTIED FUND

In Almora, Chikitsa Prabandhan Samitis have been formed in 6 block PHCs, and sub centre and village level committees are being progressively constituted. The Government order for VHSCs was issued 4 months back and 1122 committees have been formed in each gram sabha. In Nainital, Chikitsa Prabandhan Samitis have been set up after the 29 May 2009 circular from the state. Delays in formation of VHSCs and RKS at PHC level is an issue that needs to be addressed. The untied funds were released to Almora district In October and are being used in PHCs such as Takula for example for providing an examination bed for pregnant women with curtains, safe drinking water, labour room equipments etc. The plan of action for further strengthening and utilization of untied fund is dependent upon strengthening the functioning of sub centre level committees, VHSCs. Here the participatory development approach adopted by the Swajal district plan and village resource teams provides good opportunities for convergent action.

7. THRUST ON DIFFICULT AREAS AND VULNERABLE SOCIAL GROUPS

The state has initiated several efforts to reach communities living in difficult terrains, classifying them into 3 types - sugam, durgam, ati durgam areas. An incentive of Rs. 3000 per month for Durgam and Rs. 5000 per month for Ati-Durgam is being given, but division of areas into Durgam, Ati Durgam is not based on the ground situation. The hill districts of Uttarakhand are considered difficult areas. However even within the hill districts there are remoter areas and it may be useful to consider variability within a district for classification into difficult areas.

Intensive efforts are being made to reach durgam and ati durgam areas, including through outreach VHND sessions. In Almora, it is also using State Allopathic Dispensaries with Ayurvedic doctors and pharmacists, and training the same to reach these groups. The paucity of private providers in these areas also requires such stop gap solutions, till adequate staffing of facilities in ati durgam areas is addressed. However it is clear that a longer term policy will be needed to address the human resources needs in the state.

It was observed in Ramnagar hospital that intensive efforts were made by the polio team to mobilize mothers with children from minority communities, and a key factor was recently conducted training/ orientation for these teams.

No special concessions available for treatment of SC/ST/BPL. However, Hospital poor patient Card is being used in hospitals for providing free treatment, which is certified by the Chief Medical Superintendent for poor of any category.

Uttarakhand has a range of gender related practices which are key determinants of women's health. These include exclusion/ pollution during menstruation and in the post partum period, heavy load bearing, including heavy load bearing immediately after delivery. There are also various dietary taboos for the postnatal period. These are closely related to RTIs, prolapse of the uterus as well as nutritional status of the mother and the new born. These issues have been reported earlier through the National Commission on Women's report on women on Uttarakhand (http://ncw.nic.in/frmReportGeneral06.aspx). However there was no evidence of including these issues within the planning at the state or district level.

8. QUALITY OF SERVICES PROVIDED

Privacy was seen in the OPD and labour rooms. Staff nurses/ANMs were maintaining partographs in the labour rooms. The labour rooms were hygienic, well maintained, adequately equipped, partitions and screens for privacy had been provided. Information on JSY payments, entitlements, safe delivery, early and exclusive breastfeeding, newborn care was prominently displayed, as also the monthly fixed day session plan. State has developed a tool for facility-based maternal death audit.

However, 48 hours stay post delivery was consistently not ensured, and this was usually due to client insistence, either due to the cultural practices highlighted above or due to lack of availability of the referral transport for the return journey. Additionally, public disclosure of JSY beneficiaries was not uniformly seen, and grievance redressal mechanisms are yet to be systematically set up.

Bio-medical waste management is an area of concern for the state. Waste disposal is mainly done in deep burial pits, however their location is sometimes very close to the main facility building, due to space constraints. Hub cutters and needle destroyers are available in most facilities, however no common BMWM common treatment facilities are available in the districts. Most of the plastic waste is being disposed with the general waste.

9. DIAGNOSTICS

Range of laboratory services is limited. In District Hospital Almora, only routine blood and urine tests are being done. No Histopathology, cultures, biopsies are being done. X-ray and Ultrasound facilities are available at district hospital but CT scan was not available.

10. LOGISTICS & SUPPLY CHAIN MANAGEMENT

60% of the procurement for the District is being done by the District CMO and 40% by Medical Store Depot of state. District CMO office (Central Medical Supplies Depot of

District) purchases for sub-centres, PHCs and CHCs. Similarly 60% of the supplies are purchased by Sub-district and District Hospitals on their own. 40% of the supplies are received through central store of the State Government at Dehradun. Rate Contracts are decided and approved at State level by Director Health Services. If rate contract of an item is not available, then rate contract of ESI or any other Government of India undertaking is used. Local purchase of Rs. 15,000 worth of medicines at a time can be done through an approved agency in case of emergency requirements. Categorization of drugs into categories 1, 2, 3 has been done based on the priority basis. Demands are calculated based on: demand from health facilities; seasonal requirements e.g. Increase requirements of ORS during summer and rainy months; and emergency drugs.

Central Medical Supplies Depot for the district is located at the District CMO office and has following staff: CMO; Deputy CMO /SMO (Store); Chief Pharmacist; 1 Pharmacist. The Purchase Committee approves the demands calculated. It has following members: District CMO; Chief Medical superintendents of all District and Sub-district Hospitals; 1 Deputy CMO; and 1 Senior Chief Pharmacist.

Depending upon the requirements, meeting of Purchase committee is held 3 to 4 times in a year for approval of the orders to be placed. Orders are placed directly with the manufacturers (around 25) for supply of around 200 items. Usually it takes 45 days between orders to receiving the supplies. Supplies are distributed every 3 months to the CHC, PHC, Addl. PHC, SC etc. Drug Kit A&B are available regularly now since February, 2009.

Cold chain maintenance was satisfactory in most facilities, other than Barechina, where there was no generator and no temperature record. The non availability of a Cold Chain Maintenance officer in Almora was perceived as a constraint.

Nischay kits are available in sub-centres and PHCs and being used. Kit A, Kit B supplies from GOI were disrupted over the last two years and now large stocks have come in. There is need to orient/inform MOs and paramedical staff about the changes in kit item specifications/ additionalities. Because of this, Vitamin A and IFA supplementation coverage has been adversely affected over the last two years.

Some areas require attention: Supply needs assessment and planning is inadequate; procurement procedures are tedious (e.g. currently, 25 companies are to be contacted 3 times in a year to procure 200 items); no buffer stocks are being maintained either at district stores or the health facilities; stockouts of certain medicines (e.g. Inj. Magsulph, inj. Dexa, and inj. Etophylline) noted at some facilities; standard methods of inventory management are not being followed.

11. DECENTRALIZED PLANNING

District health plans have been made in all districts. However, there has been inadequate analysis of district level issues leading to generic plan without any local focus. There has been inadequate involvement of PRIs/ CSOs/ user groups / Block MOIC / ANM's / ASHA leading to a lack of uniform awareness of a DHAP. Approval of the DHAPs was

neither formally communicated by the District Health Society for onward submission to the State, nor by the State Health Society.

No village level health plans were available, and block level capacities were not adequate for planning.

12. DECENTRALISED LOCAL HEALTH ACTION

Several facilities show that untied funds and RKS funds have been used for facility improvement, however MOs need orientation on use of RKS funds. RKS meetings are taking place irregularly.

Contract Medical Officers not involved in planning for AMG and Untied Fund expenditures.

13. COMMUNITY PROCESSES UNDER NRHM

Rogi Kalyan Samitis or Chikitsa Prabandhan Committes have been constituted and are functioning in district, sub-district hospitals Community Health Centres. The formation of RKS needs to be reviewed as they do not reflect the spirit of community participation. The participants of these committees are overwhelmingly government functionaries. Members of the RKS at Belparao included CMO, DyCMO, BDO, CDPO, Junior Engineer of the Jal Nigam, AYUSH doctor of the PHC, ICC/Computer, Private practioner, and 1 BDC member one Gram Pradhan. This clearly shows that the RKS will not be able to reflect community interests.

The State is lagging behind in formation of Village Health & Sanitation Committees (VHSC). Government order has come out only a few months back. Gram Vikas Adhikari and Gram Pradhan have been authorized to operate account of VHSC. Even within the VHSCs being formed in Dwarahat block 6 out of 10 members were Government related – VDO, Jal Sansthan functionary, AWW, ANM, CDPO, Mahila Samakhya functionary.

14. ASHA

ASHAs are the most visible face of NRHM, of the positive change in the health system. Overall, ASHAs have been recruited across the state and have completed all 5 training modules. They have a level of high motivation and a desire to take on more and be rooted in the health system. Their role and support are well acknowledged by ANMs, ICDS AWWs, mothers and communities.

The ASHAs appeared to have adequate knowledge of maternal health services, however child / neonatal health, nutritional counselling, and family planning need re-orientation/ strengthening.

The state has entered a PPP arrangement with the MNGOs in the districts to act as District ASHA Resource Centres (DARCs). The DARCs have been responsible for training the ASHAs in the 5th module, which has been appreciated. Additionally there is a monthly meeting of all ASHAs with MO of the block PHC. However, there is inadequate mentoring support to ASHAs at local levels, especially in hard to reach areas.

Mechanisms are in place for ensuring ASHA entitlements under JSY, and timely payments are reported by ASHAs [13], mostly by cheque. Need for honoraria for ASHAs has been expressed by ANMs, MOs, ICDS staff, and NGOs, however there also appears to be inadequate information about ASHA entitlements with related sectors, e.g. Rs. 50 under Swajal; and there is a felt need for a ASHA help desk at district hospitals / FRUs (with some reported related to demands made of her).

However, there are following areas for concern: ASHA has to be available at the time of delivery, only then incentive is paid to her (if delivery is delayed especially in a primi case and if ASHA has to stay for say 3 days, it may not be feasible for her); if patient opts for private ward at the time of delivery then ASHA is not given payment; facilities for stay of ASHA are not being provided at the health institutions.

15. NATIONAL DISEASE CONTROL PROGRAMMES

- Slide examination for malaria inadequate – especially in terai area
- No leprosy case under treatment in Almora; 3 cases in Tehri
- 759 TB cases under treatment in Almora - but not seen as a priority
- Integration of district level societies has not taken place

16. RCH II

- Institutional deliveries and immunisation coverage have increased.
- Inadequate attention to neonatal care; newborn baby corners not systematically setup
- Referral transport available through 108; however referral linkages and systems not well defined; difficulty in transporting pregnant women in hard to reach areas to roadside
- No public sector facility for EmOC / C-section; patients going to Shri nagar medical college or to the only private sector provider in Chamba block (who being a surgeon, is not accredited under JSY) – hence women not getting JSY benefit.
- JSY payments timely in Tehri; no inconsistencies noted in number of deliveries and beneficiaries
    - Delays seen in Almora – Dwarahat block
- Counselling on postpartum care and breastfeeding being largely provided at facilities

Safe abortion services not available across facilities Some MOs received training in MVA through Ipas.

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[13] Delayed payments to ASHAs reported in some cases- CH Ramnagar

- District institutions have inadequate load, hence cannot be used as sites for skill-based trainings
- Sub-centres in government buildings not being accredited for JSY deliveries since no running water available

An area of concern relating to JSY

The state has introduced a voucher scheme for including PPP for institutional delivery. Women who avail this voucher become ineligible for JSY payments.(this is as per GOI norms) This is felt to be against the principle of JSY being an incentive for institutional delivery and also may be against the Supreme Court guidelines for providing all women Rs. 500 for nutritional support.

17. PREVENTIVE AND PROMOTIVE HEALTH ASPECTS

Joint health ICDS reviews are being held on fixed days at district and block levels are being - good platform for joint action. Co-location of schools and AWCs is opening up new possibilities for converging nutrition support and infrastructure

Convergence with Swajal SWAP, TSC is also encouraging, with mostly ASHAs being sanitation motivators and receiving incentives for the same.

School Health Check Ups are held regularly twice a year, where nutrition education component could be enhanced

18. NUTRITION

There is good intersectoral convergence in the state between NRHM and ICDS, with potential for supporting improvements in Nutrition. However since Uttarakhand is not one of the malnutrition high burden states (38% children under-5 years underweight- NFHS 3), a state specific strategy for accelerating reduction in maternal and child undernutrition has not been formulated. Significant improvements have been seen in some IYCF practices - Early initiation of breastfeeding (63%), and in introduction of complementary feeding (64%) as per DLHS-3, however exclusive breastfeeding for at least 6 months has reduced between DLHS 2-3 (61.3% to 37.1%). This is also linked to increased institutional deliveries and inclusion of early initiation of breastfeeding in the incentive to ASHAs. However, the new ASHA incentive also includes exclusive breastfeeding.

Under ICDS Universalisation With Quality, in Uttarakhand, the number of AWCs has increased with 8375 additional AWCs and 2444 mini AWCs (total now 23159). But joint microplanning with NRHM and village mapping is needed to identify potential requirements, including AWCs/ miniAWCs for hard to reach areas, especially in view of the revised/ reduced population norms for ICDS, applicable to hilly terrains. This will anchor and sustain the NRHM outreach sessions for Maternal and Child Health and Nutrition in hard to reach hamlets.

In Uttarakhand, it was encouraging to observe in the field that enhanced Nutrition and feeding norms have been introduced in ICDS, with good response from the community to the Morning snack, hot cooked meal and THR (SNP @ Rs 4/- per child 6m - 6 yrs, 500 kcal,12-15 gm protein) Increased resource allocations for improved feeding and care for severely malnourished children are being used. However the growth monitoring and promotion component needs to be strengthened, as `there is a shortage of functioning weighing scales, growth cards, and charts with new WHO growth standards. These have not been supplied over the last year. Severe undernutrition in children will be better assessed .when training on the new WHO child growth standards and Mother Child Protection Card has been completed for CDPOs, LS, AWWs and also for health functionaries (MOs, LHVs ANMs) in NRHM.. There is interest in initiating community based approaches to preventing undernutrition, improved care and feeding of undernourished children through Nutrition Care and counselling sessions (such as Positive Deviance in West Bengal). Counselling support for young child growth and development needs to be enhanced through capacity development of AWWs, linking with ASHAs, ANMs. Given the nutrition profile of the state Nutrition Rehabilitation Centres are not currently envisaged in the state PIP.

There has been limited progress in addressing micronutrient deficiencies- VAD, anemia, because of a lack of Vitamin A, IFA supplements over the last 2 years. Deworming interventions bi annually were not envisaged in state PIP, and implementation will be determined by recent national guidelines. Currently because of a lack of supplies of salt testing kits over the last year, salt testing for iodine content is not being done in ICDS. VHNDs offer a good platform for doing this, also as a means of community mobilization.

Other recommendations which emerged for addressing maternal and child undernutrition include-

- Joint NRHM ICDS microplanning to extend outreach in hard to reach areas
- Strengthen skilled counselling support for Infant and Young Child Caring and Feeding Practices
- Pilot community based child care models – such as Positive Deviance West Bengal
- Enhance priority to nutrition in training of ASHAs, ANMs, MOs, and in their responsibilities
- Ensure capacity / skill sets for nutrition with the SHSRC.
- Joint training of ICDS health functionaries on new WHO child growth standards and Mother Child Protection Card.
- Ensure adequacy of supplies, e.g. weighing scales, growth charts, cards, and supplements.
- Involve VHSC s in monitoring nutrition interventions through ICDS also. A common committee could be considered, as in Orissa Gaon Kalyan Samitis where AWW is also a joint signatory.

19. NON-GOVERNMENTAL PARTNERSHIPS

The state has undertaken several PPP schemes, e.g. Mobile Medical Units (MMUs); District ASHA Resource Centres (DARCs); and Voucher Scheme for institutional deliveries among BPL women.

Mobile Medical Units (MMUs)

Mobile medical units are running in all districts of Uttarakhand, providing outreach services to under-served and un-served areas. The objectives of the MMUs are: to provide periodical, accessible primary health services to rural people at their doorstep; improve reporting of infectious diseases; and improve delivery of RCH services. They work between 13-16 days a month, on a pre-determined schedule, staffed by a lady MO, radiologist, MO, lab technician, X-ray technician, and a staff nurse. Ultrasound, X-ray and Auto Analyser facilities are available. User Charges: Rs. 2 is charged for registration in OPD and there are user charges for all the services being provided. 50% of the user charges are deposited in treasury and 50% are given to the facility for use. These are run by the MNGO of the district, in addition to mobile hospitals (acquired during the UAHSD project) run through Jain Video. Rs. 17.60 lakhs have been provided per year per MMU in each district. Exact performance benchmarks and payment based on results will be introduced from 2010-11 onwards, since the thrust has been so far to at least get the system up and running. Monitoring formats have been developed by the MNGO, and approved by DHFWS. Quarterly progress reports are to be submitted, highlighting the progress, and the activities that were not completed according to time schedule, along with reasons for the variance.

District ASHA Resource Centres (DARCs)

ASHA scheme in Uttarakhand is being run in PPP mode. All District CMOs have signed MoU with concerned Mother NGOs for running District ASHA Resource Centers. An MoU is signed between the Department of MH&FW and the State ASHA Resource Centers in Uttarakhand. Overall management of ASHA scheme is being done by the DARC. State capital based Mother NGO is State ASHA Resource Center (SARC) and District level Mother NGOs are District ASHA Resource Centers. Two districts are being managed by the Field NGOs. Rs. 11,300/- per annum is released for SARC and Rs. 2, 76,000/- for DARCs. In addition department provides additional funds for training of ASHAs. The state has completed 5th module trainings and 6th module training is going on. State has developed 6th module training with the help of SARC. Mother NGOs and Field NGOs are facilitating new selection of ASHAs. New selections are being done in case of drop out or if ASHA is selected in Panchayat.

Voucher Scheme to promote institutional deliveries

It has been started on the pattern of Chiranjeevi scheme of Gujarat in five districts: Haridwar, Dehradun; Udham Singh Nagar; Almora; and Nainital. The scheme is implemented through a Voucher management unit. Each of the project districts has one Voucher Management Unit with the following staff: 2 field coordinators; One Accounts Assistant; One MIS Assistant. The VMU is tasked with monitoring, evaluation, and voucher control. ASHAs are given 10 vouchers in advance and trained by the MIS Assistant. Each voucher is for providing services of ANC, delivery at the private institution, PNC and Family Planning. Motivational charges @ Rs 200 for each delivery and Rs. 150 for each family planning are paid to the ASHA. Average cost for delivery is Rs. 2690 (factoring in C-sections, complications, ANC, PNC, and investigations). Additional package is set aside for neonatal complications.

Provision of separate manpower to manage Voucher scheme may not be justified, as the programme management unit of district could manage this.

20. OVERALL PROGRAMME MANAGEMENT

Overall programme management arrangements are in place at the state, district and block levels: SPMU positions are filled; there is only one DPM position vacant at district level (out of 13 districts); and all block level accountant positions (except one vacancy out of 95 blocks) are filled. However, block program managers (BPMs) show 40 vacancies. Advertisements for recruitment of BPMs were taken out only on the website of the SHFWS, which may have missed out on local candidates. Additionally, qualification requirements for BPMs may have been higher than the locally available capacities.

Several of the DPMU staff have been working for many years, however there has been regular attrition, possibly due to low remuneration. Roles and responsibilities of DPMU were not uniformly clear, and though performance appraisal systems are in place, the appraisal is not linked to clear performance benchmarks based on the job description.

Systems for induction and refresher training of PMU staff need to be introduced. Even the old DPMU staff did not recall any induction training, while training of the BLAs and BPMs have been carried out by the DPMU staff, without any state level initiative.

21. FINANCIAL MANAGEMENT

District Headquarter has 3 Savings accounts in a Nationalized Bank; one each for RCH Flexi pool, Mission flexipool, and Immunization, and individual accounts for the NDCPs. In addition, separate accounts for National Health programmes exist: for TB. (Account of district TB society), Leprosy (District leprosy society), Blindness (District Blindness society), IDSP, Iodine Programme, NVBDCP and NPPCD (wherever applicable).

Funds are received from State Headquarter to the districts through e-banking, and are further e-transfered to DH, SDH, CHCs and PHCs. However, the release to districts is not necessarily untied or even against any approved IDHAP: RCH II tranche comes as separate amounts for JSY, sterilisation compensation, and a lumpsum amount for the base flexipool / supply side activities; Mission flexi pool tranche comes activity-wise; Immunisation tranche comes lumpsum, and same for the individual NDCPs.

Monthly audit by authorized chartered accountant will be done now onwards. Annual audit is being done by chartered accountant of state and Auditor General. Based on the audit reports, corrective actions are carried out. District audit reports are usually shared with the concerned district CMO for taking appropriate corrective actions. However, district audit report sometimes get delayed which delays the required corrective actions. Utilization Certificates for the funds released should be obtained quarterly by the state instead of annual.

22. DATA MANAGEMENT

First level of Data Entry in HMIS format is District Level. Staff at PHC and below is not yet trained in data management.

HMIS data reported for Apr-September 2009 has a few inconsistencies, e.g. HMIS reports show Zero functional FRUs and 24x7 PHCs. During recent JRM-6 review in June 2009, the state reported 37 functional FRUs and 34 PHCs providing 24x7 services. Additionally, the total number of JSY beneficiaries for deliveries at public institutions (57,897) is much higher than the total deliveries conducted at such institutions (37,923). This is primarily due to an inordinately high number of beneficiaries (37,699) reported in June 2009. The total number of ASHAs receiving JSY incentive for deliveries in accredited private institutions (758) is higher than the mothers receiving the incentive for such deliveries (707).

PART II

Progress against the approved PIP of the State

RCH II

S. No.	Budget Head	Approved Budget 2009-10		Year to quarter (Cumulative Apr-Sep 2009)		
		Amount (Rs. Lakhs)	%	Planned (Rs. Lakhs)	Reported (Rs. Lakhs)	Variance %
1	Maternal Health	42.75	1.7	21.38	17.81	-16.7
2	Child Health	206.01	8.4	103.01	24.74	-76.0
3	Family Planning	2.46	0.1	1.23	1.25	1.6
4	ARSH	120.00	4.9	60.00	0.00	-100.0
5	Urban RCH	127.83	5.2	63.92	0.00	-100.0
6	Tribal RCH	0.00	0.0	0.00	0.00	
7	Vulnerable Groups	0.00	0.0	0.00	0.00	
8	Innovations/ PPP/ NGO	564.57	22.9	282.29	26.30	-90.7
9	Infrastructure & HR	763.58	31.0	381.79	60.53	-84.1
10	Institutional Strengthening	74.95	3.0	37.48	18.02	-51.9
11	Training	199.67	8.1	99.84	28.26	-71.7
12	BCC / IEC	171.25	7.0	85.63	8.46	-90.1
13	Procurement	0.00	0.0	0.00	12.66	
14	Programme Management	188.12	7.6	94.06	52.05	-44.7
	Total RCH II Base Flexi Pool	**2461.19**	**100.0**	**1230.60**	**250.08**	**-79.7**
16	JSY	1350.00	78.8	675.00	569.65	-15.6
17	Sterilisation and IUD Compensation, & NSV Camps	362.72	21.2	181.36	54.49	-70.0
	Total RCH II Demand Side	**1712.72**	**100.0**	**856.36**	**624.14**	**-27.1**
	GRAND TOTAL RCH II	**4173.91**		**2086.96**	**874.22**	**-58.1**

1. Overall expenditure reported by the state for Apr-Sep 2009 is Rs. 8.74 crores, which is 42 % of total budget[14] for the period. This expenditure includes Rs. 2.51 crores for base flexipool (20.3% of the half-yearly budget). NIL expenditure has been reported under the head of *ARSH* (budget Rs. 0.60 crores). Urban RCH also shows no expenditure however it is to be noted that the budget approved in supplementary PIP was sent in June'09. In the base flexipool, except for institutional strengthening (-51.9% variance) and program management (-44.7% variance), all other major budget heads show high negative expenditure variances, indicating very low expenditure (Child health -76%, Innovations/ PPP/ NGO -90.7%, infrastructure & HR -84.1%, Training -71.7%, and BCC/IEC -90.1%). This needs to be looked at considering early approval of PIP for 09-10.

2. The expenditure on JSY (Rs. 5.70 crores) and sterilization & IUD compensation and NSV camps (Rs. 0.54 crores) account for 71.4% of the total reported RCH II expenditure for Apr-Sep 2009 while expenditure on base flexipool accounts for only 28.6% of the total expenditure, while the corresponding proportions in the approved budget are 41% and 59% respectively.

[14] The budget also includes the approved supplementary PIP of Rs. 487.39 lakhs for the year 09-10.

3. An increasing trend is seen in the expenditure across the quarters, with Rs. 2.82 crores reported during Apr-Jun 2009 and Rs. 5.92 crores reported during Jul-Sep 2009 (an increase of 110%), including a nearly four-fold increase in base flexipool expenditure (Rs. 0.56 crores to Rs. 1.94 crores)

4. HMIS data shows that the total number of deliveries reported during Apr-Sep 2009 in public facilities has more than doubled (114% increase) compared to the first half of 2008-09. There is also a decrease of 22.5% in the number of home deliveries reported, indicating a possible shift in some of the home deliveries to institutions / better reporting. The number of pregnant women registered for ANC has gone up by 11%; and the number of women registered for ANC within the first trimester has gone up by 37%. Also, a greater proportion of ANC registrations are being reported in the 1st trimester: 43% during Apr-Sep 2008, increased to 53% during Apr-Sep 2009. There is an increase of 40 percentage points (during Apr-Sep 2009) in the proportion of babies breast fed within one hour of birth compared to the same period last year. The number of babies weighed at birth has increased by almost 23% compared to Q1-Q2 08-09, while there is a decrease of 30 percentage points in proportion of babies weighing less than 2.5 kg. A sharp increase is seen in the number of female sterilizations (167%), male sterilizations (104%), and IUD insertions (159%) at public facilities during Apr-Sep 2009, compared to the same period in 2008.

Mission Flexi pool

S. No.	Activity	Approved Budget 2009-10	Utilization Apr-Sep 2009	%age Utilisation of PIP
B1	ASHA	985.00	62.98	6.4%
B2	Untied Funds	1229.90	19.97	1.6%
B3	Hospital Strengthening	260.00	88.18	33.9%
B4	Annual Maintenance Grants	254.50	4.82	1.9%
B5	New Constructions/ Renovation and Setting up	246.00	0.00	0.0%
B6	Corpus Grants to HMS/RKS	403.00	4.61	1.1%
B10	IEC-BCC NRHM	1.53	0.46	30.1%
B11	Mobile Medical Units (Including recurring expenditures)	360.00	198.15	55.0%
B12	Referral Transport	1335.00	223.92	16.8%
B14	Additional Contractual Staff	243.60	36.33	14.9%
B15	PPP/ NGOs	40.00	8.37	20.9%
B16	Training	71.30	8.45	11.9%
B18	Planning, Implementation and Monitoring	15.00	13.09	87.3%
B19	Procurements	13.75	0.00	0.0%
B25	State level health resources center (SHSRC)	33.78	1.20	3.6%
B27	NRHM Management Costs/ Contingencies	274.28	40.13	14.6%
	Total	**5766.64**	**710.66**	**12.3%**

RECOMMENDATIONS

- Overall orientation to NRHM and guidelines at all levels

Infrastructure planning / location – needs to be linked to decentralised village microplanning/ tagging of hard to reach areas ,eg focus on operationalising key facilities including the DHs as FRUs,rather than spreading resources thinly.

- Rationalise posting and transfers, improve incentives for hard to reach area within districts (refer package in neighbouring state + specialised training)
- Adapt recruitment procedures and requirements to tap and strengthen local capacity
- Define opportunities for increasing contribution of SADs and AYUSH within NRHM eg. multi-skilling
- Strengthen decentralised district planning processes, linking with other sectors – ICDS, TSC
- Strengthen VHNDs with expanded activities e.g. GMP, Nutrition Counselling, referrals, salt testing
- Orientation on add on interventions e.g. Kit A
- Provide a platform for adolescent girls and women to share and discuss health and nutrition issues linked to other development opportunities
- Communication campaign based on local health issues eg. workload in post partum period linked to prolapse
- Consider District Resource Centre for NRHM which will guide overall training and communication
- ASHA mentoring support to be extended through cluster level networking/ facilitation
- Greater orientation and sensitisation of PRI and Mos for greater community ownership/communitisation
- Joint training eg. NRHM –ICDS-SWAJAL for improved convergent action
- Provide greater mobility support to MOIC for improved support to peripheral action
- Develop common bio-medical waste management facilities in urban places like Haldwani with linkages to hilly areas
- Give more focussed attention to addressing neonatal health at the facility and community levels
- Arrange hands on training for utilisation of HMIS for review and planning
- Feedback from 108 about functioning of emergency and referral services

The state needs to develop a creative mechanism to provide services effectively to all. Some suggestions based on current practice are as follows:

- Pharmacists are one cadre that is available in the Kumaon region in adequate numbers. Pharmacists are being trained to become Emergency Medical Technicians by the EMRI, including training to conduct delivery services. Pharmacists are posted as the primary provider in many State Allopathic Dispensaries without the support of a doctor.
- Mobile medical unit is functioning in Uttarakhand through a PPP mechanism providing Specialist services.
- EMRI 108 services are working in the remote areas and the mobile phone is effective in conveying messages.

Considering these three one may consider the following mechanism for providing appropriate services

- Pharmacists trained in basic clinical-diagnostic skills to run OPD (they are doing so in default without appropriate training)
- Hub and spoke arrangement of telemedicine where the spokes consist of such pharmacist, ANM/nurse, Lab technician run clinics which provide treatment for basic illness based on thorough examination and investigation and using appropriate diagnostic algorithms and protocols. These should be vetted by a clinician / doctor available for consultation over phone at the Hub.
- Periodic specialist services through mobile medical unit for all chronic/cold cases at appropriate points. This service will necessarily be a referral service linked to the clinic / PHC referral. These mobile services have to provide minor OT facilities and refer to designated institution for institutional care/surgical care. Pooled arrangement for Referral transport may be arranged for all such referrals
- Emergency care provided through 108 services to designated facilities where full/ appropriate complement of services are available.
- Well staffed base hospital with specialist services available round the clock. The base hospital will primarily provide a)specialist consultation (over telephone with the Pharmacist/ANM/LT staffed dispensaries); b) emergency institutional and surgical services (from 108 referrals) c) Cold/Chronic case care through Mobile Medical Unit referrals.

Advantages of such a system

- Wide coverage – coverage not limited by availability of extremely skilled persons eg. doctors.
- Based on convergence of already tested/working mechanisms and technologies – Pharmacist as prescriber; multi-skilling of pharmacist; availability of Mobile Medical Unit, Availability of 108 services, robust telecommunication infrastructure
- Wide range of services availability ensured for people living in remote areas through a mix of clinic/dispensary with telephonic support; Mobile Medical Unit based expert opinion and referrals; Emergency management/stabilization support and transportation through 108 system. Through this system the patient living in the remote villages does not need to visit a referral hospital through their own effort. They need to approach the decentralized clinic from where the arrangements for treatment, expert opinion, referral transport etc will be organized.

POLICY RECOMMENDATIONS

NRHM is showing significant improvement in transforming public health services, with greater decentralization and responsiveness, strengthening basic management structures, infrastructure and human resources. ASHAs are the most visible face of change at village level. The progress of the ASHA initiative is contributing to better community involvement, linkages with the health system and convergence with ICDS. Village level convergence presents new opportunities for an integrated approach to reducing maternal, newborn, infant and young child undernutrition and mortality. In this perspective, the following may be considered:

- Common Village level Committees for ICDS NRHM – expand VHSC to Village Health Sanitation and Nutrition Committee
- Joint community based microplanning by NRHM ICDS community groups- especially for difficult to reach areas, using opportunities provided by ICDS Universalisation and revised population norms for AWCs, mini AWCs and AWCs-on-demand
- Updating the roles and responsibilities of frontline workers team and the MHFW operational guidelines for Village Health and Nutrition Days
- Create a nutrition resource network to support convergent planning – including at national/state levels
- Include Nutrition status of children under 3 years as a progress indicator also in NRHM

.

Long term Human resource strategy needed – including

- Capacity Building -Setting up of Medical Colleges, ANMTCs
- Multiskilling and innovative approach to curative care
- Telemedicine
- Career progression and specialised training opportunity coupled with enhanced incentives for providers serving in hard-to-reach areas, with rotation policy
- Way forward for ASHAs

Defining progressive quality standards for different service delivery levels, with flexibility in approach for hard-to-reach areas needs to be done.