4th Common Review Mission, Uttarakhand Visit Report

(16 – 22 December 2010)

Under

NRHM division,

Ministry of Health and Family Welfare,

Government of India

New Delhi.

Contents

Abbreviations used:

ABER	Annual Blood Examination Rate
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
AMC	Annual Maintenance Contract
APHC	Additional Primary Health Centre
API	Annual Parasite Incidence
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AWTC	Anganwadi Training Centres
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga Unani Siddha Homeopathy
BCC	Behaviour Change Communication
BHAP	Block Health Action Plan
BPM	Block Programme Manager
CDPO	Child Development Project Officer
CHC	Community Health Centre
CRM	Common Review Mission
C-section	Ceserian section
CSR	Corporate Social Responsibility
DAM	District Accounts Manager
DDT	Dichloro-Diphenyl-Trichloroethane
DH	District Hospital
DHAP	District Health Action Plan
DHS	District Health Society
DMO	District Malaria Officer
DPT	Diphtheria Pertussis Typhoid
DTT	District Training Team
EAG	Empowered Action Group
EMRI	Emergency Management Research Institute
FMR	Financial Monitoring Report
FP	Family Planning
GNM	General Nurse Midwife
GoI	Government of India
HMIS	Health Management Information System

HSC	Health Sub Centre
ICDS	Integrated Child Development Scheme
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education Communication
IFA	Iron Folic Acid
IMEP	Infection Management & Environment Plan
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In-Patient Department
IPH	Institute of Public Health
IPHS	Indian Public Health Standards
IRS	Indoor Residual Spraying
IUD	Intra-Uterine Device
IYCF	Infant and Young Child Feeding
JSY	Janani Suraksha Yojana
LAMA	Leave Against Medical Advice
LHV	Lady Health Visitor
LS	Lady Supervisor
LT	Lab Technician
MIS	Management Information System
MMR	Maternal Mortality Rate
MMU	Mobile Medical Unit
MO	Medical Officer
MO I/C	Medical Officer in-charge
MP	Malaria Parasite
MPW	Multi-Purpose Worker
MTC	Malnutrition Treatment Centre
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NBW	New-Born Weight
NGO	Non Government Organisation
NLEP	National Leprosy Eradication Programme
NRDWP	National Rural Drinking Water Programme

NRHM	National Rural Health Mission
OPD	Out-Patient Department
OPV	Oral Polio Vaccine
OT	Operation Theatre
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PPI	Pulse Polio Immunisation
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
PTG	Primitive Tribal Groups
PWD	Public Works Department
RCH	Reproductive and Child Health programme
RDK	Rapid Diagnostic Kit
RI	Routine Immunisation
RIMS	Rajendra Institute of Medical Sciences, Ranchi
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
SARC	State ASHA resource centre
SBA	Skilled Birth Attendant
SC	Scheduled Casts
SDH	Sub Division Hospital
SDO	Sub Division Officer
SFM	State Finance Manager
SHS	State Health Society
SHSRC	State Health Systems Resource Centre
SNCU	Sick Newborn Care Unit
SOE	Statement of Expenditure
SRS	Sample Registration Survey
ST	Scheduled Tribes
SSS	Soodurvarti Swasthya Sahhayak
TB	Tuberculosis
TFR	Total Fertility Rate
THR	Take Home Ration

TOR	Terms of Reference
TSC	Tribal Sub Plan
UF	Untied Funds
VHC	Village Health Committee
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WCD	Women and Child Development

Chapter 1: Common Review Mission

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Note: The Team members 1,3,6,7 visited Chamoli district & others, Uttarkashi district.		

Chapter 2 Introduction

The National Rural Health Mission (NRHM) mandates provision of accessible, affordable and accountable quality health services to the rural population with emphasis on vulnerable sections of the community. The thrust of the Mission is to establish a community owned fully functional & decentralized health delivery system with inter-sectoral convergence at all levels to ensure simultaneous action on a wide range of health determinants like water, sanitation, education, nutrition, social and gender equality.

The 4th Common Review Mission visit to the state of Uttarakhand is based on the mandate of Mission Steering Group for concurrent evaluation of NRHM. An Eight member CRM 4 - team visited the State from 16th to 22 December 2010.

A State presentation was made by the Mission Director to the CRM 4 – team on the 16th Dec 2010. A de-briefing was held on December 22nd 2010 chaired by the Mission Director, NRHM Uttarakhand and DG Dt. Health Services Uttarakhand where the CRM 4 - team shared its findings. The team also met secretary, health and family welfare Uttarakhand, and shared the key findings.

1. Introduction:

Uttarakhand was carved out of Uttar Pradesh as the 27th state of the Republic of India on 9th Nov 2000. The State has two Divisions (viz; Garhwal and Kumaun) with 13 Districts. The State can be grouped into three distinct geographical regions, (i) the High mountain region, the (ii) Mid-mountain region and (iii) the Terai region.

The state is spread over an area of 55,845 square km having 78 Tehsils, 95 blocks ,7227 Panchayats and 16,826 inhabitated villages, 86 cities/towns and only five are major cities with population over 1 lakh. Dehradun is the state head quarters from where all State Government departments function.

Geographical features: The state borders Himachal Pradesh in the north-west and Uttar Pradesh in the South and has an international border with Nepal and China. The famous peaks of Nanda Devi, Kedarnath, Trishul, Bandarpunch and Mt Kamet, the major Glaciers including Gangotri, Pindari, Milam and Khatling are located in Uttarakhand. The Ganga, the Yamuna, Ramganga and Sharda are principal rivers of this region. The state is very rich in natural resources.

2. **Public Health System**: The current public health system was carved out of the earlier state's (Uttar Pradesh) human resources and infrastructure. The current number of health facilities in the state are as under:

Table 1: Health Facilities in Uttarakhand

Particulars	**In position**
Sub-centre	1847
Primary Health Centre	254
Community Health Centre	55
District Hospital	18
Sub district Hospitals	20
Medical Colleges	03
ANM Training Centres	06
Ayurveda college	01

The state has 3 medical colleges, 6 nursing schools. The state is planning to develop nursing school at various district head quarters. The share of AYUSH systems of medicine and its practioners is reported to be quite significant in the state. It has one Ayurveda college at Haridwar.

3. The Infrastructure In the districts visited:

District	Total No. of	Health facilities in the district				Total
		SC	PHC	CHC	DH	
Chamoli	364343	104	16	5	1	126
As per norm		121	12	3	1	
Uttarkashi	352339	82	15	3	1	101
As per norm		117	12	3	1	

The above table shows that both the district have adequate infrastructure except the number of Sub Centres (SC) in Uttarkashi, which is significantly short. The districts have a number of State Allopathic Dispensary (SAD) which are in various stages of completion and are yet to be handed over to the Dept.

Human Resources:

As seen from the table below that, there is a significant shortfall of Medical Officers (59% vacant posts), paramedical staff (41% vacant posts). However the state has substantial number of pharmacists in position (03% vacant posts).

Table 2: Human Resources in Uttarakhand

Category	Sanctioned	Working	Vacant	Percentage of Vacant posts
Medical Officers	2308	972	1346	59%
Staff Nurses	1203	952	251	20%
Paramedical staff	804	471	323	41%
Pharmacist	1497	1453	54	03%
Drug Inspector	19	15	04	21%
Food Inspector	163	47	116	71%
Fourth Class	3368	3009	759	23 %
Total	**9672**	**6911**	**2753**	**29 %**

1. Health and Performance Indicators:

The Maternal Mortality Ratio (440/10,000) in the state is higher than the national average of 254/10000 and has a poor ANC (15.7%) and Immunization (79%) as compared to national average of 18.8% and 100.62% respectively. The higher maternal mortality is attributed to the poor accessibility and transport facilities due to difficult geographical terrains existing in the state. In order to reduce the high maternal mortality the Uttarakhand government is promoting access to health facilities by improving transport (especially EMRI) services. The infant mortality (44/1000) is better than the national average (53/1000).

Table 3: Key Health Indicators- Uttarakhand

Indicators	Uttarakhand	All India
Infant Mortality rate	44	53
Maternal Mortality Rate	440	254
Total Fertility Rate	N/A	2.6
At least 1 ANC (DLHS-3)	55.4%	75.2%
Full ANC (DLHS-3)	15.6%	18.8%
Full immunization (In Lakhs) (MIS)	79	100.62
Early initiation of breast feeding (DLHS-2)	27.2%	
Note: **This is combined with Uttar Pradesh**		

List of Health facilities visited by CRM team:

4th Common Review Mission				
17th December 2010 to 23rd December 2010				
Name of State			**Uttarakhand**	
Names of Districts visited:				
Sno	Name	District HQ	Name of DM	Name of CMO
1	**Chamoli**	Gopeswar	Dr. P.S Gusian (IAS)	Dr. D.S. Rawat 09410947752
2	**Uttarkashi**	Uttarkashi	Dr. Hemlata Dhaundiyal	Dr Mayank 09412073733
Health Facilities visited				
Sr no	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
Chamoli				
1	District Hospital, Chamoli	Gopeswar	DH	Dr D L Shaha, CMS, 9412026646
2	Joshimath, CHC	Joshimath	CHC	Dr. M.S. Khati 09412061783
3	Karnaprayag, CHC	Karnaprayag	CHC	Dr. Nirbhay Kumar Medical superintendent 01365-244225
4	Gairsain CHC	Gairsain	CHC	Dr. Amlesh kumar Dr. Sudha, Dental 0941066171
5	BPHC, Chamoli	Chamoli	BPHC	Dr. T.S. Dungriyal 09411387125
6	APHC: Pipalkoti	Pipalkoti	APHC	Dr. C.B. Semwal 01372-266241 09690150608
7	Sub-centres: Lungsi	Lungsi	HSC	Smt. Pushpa Kandari, ANM

				Sh. B.L. Verma, Male Supervisor Sh. Anil Kumar, Pharmacist
8	AWCs, Mayapur	Mayapur	Anganwadi Centre	Mrs. Uttra Pant 09012776377
Uttarkashi				
9	CHC Chinayali Saur	Chinayali Saur	CHC	Dr Bhandari 09412312300
10	Block PHC,	Bhatwari	BPHC	Dr Mohan Singh 094115533040
11	Sub-centre Harshil	Harshil, Bhatwari	HSC	Smt. Padma Pawar ANM
12	CHC , Naugaon	Naugaon	CHC	Dr Anup Dimiri 09411339322
13	CHC, Purola	Purola	CHC	Dr R C Arya 09412914902
14	BPHC Dunda	Dunda	BPHC	Dr H K Yadav 9412363889
15	HSC Mansiyari Saur	Judi Dunka	HSC	ANM
16	DH Uttarkashi	Uttarkashi	DH	Dr R P Singh CMS

Chapter 3 Findings of the 4th CRM in the State

3(a) Comment on the 11 Items listed to be reviewed under the 4th CR is detailed in the preceding chapters.

The CRM 4 team visited two districts in Uttarakhand separately along with the state officials Dr Abhay Kumar (State Program Manager, NRHM, Uttarakhand) and Dr Lata Bisht (State Immunization Officer). The CRM team split into two teams one team consisting of Dr Anil Kumar, along with Dr Vandana Prasad, Mrs V. Bose & Dr Amar Nawkar visited *Chamoli* district. While the other team consisting of Dr Baya Kishore, along with Dr Paul Francis, Dr Anuradha Jain and Mrs Sulekha Kulashari visited *Uttarkashi* District.

The team's findings on the eleven key areas as per the TOR are listed as follows:

1. Infrastructure Up-gradation:

1. **Infrastructure** in the State has been upgraded with the help of inputs from NRHM over a period of time. These were mostly confined to the CHCs; however the upgradation is not as per the needs of services required at these facilities.
2. Linkage of services with the Human Resources was noticed to be poor at several health facilities, for instance at BPHC Chamoli there was a CEMOC trained medical officer, but had no labour room to conduct deliveries. The labor room was yet to be constructed.
3. **Staff Quarters**; were mostly housed in rented houses which were not easily available in the villages, the residential quarters found at places were inadequate and in bad shape.
4. It was observed that completed constructions (BPHC Bhatwari) were not being transferred to the health department. (Uttarkashi). This would help ease the problem of congestion.
5. Staff quarters till BPHC level were being utilized but not enough in number.
6. **Infrastructure Training facilities (**for training of nurses, ANMs and paramedics) were generally not available at district level.
7. **Electricity** was generally irregular at both districts, and shortage of electricity and low voltage was affecting the cold chain equipment, and was causing hindrance in operating baby warmers, room heaters and geysers. Back up facilities in the form of invertors were missing.

8. In Uttarkashi district it was seen that the Drug storage room also had electricity switch boards and generator in the same room (Chinyali Saur PHC of Uttarkashi District) which may cause fire.
9. **Water** filters were available for staff however health facilities generally lacked potable water for patients / attendants. There was no provision of hot water during winters in wards or labor rooms making it difficult for health staff and patients to work. There was no piped water facilities (Chinyah Saur PHC)
    1. Toilets were either not attached to wards/OPDs or lacked water supply or functional flush systems.
1. **Drugs** were being dispensed by the pharmacists as per the MO's directions; however shortfall was seen in the supply of drugs at few facilities. In the District Hospital at Gopeswar, patients were buying drugs that were supposed to be available from the health facility/hospital. .In Uttarkashi drugs were available and the BPHC ware house was well stocked.
2. **Disability friendly features** were observed at some places (DH Gopeswar, CHC Joshimath), but were found lacking at many health facilities such as (BPHC-Chamoli, CHC- Karnaprayag, CHC Gairsen, CHC Naugaon)
3. **Equipment** was generally available at all facilities however there was a mismatch between the equipments and human resource (eg Gairsain: X ray machine was available but these was no technician). Operation theatre were available at various facilities but were not being used (CHC Joshimath, CHC Gairsen and BPHC Chamoli). District Hospital Chamoli had 2 additional packed Blood Bank refrigerators lying there despite having one working refrigerator. Keeping in view the consumption of Blood in this hospital (15-20 units per month), the additional refrigerators were not required and could very well be utilised at other CHCs.
4. **There was no annual maintenance plan for existing equipments** at facilities and this was specially affecting neonatal care (baby warmers and oxygen cylinders).
5. Temporary arrangements for attendants stay were available at district hospitals (*ASHA- ghar*) but were insufficient to cater to the load.

6. Human Resources Planning:

7. **Availability**: It was seen that, there was an overall shortage of skilled human resource (specialists & Allopathic Medical officers in Chamoli and Uttarkashi District). Specialists were not present at the MCH Level 3 centres for considerable period of time.

8. There is shortage of MPWs in the State resulting in poor presence of (2nd) ANMs in the field as the second ANM is provided to States, only in the presence of MPW.

9. Mismatch in deployment:

1. Pipalkoti APHC in Chamoli district had three doctors (1 LMO, 1 MO, 1 Ayush Doctor under NRHM) however the case load at this centre was extremely low. The newly joined lady medical officer was not conducting deliveries.
2. No Paediatrician was present at Naugaon (> 200 deliveries/month); No LMO at Purola(> 40 deliveries/month)
3. No anesthetist at district hospital Chamoli
4. Orthopedic surgeon was posted at Joshimath CHC, but the health facility lacked functional Operation Theatre (OT).

10. Blood bank (District Chamoli) not provided with staff (as per norms) although Laboratory Technicians were available.

11. **Pre-service training capacity**: the state has not addressed the issue of pre-service training to the extent it should. The state has not utilised existing Medical & Nursing colleges for pre-service training.

It has very few training institutions leading to poor capacity building in the state. (MBBS doctors, GNM, ANMs, Health worker male, other paramedical skilled manpower) however it has institutions to train dental surgeons, AYUSH doctors and pharmacists (a potential resource) more than required and thus can be deployed for other allied functions in the state.

12. **In service training:** The case load at the facilities is poor for adequate RCH trainings at the district level (Chamoli & Uttarkashi) thus limiting the sites for in-service training in the district. As far as training of ASHAs is concerned MNGOs were involved for ASHAs training but were facing difficulties in training module 6th & 7th as they had more of clinical training.

13. **Recruitment and cadre management:** Plan for augmentation of HR at district level was missing. Although AYUSH practitioners are being utilized for MCH service at places (Chinyali Saur and Purola) they however require constant reorientation and training.

14. During the interactions with the dean of Srinagar Govt. Medical College it was observed that there would be a 5 year bond period for rural posting for the 80/100 students who will pass out in 2 years from now.

15. There were few opportunities for public private partnership in Uttarakhand since the private sector is largely absent.

16. The District Hospital at Gopeswar has a system of rotation of doctors during the Badrinath yatra period; however, this practice is not being followed throughout the year – to augment critical gaps in services.

17. Efforts for Area specific recruitment were being made by the state, however the response was poor. Financial incentives were being given for postings in difficult areas. Recruitment through public service commission had failed to comply with the area-wise needs of medical doctors in the state. Some cases of private practice by government sector doctors was reported.

18. **Skill Quality of HR:**

1. Random trainings were seen at many places, no assessment of training needs was being done and no training plans were available at the district level.
2. In district hospital Uttarkashi the EMOC trained lady doctor and LSAS trained doctor were performing surgeries both C section and the LSAS trained doctor were assisting the General surgeon and the orthopaedic surgeon quite well.
3. Basic skills (measuring BP, estimating Hb, Urine examination) were lacking amongst most ANMs.
4. Post training deployment was not according to the skills acquired. (For instance, the BPHC Chamoli MO is trained in EmOC but not utilizing his skills).
5. There is poor post training follow up.
6. Contractually appointed AYUSH doctors were not trained in management of national programmes.
7. ASHAs interviewed were found to have good knowledge of IYCF practices.

19. Health Care Service Delivery – Facility Based - Quantity and Quality.

20. The utilization of health facilities was poor at most facilities (additional PHC, BPHCs, CHC). Very few facilities were having good utilization like CHC Karnaprayag. The following table explains the average OPD IPD of facilities seen. The health facilities connected by arterial roads are more likely to be utilized against remotely located health facilities.

20.21.

Facility	Services

CHC Gairsen	average OPD 80 patients per day, IPD 40 per month no operations
Joshimath CHC	Average OPD 40.
Karnaprayag CHC	Average OPD 120-150, Bed Occupancy: 100%, Deliveries- 79 per month
BPHC Chamoli	OPD 20 per day, no IPD, no Deliveries
DH Gopeswar	OPD 200 per day, bed occupancy 30 to 35%,
Subcentre Lungsi (Population: 1530)	ANC 42, Immunization: 38, (ANC and Immunization almost 100%) Copper T: 48 in last one year

21.22. Blood storage and transfusion facilities (Uttarkashi & Chamoli) were available at District Hospital, however at the DH Chamoli, there was no blood units available at the time of visit (and no blood had been collected in the entire month of December preceding the CRM). Most of the CHCs did not have Blood Storage facilities.

22.23. 8 maternal deaths were reported from Uttarkashi District. Although health facilities were designated as FRU they however were not fully operational. No maternal Death inquiry was being conducted.

23.24. The road transport was difficult; especially during the monsoons where roads are blocked due to landslides and many patients were unable to reach facilities in time. Though states is trying to improve this through EMRI.

24.25. **Laboratories** were observed to be operational with basic biochemical investigations, however not all the health facilities had comprehensive laboratory services. The lab in Chinyali Saur was performing tests to detect Typhoid antibodies. RA factor etc

25.26. **Drug use:**

1. Overuse of antibiotics was observed at Uttarkashi and Chamoli District.
2. Patients reported that there was substantial out of pocket expenditure for drug purchase.

26.27. **ANC and PNC:**

1. At Sub centre level the ANC was incomplete and of poor quality. Records showed complete ANC and normal status but on questioning the ANMs further and asked to demonstrate, they were not able to explain even normal blood pressure recording.

2. ANC was confined to distribution of iron folic acid and TT injections, no abdominal examination, weight recording, haemoglobin estimation, urine examination and blood pressure check up was being done.
3. Labour tables were available at the HSC in Chamoli District, but no deliveries were being conducted; however in HSC Hershil (Uttarkashi) 2 deliveries were reported in first 6months. No deliveries are conducted in the months of winter due to migration in response to snow fall (as reported). It was observed that, the supervision of the ANMs by the supervisory staff like LHV, male supervisors and PHC medical officers was lacking.
4. 48 hours stay post delivery was reported at facilities in Chamoli district however in Uttarkashi district it was reported that women were not staying in facilities for 48 hours after delivery (in most places). The reason being (as told by most of staff during group discussion) that the health facilities were cold & had no staying arrangement for family, no hot water, no food etc. People usually hire their vehicle and come and go back as early as possible which is few hours.
5. In Uttarkashi most facilities had functional new born corner with functional baby warmers; however facilities visited in Chamoli did not have a functional baby warmer or new born corner.
6. Use of partograph for delivery was not observed in Chamoli.

28. **Family planning services:** IUCD insertion happening at sub centre level in Chamoli but not at Uttarkashi. In fact most ANMs informed the team in Uttarkashi that they have just practised on 'dummy' as cases were not available.

29. **Biomedical waste management:**

1. Poor biomedical waste disposal systems at both the districts.
2. Disposal Pits are being used in almost all places (Uttarkashi), but IMEP guidelines are not being followed. Deep burial pits are not available in all facilities in Chamoli district.
3. Even plastic waste was observed being burnt in CHC Karnaprayag
4. Very few facilities were observed to have segregation facility. No segregation & disposal of waste as per BMW rules.
5. Disinfection of laboratory wastes observed at some place
6. Needle destroyers, hub cutter available in the immunization rooms

30. **Vaccine delivery** for VHNDs is cumbersome (more travel time), which may compromise quality of cold chain. No alternative vaccine delivery system was in place.

29.31. **Display of service guarantee and citizen's charter** was being displayed at facilities visited. Signage at all the PHCS and CHCS were adequate, posters and even electronic displays was evident (although the languages were predominantly English and Hindi) for TB-DOTS, HIV/AIDS, tobacco control, blindness and other national health programmes.

30.32. There are some doctors who are informed and motivated. The doctor running the PHC at Chamoli was a case in point. A dentist by profession was assisting deliveries at the CHC Gairsen.

31.33. As informed by district administration, **Dietary services** were outsourced at district hospital; however most of the patients were not aware of the free diet that was supposed to be procured from the catering agency under contract with state government.

32.34. **Diagnostic services were** available at DH and CHCs but not at all PHCs.

33.35. Outreach services:

34.36. **VHNDs:**

1. Immunization was the only focus area at VHND. Rest of the components like counselling for nutrition, breast feeding was absent. The reason being ANMs have to cover large walking distances to reach villages and for some had more than 5-6 villages to cover.
2. Nutritional supplementation (Take-home Rations) was not being given to less than 3 year & pregnant and lactating women. The supplies had not been available for more than a year. This had not been noted Health Department thus defeating the idea of a convergence activity.
3.
4. Involvement of ASHA facilitators, LHV, male supervisors lacking in the VHNDs.
5. Monitoring of VHNDs was poor.

1. **Mobile Medical Units** were noticed functioning, and managing cases.

2. **Sudoorwarti Swasthya Sahayak** is a new scheme in Uttarakhand, where a male volunteer from the hamlet supports community access to health facilities. This needs to be reviewed against the existing ASHA program because of replication of work by ASHAs. This has an expenditure of Rs 6000 / year (Rs 500 per month) from the Rs 10,000 untied fund of the VHSC. The SSS persons are providing First Aid and other small primary care services and given the difficult terrain and access issues, are able to serve communities at the village level. However, these skills can also be imparted to ASHAs.
3. **The state has initiated a school health program.** The district level team (consisting of three AYUSH doctors - two men and one lady MO) examine students in the schools in the district. The program is in the initial stage. Although the team is expected to visit the school and screen children twice a year as per fixed schedule, they are possibly visiting the primary government only schools leaving the private and secondary schools. The follow-up is poor.

4. ASHA Program:

1. **Training:** In Chamoli district it was noticed that the ASHA Resource Centre was in place (*Sri Bhuvaneswari Mahila Ashram*). During the interactions with the participants of training (ASHA facilitators) it was observed, that the quality of training provided at the ASHA Resource Centre was good. Trainee were able to demonstrate practices like keeping a baby warm, using a growth chart and correct way to wash hands.. **ASHA training is following the nationally recommended schedule and materials.**(Module 6 TOT was observed).

   As reported by Deputy CMO the MNGOs at Uttarkashi responsible for ASHA training were having some problems in training the ASHA in 6th and 7th module as the modules (6th &7th) were more of clinical training. However no meeting could take place with the MNGO.

2. **Issues *reported* by ASHAs:**
   1. *Inadequ*ate funds for transport to attend meetings – only 50 Rs whereas out of pocket expenditure was sometimes up to 300 Rs
   2. Inadequate facilities for stay at health institutions.
   3. Delayed payments reported at some places.
   4. Expenses for stay & time not covered **when patients referred to higher facility which happens frequently**
   5. System is not responsive to needs of the referred patients.

3. **ASHA looking after sma**ll hamlets hardly made any money, whereas Sudoor Swasthya Sahayak were **getting Rs 500 per month.** The *average monthly income* of ASHAs as reported by them was Rs 200-300.
4. **An ASHA** is eligible to receive Rs. 250 per beneficiary as incentive money for **the following activities;**
   1. Early registration and 3 ANC
   2. TT immunization
   3. IFA tablets
   4. Birth registration
   5. Early breast feeding

However it is observed that ASHAs were not providing all the services motioned.

ASHA Ghar was provided at DH level as per State PIP but not at lower levels (FRU/CHC/PHC).

5. RCH II (Maternal Health, Child Health and Family Planning Activities)

Status:

6. Pregnanat women tracking is being done but the database is currently not able to furnish data on outcomes.
7. The blood transfusion facilities at both of the districts require improvement.
8. The percent of institutional deliveries varies between 35 to 40 % out of the expected pregnancy (Chamoli 39%, Uttarkashi 35.6%)
9. ASHAs are not able to reach all the pregnant women, (e.g. ASHAs provided assistance for early ANC registration in 530, & 2TT injection for 606 women out of the expected 4900 deliveries in Chamoli, In Uttarkashi ASHAs assisted 1202 women of the total 2042 institutional deliveries)

10. JSY
    1. Payments mostly on time.
    2. Some discrepancy between institutional deliveries and JSY payments because of patients leaving the hospital against medical advice (LAMA) / not staying 48 hours (some of this may be related to the lack of heating arrangement in wards and the attitude of providers)
11. Maternal Death Reviews (FBMDRs & CB MDRs) are not being conducted in districts despite many (eight) Maternal Deaths (in Uttarkashi). MDR formats were available in Chamoli district. (3 maternal deaths in last year)
12. There seems to be no line listing (including service components) for micro plans / gap analysis for either ANC / Immunization at ANM level.
13. Family planning: Number of RCH camps was below the targets e.g. Only 16 camps out of a target of 678 organized so far in Chamoli district. Possibly there is a high unmet need for family planning service
14. MTP services are not being provided at the PHCs and most CHCs (12 abortions/MTP between April and September 2010 were reported in the Chamoli district.)
15. Increase in reporting of RTI / STIs cases in the last quarter (27→ 249 this quarter) as a result of recent training.
16. No support for transport of pregnant women to nearest road (eg: Palki) is being provided.

17. Nutrition:

18. No Take Home Rations service available for pregnant & lactating women and children under 3 yrs.

19. Anganwadi visited was functional except for THR
20. Mid Day meal program is functional
21. No Nutritional rehabilitation centres, were seen in both of the districts.
22. Anganwadis data not showing any severe malnutrition.

23. National Disease Control Programmes (NDCP) :

24. RNTCP: the program is operational through the establishment of TUs, DMCs, and DOTs centres. However the field level workers suggested that the lag in payment of incentives to the ASHAs for completing the treatment of patients might be responsible for under achieving the desired treatment completion.
25. Leprosy cases were being diagnosed and treated, e.g.: BPHC Chamoli reported 3 cases at present.
26. NIDDCP: Awareness & focus on importance of using iodised salt is poor.
27. NPCB: Optometrist available at CHCs, BPHCs however Follow-up of referred cataract patients was not being done.
28. IDSP: Surveillance of diseases is poor, though infrastructure and rapid response teams are in place. Lab support for IDSP was observed to be adequate. (Chinyali Saur and Naugaon CHC laboratories were functional and performing tests for typhoid, sputum for tuberculosis etc.). At Sub-centre level ANMs reported that they were sending IDSP reports on phone directly to the district head quarters. However, disease reporting is not being validated at MO level.
29. HIV screening, detection, treatment facilities (ICTC, ART centre) were apparently adequate. ICTCs are functional at district hospital and Naugaon CHC.
30. The HMIS data is not being analyzed /used at the district / MO level for feedback of programme action.
31. Adequate validation of reported disease incidence data needs to done by Medical Officers and programme actions like outbreak investigation needs to be conducted.

32. Institutional mechanisms and Programme Management:

33. No evidence of adequate use of available data for planning by PMUs.
34. The RKS institution appears to be in place in most of the facilities, the presence of PRI is significant. RKS meetings register showed that meetings took place but twice or thrice in the whole year. Some important issues like that of canteen in

Purola, underground water tank and water problem at CHC in Chinyaly saur were discussed in the meetings as per the registers

35. Roles and job responsibilities of DPMU/BPMU are not uniformly clear to the incumbents.

36. Induction and refresher training not being carried out regularly

37. Untied funds being used mostly for maintenance and infrastructure up gradation (furniture and fixtures). As noted above VHSC untied funds are being used for the Sudurwarti Swasthya Sahayak (SSS).

38. Financial management:

39. **Statutory Audit report for F.Y. 2009-10:** The District Uttarkashi was not having the copy of the Statutory Audit report of the District for the F.Y. 2009-10.

40. **Finance Staffing**: At District Health Society DHS, DAM & DPM are in position while at Block level; BPM & BLA are in position in both the districts visited. The DAM & BLAs have not received training in Financial Management. There is a lack of interaction and training between State, District and block level Accounts staff. No field visits have been undertaken by SFM/DAM to monitor utilization of funds.

41. **Fund Flow:** Funds are transferred electronically from State to districts and districts to blocks through E-Transfer. Punjab National Bank is the lead bank at state level while PNB & SBI is at district level. CMO and Dy. CMO are signatories while at block level, MOIC and BPM/BLA are signatories. Activity-wise funds are transferred from District to Blocks.

42. **Maintenance of books of accounts:** Proper books of accounts are not maintained at District Hospital and Blocks. At district hospital, Cash book of RCH is not maintained while one cash book is made for Mission Flexible Pool fund and State Govt. fund. At blocks Chinyalisour and Dunda , cash books are not updated regularly. At block Dunda, overwriting and cutting has been done in cash book and ledger. Further, TALLY is installed at DHS & Blocks but TALLY is not used for maintaining Accounts Books due to some technical problem. Books of Accounts are maintained manually. Further, Books of Accounts were not available in PHC Bhatwari except JSY payment Register. The Books were kept in the Almirah and keys were taken away by BLA who was on 3 days leaves.

43. **Internal Control:** Reconciliation Statement between FMR & Audited expenditure has not been given. In all of the PHCs/CHC visited, Bank Reconciliation has not been done ever. At district level, bank reconciliation is

done on quarterly basis. Further, in Bank Reconciliation statement of DHS as on 30.09.2010, cheques dated. 22.09.2007 are still outstanding for payment and not yet been reversed by district.

1. At CHC Chinyalisour, there was a withdrawal of Rs. Rs. 80,000/- for RCH Camp while expenditure of Rs. 35000/- was booked for compensation under Family Planning. However, the balance amount of Rs. 45,000/- was not available in the block. Further, Cheques are issued in the name of MOIC (Rs. 10000/-) & BLA (Rs. 13584) for petty expenses while petty cash register is not made.
2. At PHC Dunda, as per cash book of RCH, the unspent balance is Rs. 6,19,771/- while as per DHS record, unspent balance is Rs. 6,71,659. Further, Tiles of Rs. 42,803/- were purchased while there was no Bill No. & TIN printed on the Bill.

44. **Concurrent Audit**: Concurrent Auditing is conducting on quarterly basis while as per GOI instructions, it should be done on monthly basis. As per concurrent audit report of September, 2010 of District Health Society, Uttarkashi, the auditor has given comments on only 1 CHC and 2 PHCs while comments on other 2 CHCs and 1 PHC is not given. It seems that auditor did not visit in these blocks.

45. **Integration with NDCPs**: The funds transferred by the State to NDCPs are not routed through DHS except IDSP Programme. The expenditures are directly reported to SHS by NDCPs while a copy of the SOE is not given to District Health Society. Further, the Funds and expenditure of IDSP Programme is looked by DAM, Uttarkashi.

46. **Untied funds for Sub Centre & VHSCs:** Instructions are given from state to district to treat expenditure to grant released to VHSC under Untied fund. Untied funds to VHSC & Sub Centre for the F.Y. 2010-11 have been transferred, however, only 30% expenditure is reported till Nov-2010 by Sub-Centres under Untied Funds.

47. The authorised signatories for utilization of funds at Sub Centre & VHSC are ANM/Village Development Officer & Pradhan, hence, usage of funds at this level needs to be monitored.

48. **Rogi Kalyan Samiti (CPS):** The RKS institution is in place in most of the facilities. Funds are transferred to facilities for RKS. It is noted that as per state Govt. orders, 50% of user charges are deposited into Treasury while 50% is deposited in the bank A/c of RKS. There is no State Govt. budgetary support to RKS societies constituted in the District.

49. **State Health Budget:** The state has to increase their annual health budget by 10% every year, however, state budget is declined during the F.Y. 2007-08 & 2009-10. we have to put a table here.

50. **JSY Payments:** In few cases, the delay has been observed for JSY payments. As clarification was given by MOIC that due to the cold climate, beneficiary does not want to stay for 48 hours, hence cheques are collected by them later. It was observed that a delivery was held on 18.12.2010 at 07.40 A.M. and the beneficiary was released on the same day without JSY payment and clarification was given by MOIC that other signatory (paediatric) was on leaves, hence, payment was not given to her.

51. Diversion of Funds of Rs. 14.07 Lakhs from NRHM to RCH was taken place which is not permissible.

52. **Finance Staffing:** The DAM & BLAs have not received training in Financial Management.

53. Decentralized Local Health Action:

1. Village and block level planning missing, however district level planning is done.

2. No integration of DHAPs in state plans visible

3. Village Health & Sanitation Committee:

    1. VHSCs have been formed and joint accounts opened but One Gram Pradhan heads 5VHSCs thus defeating the purpose of decentralisation.

    2. VHSCs leading to irregular meetings and lack of accountability at village level.

    3. In some of the VHSCs Rs. 500 has been earmarked for Sudurwarti Swasthya Sahayak.

    4. VHSC training not complete at places — resulting in non functional VHSC

    5. The VHSC proceedings are not known to ASHA or ANM as the register was with the Pradhan .Thus nobody from the village is actually on the VHSC ,who can question on the whereabouts of the VHSC fund

    6.

4. Chikitsa Prabadhak Samiti (CPS) /RKS:

1. It has adequate people's representation like PRI, NGO, private medical practitioner

2. They are supported with good quality registers for maintaining the minutes of meeting and the proceedings.

3. For instance, CHC Gairsain had a journalist as part of RKS/CPSRKS: Only at two PHCs in Uttarkashi the RKS meetings were being held quarterly and local decision like canteen and waiting area for patients and sanitation at the sites were being planned.

3(b) Status of progress of Uttarakhand against PIP

Progress against PIP is based on the data provided by Uttarakhand State Annexed. The expenditure is expressed in percentage and the amount is in lakhs, following items are primarily reviewed.

1. Maternal Health (A.1):
    1. RCH outreach camps: 286 camps were conducted so far against 678 camps planned at the beginning of year. The expenditure was found to be 26% of the total approved amount.
    2. VHNDs: 48.20% VHNDs have been conducted with 49% expenditure.
    3. JSY: it is observed that there are no expenditure for the cesarean sections that might have been conducted till now.
2. Child Health (A.2):
    1. The state has established 2 SNCUs (Dehradun and Haldwani), against 6 planned SNCUs, 0.2 % expenditure.
    2. 28.93 % (81.78/282.59) expenditure on the School health program (first year)
3. Family Planning (A.3) :
    1. No NSV camps have been organized till date.
    2. The compensation is given to 11953 beneficiaries (FP cases) against the expected beneficiaries 43200. 20% of the approved amount has been spent.
4. Adolescent and Reproductive Child Health (A.4):
    1. 495 (against expected 750) Peer educators have been trained till now, the expenditure done so far is 60% (119.20/195.90 lakh).
5. Urban RCH (A.5):
    1. All UHC's (9 UHCs in Hardwar and Haldwani; 12 UHCs in Dehradun and Roorkee) have been established and are working.
6. PNDT and Sex Ratio (A.8.1):

1. Only one PNDT workshop was conducted against the 26 district level workshops planned. The expenditure is 6.7%. (1.08/16 lakh)

7. Institutional Strengthening (A.10):

    1. Monitoring & Evaluation / HMIS: E-Mamta, and Maternal and child tracking have been initiated. However no clear-cut expenditure statement is mentioned.

8. Training (A.11):

    1. The overall expenditure on training activities by the states is only 16.72 %.

    2. Achievement till 30th November on the SBA training of ANMs was "training of 18 ANMS" against the expected outcome of training "300 ANMs/ LHVs and 25 medical officers.

9. Full Details are not provided on the activities under some FMR headings such as BCC / IEC (A.12), Program Management (A.14), Procurement (A.13); however the expenditure have been mentioned.

Following are the comments on the expenditure and activities under mission flexi pool submitted by the State:-

1. ASHAs (A): The state has recorded expenditure and achievements on training of ASHAs, distribution of ASHA kits and Management Structure of SARC and DARC, 14.3 % (158.62/1108 lakh) expenditure has been incurred for the following activities.

    1. 4 days trainings of ASHA in ARSH, RSBY & Homeopathy in process.

    2. 08 State trainers are trained.

    3. 157 DT Teams are trained

    4. Rests of the trainings of DTT is in process. Total 255 DTT is to be trained in March 2011

    5. ASHA Facilitators trainings

2. Infrastructure (B): The activities included (MMU, NRHM Vans, HLFPPT Vans BISR Vans, Emergency & Referral Services Capital Expenditures and Operational Cost) are ongoing and the expenditure is being reported.

    1. It is observed that the "ASHA Ghar" are being established in some of the health facilities(DH of Dehradun, Haridwar, Pauri, Almora, haldwani and pithoragarh)

2. The overall expenditure on the infrastructure under mission flexi pool is not mentioned.

3. Human Resources (C):

    1. 323 ANM's have been recruited against the expected number of 200ANMs.

    2. Incentives for Govt. Doctors and Paramedical Staff working in difficult areas have not been mentioned.

4. Programme Management (D):

5. Untied Funds, AMG and RKS funds (E):

    1. The overall expenditure reported is **100% (3230/3230lakh)**

    2. following are the achievements recorded.

        1. RKS formed in 18 DH (against 19), RKS formed in 53 (against 55CHC), RKS formed in 219 (against 239) PHCs.

3(c) State specific Issues:

Table 4: Population and Health facilities in the Districts Visited

Districts name	District Population	Existing Institutional Deliveries % against estimated	No. of Facilities identified as Level-1		No. of Facilities identified as Level-2		No. of Facilities identified as Level-3		Total MCH centres
			SC	PHC	PHC	CHC	CHC	SDH/DH	
Chamoli	364343	21.30%	10+2	11	0	4	1	1	29
Uttarkashi	352339	21.50%	5	4	3	3	0	1	16

6. District Uttarkashi and Chamoli has proposed very few level I even though well functional level I was a dire need in the districts.

7. Similarly CHC Naugaon was found to be a potential site for Level III with a little effort like posting a paediatrician on rotational posting within district. Thus overall MCH planning has not been adequate in the state especially for level I

8. Injuries, Accidents and doctor's apathy:

Most providers were either unaware or unwilling to speak about terrain and economic hardships faced by patients (including acknowledgement of Out of Pocket expenditure by patients). AYUSH medical practitioners had better idea of local conditions.

9. **Other issues regarding the provider attitudes and behavior:**

1. uncaring and apathetic provider behavior was noticed (e.g. CMS of District Hospital) with a few exceptions such as – a dentist at a PHC who was available for late night delivery cases, an MO who was running a well-equipped PHC, CHC Karnprayag that had bed occupancy and was providing treatment even though these winter months are perceived as a "healthy season"

2. District CMO feels disempowered since even an ANM transfer is met with resistance
3. ANMS are unable to help pregnant women since they lack skills
4. ASHAS bring patients to PHCs and CHCs but they are often referred to the DH or the Base Hospital at Srinagar which is very far
5. ASHAS face problems because they have no place to stay the night when they bring patients to CHCS for delivery and treatment. Some of them are unaware that there are ASHA-ghars where they can stay.
6. ASHAS have the confidence of the community, whereas the district health services are not accessed because the quality of care is poor and providers are unavailable or uncaring.
7. Personnel in the 108 EMRI services are motivated and have a very good system for attending to patients despite the difficult terrain and climate.
8. EMRI personnel and paramedics who accompany the MMUs seem more informed about health status of the district.
9. MMU doctors reported seeing 'growths' in X-rays, suspect TB cases and fevers, whereas medical logs reflect coughs, colds and diarrhoea – nothing more severe than that. This includes the OPD register maintained by the MBBS doctor attending to MMU cases.

Chapter 4: Recommendations

Based on its observations & findings CRM team made the following recommendations:-

1. Infrastructure

2. Following are the suggestions for consideration by the state:

    1. Development of Infrastructure should be commensurate to 'type of services (MCH) to be provided' and the 'case load' available at the health facility. Prioritization may be done as per the need of the region.

    2. As observed at many of the health facilities, there was enough scope for improving the accessibility to disabled (differently able) persons, the new constructions undertaken should strictly comply with the norms laid down by disability Act of India 1995

    3. The districts being disaster prone, disaster prevention measures (Flood, Earthquake, and Fire) should be applied for all new constructions.

    4. Promotion of environment friendly features like, rain water harvesting, use of solar power, green buildings may be encouraged.

    5. It will be beneficial to situate the new Anganwadi centres close to the as the Sub-centres.

3. Accommodations for health functionaries and ASHAs:

    1. It is suggested that the rent of Rs 250 for sub-centres for ANMs be revised according to current prevailing prices.

    2. Residential quarters should be provided for all health functionaries especially for ANMs with in the health facility campus.

    3. Staying facilities for attendants and ASHAs should be provided at all levels of health facilities.

4. Equipments:

1. Critical equipment gaps (generators and baby warmers) need to be filled urgently.

1. Systems for regular maintenance / AMC for all equipments (including cold chain equipment) should be put in place at appropriate level.

2. The district headquarters should coordinate the work of annual maintenance of equipments with regular reporting as per ProMIS. ProMIS (Procurement management information system) be installed and should be utilised.

3. Medical Officers should supervise equipment/drug procurement and distribution in the State and Pharmacists & Supervisors should assist them in monitoring drug stocks at PHCs and Sub-centres under the overall supervision of District CMO.

4. First Expiry First out (FEFO) and First in First out (FIFO) rule should be followed for all drugs during storage at all levels. This is being recommended as many places the drugs with short expiry or already expired were found.

5. Call centres should monitor requests for supply and maintenance of equipment and instruments this will help centralised monitoring.

2. Capacity Building:

3. Training:

1. Develop Medical colleges for both pre-service and in-service capacity building e.g. Srinagar Medical college can be considered for capacity building of "providers" (pre-service, In-service).

2. GNM/ ANM/ Paramedical School to be set up/strengthened on priority

3. Health facilities with higher case load of deliveries should be considered for SBA training (e.g. Naugaon CHC, Purola CHC, Karanprayag CHC).

4. Basic SBA/IMNCI training to be provided to AYUSH practitioners and utilized for service provision at MCH Level 1 centers (hardest to reach) sites

5. Retraining of ANMs in basic clinical skills.

6. All MO's & SN's should be trained in F-IMNCI and all MO/SN/ANM involved in conducting deliveries should be trained in NSSK at different MCH levels.

4. Training Needs for districts should be addressed:

1. Training in effective vaccine management at all levels should be conducted

2. BPMs, BLAs have to be trained on programs and technical issues together as a team

3. F-IMNCI, NSSK and BEMOC, CEMOC/LSAS training needs to be accelerated.

4. Monthly meetings of ANMs at PHC, could be used to train them in basic skills of BP recording, blood sugar testing, ANC care

5. Supportive supervision of peripheral workers like ANMs, ASHAs should be implemented to ensure quality of services (RCH, MCH and health promotion).

5. Quality Assurance of ANM / EMOC / SBA and LSAS training to be undertaken

6. Human Resource Management

Following issues need to be addressed by the state in this regards.

1. Residential Quarters for all service providers especially remote areas.

2. Assured rotational postings in the remote and inaccessible areas.

3. Incentives in the form of educational facilities for children of health staff, quota in PG seats for doctors posted in remote areas.

4. Enhancing remuneration packages in the remote and most remote areas.

5. Stop private practice by Health Staff

6. Post training deployment should be commensurate with skills acquired, and on priority at the facilities with higher case loads.

7. The pending State Policy for Human Resources should be expedited.

7. Program Management:

1. Possibility of utilising dental surgeons & pharmacists for programme management to be explored.

2. Monitoring of DPMU and BPMU performance should be reviewed frequently.

3. Monitoring of programs by PMUs needs to be improved.

8. Service Delivery

1. **Blood transfusion facilities:**

One functional blood bank in each district and license for 2 to3 blood storage should be expedited at state level along with provision of Blood storage facilities at each FRU.

2. Location of MCH:

Service delivery points (MCH care centres (CEMOC and BEMOC), newborn care facilities) should be selected more strategically (priority for "hard to reach area)**.** For instance Naugaon and Mori CHCs could be considered for up-gradation in the level of services being provided.

1. Provision of safe abortion services at all CHCs should be assured.
2. State Allopathic Dispensaries buildings can be linked with health facilities wherever possible, and used for MCH Level care.
3. The concept of "Delivery Shelters" attached to MCH Level 1 be considered.
4. Support for safe transportation of pregnant women from remote areas to nearest road and EMRI service through the Palki system and payment for the same through VHSCs needs to be considered strongly.
5. The MCH service norms to be displayed as citizen charter in local language outside each level facility.

3. Reproductive and Child Health service delivery should be improved, through Community based campaigns and use of mass & mid media to address 'unmet needs' for family planning. Counselling of families on care of the new born and recognition of danger signs is importnats for child survival . Facility based Maternal Death Reviews (FBMDRs) need to be institutionalized as early as possible.

4. Standard Operating Procedures (SOP) and protocols to be developed in local language – Care of the New born- resuscitation, Management of PPH etc - should be displayed at relevant areas of the facility.

5. Planning for service delivery can be improved such as:-

1. Data discrepancies should be reconciled & use of data for planning at all levels (Investigate the process of tracking pregnant women and outcomes of tracking with more care) should be encouraged.

2. Development of micro plans and gap analysis for ANC & immunization at ANM level.

6. Outreach Services:

1. VHNDs should provide all recommended services like counselling on lifestyle, nutrition and health promotion through 'interpersonal' communication.

2. The VHSCs should have an active member from the village who can help to decide and advocate on actions required for the village.

3. Mobile medical units should be improved in the following:

    1. Seating arrangements for the patients

    2. Facilities for examination of patients

    3. Record maintenance of diseases

    4. Follow-up of referred cases

7. Communitization:

1. RKS guidelines should be strictly followed and minutes of the meetings should be circulated amongst members to expedite decision making.

2. Involve ASHA facilitators, LHV, male supervisors in VHND service, supervision and monitoring.

3. Dietary facilities for inpatients using state government's/ RKS fund should be made mandatory for all JSY cases.

4. Forced utilization of the Untied funds of the VHSC should not be directed by the State for any purpose whatsoever and due respect should be given to the objective of decentralisation.

5.

8. School Health program:

The SHP is important outreach to children and should be used as a health education/promotion opportunity. Although the programme covers primary schools, the reach could be expanded to higher classes. The nodal teacher should be trained to start a weekly School Health Assembly (most schools have prayers at the beginning of the school day). This is an opportunity for students from all classes to receive health communication messages. Students tend to take these messages home, benefiting adults in particular and the community in general. Linkages to treatment with the health infrastructure should be strengthened and services should be available for the SHP (e.g. some states strengthened services related to school-going children and adolescents in the district).

9. Biomedical Waste Management:

Develop common bio-medical waste management facilities IMEP, BMW rules & CPCB guidelines should be followed. The state may choose to provide guidelines and collective management of BMW from the state level.

10. Transport:

1. Increase in the number of EMRI vans and their placement at strategic locations in hilly regions and linking up with Palki Services and delivery shelters. EMRI should be tied with the Palki facilities in remote areas.

2. EMRI should develop system of 'advance intimation' to the health facility, to which they intend to take the pregnant woman/any other emergency case, so that the facility is prepared to handle the case immediately on arrival.

3. Communication and counselling:

ASHA should be trained to use basic communication and peer counselling skills so that they are able to raise awareness about health issues other than RCH (e.g. non-communicable diseases, reporting disease outbreaks) and promote access to treatment.