5\textsuperscript{th} Common Review Mission
\textit{(November 9 – 15, 2011)}

Uttararakhand
Uttarakhand

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- Dr. Ravinder Kaur
- Mr. Sumantha Kar
- Dr. Geom Abraham
- Dr. Sushma Dutta (State)

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- Mr. V.P Rana
- Mr. K.K Bansal
- Dr. V. K Anand
- Dr. Rajeev Aggarwal
- Ms. Divya Shree
- Dr. Anil Shah (State)
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CRM Findings
## Irrational Deployment

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Irrational Deployment Contd...

• Severe shortage of specialists, doctors & SNs, LT, X ray technicians

• Multiskilled MOs are not rationally deployed and no performance monitoring of LSAS and EmOC trained doctors.

• Underutilization of staff like Health supervisors, pharmacist, Sudoorwati Swasthya Sahayak.

• Hard to reach area allowances/ incentives not in place

• Comparative package for MOs in MMU (PPP) is much higher

• Yatra duties engaging already thin human resource for six months.

• Specialists are being hired at higher packages on contractual basis but performance not being monitored
Health Care Service Delivery

- Very few Delivery points and Functional FRUs
- Safe abortion services, RTI/STI, ARSH services not available.
- Underutilization of all facilities
Good Practices

- **School Health Programme:** Two dedicated teams to screen-disability, deficiency and disease.

- **AYUSH** doctors and Pharmacist co located and AYUSH Medicines available in plenty

- **PNDT:** Active District Appropriate Authority and Form F is being filled.

- **EMRI:** Call centre based, strategically placed ambulances, In collaboration with police, fire and forest department
Good Practices Contd...

- ANMTC- Ranipokhri; Model ANMTC
- Bharat Gas: Community kitchen
- Mobile phone: SMS reporting of IDSP. MDR and IDR can also be added.
- NGOs working in remotest areas generating awareness on immunisation, FP (NSV, spacing), ANC/PNC, ARSH, age at marriage, ID.
- IDSP priority lab functional.
- LT for RNTCP also managing hospital diagnostic services
Maternal Health:
- JSSK is implemented with Free drugs, diagnostics, diet, blood for delivery.
- Drop back by EMRI by contract vehicle “Khushiyon ki sawari”
- Delivery points are identified by name
- JSY payment on time by cheque to PW, to ASHAs by e-transfer.
- Quality of ANC is not satisfactory, 3 ANC is quite low (32.3%)
- Very high unreported deliveries (40%)
- Post natal stay is of 24hrs or less
- MCP card not implemented.
- Trained Dias conducting deliveries in the remote areas.
- Minimal availability of C-Section Services.
- RCH kits/DDKs not available at all centers.
- Grievance redressal is not in place - Nodal officer not identified.
- LR protocols not displayed in any facility
- No training on RCH in the State, so far.

Newborn and Child Health:
- Only one New born corner functional in RP
- Nil NBSU or SNCU in both the districts.
- No NRCs
- Zero dose Hepatitis- B not being administered
RCH Contd..

Family Planning:
- FP performance has been much below the ELA since last two years.
- Services provided mainly during camps

Outreach Services:
- VHNDs are focusing only on immunisation services with limited focus on ANC & nutrition counselling.
- Take home rations not available in AWC
- Convergence with other departments including VHSNCs --not happening.
- MMU placed near PHC/SAD/SC and No follow up of patients.
- Complaint of USG Sex determination in MMU.
Financial Management

- Tally ERP-9 software is not being used at any level.
- Model accounting hand book has not been disseminated at subdistrict level.
- State has not reported the physical progress of any program and the expenditure of the NDCPs in the FMR.
- No audit report has been submitted for Concurrent audit.
- Operation of NRHM account at block level for RCH, NRHM and immunization (Part-A,B,C) are operated singly by the MOIC instead of joint Signatory.
- Financial management reporting format are not according to GOI.
- Transfer of VHSC untied funds treated as expenditure without taking any SOE.
- Opening balances not considered for fund release.
- State, district & block have not informed the Reversal of bank charges to bank.
- Opening balances of district level are not tallied with their audit report.
- Training for DAM, BAM need to be provided at regular intervals.
**HMIS/MCTS**

**Positives**
- MCTS operationalized and has picked up in the districts since October, 2011.
- ANMs, DPMs, BPMs and BLA have been trained on MCTS.
- ASHA diary is synchronized with the MCTS registers.
- BPMs are entering the data and spend approximately 3-5 hours/day in entering the data at SWAN center.
- MCTS data base is being used for:
  - Alerting the ANMs on EDD,
  - Work plan for ANMs,
  - EMRI for following up on pregnant women.
- At the state level, HMIS data is being analyzed quarterly and feedback provided to districts.
- Facility wise reporting of HMIS started from October.

**Concerns**
- Poor internet connectivity in the districts has affected data entry of MCTS.
- A full time data entry operator needs to be put in place at the block level.
- Neither the state nor the district has made any verification calls so far.
- No evidence of analysis of HMIS data at the district and block level. Evaluated data is not used.
Other Concerns

• Approachability by road to remote sub centres.
• Inadequate residential facilities
• Non Functional BB/BSU- RP.
• Weak District Quality Assurance Cell.
• Inadequate mobility support to BMOs.
• Lack of full fledged Programme officer (Additional CMO).
• RNTCP: Case detection rate and cure rate is low.
• NPCB : Vitamin A supply not available since the last six months.
• IEC on NLEP , NVBDCP and NPCB not visible.
Recommendations

• At least **two FRUs** beside DH/MC need to be made operational in each district at the earliest.
• Transparent, time bound and rational transfer policy
• Rationalization of training and redeployment.
• High number of deliveries going unreported and tracking system needs to be made use of.
• Maternal Death Review process needs to be strengthened.
• NBCCs, NBSUs, SNCUs need to be planned and made functional at DPs on priority.
• Construction of LR in SCs situated in very remote areas.
• Program Managers should regularly monitor.
• Retired contractual staff at State Level needs to be actively involved in monitoring with fixed TORs, accountability and responsibility.
Recommendations Contd...

• ANMTCs require more support to improve training quality of ANM students.

• Micro planning for supportive supervision of ASHA to be strengthened through ASHA support structure at the block, district and State level.

• In areas where SADs are adjacent to SCs, the two should be merged and may be designated as APHC for optimal utilisation of staff.

• Better integration with VHSNC and micro planning at VHND

• Addition of dentist in the SHP to take care of dental health and prescribe allopathic medicines for common ailments.
Thank you...