

2012

2nd – 9th November

UTTARAKHAND

[6th COMMON REVIEW MISSION- UTTARAKHAND]



Image 1: Happy mother with her child - District Bageshwar



## SIXTH COMMON REVIEW MISSION

### STATE VISIT REPORT (UTTARAKHAND NOVEMBER 2-9, 2012)

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# CRM Team for Uttarakhand

## Districts Visited:

1. Bageshwar
2. Pithoragarh

## Team Bageshwar:

- Dr AnjanaSaxena, ex-Deputy Commissioner, MOHFW
- SmtRekhaChauhan, Under Secretary, MOHFW
- ShPrabhashJha, Consultant-FMG, MOHFW
- Ms AsmitaJyoti Singh, Consultant NRHM,MOHFW
- Ms SandhyaAhuja, Senior Consultant, NHSRC
- Dr MeerambikaMohapatra, Associate Professor, NIHFW

## Team Pithoragarh

- Ms AnuradhaVemuri, Director, MOHFW
- Sh B B Sharma, Director, Planning Commission
- Dr ManpreetKhurmi, Consultant-RCH, MOHFW
- Dr Satish Gupta, Health Specialist, UNICEF
- Dr SharmilaNeogi, USAID
- Sh Sanjay Samadar, Project Director, HUP

## Representatives from NRHM Uttarakhand:

- Dr PremLal (AD MCH UK)
- Dr Badauni (JD Disease Control UK)

## List of Facilities Visited:

Type of facility	Bageshwar	Pithoragarh
DH	DH Bageshwar	DH Female District Hospital
CHC	CHC Kapkote, CHC Baijnath	CHC Dharchula CHC Gangolihat
PHC/APHC	PHC Kausani, APHC Sama, PHC Chani, APHC Kanda	PHC Berinag PHC Kanalichina PHC Askot PHC Egyadevi PHC Muwani PHC GaucharThal
SC	SC Sama, SC Kasauni, SC Chani SC Kanda SC Kupkote SC Baijnath	SC Askot SC Gangolihat SC GaucharThal SC Egyadevi
Others	ArogyaRath (MMU) DARC, FGDs (ASHAs, AWWs , community), EMRI	FGD (ASHAs, ANMs, RKS and VHSNC)

## Introduction

Uttarakhand, the 27<sup>th</sup> State of the country was carved out of Uttar Pradesh on 9<sup>th</sup> November, 2000. The State is flanked by Himachal Pradesh in the north-west and Uttar Pradesh in the South and shares an international border with Nepal and China. The State, with its headquarters in Dehradun is spread over an area of 55,845 square km having 78 Tehsils, 95 blocks, 7227 Panchayats and 16,826 inhabited villages, 86 cities/towns. The State has 13 districts which are classified into two Divisions: six districts forming the Garhwal division and seven included in the Kumaun division. There are five major cities with a population of over 1 lakh. The State can be grouped into three distinct geographical regions based on the mountainous terrain - the High mountain region, the Mid-mountain region and the Terai region or the foothills. Richly endowed with rich forest ranges and the famous peaks of Nanda Devi, Kedarnath, Trishul, Bandarpunch and Mt Kamet, the state is home to major glaciers including Gangotri, Pindari, Milam and Khatling. Ganga, Yamuna, Ramganga and Sharda.

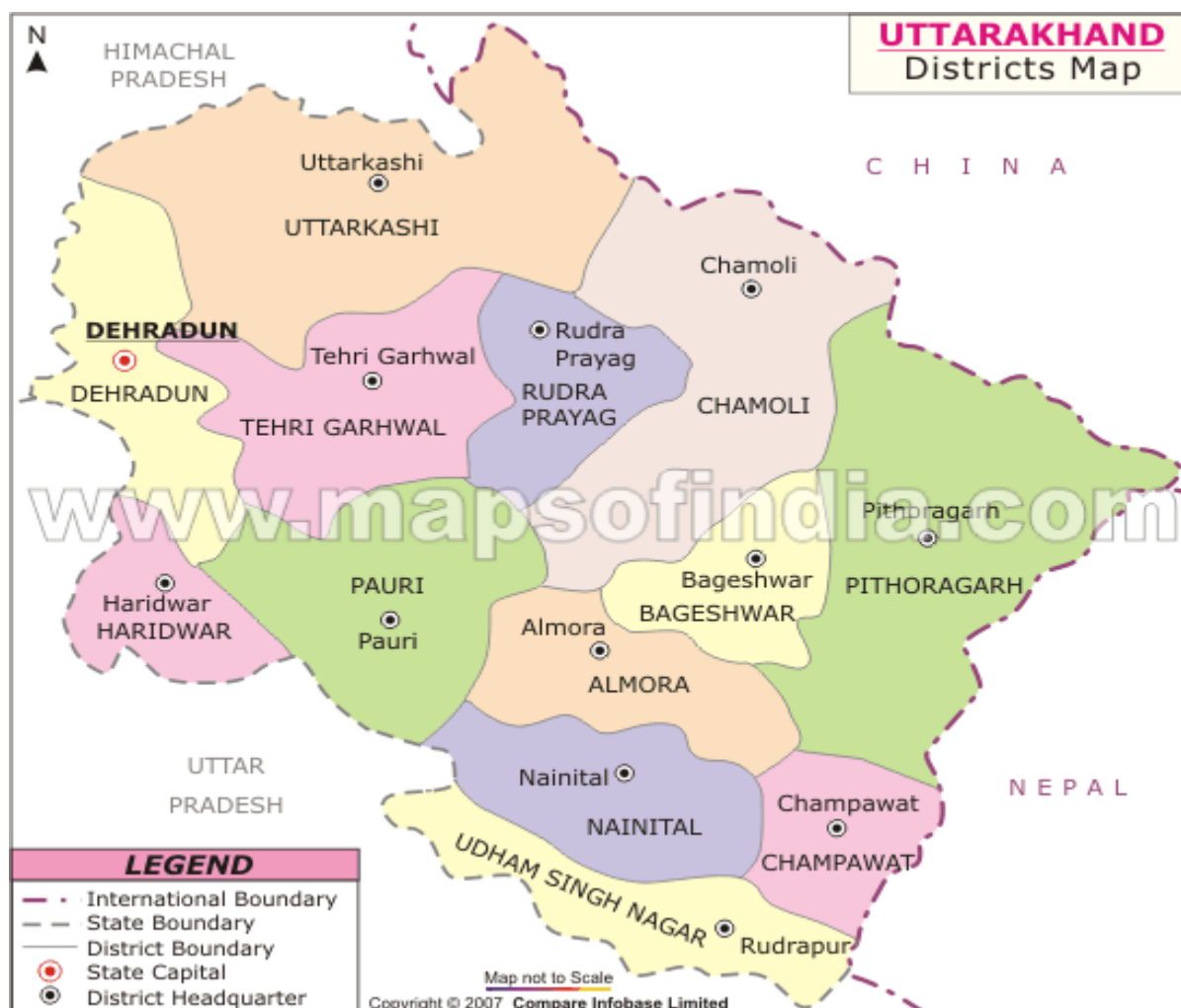


Image 2: Uttarakhand District Map

## State Profile

Table: 1

Parameter	Status
Rural Population (In lakhs) (Census 2011)	70.26
Number of Districts (RHS 2010)	13
Number of Sub Division/ Talukas	78
Number of Blocks	95
Number of Villages (RHS 2011)	16793
Number of District Hospitals	19
Number of Community Health Centres (RHS 2011)	55
Number of Primary Health Centres (RHS 2011)	239
Number of Sub Centres (RHS 2010)	1765

## Status of Health Indicators

Table: 2

Sl. NO	Indicators	Uttarakhand	India
1	Infant Mortality Rate (SRS- 2011)	36	44
2	Maternal Mortality Ratio (SRS 2007-09)	359	212
3	Total Fertility Rate (SRS 2010)	NA	2.5
4	Under-five Mortality Rate (SRS 2010)	NA	59
5	Institutional Deliveries During 2012-13(UptoSeptember) (MIS)	39860	8039657
6	Full immunisation (In thousands) During 2012-13(UptoSeptember) (MIS)	85	10686

## Demographic Profile

Table: 3

Indicator	Uttarakhand	India
Total Population (In Crore) (Census 2011)	1.01	121.01
Decadal Growth (%) (Census 2011)	19.17	17.64
Crude Birth Rate (SRS 2011)	19.3	21.8
Crude Death Rate (SRS 2011)	6.2	7.1
Natural Growth Rate (SRS 2011)	12.8	14.7
Sex Ratio (Census 2011)	963	940
Child Sex Ratio (Census 2011)	886	914
Schedule Caste population (In Crore) (Census 2001)	0.152	16.67
Schedule Tribe population (in crore) (Census 2001)	0.026	8.43
Total Literacy Rate (%) (Census 2011)	79.63	74.04
Male Literacy Rate (%) (Census 2011)	88.33	82.14
Female Literacy Rate (%) (Census 2011)	70.70	65.46

## Progress of NRHM

Table: 4

Sl. No	Activity	Status
1	24x7 PHCs	Out of 239 only 99 PHCs are functioning on 24x7 basis.
2	Functioning as FRUs	27 Health facilities including 12 DH, 10 SDH and 5 CHC are working as FRUs
3	ASHAs Selected	11086 ASHAs selected & trained upto 4 <sup>th</sup> Module and 10313 ASHAs are trained in Round 1, 10064 ASHAs in Round 2 & 10209 ASHAs in Round 3 of 6 <sup>th</sup> and 7 <sup>th</sup> Module
4	ANMs at SCs	Out of 1765 SCs, 107 SCs are functional with 2 <sup>nd</sup> ANMs.

5	Contractual appointments	2 Specialists,190 Staff Nurses, 243 ANMs, 210 AYUSH Doctors and 413 AYUSH Paramedics are positioned under NRHM.	
6	RogiKalyanSamiti	330 facilities (19 DH, 53 CHCs, 19 Other than CHCs & 239 PHCs) have been registered with RKS.	
7	Village Health Sanitation & Nutrition Committees (VHSNCs)	Out of 16793 Villages(RHS 2011), 15431 Villages Constituted VHSCs.	
8	MMU	15 MMUs are operational in 13 Districts.	
9	ERS (108-type)	139 ERS (108-type) vehicles are operational	
10	VHNDs	30385 VHNDs were held during 2012-13 (upto September).	
11	New Born Care Units established	Special New Born Care unit (SNCU)	2
		New Born Stabilization Unit (NBSU)	6
		New Born Care Corner (NBCC)	140

### Physical Progress of Institutional Deliveries and JSY

Table: 5

Year	Institutional Deliveries	JSY beneficiaries
2005-06	19713	1000
2006-07	35608	23000
2007-08	60007	69000
2008-09	73646	71000
2009-10	98000	79000
2010-11	102992	79925
2011-12	106501	87937

2012-13 (up to Sept)	39860 <sub>(HMIS)</sub>	41973 <sub>(as per Division)</sub>
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## Services

Table: 6

Services	06-07	07-08	08-09	09-10	10-11	11-12	12-13
Male Sterilisation	1417	1112	3092	2617	2642	2587	445
Female Sterilisation	27256	27050	33772	31005	30602	29552	3668
Full immunization (In thousands)		201	200	200	228	197	85

## Reproductive and Child Health Programme (RCH)

### a) Immunization Coverage

Table: 7

*(Figure in percentage)*

Year	NFHS-2	NFHS-3	Coverage Evaluation Survey		
	1998-99	2005-06	2005	2006	2009
Fully Immunized	40.9	60.0	61.1	72.2	71.5
BCG	76.8	83.5	80.6	90.2	88.3
OPV 3	62.4	80.3	69.3	77.2	78.9
DPT 3	56.1	67.1	69.7	77.5	78.1
Measles	56.0	71.6	72.0	78.6	75.8

### b) Information on selected MCH indicators

Table: 8

Indicators	DLHS -2 (2002-04)	DLHS-3 (2007-08)
<b>Child feeding practices (%)</b>		
Children under 3 years breastfed within one hour of birth	27.1	63.4

Children age 0-5 months exclusively breastfed	NA	52.6
Children age 6-35 months exclusively breastfed for at least 6 months	61.3	37.1
Children age 6-9 months receiving solid/semi-solid food and breast milk	NA	63.8
<b>Awareness about Diarrhoea and ARI</b>		
Women aware about danger signs of ARI (%)	60.7	64.4
<b>Treatment of childhood diseases</b>		
Children with diarrhoea in the last 2 weeks who received ORS (%)	21.6	44.0
Children with diarrhoea in the last 2 weeks who were given treatment (%)	69.0	60.9
Children with acute respiratory infection of fever in last 2 weeks who were given advise or treatment (%)	78.8	67.1

### Funds Released under NRHM

Table: 9(In Crores)

Year	Allocation	Release	Expenditure*
2005-06	48.83	50.29	40.63
2006-07	66.20	44.31	46.99
2007-08	91.33	89.20	72.74
2008-09	100.16	98.44	132.48
2009-10	117.75	130.85	144.00
2010-11	129.18	147.39	206.31
2011-12	169.95	208.45	212.90
2012-13	206.67	124.48	46.26**
<b>Total</b>	<b>930.07</b>	<b>893.41</b>	<b>902.31</b>

#Release figures for the F.Y. 2012-13 are upto 31.10.2012 (as per sanction orders received by FMG).

\*Expenditure for the F.Ys 2009-10, 2010-11, 2011-12

The above Release relates to Central Govt. Grants & does not include State share contribution.

Expenditure is more than release due to state share contribution and previous unspent balance.

\*\* expenditure up to 30<sup>th</sup> September 2012 (provisional).

The Programme wise status of Allocation, Release and Expenditure for 2012-13 (till 2nd quarter) is as follows:

Table: 10

Sr.No	Programme	Allocation	Release	Expenditure	% of Expenditure to SPIP
1	RCH	46.38	31.26	24.98	79.91%
2	NRHM	57.62	28.81	18.89	65.56%
3	Immunization & PPI	10.90	0.00	1.63	N/A
4	Infra-Structure Maintenance	72.15	59.61	0.00	0.00%
5	IDSP	1.20	0.61	0.00	0.00%
6	NIDDCP	0.24	0.15	0.00	0.00%
7	NLEP	0.54	0.26	0.00	0.00%
8	NPCB	4.79	0.00	0.00	0.00%
9	NVBDCP	2.16	0.42	0.00	0.00%
	RNTCP	10.69	3.35	0.75	22.42%
Grand Total		206.67	124.48	46.26	37.16%

## Learning from previous CRMs:

Differential pay packages for Specialists in high focus areas

Adolescent health programs are visible-ARSH, MHS

NBCC are available at all delivery points

NBSU being constructed in DH (Bageshwar) and operational in DH Pithoragarh

State preparedness for WIFS

ASHA ghar constructed in DHs

## Best practices observed – 6th CRM

- Dedicated and hard working health workers were noticed, with their spirit of working round the clock and without taking leave even on gazetted holidays e.g. Independence day. ANMs are staying at sub-centers in hard to reach areas.
- Designated space earmarked for SNCU, NBSU and knowledge for planning of new-born care facilities was found to be excellent.
- MCTS data entry has improved significantly.
- JSY payments were up to date and JSSK entitlements were clearly displayed at various facilities visited. Deliveries in public health facilities have risen sharply under NRHM, after launch of JSSK.
- ASHA facilitators were highly motivated.
- Knowledge on financial aspects was found to be good at the district level.
- Regular review of programme is being carried out by DHS.
- Awareness regarding provision of 108 service “KhushionkiSawari” under NRHM was found to be good and beneficiaries were satisfied with their services.
- Facilities are well built and well maintained.
- Delivery points have been prioritized for strengthening that was visible in state and district plans.
- Door to door supply of contraceptives was being done regularly by ASHAs in hard to reach areas.
- The Arogyarath “MMU” was providing regular services with a well maintained micro plan and was providing services to unreached/ remote areas.
- E-banking facility has started at all levels.

## Critical Analysis

Table 11:

S.No.	Indicators	Uttarakhand		Bageshwar		Pithoragarh		Remarks
		DLHS III	AHS 2011	DLHS III	AHS 2011	DLHS III	AHS 2011	
<b>ANC</b>								
1	ANC Check-up in first trimester	33.6	59.5	21.1	51.6	34.2	49.7	There is substantial increase in ANC services, except for 100IFA tablets given to pregnant women, in the state of Uttarakhand and its districts Bageshwar and Pithoragarh. 100 IFA tablets given has gone down by more than 50 points.
2	3 or more ANC Check-up	32.2	52.3	20.1	47.2	29.3	50.7	
3	At least 1 TT received	53	83.6	37.5	81.6	52.9	82.4	
4	100 IFA Tablets	66.6	14.9	74.8	17.4	73.4	16.6	
<b>Deliveries</b>								
1	Institutional Delivery	30	50.5	17	33.9	24.3	49.4	Institutional deliveries and home deliveries by SBA have gone up and home deliveries have gone down but it is still of great concern
2	Home Delivery	69.5	49.0	82.7	65.8	75.6	50.4	
3	Home Delivery by SBA	5.2	32.0	6.5	16.9	10	23.1	
<b>New born &amp; post natal care</b>								
1	Still Birth	0.7	-	0.6	-	0.5	-	Breastfeeding within one hr has gone up in the state as well as in the districts. There is good improvement in post natal check up within 48 hrs but it needs further improvement
2	Live Birth	97.5	-	97.5	-	98.7	-	
3	Breastfed within 1 hour of birth	63.5	62.3	50.5	62.6	73.1	76.9	
4	PNC within 48 hrs of delivery	-	59.1	18	39.0	27.7	54.1	
<b>Immunization</b>								
1	BCG	91.2	91.9	85.9	93.2	94.9	97.0	There is slight increase in Immunization

S.No.	Indicators	Uttarakhand		Bageshwar		Pithoragarh		Remarks
		DLHS III	AHS 2011	DLHS III	AHS 2011	DLHS III	AHS 2011	
2	DPT3	72.3	83.0	65.5	89.8	75.6	92.7	coverage.
3	Measles	82.3	82.6	72.6	87.2	88.8	91.4	
4	Full immunization	62.9	75.4	53.5	78.8	58.8	87.5	
<b>Unmet need for Family Planning</b>								
1	Spacing	6.2	12.0	6.6	13.2	6	12.8	Unmet need for spacing method has gone up in the State as well as in both the districts and unmet need for limiting has gone down in the state and in Bageshwar but it has gone up in Pithoragarh
2	Limiting	13.8	11.2	19.6	14.4	9.1	12.2	
3	Total	20.1	23.2	26.2	27.7	15.2	25.1	

Table 12: Analysis of Delivery point's vs. staff required as per IPHS 2012 and rational deployment:

Type of HR	Number per facility required as per IPHS				Staff required at DPs in Uttarakhand				Total	HR available
	DH	CHC	PHC	SC	DH	CHC	PHC	SC		
Specialists	29	5	-	-	435	160	-	-	595	332
MOs	29	4	1	-	435	128	14	-	577	1195
SNs	45	10	4	-	675	320	56	-	1051	1026
ANMs	-	-	-	2	-	-	-	74	74	2427

- ✓ From above table it is clear that the deficiency of Specialists could be filled by conducting EmOC, LSAS training along with new recruitment.
- ✓ Specialists positions could be filled by preference for couple postings e.g. Gyn, Ped, Radio etc.
- ✓ MOs should be trained in LSAS, EmOC, BEmOC to fill shortage of specialists.
- ✓ State needs to prioritize strengthening of DPs first and focus on other facilities later in terms of rational deployment.

## General Observations – 6<sup>th</sup> CRM

### Financial:-

- Record of AMG/ RKS fund/ untied funds were satisfactory in Pithoragarh but not shown at any facility in Bageshwar district.
- MO- I/C and related account staff were unaware of the guidelines for fund utilization in Bageshwar district.
- Informal payments were observed between staff and patients in some places, eg - CHC Kupkote, Bageshwar.
- The untied/RKS/AMG are clubbed together at the facility level, and the decision making power regarding the utilization of this pool of funds lies with ChiktishaPrabandhamSamiti at the facility in Bageshwar district.
- The meetings of CPS are highly irregular in the entire district of Bageshwar (except CHC Baijnath).
- It was informed that 50% of the RKS funds were remitted to state treasury in Pithoragarh district.
- The financial management was comparatively better in Pithoragarh district regarding knowledge of guidelines and regular conduct of meetings.

### MCH

- No operational FRU in Bageshwar as DH has any Blood Bank/BSU. C-Sec rate is 1% (HMIS 2011-12) of total deliveries and very High % of home delivery [45%].
- CMO Bageshwar was out of district with no one deputed to meet the CRM team, on his behalf. Only Program Management staff present.
- On issue of Maternal and Child health, greater focus on refresher trainings and Skill building on critical issues of Skilled Birth Attendance and New-born Care for ANMs, needs to be ensured.
- Only day care facility given to patients admitted in many facilities visited except CHC Baijnath( Bageshwar). However in In Pithoragh the staff were residing in the facility premises in most of the CHCs visited and hence they were providing services 24/7 services.
- Availability of some emergency drugs like misoprostol and Magnesium Sulphate need to be assured at the facilities. Use of Partograph needs to be emphasized.

- (HMIS) and Maternal Child Tracking System (MCTS) data is collected but not being used for improving quality of services and follow up eg: using line listing of anaemia and list of un-immunised children for generating work plan of ANMs.
- Birth dose of Hep B, OPV and BCG not provided to children born in 24\*7 health facilities.
- New MCP cards not available in many facilities visited
- District drug warehouses need up gradation to cover upcoming generic drug scheme-Pithoragarh.
- A large of non-repairable cold chain equipment's were lying at district store and PHCs, needed to be condemned to free up space.
- Information dissemination of grass-root workers to the pregnant women is limited only to IFA and TT
- Zinc was not available in the ASHA drug kit and not many ASHAs heard about it.
- Weak postnatal follow up
- All new equipment available at all delivery points but staff/ANMs do not know how to use them.
- Facility based MDR analysis is not being done in DH Bageshwar and community based deaths are not being reported.

### **Infrastructure:-**

- Overall health facilities are spacious, clean and well maintained. Security needs to be strengthened in some facilities in form of boundary walls/gates/barbed wires etc.
- Access to health services is an important issue in terms of difficult terrain, the state needs to plan infrastructure keeping in mind the time to reach the public health facility.
- In both the district visited by the CRM teams it was observed that SCs are mostly collocated with another higher facility (PHC/APHC/CHC).

### **Human Resources:-**

- Staff position has been analysed and irrational deployment of most of the multiskilled MOs was observed. There are 26 LSAS and 16 EmOC trained MOs in the State. They have been posted to various PHCs and even those in CHCs are not performing. Detailed table is given in annex 1. This is the same table analysed in CRM 4. Unfortunately despite letters going from GOI no action has been taken in the last one year regarding rational deployment.

- ANMs are staying at most of the SCs in Bageshwar district.
- Lab Technicians are not doing comprehensive testing eg in CHC Kopkote Lab technician was only involved in sputum testing.
- Underutilization of staff like health supervisors, pharmacists who have been posted to SCs for last 5 years and have no work in SCs).
- There is no mechanism to assess staff performance and complete absence of monitoring in the districts by PMUs.
- There is no provision of special leave rules for contractual women staff.
- Skill building of Medical officers on EmoC as LSAS is urgently required. There is also no post training performance monitoring system of LSAS and EmOC doctors
- Post training more emphasis would be needed on rational deployment and supportive supervision
- There has been no skill based multi skill training of MOs in the last one year. Post training more emphasis would be needed to hand hold.
- The transfer policy is not yet in place, Therefore there has not been any rational deployment of trained staff as was suggested in report of CRM 4.

#### **Registers:**

- Expiry register for drugs not maintained at most facilities.
- Expiry drug disposal procedure was not clear to pharmacists.
- Certain registers were not duly certified.
- Drug dispensing registers of pharmacists were collecting limited information.
- Labor room registers were not collecting information on initiation of breastfeeding within 1 hour (time of initiation).

## Findings of 6<sup>th</sup> CRM

As mandated by the 6<sup>th</sup> CRM Terms of Reference (TORs), an in depth studies of major programme components was carried out for the State of Uttarakhand. This CRM report has been divided into the following TORs (i) Facility based health care services- access, affordability, quality and equity, (ii) Outreach and Patient transport services (SCs, MMUs, EMRI), (iii) Human Resources for Health – Adequacy, skills, performance, (iv) Reproductive and Child Health programme, (v) Disease Control Programmes, (vi) Community processes including ASHA, PRI, VHSC, CBM. NGO, (vii) Promotive Health Care, social determinants and equity, (viii) Programme Management, monitoring, logistics and issues of integration and institutional capacity, (ix) Knowledge management including technical assistance, use of IT, (x) Financial management.

### TOR 1: Facility based health care services- access, affordability, quality and equity

- The Status of infrastructure available in the state and the districts visited facilities in the state is as follows:

Table: 13

Health facility	Number of functional facilities as in 2005 (As per RHS Bulletin)	Number of functional facilities as of now in state(RHS Bulletin 2011)
SC	1576	1765
PHC	225	239
CHC	44	55
SDH	NA	18
DH	NA	18

- The number of SCs has increased to 1765 in 2011 from 1576 (in 2005), the state has also made 11 and 14 more CHCs and PHCs functional respectively.

The Health infrastructure in the districts visited is as follows:

Table: 14

Health facility	Uttarakhand	Pithoragarh	Bageshwar
SC	1765 + 82 (Under AtalAdarsh Gram Yojana)	156	87
PHC	239 + 18 (Under AtalAdarsh Gram Yojana)	4+14 (additional PHC)	13
CHC	55	4	2
SDH	18	0	
DH	18	1+1 (male /female hospital)	1

Number of Blocks	95	4	3
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- The Status of infrastructure facilities functional in the state and the population covered per facility in the state is as follows:

Table: 15

Health facility	Number of functional facilities *	Population covered per facility
SC	1765 + 82 (Under AtalAdarsh Gram Yojana)	3980
PHC	239 + 18 (Under AtalAdarsh Gram Yojana)	29395
CHC level hospitals	55	127737
Sub District Hospitals	18	562041
District Hospitals	18	562041
Medical Colleges	2 Govt and 2 Pvt.	5058376

\*state presentation at briefing to CRM team

- In so far as availability of buildings for Sub-Centres is concerned, the state has made improvement in terms of SC functional in government buildings. In 2005, out of 1576 functional SCs 562 SC were in government buildings (36%), the number increased to 1040 SCs in government buildings out of total 1765 functional SCs (59%).

Table: 16

Type of facility	2005				2011			
	Total number of facility functional	In government building	Rented Building	% of facility in government building	Total number of facility functional	In government building	Rented Building	% of facility in government building
SC	1576	562	1014	36%	1765	1040	718	59%
PHC	225	182	43	81%	239	195	44	82%
CHC	44	44	0	100%	55	55	0	100%

- Overall health facilities are spacious, clean and well maintained. Security needs to be strengthened in some facilities in form of boundary walls/gates/barbed wires etc.
- Access to health services is an important issue in terms of difficult terrain, the state needs to plan infrastructure keeping in mind the time to reach the public health facility.
- In both the districts visited by the CRM teams, it was observed that SCs are mostly co-located with another higher facility (PHC/APHC/CHC).
- In district Bageshwar, in some blocks the SC is not accessible within 30 minutes by walk from the village, 24x7 facility is at a distance of more than 1 hour from SCs. In the event of EMRI not being able to reach the facility, it is not possible to take the PW to the facility.

- Improvement in infrastructure and availability of equipments is clearly seen but that has not translated to improvement in service delivery. At many places, the labour rooms were found cramped with equipments.



Image 3 & 4: SC Kasauni, Bageshwar (The room of the size of 10ft x 10ft had 2 labour tables, 1 NBCC, 1 bed, a medicine table, inverter etc with no room to move).

- User fee is being levied to PW (pregnant women) at most centres. In absence of labs in facility, PW have to pay to private labs. All PW are advised USG as complete ANC's are not being done.
- NRHM logo seen at all facilities; IEC regarding National programmes was visible. Though citizen's charter was missing in all of the facilities except CHC Baijnath.



Image 5 & 6: IEC regarding JSY, Pndt displayed at facilities, district Bageshwar, Uttarakhand

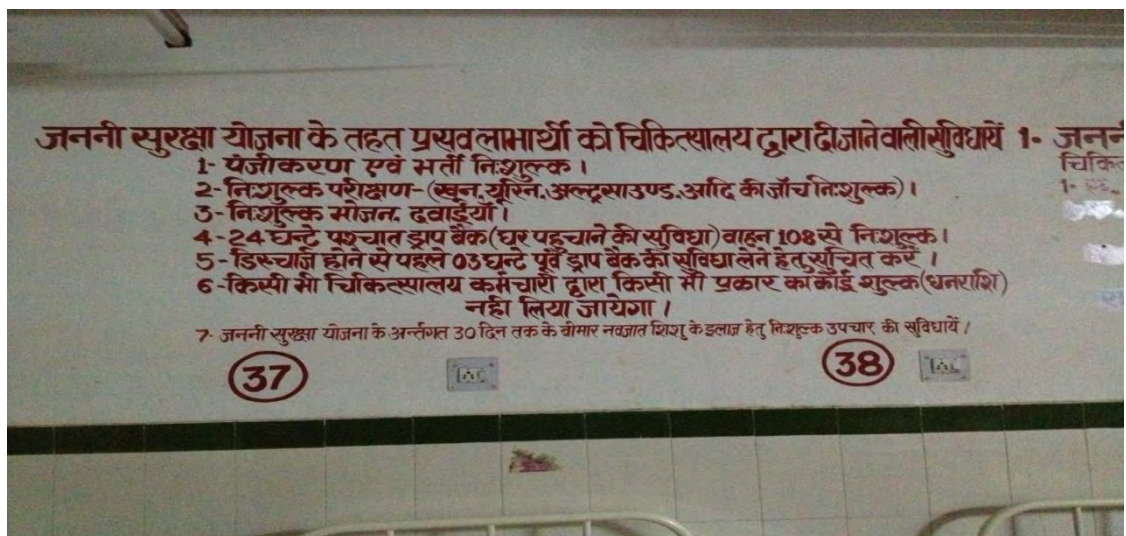


Image 7: IEC regarding JSSK at DH Bageshwar, Uttarakhand

- Lack of signage for public health facilities and IEC regarding national schemes/programmes in the districts however IEC at facilities was satisfactory.
- The facilities are grossly under-utilized because of lack of assured services and confidence building of community.
- Infrastructural planning of labour room is in-appropriate at all the facilities visited. No attached toilets with running water seen. (except CHC Baijnath) and some CHCs in Pithoragarh: Gangolihaat) In CHC Dharchula only one toilet was available for all staff and patients and was not clean.
- The approach to most of the delivery points was found to be rough for pregnant women. The image below shows the passage to SC Kasauni, Bageshwar.



Image 8 & 9 (above) Approach to SC Kasauni, District Bageshwar, Uttarakhand

- Record keeping was observed to be poor, lack of knowledge of condemnation procedure, registers of pharmacists were not collecting information for patient name, age/sex, diagnosis and drugs given in numbers in some facilities.
- The state is expected to make comprehensive plan for establishment of NBSU at facilities keeping in mind the requirement & staff in position and their skills. DFH Pithoragarh needs an SNCU considering the high delivery load. DH Bageshwar has a NBSU being made but has no Pediatrician. State should do proper gap analysis while planning equipments for facilities.
- Each DP had 2 NBCCs, none of the facilities visited; the staff could use the NBCC unit when asked by the team in district Bageshwar.
- Doctors and others are staying in the facility (staff quarters) though most ANMs are not staying at the SCs in Bageshwar.
- BMW (Bio waste management) management system in place at facilities though Universal precautions in ArogyaRath are not followed for HIV testing.
- LTs are not providing comprehensive services eg in CHC Kopkote.
- Quality of care: Elbow operated taps, safe drinking water, curtains (labor room and ANC rooms/ OPDs), clean toilets not available at some facilities; soap was not available for ANC OPDs for doctors in some facilities. Non availability of regular water supply was an issue at Pithoragarh due to un-availability of overhead water tanks e.g. CHC Dharchula, Pithoragarh.

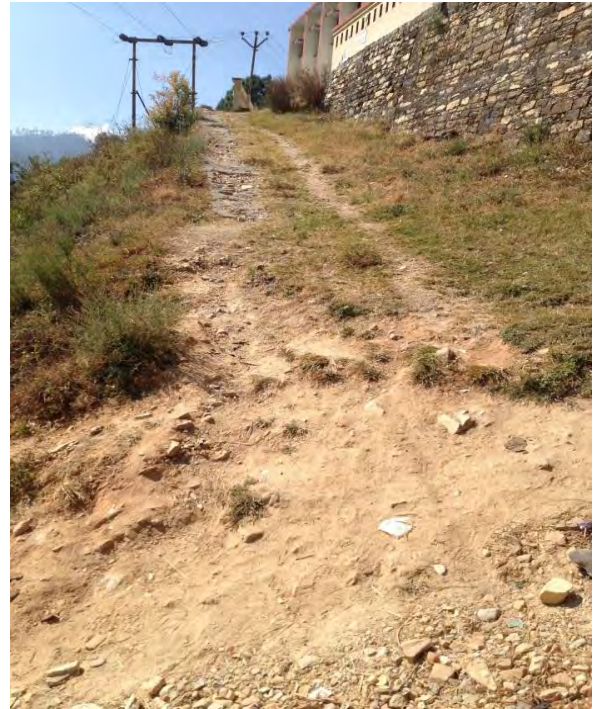


Image 9 & 10: Approach to APHC Kanda, District Bageshwar, Uttarakhand

## TOR 2: Outreach and patient transport services (SCs, MMUs, EMRI)

### ○ Immunization



Image 11 - Immunization day, DH Bageshwar

- Immunization coverage showing an increasing trend in both the districts, but Children were not being brought by ASHAs as no line listing of children to be immunised is being done by ANMs/ASHAs
- ANM duty roster was available for RI/ VHND sessions only. However, there were no micro plans available, with key information of village population, target beneficiary and vaccine requirement.
- Due list and tracking of beneficiaries was not being followed (even through MCTS)
- Cold chain equipment was available up to the PHC level but SCs were collecting vaccines from block PHC or CHC in Pithoragarh and from District HQ in Bageshwar. This led to long travel time for collection of vaccine, and closure of sub center a day prior to vaccination day. In some cases, vaccines were distributed for a month/ week to ANMs and at places were stored in domestic refrigerators of ANMs/ ASHA.
- Functional Vaccine van was not available.
- At many SCs ,it was observed that both ANMs from the SC have gone to collect vaccine, leaving the facility unmanned. (Bageshwar).
- There was a shortfall of stabilizers and thermometers to monitor cold chain temperature.

- There was no record of diluents issued or received and in some places distilled water was being used.
  - Waste management – Hub cutter, red bags and black bags not available for outreach sessions
  - Equipment which were non-functional and non-repairable were piled up and not yet condemned, occupying unnecessary space in the facility.
  - Many equipment were found to be non-functional but repairable.
  - **Urban slums:** Due to over burden on the existing structures, especially at district headquarter, Pithoragarh there is a deficiency in service availability (structure and HR)
  - AYUSH- Integration with AYUSH (ISM) was found to be existing, but not fully utilized
  - It was observed that in some cases AYUSH doctors are prescribing allopathic medicines (PHC Askot), Pithoragarh. In one case (Gamgolihat) it was observed that the Ayush lady doctor was also trained to conduct deliveries and was doing so in the past but was asked not to do this.
  - Some facilities had 3 AYUSH staff (Dr, Pharm and helper) with a case load of 5-7 patients only. Yet records were not well maintained.
- Emergency Response System: The EMRI is being used for all kind of referrals even inter facility. The doctors are not mentioning the vital parameters/reason for referral of the patients in the referral slip nor is there a system of followup for the referred PW.
  - The EMRI covers most of the geographical area in the districts however there are many areas in the district which have no road connectivity, the state needs to ensure availability of Doli/Palki in such villages; also the PRI members needs orientation and require guidelines for emergency transport.
  - There is no monitoring mechanism in place to monitor the referral services, MMU, VHSNC and outreach programmes.

**MMU:**

- No monitoring in place to monitor the services provided by these vans. 1 MMU (Bageshwar)(run in PPP mode) is parked at the facility only as it is so huge that it cannot travel on the narrow roads to remote areas; however AROGYA Rath (NRHM MMU) goes to interior and unreachable areas.
- The staff posted in these MMUs is not trained /aware of the National programs and is conducting only immunisations and OPD services.
- MCTS is not used to generate route plans for MMUs.



Image 12: AROGYA Rath , District Bageshwar, Uttarakhand

- Awareness generated thorough ASHA about the visit plan of MMU for higher utilization of the services of MMU.
- In absence of complete ANC, all pregnant women are advised for Ultrasound provided by the MMU (PPP) in Bageshwar resulting in huge out of pocket expenditure by the JSSK beneficiaries.
- The generator & X-ray for AROGYA Rath in Bageshwar is out of order for last two months due to which the range of services are just limited to general OPD. Rational use of ultrasound and prevention of misuse is needed.
- The LT posted in this van conducts HIV testing but is not aware of Universal Precautions there by exposing himself to HIV infection. There was no bleaching solution nor a method to dispose the syringes. They were being collected in a bucket. However a hub cutter was available.
- Another MMU in the district of Bageshwar which is run under PPP mode, the district needs to come up with a plan for stringent monitoring of this MMUs. The MMU was reported to be parked at facility itself and do not go to the interior/unreached areas. It was reported that from a period of April to March 2011, the total number of sessions/camps held by this MMU were 180, during which 2780 Ultrasounds were done.

### TOR 3: Human Resources for Health- Adequacy, skills, performance

Shortage of specialists, doctors, Staff Nurse, Lab Technicians, Male MPW/BHW and X ray Technicians was observed in the state of Uttarakhand. The HR status is given below in the table

Table: 17

<b>Staff Position – Uttarakhand – district Bagheshwar</b>			
<b>Designation</b>	<b>Sanctioned</b>	<b>In-Position</b>	<b>Vacant</b>
Chief Medical Officer	1	0	1
Chief Medical Superintendent	1	1	0
District Tuberculosis Officer	1	0	1
Senior Medical Officer-CMSD	1	0	1
Additional/ Deputy CMOs	2	1	1
Medical Superintendent-CHC	1	0	1
Medical Officers including specialists	76	23	53
Lab Technicians	5	3	2
Staff Nurse	13	8	5
ANM	99	99	0
Male MPW/BHW	28	2	26

Bagheshwar District Hospital has no anaesthetist, Eye surgeon, Paediatrician and Pathologists.

The contractual staff position is:

Table: 18

<b>Contractual Staff – Bagheshwar</b>			
<b>Designation</b>	<b>Sanctioned</b>	<b>In-Position</b>	<b>Vacant</b>
District Program Manager-NRHM	1	1	0
District Accounts Manager-NRHM	1	1	0
District Data Manager-NRHM	1	1	0
Data Manager IDSP	1	1	0
Councillor ICTC	2	2	0
Data Entry Operator	4	4	0
STLS RNTCP	1	1	0
STS RNTCP	1	1	0
Sputum Microscopist RNTCP	3	3	0
Block Program Managar	3	3	0
Block Level Accountant	3	3	0

Staff Nurse	12	6	6
ANM	22	2	20
Asha Facilitator	16	16	0
Block Coordinator	1	1	0
Medical Officer Male (School Health)	2	2	0
Medical Officer female (School Health)	2	2	0
Pharmacist (School Health)	2	1	1
Community Mobilizer (School Health)	1	1	0
Hospital Manager(District Hospital)	1	1	0
DOTS Plus Supervisor	1	1	0
PROMIS- DEO CMSD	2	2	0

Bagheshwar has 7 functional delivery points. Most of the Subcenters which are delivery points are co-located with CHCs are PHCs/APHCs. The delivery load of these subcenters is, on average one per month. The ANMs are present in the subcenters two days in a week, on Wednesdays for immunisation and on Saturdays for VHND. Rest of the days they are in the field and SCs remain closed on these days. Work plan for the ANMs are not generated. The ANMs have been in the same Subcenter for 15 to 20 yrs. Bagheshwar has around 45% institutional deliveries, remaining are home deliveries and most of the ANMs are assisting in home deliveries. ANMs are not SBA trained across the district. ANMs are not residing in the SC, therefore, most of the time the SCs are locked.

In the Bageshwar district hospital the ANMs are not trained SBA/IMNCI. There are very few C-sections, only 13, are done in this hospital, whereas total surgeries done are 262 from Jan to Oct'12. Here same MO is trained in different skills but there is no post training skill utilisation. Bed occupancy at night is almost nil.

Table: 19

<b>BAGESHWAR - FUNCTIONAL DELIVERY POINTS</b>				
S.No.	Name of Block	Name of functional Delivery Points =7	Delivery load - Jan to Oct'12	Average delivery load per month
1	Bageshwar	District Hospital Bageshwar	621	62
		KafligairSubcenter	14	1
2	Bajjnath	CHC Bajjnath	290	29
		CHC Kapkote	139	14
3	Kapkote	BadiyakoteSubcenter	7	1
		KarmiSubcenter	12	1

		BagarSubcenter	7	1
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The HR status of Pithoragarh is given below:

Table: 20

<b>Staff Position –Uttarakhand - Pithoragarh</b>			
	<b>Sanctioned</b>	<b>In-Position</b>	<b>Vacant</b>
<b>District hospital</b>			
Specialists	18	12	6
General grade Staff	7	4	3
Lady medical officer	0	0	0
Dentist	1	1	0
Ayush	0	0	0
<b>Female Hospital</b>			
Specialists	4	2	2
General grade Staff	2	2	0
Lady medical officer	2	2	0
Dentist	0	0	0
Ayush	0	0	0
<b>CHC</b>			
Specialists	23	0	23
General grade Staff	8	7	1
Lady medical officer	4	4	0
Dentist	3	2	1
Ayush	0	0	0
<b>PHC</b>			
Specialists	1	0	0

General grade Staff	8	5	3
Lady medical officer	1	0	1
Dentist	0	0	0
Ayush	0	0	0
<b>Additional PHC</b>			
Specialists	0	0	0
General grade Staff	14	5	9
Lady medical officer	7	0	7
Dentist	0	0	0
Ayush	6	0	6

In PithoragarhDH, there has been 1422 deliveries and 112 C- section deliveries since January till October '12. In CHC, 634 deliveries and in PHC 510 deliveries have taken place.



Image 13: CHC Kapkote, Bageshwar

## **TOR 4: Reproductive and Child Health programme**

### **PC&PNDT:**

- Implementation and general awareness of the Pre-conception and Pre-natal Diagnostic Techniques(Prohibition of Sex Selection) Act,1994 was generally found lacking. Given the highly skewed sex ratios at birth in both districts, the issue needs to be accorded high priority, by Appropriate Authorities. Regular meetings of the Advisory Committees at the district/sub-district level are not being held,which is further compounding the lack of effective implementation of the PC & PNDT Act in the districts. Monitoring of clinics/facilities offering ultrasound diagnostic facilities require to be scaled up,including surprise inspections of such facilities.
  
- The sex ratio at birth in Bageshwar is 823 (AHS 2011) and Pithoragarh is 764 SRB (AHS 2011)
  - Lack of clarity of interpretation of PC&PNDT Act (although training workshop was conducted for implementation agencies).
  - Form F being filled by clinics – not as per Performa prescribed in the rules, varying Performa submitted by clinics.
  - RMPs were offering USG services on the basis of certificates indicating 150 hours of experience (not as per norms)
  - A total of 18 ultrasound clinics registered with District Appropriate authority in Pithoragarh and 5 in Bageshwar
  - 2 clinics de-registered recently in Pithoragarh, operated by BAMS (not qualified as per norms)
  
- Regular inspections and monitoring need to be scaled up, including provision of a system of reward for informers (presently only Rs 5000)
  
- IEC/ BCC awareness display materials found in facilities, bus panels, MMUs but awareness activities through NGOs, capacity building for judiciary, implementing bodies to be organized regularly
  
- On line F-form – initiated although some operational issues were noticed.
  
- Decoys to be sent to MMUs in absence of online form F

### **Immunization**

- Skills of ANMs were good e.g. route, site, dosage, side effects
  
- Most of ANMs and cold chain handlers received training in last 2 – 3 years

- Contractual refrigerator mechanic was untrained in Pithoragarh
- Due list was not prepared to cover drop outs and left outs
- Birth dose for BCG, OPV and Hepatitis B not given for institutional delivery (except CHC Baijnath)
- No bundling of vaccines and diluents leading to mismatch - distilled water being used instead of diluent for measles vaccine (PHC Gangolihat)
- AEFI being reported monthly, no outbreak of VPD reported. One child died in Bageshwar due to AEFI

### Child Health

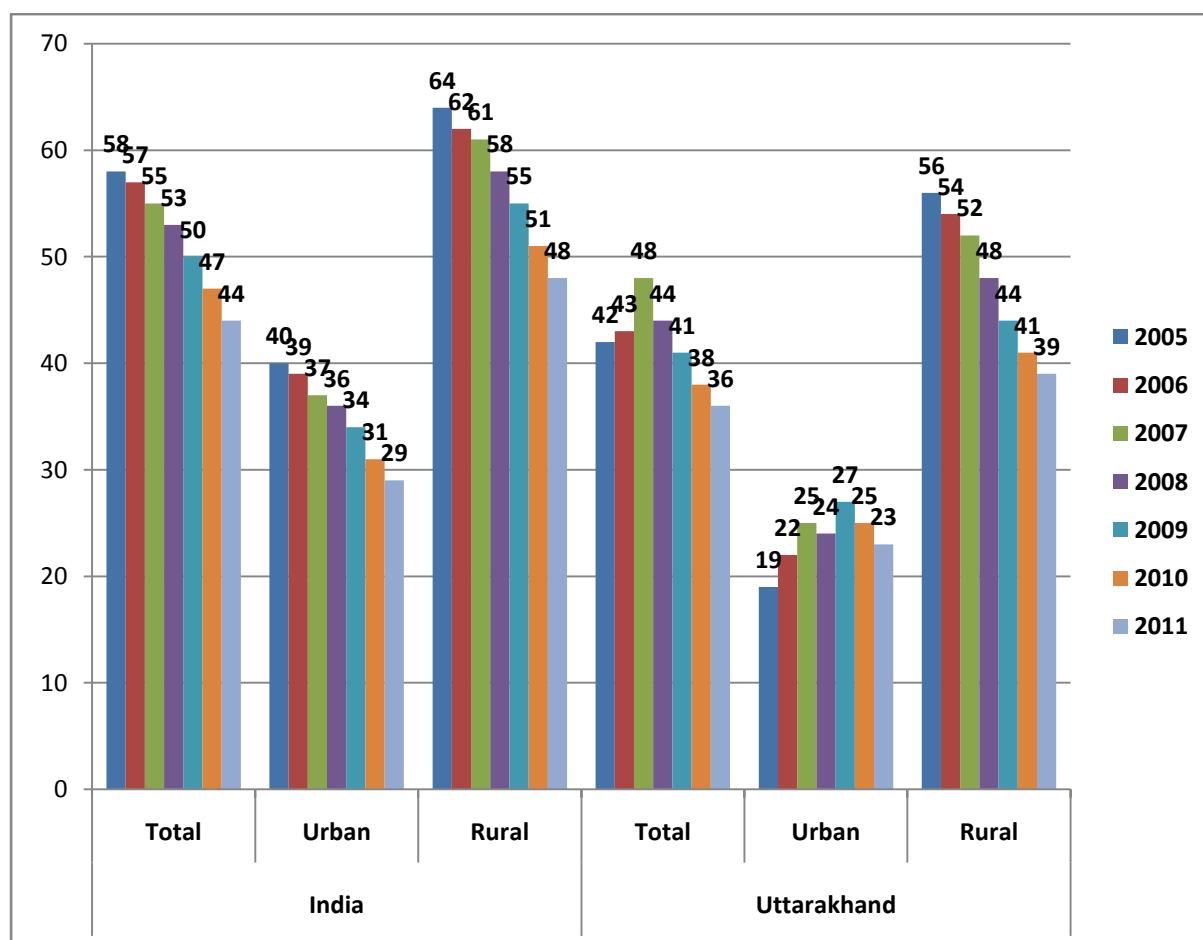
#### Key Indicators related to Child Health at a glance:

Table: 21

		Indicators	Source of Data	National Average	Uttarakhand
Outcomes	Mortality	Under-five mortality rate (per 1000 live births)	Sample Registration System 2011/ AHS 2011	59	53
		Infant mortality rate (per 1000 live births)	Sample Registration System 2011	44	36.0
		Neonatal mortality rate (per 1000 live births)	Sample Registration System 2011	33	30
		Maternal mortality ratio (per 100,000 live births)	Sample Registration System 2011	212	188.0
	Nutrition	Stunting (moderate and severe, %) -3 SD	National Family Health Survey 2005/06	23.7	23.1
Adequate Coverage	Cross-cutting	Measles immunization (% of one year olds)	Coverage Evaluation Survey 2009	74.1	75.8
		Population practising open defecation (%)	Census of India 2011	53.1	34.2
		Demand for family planning satisfied (met need for contraception) (%)	District Level Household & Facility Survey 2007/08	79.5	79.9
	Diarrhoea	ORS Use (% under-five with diarrhoea)	District Level Household & Facility Survey 2007/08	34.2	43.6
	Pneumonia	Treatment for ARI (% children under 2 years receiving treatment)	Coverage Evaluation Survey 2009	82.6	72.3

	Neonatal	Antenatal care, four or more visits (%)	Coverage Evaluation Survey 2009	53.1	39.4
		Skilled attendant at birth (% of births)	Coverage Evaluation Survey 2009	76.2	58.7
		Post-natal visit within 48 hours (%)	District Level Household & Facility Survey 2007/08	47.5	30.1
		Initiation of breastfeeding within 1 hour (%)	Coverage Evaluation Survey 2009	33.5	24.9
		Exclusive breastfeeding for six months (%)	Coverage Evaluation Survey 2009	38.5	32.8
Supply		Density of Health workers (per 10,000 population)	National Sample Survey Organization, Employment Survey 2004-05	19.7	31.1
Enabling environment	Social factors	Birth registration (% of births)	Civil Registration System	74.5	66.0
		Girl's enrolment in lower secondary education (Classes VI-VIII) (%)	District Information System for Education 2009-10	38.5	32.8

Table: 22 - Decline in IMR under NRHM (source SRS, RGI)



Analysis of above graph wrt percentage decline in IMR:

Table: 23

	India			Uttarakhand		
	Total	Urban	Rural	Total	Urban	Rural
2005	58	40	64	42	19	56
2011	44	29	48	36	23	39
Drop in points	14	11	16	6	-4	17
<b>% decline</b>	<b>24</b>	<b>27</b>	<b>25</b>	<b>14</b>	<b>-21</b>	<b>30</b>

**Key points of the above table:**

- Decline in rural IMR in India is 27% in comparison to overall decline of 24%
- Decline in rural IMR in Uttarakhand is 30% in comparison to overall decline of 14%
  
- Facility based newborn care: NBSUs are catering to delivery load where SNCU could be made operational e.g. DFH Pithoragarh. Dedicated staff not available for NBSUs. The existing doctors and staff nurses are mobilized to provide care to newborns impacting their usual duties.
- NBSUs: Tests for serum bilirubin not available leading to poor utilization of phototherapy. Progress in F-IMNCI training is slow.
- In Pithoragarh NBSU could be upgraded to SNCU.
- NBCCs are not providing all components of essential newborn care viz operational radiant warmer, clean pre warmed cloth to dry the baby, initiation of breastfeeding within 1 hour, staff untrained in NSSK and those trained lacking skills.
- It was observed during review of treatment case sheets of admitted newborns that Input – output monitoring for fluid intake is not being done. This impacts what was the actual fluid requirement and what has been given in the last day.
- Room thermometers not available to check the inside temperature that is recommended to be between 26 – 30°C.
- Equipments are not covered under AMC/ CMC and it was observed that there is no concrete plan in this direction.
- Delivery points not saturated with staff trained in NSSK and SBA.
- HBNC: Implementation has started, ASHAs were aware of the conditionality. However, there is severe lack of quality monitoring including delay in payment of incentives.
- Diarrhoea cases are rare, ORS is available but Zinc is not available (Bageshwar); ORS use in diarrhoea increased from 43.6 to 83.3 [DLHS III, AHS 2011]. Still antibiotics are being prescribed for diarrhoea treatment.

- ARI cases are being managed and drugs are available for treatment (Care seeking for ARI increased from 69 to 95 [ DLHS III, AHS 2011])
- Nutrition Rehabilitation Centres are not yet operationalized and there is lack of awareness of GoI norms for their operationalization. District authorities were unaware of the government of India guidelines for the same.
- Vitamin A is being given along with RI sessions and in VHNDs. (Vitamin A supplementation first dose decreased from 69.9 to 55 [DLHS III, AHS 2011])
- IFA syrup was available in many facilities visited (Not in Bageshwar) (IFA coverage 14.3 %, AHS 2011).
- WIFS is yet to start, although supply has started, training and orientation is ongoing.

### JSSK:



Image 14 & 15 above: IEC regarding JSSK entitlements, Bageshwar, Uttarakhand

- Analysis of JSSK entitlements:
  - ✓ Entitlements are clearly displayed at facilities visited.
  - ✓ Referral and drop back has improved significantly.
  - ✓ However, diet and diagnostics need to be improved.
  - ✓ User fees are still being charged for investigations and registration at some facilities. Diet is being provided in most of the facilities. Linking 48 hour stay to drop back is not being practiced. In many cases women were found to leave the facility within 6-8 hours of delivery.

- ✓ Provision of blood is available only at DH, Pithoragarh and not elsewhere in both districts (not even at DH Bageshwar).
- ✓ Huge out of pocket expenditure for investigation/ diagnostic services and drugs(Bageshwar)

***Some examples of user fees being charged***

*CHC Gangolihat: Mrs Asha Devi (30/F) was charged Rs 50 for investigations (18.09.12), Mrs Seema Tamta (30/F) was charged Rs 30 (06.10.12). Similarly CHC Dharchula: Mrs Jyoti was charged Rs 95 for investigations (OPD no 28578).*

**Maternal Health:**

- Labour rooms are cramped with extra equipments, therefore not optimally used (Bageshwar). In Pithoragarh facilities were found to be cleaner and better equipped.
- In most places toilet facility, running water was not available in the LRs and was located far away sometimes even in the next building.
- Partographs are not being filled up in Bageshwar except at CHC Baijnath, however the situation was better in Pithoragarh.
- JSY payments updated at most of the facilities visited
- 5% JSY beneficiaries are not being verified (Pithoragarh).
- Magnesium Sulphate is not available for treatment of Eclampsia
- Most of the Misoprostol drug was found to be of batch which had expiry on 30<sup>th</sup> Nov 2012 in Pithoragarh
- ANMs are still using Inj Methergin as against Inj Oxytocin as very few ANMs are SBA trained. Only 3 batches of SBA training has been done in Dist Bageshwar.
- Strengthening of monitoring system is required. It was seen that Health Management Information System (HMIS) and Maternal Child Tracking System (MCTS) data is collected but not being used for improving quality of services and follow up eg: using line listing of anaemia for generating work plan of ANMs
- MDR: Facility based Maternal deaths are not being analysed. Community deaths are not being reported. (Sp deaths in EMRI) in District Bageshwar.

Summary: Maternal Death Review: 2012-13  
District: Pithoragarh

Table: 24

Sr. No.	Facility Based MDR	Community based MDR	Month & year	Cause of death
1	Yes (District Female Hospital, Pithoragarh)	-----	April, 2012	Death 16 hours post delivery, Embolism, Pulmonary
2	-----	Yes (Munakot Block)	June, 2012	History of convulsion since childhood
3	Yes (District Female Hospital, Pithoragarh)	-----	July 2012	Thromboembolism

#### Family planning:

- NSV cases are not being done) due to non-availability of trained doctor (Dr Joshi, PHC Egyardevi is the only doctor trained in NSV in Pithoragarh but is not performing for the last three years).
- Many ANMs were found to be trained on SBA however ANMs need refresher on certain aspects of SBA (AMTSL) and New born care. Supportive supervision and refresher trainings was found to be missing.
- Most of the ANMs were found to be trained on IUCD and IUCD insertions were being done satisfactorily.
- Only one SN in FDH Pithoragarh was trained on PPIUCD (through MCHIP project) but has not inserted PPIUCD after training
- It was found that gynaecologist trained in PPIUCD is not inserting IUCDs-DH Bageshwar.
- Spacing methods and family planning counselling is to be further strengthened. Though Condoms were available in adequate quantity and were covered under door to door social marketing scheme by ASHAs (Bageshwar). In Pithoragarh ASHAs were found to be well versed with Social marketing of contraceptive scheme but strangely no supply of condoms or pills was available at subcentre or PHC.

#### School health:

- Schools are being visited on once a year basis by AYUSH doctors. (only 2 teams in Bageshwar)
- Could be linked with ARSH programme
- School health teams covering approx. 50% children only for curative services (no preventive or promotive services)

- No referral linkage with health facilities or follow up for disease, disability or deficiency

Table: 25

Analysis of Quarterly Progress report of School Health, Pithoragarh						
	Male	Female	Interventions		%age	
			Male	Female	Male	Female
<b>Children screened</b>	<b>5129</b>	<b>5655</b>	<b>3025</b>	<b>3431</b>	<b>59</b>	<b>61</b>
<b>Vitamin</b>	604	802	0	0	0	0
<b>Other micronutrient</b>	162	267	0	0	0	0
<b>Underweight</b>	789	564	0	0	0	0
<b>Overweight</b>	25	40	0	0	0	0
<b>Anemia</b>	256	561	125	269	49	48
<b>Disease</b>	183	124	0	0	0	0
<b>Refractive errors</b>	42	36	6	4	14	11
<b>ENT</b>	229	134	0	0	0	0
<b>Dental</b>	1022	1367	0	0	0	0
<b>Infections</b>	246	345	0	0	0	0
<b>Worm infestations</b>	2978	3578	2890	3156	97	88
<b>Physical disabilities</b>	31	18	0	0	0	0
<b>Learning disorders</b>	28	15	0	0	0	0
<b>Behavioural problems</b>	22	8	0	0	0	0
<b>Hearing problems</b>	8	5	4	2	50	40
<b>Treated on the spot</b>	1796	1849				
<b>Followed up</b>	56	71				

- It was observed that the children screened are not being followed up.
- A child was interviewed in a school that was visited in district Pithoragarh, who was diagnosed for refractive error and advised spectacles, even after 1 year of the visit the child has not been provided the same and even taken to a nearby PHC, thus impacting the very purpose of screening.

#### ARSH

- The School health program is being rolled out and the state is poised to launch Adolescent Reproductive Health Program and Weekly Iron and Folic acid Supplementation (WIFS).

- Fixed day services with doctor was being offered in district hospitals (Homeo doctor – Untrained in DH Bageshwar).
- No counselling services available in DH Bageshwar on other days.
- ICTC counsellor are counselling adolescents in DH PTG and CHC Baijnath
- First lot of sanitary napkins have reached PHC Baijnath under Menstrual hygiene scheme but not in other PHCs.
- Under the Udaan scheme - NGO has identified adolescents and started peer education training
- Targetted Intervention for Single male Migrant (TI-SMM) operational in DH PTG through 2 NGOs.
- School health could be linked with ARSH programme for referral of such cases requiring counselling at ARSH clinics.

## TOR 5: Disease Control Programmes

- Disease control programme are not integrated with RCH and work in isolation.
- Internet Connectivity is an issue in the districts for uploading of data especially for IDSP.
- Surveillance units have been established at various levels, but because of lack of monitoring the operationalization of these units is an issue.
- NLEP: 2 Cases of leprosy are under treatment currently and require no cosmetic correction. No IEC visible in order to address the stigma against leprosy.
- NIDDCP: Iodised salt distribution has improved; salt testing kits were not available with ASHAs. Cases of endemic goitre have dropped significantly.
- NVBDCP: The laboratory records were reviewed and it was noticed that blood smear are being prepared, but no positive cases have been diagnosed so far.
- NBCP: Although no eye surgeon is available, one Deputy CMO (Ophthalmologist) is looking after the whole programme in Pithoragarh district.
- IDSP: Reporting is adequate and information is used for appropriate action, online reporting is being done on weekly basis.
- Case of outbreak of diarrhoea, June 26, 2012:
  - 156 cases found and treated (M: 68, F: 88)
  - Water tanks were contaminated with faecal matter and could have caused water borne epidemic
  - Community educated to take boiled/ chlorinated water
  - Chlorine tablets, bleaching powder distributed
  - Community advised to maintain hygiene and regular cleanliness in and around water source.

## **TOR 6: Community processes including ASHA, PRI, VHSC, CMB, NGO**

### ● Focus Group Discussion with ASHAs:

- ASHAs are satisfied with their work and performance.
- They are highly motivated and willing to spend night at district hospital along with delivery patients instead of ASHA resting room.
- ASHAs were aware about various incentives average Monthly incentive earned is Rs 800-1000, this may increase with new schemes to promote spacing method and HBNC. However ASHA drug kits need urgent refilling after initial supply
- All ASHA are not fully informed about incentives for different activities, Bageshwar.
- No adequate support from ANMs to ASHAs was observed in Bageshwar.
- Microplan with due list not provided by ANMs to ASHAs
- Convergence with AWWs needs strengthening
- ASHA facilitators were found to be highly motivated and dedicated at CHC Baijnath where details of work done by ASHAs was maintained by AF.

### ● Focus Group Discussion with ANMs:

- ANM were satisfied with NRHM programme and how it has made difference to the lives of the beneficiaries.
- Most of them were not being trained in SBA and NSSK
- There is a lack of knowledge on JSSK entitlements among ANMs.
- Some of them trained in SBA but they need refresher training to upgrade their skills.
- In very remote areas where ANMs are conducting deliveries in SCs, they need assistance like a 2<sup>nd</sup> functional ANM and supervision/hand holding/training.
- ANMs were not aware of the correct procedure of preparing ORS, benefits of Zinc and HBNC scheme. Some of the ASHAs were having better knowledge of these aspects in comparison to ANMs.

### ● FGDs with VHSC and RKS

- RKS, DH Pithoragarh was having no member of civil society on board. RKS not meeting at DH Bageshwar periodically.

- Community representative are not actively involved in RKS meeting and follow up, at Bageshwar
- VHSC members were satisfied with the health services offered, but non-availability of doctors is an issue
- Procurement of goods is centralised at CMO level by pooling of AMG (Annual Maintenance Grant), UTF (Un-tied fund) seed money and user fee, and not as per facility requirement-Bageshwar. Similar list of equipments was seen to be in the process of being supplied to various facilities for which the MOs were not in the loop.

### Community Based Monitoring (CBM):

- AMS Consultants were interviewed that are implementing CBM in the district of Pithoragarh.
- Trainings has been completed, 96 Jan Sunwayi Diwas (JSD) have been held in Pithoragarh, none in Bageshwar.
- JSD chaired by MOIC of the facility for which it is conducted.
- Rs 60 lakh was earmarked in 2011-12 and 100% has been spent by AMS.
- JSD should be chaired by an officer of a higher level than the facility for which it is conducted to take immediate concrete decisions as is being done in the state of Maharashtra.
- Agenda and recommendations need to be developed beforehand for smooth conduct of JSD.
- CBM should be linked with MMUs, school health and other programmes to gain detailed information rather than a one-time interview.



Image 16 & 17: Anganwadi day at CHC Kapkote, Bageshwar, Uttarakhand

## **TOR 7: Promotive Health Care, social determinants and equity**

- Existing convergence with ICDS, Education department, civil society organization found missing
- WCD has done training of AWW and given them a kit containing drugs kit and information on common ailments. ANMs and ASHAs were not aware of drugs available with ICDS workers.
- New MCP and kishoryshakti cards were available with the AWW but they were yet to be trained to use them.
- Signatories of VHSCs were not as per Norms that hinders implementation of desired services. As per the state guidelines ANM is not mandated as a part of VHSC.
- Minutes of meeting are not being recorded for VHSNCs, RKS and DHS meetings (except CHC Baijnath, this is working better in Pithoragarh)
- Nutrition Rehabilitation Centres have not been established in the State and there is a weak plan of community based management of SAM. Also, efforts to reduce incidence of malnutrition by way of improved IYCF practices was lacking.
- Civil registration system found to be weak.
- Display of IEC material was found to be satisfactory within the premises of the facilities. However, no IEC seen at the community level.
- No social auditing of health services was found to be in place.
- District Vigilance and Monitoring Committee has not been formed.
- Health Promotion: needs strengthening.
  - Pregnant Women needs to be given counselling before discharge on Breastfeeding, immunization, family planning and spacing methods, care of mother and baby, cord care, keeping baby warm, KMC (Kangaroo Mother Care, need for iron and folic acid at-least for 100 days and hand washing during diarrhoea. PPIUCD should be encouraged.

## **TOR 8: Program Management, monitoring, logistics and issues of integration and institutional capacity**

- Programme Management units are in place.
- There is good coordination between DPMU and SPMU in Pithoragarh
- However DPMU staff at Bageshwar is not well oriented due to lack of support from seniors.
- Meetings of DPMU are not being regularly held and minutes are not recorded in Bageshwar.
- Lack of coordination between PMU and Accounts Management units (Bageshwar)
- Most staff positions in programme management units are vacant
- There is no grievance redressal cell for SPMUs and DPMUs. There is lack of delegation of powers for PMUs.
- It was seen that Health Management Information System (HMIS) and Maternal Child Tracking System (MCTS) data is collected but not being used for improving quality of services and follow up. HMIS data is however being used for programme management-Pithoragarh. It was observed that BPM does data entry for MCTS only.
- Procurement is being done both at the state and district levels and even block level e.g. for JSSK entitlements
- There is no monitoring done by Prog managers at any level, especially in the remote areas.

## **TOR 9: Knowledge management including technical assistance, use of IT**

- ANMTC: Strengthening of ANMTCs is being done by the state it was observed that books were available in library and internet service could be made available-Pithoragarh. There is no training institute in Bageshwar.
- ANMs could be considered for rotation posting at delivery points to give them more exposure.
- ANMs passing out from ANMTCs could be considered for immediate recruitment
- ANMs need to be re-oriented at skill labs of ANMTCs

### **TRAINING**

The State Institute of Health and Family Welfare in Uttarakhand is under construction. Currently SHSRC has only two staff, data entry operator and documentation officer.

Haldwani Medical College/Hospital is accredited for one year for training in CEmOC, LSAS training but training has not started yet. There is no ANM, GNM training center at the district level.

Training and capacity building of health professionals at all level is very poor and the state has not conducted any training in this year.

### **HMIS**

Facility wise data is uploaded but data entry is incomplete, e.g there is data for Pregnant women having HB <11 gms but no data for ANC registration or 3 ANC check ups; total number of deliveries is entered as nil but number of live births are entered.

Two days training for HMIS was given last year but there is still poor knowledge of data element, e.g. for data element “Number of pregnant women having Hb<7 gms treated”, they are getting this data from Lab. There is no ownership and supervision for the data entered in the formats. No one looks at the data and blaming each other for the wrong data.

HMIS training is hence urgently required in both the districts we visited.

### **MCTS**

Data filled in MCTS registers are incomplete, in some registers, sex of the child is not mentioned, in some, no entry for weight at birth for the new-borns etc. The MCH register is handed over to BPM for entering data online and these registers are kept there till the entries are completed, this may take 2 to 3 weeks.

The data is not used for planning and decision making to improve the health services.

Work plans for ANM is not generated also do not have a microplan.

## Case study on use of MCTS for analysis and utilization of collected data, District Pithoragarh

Table: 26

PHC/CHC	Name & Address	Age (in Years)	No. Of Children's	Hb Value in gm %	Hb Check – Up Date	Status of next check up
Gangolihat	Prema Devi, w/o Gopal singh, Gangolihat	24	2	7 gm	15 AUG 2012	Data awaited
	Nandi Devi, w/o Manoj Singh, Village Hanera, gangolihat	24	2	7 gm	12 May 2012	Data awaited
	Maya Devi ,w/o Manoj Singh Vill. Jajut, Gangolihat	22	3	7 gm	16 May 2012	Data awaited
	Prema Devi ,w/o Nirmal Singh Singh , Vill. Henara, Gangolihat	28	1	6 gm	25 May 2012	Data awaited
	Kavita Devi w/o Mahesh Chardra, vill. Gangolihat	27	3	6.5 gm	17 June 2012	Data awaited
	Bina Devi w/o Lalit Vill. Patokhara, Gangolihat	27	1	7 gm	22 june 2012	Data awaited
Munsyari	Hansa Devi w/o ganga Singh Vill. Rasiapata , Munsyari	23	1	7 gm	26 Sep 2012	Data awaited
Dharchula	Lalita Devi w/0 Devendra Singh Vill. Dharchula	19	1	6 gm	4 july 2012	Data awaited
Kanalichina	Roshni w/o Paan singh Vill- Kanalichina	20	1	6.9 gm	Sep 2012	Data awaited
Berinag	Maya Devi w/o Raaju Vill- Rai Aagar	32	2	4.8gm	4 sep 2012	Data awaited
	Champa Pathak w/o Pawan Pathak Vill- Dasoli	30	2	4.8 gm	8 sep 2012	Data awaited
Badaloo	Kamla Devi Laxman Ram Vill. Bhatigaon	20	1	6 gm	Sep 2012	Data awaited
	Munni Devi w/o Shyamu Ram Vill. Basaur(Balteri)	28	1	6 gm	Sep 2012	Data awaited

- MCTS data capturing has led to capturing of data on severlyanemia cases in the district. It is clear from the above that the latest status of anemia in these cases is not known. Some of the above cases would have already delivered preterm babies and will continue to be at risk for future pregnancies. Initiative in use of MCTS data is lacking.

## **TOR 10: Financial management**

- Overall very poor and un-satisfactory financial management
- Accounts books maintained manually –at all facilities
- Customised version of TALLY has not been initiated
- Books of accounts are not being maintained properly as per GoI norms
- In some cases JSY payment registers are not being signed by MoIC (egPHCKasauni, Bageshwar)
- No bank reconciliation is maintained – at facilities visited except District Health services and CHC Baijnath monthly basis.
- No cash books available at most of the CHC,PHCs
- No fixed assets register maintained at DHS
- It was observed that the senior clerk, DH Bageshwar kept cash at home Rs 11503.
- Staff is untrained in financial management training
- Procurement procedures and records were not presented by Chief pharmacist
- No records of taxation are being maintained at DHS
- Only 1% TDS deducted in case of payment of contractual staff and service providers
- More than Rs 15 lakh advances are pending since six months, have not been settled till date
- There was no MIS Reports for financial management
- Printed vouchers were not maintained at all levels
- Only one register is maintained for cash & bank since 2007 till date
- RKS, AMG, Untied funds – no records found (some facilities)
- PHC Kausani payment given through CHC Baijnath since last year.
- Lack of clarity of funds for Facility based newborn care - NBCC Maintenance amount of Rs 20000/ yr, JSSK Entitlements
- Delay in JSY payment – some facilities (especially Pithoragarh)
- E-banking at all level, JSY payment through cheque & JSY register maintained at all level in Bageshwar.

- Findings of statutory audit report of 2010 -11, DH Bageshwar the following were purchased without inviting tenders
  - Rs 5,25,232 for purchase of generators (seed money)
  - Rs 7,00,960 for purchase of ultrasound machine (IPHS)
  - Rs 1,06,375 was given to NGOs but no TDS deducted (Blindness programme)

### **Field Visit Report**

Table: 27

Place Visited	District Health Society, Bageshwar, Uttarakhand
Dates of Visit	03.11.2012 to 09.11.2012
Team Member	PrabhashJha
Place Visited	District Health Society, Bageshwar, Uttarakhand
	District Hospital- Bageshwar
	CHC/PHC/SC/VHSC

Discussions were held with the following officers and staff of State Health Department:

Table: 28

S. NO.	Name	Designation
1	Shri S. Ramaswami	Secretary Health & FW
2	ShriPiyush Singh	Mission Director (NRHM)
3	Ms. KavitaNabiyal	Director-Finance
4	Sh. SariqueRao	State Finance Manager
5	Sh. R.K. Bhatt	State Accounts Manager
6	Sh. AnoopKandpal	DAM (Bageshwar)
7	Dr. Abhay	State Programme Manager
8	Ms. Pramila Joshi	BLA, Baijnath (PHC)

Observations of the team on the basis of relevant accounts/finance records on various issues of accounts and financial management and recommendations are given below:-

### **KEY OBSERVATIONS**

#### **1. Status of Humans Resource:**

In the state, Director (Finance), State Finance Manager and State Accounts Manager are in place.

#### **2. Status of Maintenance of Books of Accounts:**

Books of Accounts are not being maintained properly as per Finance and Accounts Manual at DHS/PHC/CHC/SB Level. They are maintaining books of account manually and are not updated till 3<sup>rd</sup> November, 2012. So our observations related to the maintenance of books of accounts are based on manual accounts as follows:-

### **Cash/Bank Book**

- Cash book is maintained in Tally ERP9 as well as manual (DHS only) and not updated till 3<sup>rd</sup> November, 2012.
- The closing balance has not been maintained at District level on daily basis.
- There are five Bank Accounts for NRHM programmes

### **Bank Reconciliation**

- Bank reconciliation has been prepared by the District Health Society Bageshwar for RCH and MFP as on 31<sup>st</sup> October 2012:
- Bank reconciliation has not been prepared by the District Hospital- Bageshwar, PHC Kausani, and CHC Kanda.
- It reflects that District is not preparing its MIS report from books of accounts. Which is a serious lapse as far as the reporting and the maintenance books of accounts is concern, it is recommended that all financial MIS report should be prepared on the basis of the books of accounts at state and districts level.

### **Advance Register**

- The District Health Society (Bageshwar) has not maintained Advance Register under any programme.  
The advance balance under RCH and MFP as on 31<sup>st</sup> October 2012 is given below:

RCH	:	46.02 lakh
MFP	:	142.46 lakh
<b>Total</b>		<b>188.48 lakh</b>

### **Salary Register**

- The District Health Society has not maintained the Salary Register under any programme.

### **Vouchers**

The vouchers of cash/bank transactions are properly maintained at PHC Baijnath only, but at DHS Bageshwar, CHC and PHC level vouchers of cash/bank transactions are not properly maintained. Printed Vouchers are not being used.

### **Journal**

- DHS has passed journal entries in tally but not in manual books of accounts for the Statement of Expenditure received from CHC/PHC.

- No Journal entries are passed in the manual books of accounts but in case of tally it is in place in the case of bill received from Parties at DHS Bageshwar&Pithoragarh.
- Supporting documents of journal entries are maintained at DHS/FRU/CHC level where the actual expenses are incurred.

### 3. Status of e-transfer:

State Health Society, District Health Society and CHC/PHC have maintained bank accounts with State Bank of India and Punjab National Bank. The State Health Society is sending funds to DHS through e-transfer, DHS to CHC/PHC through e-transfer and also down the line PHC it sends through e-transfer only.

### 5. Status of Tally ERP9:

The District Health Societies have not using customized version of Tally ERP9 and at the PHC/CHC level Customized version of Tally ERP9 is yet to be implemented. At DHS, they have some problems in Customized version of Tally ERP9. However, as of now the DHS has already complained to Tally solutions for the same.

6. The funds are being released by the SHS to DHS according to ROP and activity wise, DHS to CHC/PHC according to DHAP and activity wise.

## 7. Statutory Audit and Concurrent Audit

### • Statutory Audit

The State has submitted the audit report for the year 2010-11. As per the audit report, District Health Society has not maintained such records which are required as per the guidelines.

### • Concurrent Audit

The Concurrent Auditors have been appointed for 2011-12 by the SHS and DHS. First quarter concurrent audit is in process at DHS.

8. Delegation of Financial Power from State Health Society to District Health Society and DHS to down the line has been issued.

## 9. Low/Nil Expenditure during 2012-13

### SHS Level (RCH)

#### General Observations

Out of the approved annual SPIP of Rs.97.71 crore, reported expenditure is only Rs.9.06 crore up to the first quarter of 2012-13 under RCH Flexi pool i.e. only 9.27%.

#### Areas of Concern

- Low expenditure has been reported by the state on core activities i.e. Maternal Health (0.92%) of the approved PIP.
- State has reported very low (i.e. less than 10%) expenditure under Adolescent Reproductive and Sexual Health/Arsh (8.19%) and Urban RCH (7.69%).

### SHS Level (MFP)

#### General Observations

Out of the approved SPIP of Rs. 106.57 crore, reported expenditure is Rs.3.50 crore upto first quarter under NRHM Additionalities i.e. 3.28% of the approved PIP.

#### Areas of Concern

- The State has reported low expenditure on core activities i.e. Corpus Grants to HMS/RKS (0.35%) of the approved PIP.
- The State has reported **low/nil** utilization of approved PIP under Hospital Strengthening (1.30%), New Construction/Renovation and Setting (5.08%), Panchayati Raj Initiative (0.00%), and Procurement (3.25%) of the approved PIP.
- The State has reported **negligible** utilization of funds under New Construction/Renovation and Setting (5.08%), Panchayati Raj Initiative (0.00%) and Procurement (3.25%) of the approved PIP.
- The State has reported expenditure **less than 15%** under the heads Untied Funds (0.53%), IEC-BCC NRHM (12.09) and Support services (0.00%) of the approved PIP.

#### 11. Pending Utilization Certificates:

The pending Utilization Certificate for RCH Flexi Pool and NRHM Flexi Pool the details of pending UCs has given below:

Table: 29

Programme	Amount in Crores
<b>RCH Flexi Pool</b>	
2010-11	0.00
2011-12	28.59
<b>Mission Flexi Pool</b>	
2007-08 to 2011	0.00
2011-12	19.22

#### 12. Income Tax Issues:

It has been observed that, most of the CHCs and PHCs have not followed rules of Income Tax under tax deduction at sources. Some PHCs are not deducting TDS on

salary of staff. Tax deduction of Source has been deducted but shown in wrong head in the ledger by the District Health Society, also the TDS on salary of consultant is being deducted @ 1% only. However, return of TDS has been submitted on time as per Income Tax Rules.

### 13. State Share Contribution

The State share is due of Rs. 3.21 crore to be credited to SHS Account from 2007-08 to 2011-12. The break up for the same has been given below:

Table: 30

Year	Amounts required on basis of releases (Rs. in Crore)	Amount Credited in SHS Bank A/C (Rs. in Crore)	Short/ (Excess) (Rs. In Crore)
2007-08	15.74	0.00	15.74
2008-09	17.37	13.85	3.52
2009-10	23.09	13.80	9.29
2010-11	26.01	21.84	4.17
2011-12	36.79	35.65	1.14
2012-13*	13.83	22.96	-9.13
Total	<b>132.83</b>	<b>108.10</b>	<b>24.73</b>

**\*State Share for 2012-13 as per ROP**

### 14. Submission of MIS reports from CHC/PHC to DHS

The Monthly Statement of expenditure reports are not being submitted on time by the CHCs and PHCs to DHS. The dated of submission of reports is 1<sup>st</sup> to 7<sup>th</sup> of the following month and the DHS submits expenditure reports to SHS the same on 7<sup>th</sup> to 10<sup>th</sup> of the following month. The funds are released from SHS to DHS to CHC/PHC on time through electronic transfer.

### 15. Model Accounting Handbooks

The Model Accounting Handbooks have not been sent to DHS to sub-districts so that there is no status on implementation of the Model Accounting Handbooks.

### 16. Procurements

The procurement procedure is not being followed properly, Specially in case of purchases from SahakariSamiti/KendriyaBhandar etc. no records of procurement has been produced by the DHS to the CRM team.

**Key recommendations –Financial management:**

1. Advance Register should be maintained at state & district level.
2. Bank Reconciliation should be prepared on monthly basis at PHCs and CHCs.
3. Unspent balance should be reconciled on monthly basis between State and DHS, DHS and CHCs/PHCs.
4. Journal Entry must be passed in the journal and supporting vouchers should be kept as per journal vouchers.
5. Action and Taken report should be prepared at DHS level for concurrent auditor observations.
6. Low/Nil expenditure should be maintained at District and State level. The reason of Low/Nil expenditure may be clarified
7. Income Tax provision for deduction of TDS must be followed by the DHS as per Income Tax rules and regulations.
8. Bank account should be separate for each programme.
9. State should not divert funds from one programme to another programme as per the GoI guidelines.

## WAY FORWARD/ RECOMMENDATIONS

- Compliance to key conditionalities for FY 2012-13 to be ensured by state.
- State to upload all mandatory disclosures.
- Immunization
  - Start birth dose of vaccination for institutional deliveries. This will require training of staff nurses managing labour room and provision of vaccine in labour room in vaccine carrier and following open vial policy for OPV and Hep B as per national guidelines.
  - Non repairable equipment needs to be condemned and those which are repairable need to be repaired.
  - Immunization micro plan needs to be prepared and child tracking should be done for left out and drop out children using due list or MCTS work plan
  - Bundling of vaccine and logistics (diluent, syringes) should be done at all level of supply chain. Implement ProMIS for online stock management
  - Define catchment areas of PHCs (called additional PHCs), so that subcentres nearer to PHC do not have to travel long distances to block PHC or CHC to collect vaccine.
- Financial management
  - Training required urgently.
  - Proper maintenance of account books is needed.
  - There is need to follow NRHM guidelines
  - Computerized books of accounts need to be maintained at all levels and updated version of tally is to be used
  - Procurement manual need to be developed
- MCTS:
  - All provisions under MCTS need to be strengthened
    - It was seen that Health Management Information System (HMIS) and Maternal Child Tracking System(MCTS) data is collected but not being used for improving quality of services and follow up eg: this data should be used for monitoring of progress of anemic women (e.g. PHC Berinag: Mrs Champa and Mrs Maya each have Hb of 4.8%) and their present status is not known
    - This data should be used for generating work plan for ANMs

- **HR:**

Staff position has been analysed and irrational deployment of most of the multiskilled MOs was observed. There are 26 LSAS and 16 EmOC trained MOs in the State. They have been posted to various PHCs and even those in CHCs are not performing. Detailed table is given at Annex 1:

- Rational deployment of staff yet to be done with some motivational programme to change attitude of the staff.
- Transfer policy to be firmed up with all incentives for remote, hard to reach and inaccessible areas put in place.
- The state may need to look at fixed tenure, rotational posting of medical officers to remote areas with appropriate incentives.
- DH has no Paediatrician where as a paediatrician is posted at CHC Baijnath which is not a CEmOCcenter/ FRU. He should be transferred to DH to start the NBSU there.
- All facilities need to be downgraded for all AMG, RKS because of lack of maintaining specified criteria of IPHS.
- No action taken against defaulter MOs on account of lack of performance monitoring , post multi-skilling.
- Despite the fact that the civil engineer from state has planned facilities labour room across the state are housed in ill planned andsmall/cramped rooms. Suggestive Lay out of labour room has been designed by GOI for proper designing of labour rooms.
- All SCs visited were co-located with a bigger facility. There is a need to review the location of PHCs as in many cases they were found co-located with sub-centre with deliveries happening only at one place. This has led to
  - ✓ poor service provision by ANMs/MOs(MO think ANMs are doing Antenatal and vice-versa).
  - ✓ Bad record keeping-Delivery register not available either at the LR in the facility or in the SC.
  - ✓ Both ANMs posted lock the SC and are not available for any service delivery as they assume that MO present will see the PW.
  - ✓ SC only opens on immunisation day (Wednesday).
- **Strengthening of monitoring system.** Supervision is lacking at all level. HMIS and MCTS data is not being used. State level/district/block monitoring to be put in place.

- On issue of Maternal and Child health focus needs to be strengthened on refresher trainings. Urgent training and capacity building required at all levels specially SBA, NSSK, CEmOC and LSAS. State has not done any training in last one year.
- Multiskilling of Medical officers for performing caesarean sections and for providing anaesthesia is also required. Post training more emphasis would be needed on rational deployment and supportive supervision.
- Availability of some emergency drugs like misoprostol and Magnesium Sulphate need to be assured at the facilities.
- Use of Partograph needs to be emphasised in view of difficult terrain as it would help to identify complications early.
- DAM to be urgently trained.
- Strong steps need to be taken for urgent reshuffling of ANMs as most of them are politically connected in same position for last 15-20 years.
- PRI/community should be involved in monitoring.
- IEC, awareness generation should be given in community.
- State needs to monitor NGOs performance.
- Grievance redressal mechanism to be set up for facilities at all level.
- All components of JSSK need to be implemented on the ground.
- District Collector to be brought to the board for monthly meeting and monitoring.
- No records (AMG, untied, RKS) maintained at all facilities in Bageshwar. 100% registers were reported to be with CMO of the district.
- One of the districts (Pithoragarh) has the lowest child sex ratio at birth as per the recent Annual health Survey (AHS) 2011, therefore strict implementation of PCPNDT Act needs to be ensured. Involvement of civil society, PRIs and community members is essential to address the problem. Selective IEC to increase the value of girl child and increase in reward money for persons reporting sex selective abortion were some mechanisms suggested by the team.
- The state should focus on Mobile Medical units (which are equipped with ultrasound and need stringent monitoring to prevent misuse).
- An assessment may be undertaken for equipments as working, not working but repairable and not working and non-repairable which can be then condemned and removed from the facility.

- The state should focus on a prudent mix of basic level ambulances and emergency response vehicles. DH need to use their ambulances for interfacility transfer as there are only 4 EMRIs in the district Bageshwar.

# Facility Wise Observations

## District Bageshwar

1 & 2. Name of facilities: **PHC Kasauni and SC Kausani**

Date of Visit: 4<sup>th</sup> November, 2012

### Major Observations:

- The facility is at an accessible place. The infrastructure is reportedly 20 years old. Although the building is well maintained.
- The IEC/BCC is well displayed at the facility; the entitlements for JSSK are well displayed in the facility.
- The signboard for facility had gone for maintenance.
- Enough waiting chairs and space for patients available at the facility.
- The MO, AYUSH doctors stays at the facility. The 2 staff nurses who are posted at the PHC have been sent for SBA training at DH Bageshwar.
- The SC Kausani is collocated with the PHC.
- Out of the 2 ANM posted at the SC only one is SBA trained. However the quality of training is poor and there has been no post training assessment/hand holding.
- Though the passage for the facility is disable friendly but the approach to SC is not appropriate for pregnant women (refer image 1).
- Labour room at the SC needs attention, at the time of visit the labour room was found poorly managed, cramped with equipment which clearly showed non use and there was hardly any space left for providing services. There was no attached bathroom/no running water in the labour room. The labour room has 2 labour tables (1old + 1new).
- The 2 NBC machines are lying unused for last two years out of which only 1 was found functional, however even the SBA trained ANM could not use these machines or the resuscitation kits when asked by the CRM team. No protocols were being displayed.
- Both the collocated facilities are getting untied/RKS funds.
- The AYUSH doctor said that there was a backlog of 6 months in the release of their salary. The average AYUSH OPD is around 10-15/month.
- The colour coded bins for biomedical waste management are being used, also there were 2 pits in the facility for waste management.
- The facility charges Rs 4/- as user charges, however the JSSK patients are being exempted from this. The average OPD is around 40-70/month. The total institutional delivery is 4-5/month.

3. Name of facility: **DH Bageshwar**

Date of Visit: 4<sup>th</sup> November, 2012

### Major Observations:

- It is a 60 bedded facility, the total staff in position comprises of CMS (surgeon), 1 physician, 1 OBG (DGO), 1 LMO, 3 MO, 1 dental surgeon, 1 radiologist (8 doctors). However there is no anesthetist posted at this facility. There are 5 regular and 5 contractual SNs at this facility along-with 2 sisters. 1 hospital manager is also posted at this facility (BHMS).
- The labour room is small with 2 labour tables with 1 non functional phototherapy unit lying in the labour room. No IMEP measures were being followed in the labour room. The labour room does not have attached bathroom. This is a training site for SBA training and 2 SNs were being trained at that time. However none of the protocols are being followed by the OBG nor are they displayed.
- The new NBSU is still under construction; In an adjacent room near the LR there are 5 NBCC machines and 1 photo-therapy machine dumped and clearly not used for the new born care though there is an NSSK trained MO present. However there is no connecting door to labor room. To use these machines the child has to be brought through passage. The staff at the facility reported that JE from state infrastructure wing visited the site for supervision as the designing of the LR is being monitored by the State. Labor room needs modification to get NBCC inside labor room.
- This is to be kept in mind that there is still no pediatrician posted at this facility even though the NBSU was sanctioned and is under construction for last 2 years, the NBCC units were supplied to facility a year back. This highlights the fact that the procurement projected in the PIP is not based on rationale planning.
- The similar is the case with the trainings for doctors, 1 doctor was sent for LSAS training keeping in mind the non-availability of anesthetist in the facility/distict. However after training the doctor reportedly went to undertake DMRD. 1 doctor is trained in NSSK but he does not attend to the PW in the Labour room. This requires Strict supervision and if needed disciplinary action.
- At the time of visit the CRM team found OT and all wards locked at the DH Bageshwar. On detailed inquiry, it was found that the DH offers only Day-care facilities to all patients including PW who are being discharged with 6 hours of delivery by Khushiyon-ki-Sawari. The SN had taken the keys of the OT home and the other set of keys was at CMOs home. **There seemed to be no emergency preparedness at the DH.**
- The team also observed that there was no emergency room and hardly any preparedness for managing any emergency at the facility.
- The facility had good IEC regarding JSSK, ARSH (Udaan) etc in the facility, however in the entitlements displayed for JSSK the post natal stay envisaged is 24 hours in the posters/banners etc. 48 hour stay needs to be written and ensured.
- The DH was totally empty at the time of visit.
- Blood bank: the civil work for the blood bank has been completed, but as there is no LT and Pathologist posted and no equipments for blood bank it cannot be made operational in next one year. The registration has not been done for blood bank. As one doctor has been trained in BSU, it is advisable to start Blood Storage Unit first with

linkage to Almora Blood Bank. This is urgently required as there is no blood storage unit in district. There has been no supervision on this issue by state and DPMU.

- As per the range of services and the in positioned staff this facility is actually functioning like as a 24x7 PHC however the all kinds of grants are as per the category and not functionality of this facility.
- The inter-facility transfer is done by EMRI but there is NO follow up of these pregnant women. There is no system is in place to track the complicated referrals.
- The CMS is not attending the monthly meetings held at the CMO office, he had low awareness regarding the national program/new initiatives/interventions.
- ARSH clinics is been conducted every Tuesday (fixed day services)with AYUSH doctor who is not trained in ARSH, with average attendance of 25-26 adolescents. These facilities/services are not provided on all the days. The counsellors need to be present at these sessions/clinics. The ANM needs to be sensitized on the issues pertaining to ARSH clinic.
- Menstrual Hygiene program: staff at the DH unaware of this scheme.
- The CMS conducts family planning camps (every Tuesday and Thursday at Kapkote and Baijnath block respectively yet the statistics were not shared.

4 & 5. Name of facility: **CHC Kopkote**

Date of Visit: 5<sup>th</sup> November, 2012

#### **Major Observations:**

- This is a 10 bedded facility, the staff in position comprises of 2 MO (1+1-contractual), 3 SNs (2 female and 1 male nurse), 1 microscope assistant, and 30 ANMs (regular) and 2 ANMs (contractual). The MOIC has gone for PG leave; the MOIC in-charge is Dr Mandal who is MOIC for this CHC along-with 2 other CHCs in district. This inappropriate administrative process has made it difficult for him to properly monitor the facility under his charge as the facilities are situated very far apart.
- The in-position staff at this CHC qualifies it only as a PHC although since it has been upgraded to a CHC, the facility is receiving funds as per the entitlements for a CHC.
- Reportedly the RKS funds (RKS or AMG – not clear since the facility staff could not show the RKS meeting register and AMG cash book) are used for remuneration of sweeper and Guard (at Rs 3500/- per month).
- The average OPD at the CHC is about 100/day in summers and 50-60/day in winters, IPD of about 3-4/day. The user charges being levied on patients for OPD services is Rs 5/-, IPD services is Rs 22/-. The BPL patients are exempted from these services. An arrangement has been made for a cook to make food in order to provide cooked meal to mothers under JSSK yet the PNC stay is only 6 hours.
- MOi/c was not aware of his duties except running of OPD/IPD. He was not aware of the National programs though he had been working in this CHC for 2 years.
- The microscope assistant only does sputum test, there are no services available for any kind of diagnostic/laboratory services. This is leading to huge out of patient expenditure for patients. This clearly states that all components of JSSK are not been implemented.

- SC Kopkote is also collocated with this facility, which is manned by 2 ANMs. The SC was locked. The ANM opens it only on Wednesday for immunisation.
- Out of these 2 ANMs, 1 is SBA trained but was not aware of the protocols like AMTSL, Partograph etc.
- The delivery conducted in this SC per month is about 20 and around 2 ANC per day.
- This collocated facility is also receiving the untied funds.
- The ANM at the SC could not show the LR register, EC register, Village register, ANC register, untied register or any other complete register when asked by the CRM team.
- The community was found highly un-satisfied rather agitated by the staff at the CHC (SNs). Incidences of money exchanges between PW relatives and many of the staff were brought to the notice of MOi/c and State officials.
- There had been no monitoring of SNs and ANMs till date. Also the ANMs in Kopkote blocks have not been transferred from 15-18 years.

5 & 6. Name of the facilities: **APHC Sama** and **SC Sama**

Date of Visit: 5<sup>th</sup> November, 2012

#### Major Observations:

- The PHC Sama was found locked, but was later opened by the Pharmacist.
- The facility has well built infrastructure, 4 bedded, though un-utilized.
- The average OPD of PHC Sama is about 30-35/day.
- Proper stock registers were maintained at the facility.
- Huge amount of AYUSH drugs were lying shabbily at the facility (though not procured through NRHM funds).
- Labour room was in a co-located SC which did not have attached toilet.
- There was not enough case load at the facility.
- There were 2 NBCC corners in the labour room, out of which 1 was functional.
- Average delivery load is around 2-3 per month.
- In the entire facility no IEC regarding JSSK was visible.
- The APHC has a collocated SC Sama, the ANM posted at the SC (Ms Maria conducts delivery). She is highly motivated and dedicated though needs support in terms of training.
- The way to SC Sama was not appropriate for pregnant women, though the ANM stays at the SC itself and conducts delivery in the labour room. The ANM has maintained a daily diary register apart from all other registers which enables her to work more efficiently.

7 & 8. Name of the facilities: **PHC Kanda&SC Kanda**

Date of Visit: 6<sup>th</sup> November, 2012

#### Major Observations:

- The facility is at an approachable road though the passage to the facility is rough, in absence of stairs one has to climb a stony pathway to reach the PHC.
- It is a 4 bedded facility, was found clean and well maintained.
- The facility had no inpatient. The average OPD is around 18-20 per day.
- The user charges at the facility are as follows: Rs 3 as registration charge, Rs 22 as inpatient charge.
- Two doctors are posted at the facility (1 + 1 –AYUSH).
- The facility did not had IFA syrup.
- No registers regarding RKS meetings, untied funds etc were shown to the team. The team was told that all registers are kept with the CMO office. Once in a month or whenever the monthly meetings are held at the Headquarter the decisions are taken at the district level and the minutes are provided to the facility in the form of loose papers. There is no process of meeting at the facility or even knowing the demands of the facility.
- The same was evident from the fact that all the facilities have taken similar decisions for the use of funds available. The major areas of expenditure had been on purchase of inverter, landline phone, trolley, bio-waste pit construction etc. Also at all the facilities which showed us the minutes it was evident that all of them have paid Rs 6000 (Rs 500 x12) to pollution control board.
- The collocated SC Kanda was found locked, it was told that both the ANMs have gone to take vaccine from HQ Bageshwar. This is a common practice in the district that on Tuesday all the SCs remain closed since Wednesday is an Immunization day in the entire state. There is no demarcation of roles and responsibilities to both ANMs so at SCs where two ANMs are posted, both go to take vaccine on Tuesdays and thus the SCs remain closed.

8. & 9. Name of the facility: **SC Chani&APHCChani**

Date of Visit: 7th November, 2012

**Major Observations:**

- The PHC Chani has a well built infrastructure, with enough HR. The SC Chani was collocated to the APHC Chani, it has well built infrastructure. IEC for JSSK is well displayed at the facilities.
- No cash registers were shown to team; it was informed that all registers were with CMO office. No MCH registers were shown as all the register were lying for MCTS entries with the DPM.
- No diet were been provided to pregnant women at the facility. Though the JSSK beneficiary are exempted from user fee, others are levied Rs 3 for OPD and Rs 11 for indoor.
- No line listing of low birth babies and severely anaemic women is done.
- Out of two ANMs posted at the SCs, 1 is SBA trained.

- Village wise entry has not started for ANC.
- The delivery register was shown, it was seen that all females entered were of age 21, males of age 29. Mothers delivered at 36<sup>th</sup> week and babies were of 2.5 Kgs. Rest registers were shown, it was informed that all registers are at home.
- Average monthly IUCD insertion is 4-5, while removal is almost 1 per month.
- The staff had no knowledge regarding Zinc.
- There are some retired ANMs in the area who conducts home deliveries, but the same are reported by the ANM under her name in the registers.
- All blood lancet kits lying unused.
- The ANM could not use the baby warmer kept at the labour room of SC.

10. Name of the facility: **CHC Baijnath**

Date of Visit: 7<sup>th</sup> November, 2012

**Major Observations:**

- It was the only facility where the team saw one inpatient.
- The facility was well maintained, the IEC regarding National Programmes and schemes was good.
- The names of RKS members user charges, staff position, citizen charter, members of Monitoring committee displayed at the facility( though some members have changed but still old names are on the wall).
- The average Pharmacy is around 150-200 OPD/day, average X-ray load – 8-10.
- The registers for meetings of RKS, etc were shown to team. The meeting has been very few and irregular. In last 6 years only 12 meeting have taken place ( 27-10-07, 13-02-08, 29-07-09, 31-10-09, 17-2-10, 14-07-10, 21-2-11, 27-07-11, 20-10-11, 1-5-11, 30—7-12).
- The RKS was registered on 16-4-2007, the certificate is valid only 14-7-12. Still this year the facility has received money.
- All funds are pooled together and expenditure is clubbed under ChikitshaPrabhandhanSamiti.
- LR was clean, all protocols displayed and are being followed by the LMO, NBCC working, SNs trained and were knowledgeable about the protocols. IMEP, BMW in place, PPIUCD not started as the LMO is not trainees. It was suggested that the LMO should be trained in CEmOC as a Pediatrician is posted there
- ARSH- Counsellor gives services to adolescents all days of the week.
- NGO Udaan has identified adolescents to start Peer Group training.
- OT was good and minor surgeries and sterilisations are conducted by visiting OBGs.

## District Pithoragarh

### 1. Name of the facility: **DH (Mahila Hospital)-PITHORAGARH**

#### Major Observations:

- a. This is the only hospital in the district where CeMoc facilities are available, all referrals from the district are to this hospital.
- b. It is a 42 bedded hospital but is facing acute staff shortage ( in terms of doctors and staff nurses)
- c. It has well maintained OT (about 3 to 4 surgeries take place daily) mostly caesareans. The gynecologist is overloaded with both clinical and administrative work and urgently requires support.
- d. One staff nurse is trained in PPIUCD ( 6 PPIUCDs have been inserted since June 2012)
  - Total number of deliveries in October,2012-274(253 normal/ 21caesarian/2 cases referred to higher facility)
  - 152 male/124 female children born
  - Blood arrangements made from nearby Male Hospital
  - Ultrasound facility available
  - Total no. of cases provided free and cashless delivery-274
  - 179 cases provided drop-back through Khusiyonkisawari
  - Single gynaecologist in entire district
  - NBSU facility available for neo-nates
  - 21 MVA,10 D& C conducted in October,2012
  - All staff were residing either in the facility or very near to it.

### 2. Name of the facility: **DH(Male Hospital) –PITHORAGARH**

#### Major Observations:

- Functional hospital with availability of Inpatient, outpatient and emergency services.
- Blood bank facility and pathologist available. This is the only blood bank in the district. There is no blood storage point in the district beyond DH. CHC Dharchula has proposed BSU, however still to be operationalized.
- Hospital had ICTC and ARSH clinic functional, providing services once a week. There were 2 NGOs providing referral services to ICTC
- RogiKalyanSamiti functional however had no NGO member nominated in it.
- ANM training school, District drug store were located near to the hospital buildings, however both these were cramped and needed urgent up gradation. PromIS system still not fully functional. The ANM training school had 5<sup>th</sup> batch of ANM training since its re- start. Skill lab was functional in the ANM training

school. A small library was also available. Computer with internet facility was not available in the library.

- District cold chain and vaccine store, was loaded with many non-repairable and non-functional cold chain equipment. Many of the working DF/ ILR were not connected with voltage stabilizers. Some of the equipment's didn't had working thermometers.

3. Name of the facility: **BOGTA-AWW CENTRE**

**Major Observations:**

- 15 kids being taken care of in the centre,
- AnganwadiSahayika informed that drug kit has been provided by the State, including prescription drugs like Metronidazole syrup, IFA tablets,ORS packets, Crocin syrup etc.
- The ASHA informed that she receives approx.Rs.1000/- in a month that too limited to vaccination drive. She reported that under FP activities, sale of OCPs was being undertaken; however sale of condoms was not common.
- There is very little coordination with the health department and the ASHA.

4. Name of the facility: **CHC-GANGOLIHAT**

**Major Observations:**

- Caters to 1 lakh population, Citizen's Charter painted on the walls of the facility
- The staff included 2 MOs, 1 Ayurvedic doctor, 1 Dental surgeon & 1 Pharmacist,1 Staff Nurse(permanent) and 4 contractual Staff Nurses, only one is SBA trained. Only services of DOTS technician available
- 2 DF/1ILR available, hub cutters not available, no diluents found for Measles vaccine
- 0 dose polio not being given to new borns.
- Average of 100 OPD per month, no blood facility available,40-100 patients for AYUSH services
- Diet for women arranged from nearby hotel
- Payment to JSY beneficiaries not on time
- User charges were being charged except from pregnant women and BPL category
- Deliveries were being conducted by MBBS doctor, on an average 45-55 deliveries in a month
- 4-5 MTPs were conducted in a month
- The ayurvedic doctor is delinked from the allopathic department.
- The OT was well maintained and equipped
- Emergency medicines like magnesium sulfate was not available in the labor room and the staff were not aware its use.

- Most ANMs are IUCD trained but have not inserted IUCD for long time as there are very few cases.
- ASHAs were well aware of their responsibilities. They were actively involved in Social marketing of contraceptive scheme.
- Waste management was as per norms.
- USG machine available but they are not done as there is no ultra-sonologist

5. Name of the facility: **APHC-ASKOTE**

**Major Observations:**

- No MO since 2009,1 Pharmacist, 1 AYUSH MO (contractual), 1 Ward Boy, Lady Health Inspector
- No residences in the premises. All staff was residing very near to the facility.

6. Name of the facility: **SC-ASKOTE**

**Major Observations:**

- 2 ANM (contractual), 2 Staff Nurses, 1HB. (Only SNs were available the ANMs had gone to collect vaccines and taken all available records so nothing was available at the center).
- 3 deliveries in October, 2012, the facility where delivery occurs is far away from the toilet
- Food is arranged from nearby hostel during daytime and staff help out at night
- No waste segregation, placenta buried in pits on the compound, no contraceptive supply available at facility, neither any vaccine supply observed-vaccines obtained from Kanaricheena PHC and stored in referigator.
- Emergency medicines like magnesium sulfate was not available in the labour room.
- Misoprostol was found to be near expiry and fresh stock had not been ordered.
- Most ANMs are IUCD trained but have not inserted IUCD for long time as there are very few cases.
- Knowledge gaps among staff nurses on AMTSL and even some issues of routine immunization, highlighting need for refresher.
- The delivery facilities were as per norms though there is room for more cleanliness.
- No records available at SC

7. Name of the facility: **PHC BERINAG**

**Major Observations:**

- 4 bedded, 4 Staff Nurses(1-permanent,4-contractual)
- JSSK-no kitchen facility.
- About 40 deliveries had taken place last month.

- The labor room and OT was well maintained and emergency medicines including magsulf was available.
- Misoprostol was found to be near expiry and fresh stock had not been ordered.
- Waste management was as per norms.

8. Name of the facility: **CHC-DHARCHULA**

**Major Observations:**

- Medical Superintendent informed that 40-50 deliveries including those from neighbouring Nepal
- HR includes 1 LMO,4 Staff Nurses
- Complicated deliveries were referred to Pithoragarh DH (which is at a distance of about 5 hours and roads are very bad.)
- Knowledge gaps among staff nurses on AMTSL and even some issues of routine immunization, highlighting need for refresher.
- Most ANMs are IUCD trained but have not inserted IUCD for long time as there are very few cases.
- The OT was well maintained and equipped
- All staff were residing either in the facility or very near to it.
- ASHAs were well aware of their responsibilities. They were actively involved in Social marketing of contraceptive scheme and JSY and JSSK.
- Caters to 54,000 population.

9. Name of the facility: **PHC-KANARICHEENA**

**Major Observations:**

- Situated within the block, however approach road to the facility is quite tedious, especially for pregnant women. It was informed that a new building has been constructed for shifting this facility.
- Staff included 1 MO, 2 Staff Nurses,2 ANMs and 1LHV
- 6-10 deliveries per month,
- 20-25 OPD per month.
- Labor room is small and cramped and there is no bed for the delivered woman to lie down.
- No residences in the premises. All staff was residing very near to the facility.
- Emergency medicines like magnesium sulfate were not available in the labor room.
- Misoprostol was found to be near expiry and fresh stock had not been ordered.

10. Name of the facility: **PHC Egyardevi**

**Major Observations:**

- Located close to the HQ
- Referrals to the DH
- Clean and well maintained located on the main road , good ambiance
- Staff as per norms( few live in premises others live nearby)
- MO trained in vasectomy but not doing any for past 3 years
- Staff nurses and ANMs trained in SBA and IUCD insertion but not using partograms.
- Labor room is well maintained.
- JSY and JSSK are operational and payments are on time
- All essential drugs are there including Magsulf and misoprostol.

11. Name of the facility: **PHC Muwani**

**Major Observations:**

- The PHC Muwani is termed as Additional PHC and administratively controlled by PHC KanaliChhina.
- At the time of visit one Ayush Doctor, one Pharmacist, two staff nurse under NRHM was available. The ANM went to Block PHC for collection of Vaccine
- The Vaccine are collected one in a month and kept at the domestic refrigerator belongs to ANM. The staff informed that there is a problem in continuous power supply which means the vaccine which are kept in domestic refrigerator may become ineffective till the time of administration
- The four bed PHC cater services to approx. 20,000 population
- Here while speaking to PRIs who are member of Village Health as sanitation and Nutrition committee the CRM team came to know that the signatory in VHSNC is not as per the guideline prescribed by central government
- The ILR was not working properly since 2 month and complain have been registered at District Head quarter
- Integration of Ayush was missing / In absence of Allopathic Doctor the services of Ayush Doctor is not been utilized fully
- The Untied fund /Annual Maintenance Grant available of each PHC are not been used properly. The infrastructure required adequate wiring/cabling to run the equipment. The staff of the PHC are not empowered even to buy a extension wire by which the problem could have been managed temporally
- The account books are not maintained at the PHC (Cash flow register). Delay in payment of JSY fund
- The infrastructure needs some urgent fund it make it inmate friendly mainly for security purpose for the female staff nurse and ANM
- The staff of the PHC claims that the center runs 24 hours and the Staff nurses and ANM is staying nearby (in the residential quarter within the campus)

- The Baby tray of the radiant baby warmer was not available with the warmer. The staff told that it has never been supplied.
- As per the community the Mobile Medical Unit /EMRI 108 are providing good services.



Image 18: Approach to PHC Muwani, Pithoragarh

**Annexure 1:****Underutilisation of LSAS and EmOC trained MOs in the State of Uttarakhand:**

Staff position has been analysed and irrational deployment of most of the multi-skilled MOs was observed. There are 26 LSAS and 16 EmOC trained MOs in the State. They have been posted to various PHCs and even those in CHCs are not performing. Detailed table is given below:

Table: 31

S. No.	Name of the Trained MOs	Place of Posting	Performance		Remarks and recommendations (All MOs have been posted since 2009-10)
			Aug (ND/CS)	Sep (ND/CS)	
1)	Dr. Anurag Dhani k, (LSAS) Dr. Kanak Banaut h (EmOC)	CHC Vikash Nagar, Dehradun	120/0	125/0	LSAS and EmOC both are posted in one health facility yet are not doing C-Section.
2)	Dr. Rajeev Kumar Dixit (LSAS)	PHC Tyuni, Dehradun	16/0	17/0	LSAS is posted at PHC. Can be shifted within the district for optimal utilisation of the acquired skills.
3)	Dr. Veenita Sayan a <b>EmOC</b>	CHC Premnagar, Dehradun	Not DP		EmOC is conducting less than 20 deliveries/month.
4)	Dr. Lal Singh Vohra (LSAS), Dr. Namrata Tripathi (EmOC)	CHC Didihat, Pithoragarh	No CS	No CS	LSAS and EmOC both are posted in one health facility yet are not doing C-Section.
5)	Dr. M. S. Rawat (LSAS)	CHC Ganyalihat, Pithoragarh	48/0	42/0	Can be shifted within the district for optimal utilisation of the acquired skills.
6)	Dr. Monika Kharkwal <b>EmOC</b>	Distt. Female Hospital, Pithoragarh	248/27	238/19	
7)	Dr. Manjeet Singh (LSAS)	Distt. Hospital, Bageshwar	117/6	102/1	Despite being high focus district, Total 1 CeMOC, 2LSAS, 1 paediatrician. Only DH is conducting C-Sec and the rate is very low.
8)	Dr. Akhilesh Kumar (LSAS)	PHC Loharkhet, Bageshwar	Not DP		
9)	Dr. G. B. Pangariya (LSAS) Dr. Deepali Phoni a (EmOC)	CHC Joshimath, Chamoli	No CS		LSAS and EmOC both are posted in one health facility yet are not doing C-Section.
10)	Dr. Meena Kumar <b>EmOC</b>	CHC Gairsain, Chamoli	28/0	47/0	Only EmOC is posted in the facility. EmOC can be shifted to other functional delivery points or can be strengthened by providing LSAS/ Anaes to make this facility a DP.
11)	Dr. Manmohan Sharma (LSAS)	CHC Agustmini,	Left job		Only DH is conducting C-Sec and the rate is very low. (3%).

		Rudraprayag			The MO has left the Job and joined UP govt services
12)	Dr.Harendra Prasad(LSAS)	CHC Bironkhal, Pauri	Not DP		These LSAS can be shifted to other functional delivery points or can be strengthened by providing OBG/EmOC to make this facility a DP.
13)	Dr.Shailendra Kumar Bathwal(LSAS)	CHC Rikhnikhhal, Pauri	Not DP		
14)	Dr. Rahul Laspal(LSAS)	Combined Hospital, KotdwarPauri	196/17	237/5	Individual performance needs to be monitored for conducting C-section
15)	Dr.KailashGunjiyal (LSAS) Dr.RenuAuli (Gunjiyal) (EmOC)	CHC Pabo, Pauri	Not DP	(<20 ND)	LSAS and EmOC both are posted in one health facility yet are not even conducting normal delivery.
16)	Dr.RashmiRawat <b>EmOC</b>	CHC Jayharikhal, Pauri	Not DP	(<20 ND)	EmOC can be shifted to other functional delivery points or can be strengthened by providing LSAS/ Anaes to make this facility a DP.
17)	Dr.Priyanka Singh(LSAS)	CHC Bhawali, Nainital	Not DP		These LSAS can be shifted to other functional delivery points or can be strengthened by providing OBG/EmOC to make this facility a DP and vice versa.( within the same district)
18)	Dr.Kuldeep Singh Martoliya(LSAS)	PHC Bhimtal, Nainital	Not DP		
19)	Dr.AmitRatan Singh(LSAS)	CHC Kotabag, Nainital	Not DP		
20)	Dr.RichaKandwal <b>EmOC</b>	B. D. Pandey Female Hosp. Nainital	48/1	40/0	
21)	Dr. D. S. Nabiyal(LSAS)	PHC Tadikhhet, Almora	Not DP		Can be shifted within the district for optimal utilisation of the acquired skills.
22)	Dr.SantoshParkhi <b>EmOC</b>	Comb. Hospital Ranikhhet, Almora	No C-Sec		
23)	Dr.Dharmendra Uniyal(LSAS)	PHC Pratapnagar, Tehri	21/0	16/0	LSAS can be shifted to other functional delivery points or can be strengthened by providing OBG/EmOC to make this facility a DP.
24)	Dr.Sanjeev Kumar Kataria(LSAS)	<b>SAD Magron, Tehri</b>	Not DP		SADs provide only OPD services. Trained MO is a complete mismatch.
25)	Dr.Preeti Rani Chauhan <b>EmOC</b>	CHC Hindolakhhal, Tehri	24/0	32/0	LSAS can be shifted to other functional delivery points or can be strengthened by providing OBG/EmOC to make this facility a DP and vice versa.( within the same district)
26)	Dr. A. K. Srivastav(LSAS)	PHC Chamba, Tehri	32/0	37/0	

27)	Dr.Saiyad Rafi Ahmed(LSAS)	PHC Arakot, Uttarkashi	Not DP		These LSAS can be shifted to other functional delivery points or can be strengthened by providing OBG/EmOC to make this facility a DP and vice versa.( within the same district)
28)	Dr.Sudha Singh <b>EmOC</b>	Distt. Female Hospital, Uttarkashi	148/2	153/3	
29)	Dr.Dhirendra Mohan(LSAS)	CHC Jaspur, U. S. Nagar	48/0	42/0	These LSAS can be shifted to other functional delivery points or can be strengthened by providing OBG/EmOC to make this facility a DP and vice versa.( within the same district)
30)	Dr.Pradeep Kumar(LSAS)	PHC Chakkarpur, U. S. Nagar	Not DP		
31)	Dr.NeetuVerma-EmOC	CHC Gadarpur, U. S. Nagar	Not DP		
32)	Dr.Darshan Singh(LSAS)	CHC Kichha, U. S. Nagar	92/1	141/0	
33)	Dr.ParulGoyal <b>(EmOC)</b>	Female Hosp. Rudrapur, U.S.Nagar	327/6	324/6	C-section rate is very low. Individual performance needs to be monitored for conducting C-section
34)	Dr. Anjali Gupta <b>EmOC</b>	B.D. Bhatt Hosp. Kashipur, US Nagar	188/26	188/13	Individual performance needs to be monitored for conducting C-section
35)	Dr.PradeepBisht (LSAS)	PHC Manch, Champawat	Not DP		Can be shifted within the district for optimal utilisation of the acquired skills.
36)	Dr.RashiBhatnagar <b>EmOC</b>	CHC Lohaghat, Champawat	109/0	92/0	
37)	Dr. S.P. Singh(LSAS)	PHC Kota Muradnagar, Haridwar	Not DP		The LSAS can be shifted to other functional delivery points or can be strengthened by providing OBG/EmOC to make this facility a DP.

### Human Resource: Specialists and Multi-skilled MOs in Uttarakhand:

Table: 32

S.No	District	Gyne	CEMOC	Anesthetist	LSAS	Peaditrician
1	Almora	5	1	3	1	4
2	Bageshwar	1	0	0	2	1
3	Chamoli	2	2	1	1	1
4	Rudraprayag	1	0	1	1	0
5	Haridwar	4	0	5	1	5
6	Nainital	18	1	8	3	8
7	Pithoragarh	1	2	2	2	3
8	Uttarkashi	0	1	0	1	2
9	Dehradun	22	2	10	2	17

10	U.S.Nagar	4	3	3	3	8
11	Tehri	0	1	0	3	1
12	Champawat	1	1	1	1	3
13	Paurigarhwal	3	2	3	5	6
	Total	62	16	37	26	59