NATIONAL RURAL HEALTH MISSION

4th COMMON REVIEW MISSION

KERALA

15th December to 23rd December, 2010

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CHAPTER 1 - TEAM MEMBERS

The CRM members were briefed by Mr. Saurabh Jain, Mission Director on 16th December, 2010. The representatives of the Director of Medical Education and Director of Medical Services as well as the State level programme managers (RCH, IDSP, NVBDCP, TB, Leprosy, Blindness control etc) and State Health Mission Consultants were present during the briefing session. The team was apprised of the present health sector status and the progress in NRHM activities. During the interactions the Kerala officials were informed of the issues raised by various programme divisions of MoHFW, Govt. of India. Thereafter two teams were formed and one team visited Kottayam district while the other team visited Kozhikode District. The Teams visited the districts from 17th December to 19th December 2010. The teams in addition to the visit to the facilities had detailed briefing by the District Officials at the District HQs. After the visits to the districts the team provided a feedback to the hon"ble Health Minister and State Health Secretary and other officers on 20th December, 2010 at Thirurvanthapuram. Details of the team members along with the districts visited are as follows:

Table I : Details of Team Members

S. No	Name	Designation	District
1.	Dr. S. K. Sikdar	Assistant Commissioner, Family Planning Division Ministry of Health and Family welfare Nirman Bhawan, Maulana Azad Road, NewDelhi	Kozhikode
2.	Ms. Sushma Rath	Principal Administrative Officer National Health Systems Resource Centre NIHFW Campus, Baba Ganganath Marg, Munirka, New Delhi-67	Kottayam
3.	Mr. Ajith Kumar	Deputy Director NRHM-II Ministry of Health and Family welfare Nirman Bhawan, Maulana Azad Road, New Delhi	Kottayam
4.	Dr. Ravi Kumar	Office of the Regional Director, NVBDCP Bangalore, Karnataka	Kozhikode
5.	Dr. Ute Schumann	European Commission, 16, Golf Links, New Delhi – 110003	Kottayam
6.	Ms. Kavita Naryan	Head, Hospital Services Unit Public Health Foundation of India ISIS, Institutional Area, Vasant Kunj, New Delhi 110070	Kottayam
7.	Mr. K.V.Hamza	General Secretary, Delhites" National Institute in Palliative Care A-170 Pandara Road, New Delhi-110003	Kozhikode
8.	Ms. Nirmala Mishra	Consultant NRHM , Ministry of Health and Family welfare Nirman Bhawan, Maulana Azad Road, New Delhi	Kottayam
9.	Dr. Sumegha Sharma	Consultant NRHM , Ministry of Health and Family welfare Nirman Bhawan, Maulana Azad Road, New Delhi	Kozhikode

CHAPTER 2- INTRODUCTION OF THE STATE

Introduction

Kerala may be divided into three geographical regions (1) high land (2) mid land (3) low land. The high land slopes down from the Western Ghats, which rise to an average height of 900m, with a number of peaks over 1,800 m in height. This is the area of major plantations like tea, coffee, rubber, cardamom and other species. The mid land lies between the mountains and the low lands. It is made up of undulating hills and valleys. This is an area of intensive cultivation - cashew, coconut, areca nut, cassava, banana, rice, ginger, pepper, sugarcane and vegetables of different varieties are grown in this area. The 'Western Ghats' with their rich primeval forests having a high degree of rainfall, form the eastern boundary and extend from the north to Kanyakumari in the south. The entire western border is caressed by the Arabian Sea. Between these natural boundaries lies the narrow strip of land extending from Kasarkode in the north to Parasala in the south.

The state of Kerala has an area of 38,863 sq. km. and a population of 31.84 million. There are 14 districts, 152 blocks and 1364 villages. The State has population density of 819 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 9.43% (against 21.54% for the country) and the population of the state is growing at a slower rate than the national rate.

Administrative Units

There are 14 districts in the state with 63 Taluka, 152 Development Blocks, 999 Panchayat, 1452 Revenue Villages, 5 Municipal Corporations and 53 Municipal Councils. The administrative units in the State are given below:

Table II :Administrative Units of Kerala

Administrative Units	Numbers
District	14
Taluka	63
Panchayat	999
Blocks	152
Revenue Village	1452
City Corporation	5
Municipalities	53

Demographic Profile

The population of Kerala as of 1st March 2001 stood at nearly 32 millions, of which 15.5 million were males and 16.4 million were females. Kerala registered the growth rate of above 2% during 1941-71 whereas the same pattern was true for India between 1961-91. Until 1971, Kerala‟s growth rate was always higher than India's and only during 1971-81 India overtook Kerala in terms of growth rate. Over a period of 100 years, Kerala's population

increased five times (6 million in 1901 to 32 million in 2001) whereas India‟s population could grow slightly more than 3 times (238 million in 1901 to 1027 million in 2001). However the growth rate during the last decade works out to be 0.94 per cent, the lowest after the formation of Kerala State. Kerala has also registered the lowest growth rate during 1991-2001 among 35 states and union territories in India.

Table III: Census Demographic data of Kerala

CENSUS 2001		
Population	Total	31 841 374
	Male	15 468 614
	Female	16 372 760
Population Density (persons per sq. km)		819
Male Population (%)		48.58%
Estimated Urban Population	Total	8 266 925
	(%)	25.96%
Scheduled Caste population	Total	3 123 941
	(%)	9.81%
Scheduled Tribes population	Total	364 189
	(%)	1.14%
Sex ratio		1058
0-6 age group	Total	3 793 146
	(%)	11.91%
	Male	1 935 027
	(%) of total 0-6 age group	51.0%
	Female	1 858 119
Disabled persons	Total	860 794
	% of population	2.7%
	Male	458 350
	Female	402 444
	Seeing	334 622
	Speech	67 066
	Hearing	79 713
	Movement	237 707
	Mental	141 686
Household size		4.7
Population above 60 years in 2001 (%)		15%

Health Indicators of Kerala

The Total Fertility Rate of the State is 1.7. The Infant Mortality Rate is 12 and Maternal Mortality Ratio is 95 (SRS 2004 - 06) which are lower than the National average. The Sex Ratio in the State is 1058 (as compared to 933 for the country). Comparative figures of major health and demographic indicators are as follows:

Table IV: Demographic, Socio-economic and Health profile of Kerala State as compared to India figures

S. No.	Item	Kerala	India
1	Total population (Census 2001) (in million)	23.574	1028.61
2	Decadal Growth (Census 2001) (%)		21.54
3	Crude Birth Rate (SRS 2009)	14.6	22.8
4	Crude Death Rate (SRS 2009)	6.6	7.4
5	Total Fertility Rate (SRS 2009)	1.7	2.6
8	Sex Ratio (Census 2001)	1058	933
9	Population below Poverty line (%)	12.72	26.10
10	Scheduled Caste population (in million)	3.12	166.64
11	Scheduled Tribe population (in million)	0.36	84.33
12	Female Literacy Rate (Census 2001) (%)	87.8	53.7

Table V: RCH Vital Stats profile of Kerala State as compared to India figures

RCH II GOAL	KERALA	India
	Current status (Specify year & source)	Current status
MMR	95 Special Survey on MMR 2004-6 75 (as per DHS 2008 data)	301(SRS 01-03)
IMR	13 (SRS 2007) 12 (SRS 2008)	55 (SRS 2007)
TFR	1.7 SRS 2006	2.9 (SRS 2004)

(NRHM, Kerala, State Health Action Plan, PART A, B, C 2010-11, GOK, Jan 2010)

Health Infrastructure

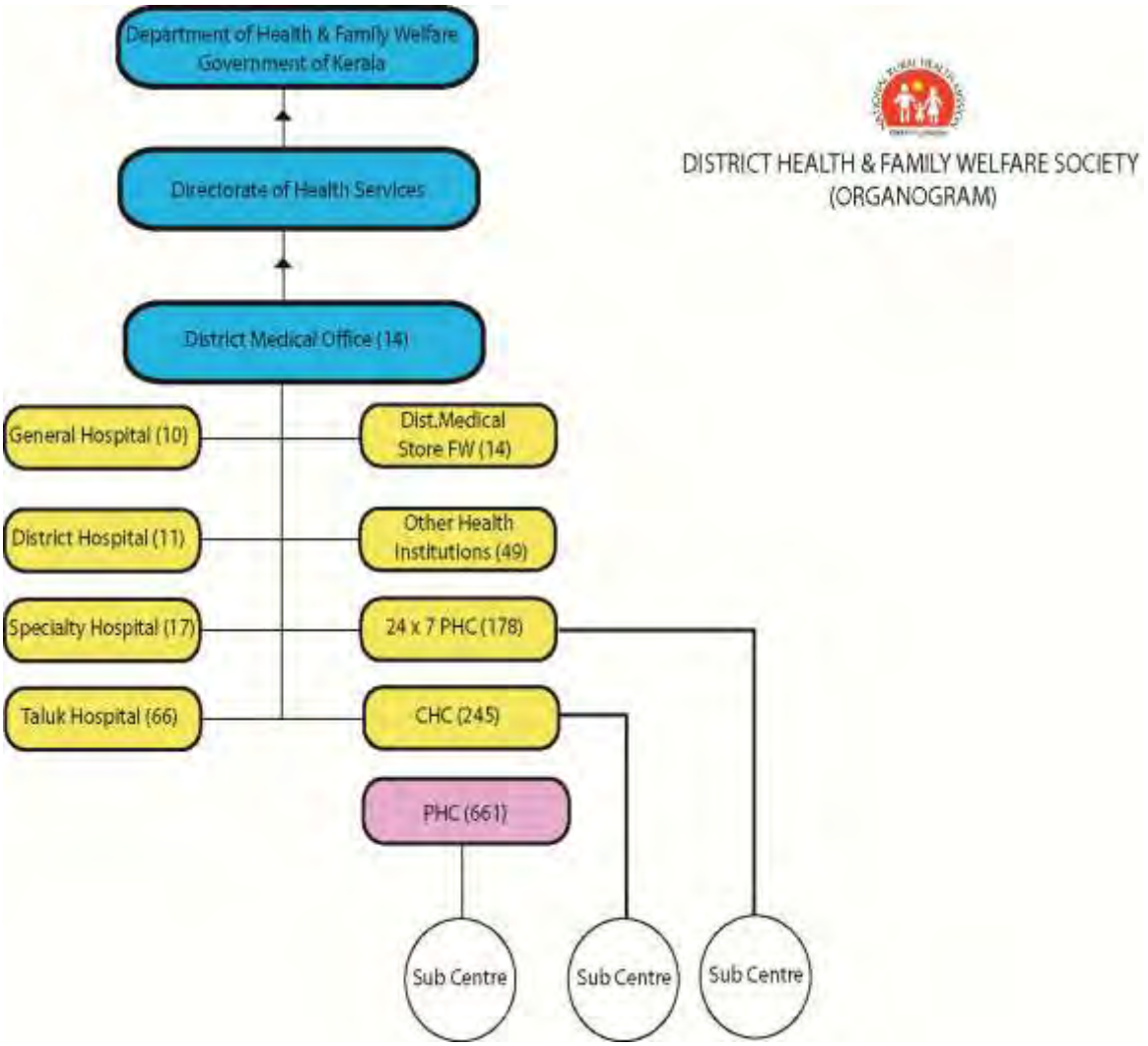
There are five directorates under Health Services Department.

1. Health Services Department
2. Medical Education Department
3. Department of Indian Systems of Medicine
4. Department of Ayurveda Education
5. Department of homeopathy

Health Services Department

The main function of the Health Department is the delivery of Primary Health Care in a wholesome manner and attainment of Family Welfare including Maternal and Child Health Care. The main activities of the Department of Health Services comprises of preventive and promotive Health Care and routine curative services besides rehabilitative aspects of total Health Care in a comprehensive manner in addition to the implementation of Family Welfare programme and other disease control programme through a three tier health delivery system.

Figure I: Organogram District Health and family Welfare society



Health Infrastructure of Kerala

Table VI: Health Infrastructure of Kerala

Particulars	Required	In position	shortfall
Sub-centre	4761	4575	186
Primary Health Centre	791	697	94
Community Health Centre	197	226	Surplus
Multipurpose worker (Female)/JPHN at Sub Centres & PHCs	5272	5320	Surplus
Health Worker (Male) MPW(M) at Sub Centres	4575	4728	1921
Health Assistant (Female)/LHV at PHCs	697	695	2
Health Assistant (Male) at PHCs	697	544	153
Doctor at PHCs	697	1063	-
Obstetricians & Gynaecologists at CHCs	226	NA	NA
Physicians at CHCs	226	NA	NA
Paediatricians at CHCs	226	NA	NA
Total specialists at CHCs	904	110	110
Radiographers	226	113	216
Pharmacist	923	1672	5
Laboratory Technicians	923	773	576
Nurse/Midwife	2279	7795	-

(Source: RHS Bulletin, March 2009, M/O Health & F.W., GOI)

Health Institutions

Table VII: Health I Institutions of Kerala

Health Institution	Number
Medical College	5
District Level Hospitals	39
Referral Hospitals	65
City Family Welfare Centre	0
Rural Dispensaries	18
Ayurvedic Hospitals	117
Ayurvedic Dispensaries	724
Unani Hospitals	-
Unani Dispensaries	1
Homeopathic Hospitals	30
Homeopathic Dispensary	526
Sidha Hospitals	3
Sidha Dispensaries	6

(Source: RHS Bulletin, March 2009, M/O Health & F.W., GOI)

Health infrastructure

Table VIII: Public Health facilities of Kerala

S. No.	Total Govt. Allopathic Institutions	Numbers	Beds
1	General Hospitals	10	4101
2	District Hospitals	11	4115
3	Speciality Hospitals	18	5392
4	Taluk Hospitals	65	9884
5	Community Health Centres	245	6942
6	24X7 Primary Health Centres	178	3300
7	Primary Health Centres	661	2169
PHCs Total 6+7		839	35903
8	T.B. Centres/Clinics	17	176
9	Other Institutions	49	198
Speciality Category Wise			
1	W&C Hospitals	7	1436
2	Mental Health Centre	3	1342
3	TB	3	508
4	Leprosy	3	1916
5	Others	2	90
Total		18	5295
Other Institutions Category wise			
1	Govt Hospitals/Health clinics	6	292
2	Mobile Units/ Mobile clinics	17	0
3	Government Dispensaries	26	82
Total		49	0

(Source: Kerala State Health Society, as on 31-12-2008)

AYUSH

The three branches of health care system of modern medicine, ayurveda and homoeopathy has acceptance in Kerala. Three systems together have 2711 institutions in the government sector. Out of the total institutions, 47% are under Allopathy and 53 % under AYUSH. In Kerala there are three separate Directorates for Indian System of Medicine, Ayurvedic Medical Education and Homeopathy.

There are 115 Ayurveda Hospitals with 2744 beds and 747 Ayurveda dispensaries. Out of the dispensaries, four are Visha chikilsa kendras, 6 Siddha and one Unani. Hospitals include 14 district hospitals, one nature cure hospital, one Marma hospital, one Siddha hospital, one Panchakarma hospital, one Ayurveda Mental hospital and 96 government hospitals.

There are now 14 Ayurveda colleges in Kerala, of which 3 are in Government sector, 2 are in private sector and 9 are in self-financing sector. These colleges have an annual intake of 680 students for BAMS/BSMS courses and 82 students for postgraduate courses.

There are 31 hospitals and 525 dispensaries under Directorate of Homoeopathy. Hospitals include 14 district and 17 other hospitals. Total bed strength of these hospitals is 970.

There are 5 Homoeopathic Medical Colleges in the State, of which 2 are under government sector and 3 are in private aided sector. Total annual intake for BHMS course is 250 and for PG course is 60. Besides, the two government colleges conduct one-year nurse cum pharmacist course with an annual intake of 60 students each. The hospitals attached to these colleges have 325 beds.

Private Medical Institutions

Table IX: Private Medical Institutions of Kerala

S.NO	SYSTEM OF MEDICINE	YEAR		
		1986	1995	2004
		No.	No	No.
1	Modern Medicine	3565	4288	4825
2	Ayurveda	3925	4922	4332
3	Homoeopathy	2078	3118	3226
4	Others	95	290	535
Total		**9663**	**12618**	**12918**

(Source: NRHM, Kerala, State Health Action Plan, PART A, B, C 2010-11, GOK, Jan"10)

Kerala has a vast health care infrastructure under Modern Medicine, Ayurveda and Homoeopathy systems of medicine. In the health sector the role of private sector is significant. Under private sector, all the three systems together have 12383 medical institutions. The total bed strength in the three main systems viz. Modern Medicine Ayurveda, Homoeopathy is 63386. Out of it, 88% of beds and 37.35% of medical institutions are under Modern Medicine, 33.53% medical institutions and 8.53% beds are in Ayurveda. Homoeopathy institutions constitute 24.97% and beds under it are 1.26%. There are 24401 doctors under private sector. The strength of nurses available for health care

services under private sector is 20164, paramedical staff consists 12910 excluding nurses. (NRHM, Kerala, State Health Action Plan, PART A, B, C 2010-11, GOK, Jan 2010)

In Kerala there is no state wise registration system for Hospitals. Hence the accurate details of the private hospitals are not available. Presently, the private hospitals are not under the control of Government. Government of Kerala has recently prepared a draft Clinical Establishment (Registration and regulation) bill 2009 for registration of all hospitals including private hospitals.

Human Resources

There are 24991 medical and para medical personnel attached to Directorate of Health Services 3862 are medical officers, 81 dentists, 8646 senior/junior nurses and 12538 para medical staff. While analyzing doctor Population ratio in Kerala, for every 8545 population there is one medical officer under Directorate of Health Services with considerable inter district variation. Doctor population ratio varies from 1:6252 in Pathanamthitta district to 1:11486 in Malappuram district.

Table X: Public Health Human Resource of Kerala

Number of doctors in health services department		3862
Number of JPHN		5583
Number of JHI		3511
Number of LHI		962
Number of HI		876
Number of LHS		157
Number of HS		168
No of Doctors in Public Health Care Institutions	TOTAL	5758
	DHS	3862
	Medical Collage	1342
	ESI	554
Doctor Population Ratio. Public		6162
Doctor Population Ratio. (Private and Public)		2305

(NRHM, Kerala, State Health Action Plan, PART A, B, C 2010-11, GOK, Jan 2010)

PRI Framework

18003 Village Health & Sanitation Committees (VHSC) are established in villages The Patient Welfare Societies (RKS) were established in all 14 district hospitals, 226 CHCs and only at 839 PHCs. The State has 991 Grama Panchayats, 152 Block Panchayats, 14 District Panchayats, 53 Municipalities and 5 Corporations. Consequent to the 74th Amendment to the Constitution of India, the Local self-government Institutions (LSGIs) are to function as the third tier of Government. In Kerala, LSGIs have been meaningfully empowered through massive transfer of resources as well as administrative powers. Coupled with a grassroots level approach of Participatory Planning whereby the developmental programmes are identified and implemented through Grama Sabhas, the LSGIs have emerged as effective agencies for the implementation of developmental programmes.

Facilities visited by the Team

4th Common Review Mission				
17th December 2010 to 23rd December 2010				
Name of State			Kerala	
Kottayam DPM Dr P R Mohandas, DMO Dr V V Venus, A-DMO, Dr Bindu and Dr Aishabai				
S.No	Name	District HQ	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	District Hospital,Kottayam	Kottayam	DH	Dr Susan, Dr Safia Beewi
2	Vaikkom Taluk Hospital	Kottayam	TH	Dr V R Vanaja, Dr Manoj
3	Arumootimangalam,	Kottayam	PHC	Dr Alex
4	Thalayolaparambu	Kottayam	CHC	Dr Ajith Kumar
5	Peruva	Kottayam	PHC	Dr Amrutha
7	Kozuvanal	Kottayam	PHC	Dr G I Sapna
8	Maruvanthuruthu	Kottayam	PHC	Dr G I Sapna
10	Kadanadu	Kottayam	PHC	Dr Jayanthi S
11	Karumannu	Kottayam	Sub center	Sub center
12	Keezhur	Kottayam	Sub-center	Sub-center
13	Orekkal	Kottayam	Village field visit	-
13	Orekkal	Kottayam	Sub-center	Sub-center
14	Kezhuvamkullam	Kottayam	Sub-center	Sub-center
15	Katti kunnu	Kottayam	Village field visit	

Kozhikode				
S.no	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	Govt. Women & Children Hospital	Kozhikode	DH	Superintendent, Dr. Muhammed Alias Kunhavutty
2	Anganawadi	Aanokundumal	AWC	
3	Kinaloor	Kinaloor	HSC	Jr. PHN Parvathy K.
4	CHC, Balussery.	Balussery.	CHC	The Medical Officer Dr. Ravi K. V.
5	Taluq Hospital,	Perambra	(Sub Divisional Hospital).	Dr. Deepa, Medical Officer
6	Primary Health Centre, Maruthonkara.	Maruthonkara.	PHC	The Medical Officer, Dr. Anandan,
7	CHC Kunnummel.	Kunnummel.	CHC	
8	subcentre Choyimadam	Choyimadam	HSC	The Jr. PHN Smt. Rakhi,
9	Community Health Centre Thalakulathur.	Thalakulathur.	CHC	The Medical Officer, Dr. Sindhu
10	MCH Unit Cherupa.	Cherupa.	MCH Unit	Dr. Lailabi, Adminstrative Medical Officer
11	subcentre Kanniparamba.	Kanniparamba.	HSC	Jr. PHN Smt. Seena
12	Institute of Pain &	Kozhikode district	Speciality	. Mr. Saif,

	Palliative Manager		care	Project
13	The Child Development Centre run by the IMHANS was visited. .	Kozhikode district	Speciality care	The Director, Dr. Krishnakumar
14	CHC Narikkuni.	Narikkuni.	CHC	Dr. Roopa, the Medical Officer.
15	subcentre Valiyaparamba.	Valiyaparamba.	HSC	Jr. PHN Smt. Chinnamma
16	DPMU Office & IDSP Unit.	Kozhikode district		
17	DH Ernakulum	Ernakulum district	DH	Medical superintendent
18	Floating dispensary Ernakulam	Ernakulum district	Special Innovation	DPM , Dr. K.L Beena

CHAPTER 3

FINDINGS OF 4TH CRM

Infrastructure up gradation

- The Public Health infrastructure in the State shows nearly an adequacy in terms of numbers but needs improvement especially for sub-district hospitals. A well-structured infrastructure development wing is present and is in process to meet the NABH standards and NABL standards for laboratories. The middle level health care infrastructure (CHC, PHC) received a major impetus in the process of upgradation and renovation. Fourteen hospitals were initially earmarked for NABH upgradation. Out of this upgradation work is completed in four hospitals (W&C Calicut, W&C Trivandrum, THQH Cherthala, GH Ernakulam) and work is in progress in three hospitals (THQH Thodupuzha, DH Kottayam, DH Palakkad). New Works to be started are in THQH- 18 works CHC -4 works, DH- 2 works, GH-1 work, PHC-4 works.

- Funds for infrastructure up gradation is drawn from different sources like state plan funds, NRHM and other sources .Construction of health facilities is carried out by different agencies like PWD, HLL ,HPL ,KHRWS, KSCC etc.). The upgradation of health institutions are carried out with the participation of local authorities, hospital authorities and other stake holders.

- Limited residential accommodation has been provided in most facilities for the health staff. Their condition was found to be poor in some. Wherever the residential accommodations found in liveable conditions they are not being fully utilized by medical and Para medical staff. There is a scope for proper planning of infrastructure (correcting neonatal units at same level as labour room, broadening the passage to labour room etc).

- The construction activities undertaken under NRHM have lead to creation of a patient friendly ambience in the health care units. Patients expressed their comfort especially in the waiting areas, OPDs etc because of infrastructure up gradation under NRHM. Chairs are available for them to be at ease and fans are also fitted in most of the waiting areas with exception of a very few. Provision of drinking water, television, herbal garden was also observed during the visit.

- At state level it was observed that about 50% of the NRHM payments go into infrastructure through the Kerala Medical Services Corporation. In view of the high variance in Infrastructure and Human Resources, the State is now opting for spending less into infrastructure in favour of improving Human resource and its Planning

Human Resource

- There are 24991 medical and para medical personnel attached to Directorate of Health Services out of which 3862 are medical officers, 81 dentists, 8646 senior/junior nurses and 12538 para medical staff. While analyzing doctor: Population ratio in Kerala for every 8545 population there is one medical officer under Directorate of Health Services with considerable inter district variation. Doctor population ratio varies from 1:6252 in Pathanamthitta district to 1:11486 in Malappuram district.
- Currently, health personnel are appointed into three main categories – regular permanent appointments; contractual appointments under NRHM; and under the Compulsory Rural Posting.
- As a motivation measure a separate cadre for specialists has been set up. Residency System has also started in the state.
- To ensure availability of practitioners in medicals colleges Private Practice in Medical Colleges has been banned by compensating it with enhanced remuneration.
- One year internship of BSc Nursing students undergoing their course in the Govt. Nursing Colleges and bonded services of 2 years for General Nursing and Midwifery has also been enforced to ensure availability of nurses .
- Family Friendly Hospital Initiative in MCH centres is being launched in active cooperation with IAP & FOGSI
- Appointment of new posts (block coordinator, bio medical engineer, quality assurance manager) and Innovations like Incentives for working in Rural / Difficult Rural Area, Incentive for Specialists, Call allowances for specialists & Para medical staff, Appointment of Doctors in Health Services as DPM ,Compulsory Rural Posting for MBBS doctors, Appointment of Para Medical Staff, Appointment of PROs, Engineering wing in Headquarters has shown visible impact on improvement in service delivery .The bio-medical engineers are responsible for supervision and ensuring the working of the equipments at all facilities. As medical officers are deputed as District Program Officers, they are more aware of the issues and are better informed to coordinate with the health service. The institution of block coordinators has also helped in better management of the programme at the block level. CRS has ensured a regular yearly supply of MBBS doctors for working the rural areas.
- Actual Training is not commensurate with the stated 2010-11 PIP, therefore stress on training of HR needs to be considered.

Health Services Delivery

- The literate population combined with empowered women in a matriarchal society demand a certain threshold of quality and quantity of healthcare services, way before the formalization of NRHM. This is apparent in the low utilization of primary healthcare centers, even CHCs which have nevertheless continued to be the recipient of funds for upgradation purposes. The state leadership clearly would like to have more flexibility to be able to better use these funds towards the sub district and district level facilities which face the largest population burden. Interestingly, most women use the district level facilities for antenatal care services, ultrasounds etc but choose to have their delivery only at the Medical College or other larger teaching facility, including BPL patients, as evidenced by our patient interviews.

- Systematic and consistent processes in health services delivery clearly need to be established in some cases and strengthened in others; eg, standard policy/procedure manuals, SOPs for blood sample collection, storage, bio medical equipment maintenance and management, labour room and OT procedures, sedation, resuscitation, biomedical waste management, to name a few.

- Unlike other states the Sub-Centres in Kerala deliver only basic car. HSCs do not conducts deliveries, immunization and IUD insertions. No RTI/STI fixed day clinics are operated. Haemoglobin estimations are not done at all centres although team found gluconometers at the HSCs provided by the Panchayats. Sub-center drugs were not found to be regularly supplied including contraceptives like OCPs,ECPs,IUDs and condoms.

- PHCs are not providing delivery service**s,** No RTI/STI fixed day clinics were observed also the registers for the same were not maintained, IUD insertions were reported to be done by LHIs, Laboratories were found to be ill-equipped or suboptimal functioning. The protocol of waste segregation is not strictly followed at all facilities. The PHCs which were visited also had no inpatients. The case in Kottayam was however fairly different, with the Maruvanthuruthu PHC clearly serving as a best-practice (annex 2).

- Most of the CHCs are not providing delivery and safe abortion services. Ratios of normal vs. C-sections is greatly skewed (In district Kottayam and Kozhikode, as against 48% caesareans in the state the percentage of caesareans is nearly 65% and 54% respectively. The figure quoted by District Hospital Ernakulam was an alarming 70%) , No RTI/STI fixed day clinics were observed also the registers for the same were not maintained, Laboratories were found to be ill-equipped or suboptimal functioning, Almost all CHCs have reported nil Post Partum sterilisation in Kozhikode, Diet & laundry support services were inadequate or not observed, No new born corners were present except at DH level, Disposal of bio-medical waste was found to be out-sourced in almost all facilities but varies from facility to facility. The protocol of waste segregation is not strictly followed at all facilities.

- After discussions with medical officers it was revealed that the Out Patients has increased specially due to evening OPDs, the OP time in selected institutions extended from 8 AM to 8 PM.
- Drug supply was adequate and well stacked in most facilities
- Privacy issues are not being addressed properly; curtains are missing at most places in labour rooms and wards, though clean separate toilets for males and females are observed in nearly all health facilities.
- After discussions with the state officials it was revealed that the ARSH programme is fully operational though initiated during 2008-09.
- Most of the facilities had displayed patient charter but the display of list of JSY beneficiaries, hygiene and cleanliness protocols, grievance box, essential drug list was not found in most of the facilities.

Outreach Services

- JPHN follows a 40-day cycle for house visits, clear demarcation of area with JPHNs is present and male health worker works in coordination with JPHNs.
- VHSC are working mainly for source detection and chlorination during household visits. The members are paid 1.15 Rupees (Kozhikode) per household for source reduction activity which is well structured. Chlorination is also done by WHSCs members during house visits.
- VHNDs are held as per the schedule programme. JPHN, ASHA, AWW in tandem contribute in organising VHNDs. Immunisation, ANC and awareness generation on different health issues are the major components of VHNDs, WHSCs are integrated with ICDS. Male worker also conducting surveillance activities and reports on completion of S-form under IDSP
- No seconds JPHNs are present at any sub centres but Male health workers as Health inspectors are attached with every sub centre and play a major role in surveillance and house hold visits for source reduction.
- Mobile outreach vans are functional to cater the health needs of the residents of difficult areas although it was observed during the visit that there is a shortage of Mobile medical units. Only 7 districts have provision of MMUs.
- Floating Dispensary is an innovative step to cater to the people of the island panchayats of Ernakulam and Alapuzha districts. The floating dispensary also works as „Bodhana Nauka‟ (information boat) creating awareness on various aspects of health. It visits an island village twice a week and caters to approximately 35 patients a day.

- Radio Health, the FM production under Arogyakeralam in collaboration with AIR is designed for the promotion of positive health through consistent health literacy campaign in collaboration with various sectors to assure people‟s participation in various Health care activities. Radio programmes of 30 minutes duration 4 days/ week on various subjects mainly focusing on health issues are telecast.

ASHA Programme

- ASHAs cherish their positions and are very motivated. ASHAs are at least 8th standard and above in education. All ASHAs seem to have undergone the 2nd to 4th training modules. Nearly all ASHAs are contributing for mobilizing community for availing health services
- ASHAs are involved in source reduction, immunization mobilization , ANC mobilization and household visit, promotion of palliative care; many of them have successfully contested and won elections for LSG
- Proper ID cards are available; One PHC ASHAs were in uniforms saris provided by the Panchayat. Currently ASHA are using a field diary to record their activities in the field which is primarily activity based. ASHA diary is being revised with all the formats needed for case based and component wise tracking.
- ASHAs spend average of 2-4 hrs a day in their work and average earning of ASHA is 350 per month. ASHA payments is done in the form of cash except in Trivandrum district.
- ASHAs are playing a vital role in promoting breast feeding and counselling on nutrition during ANC and PNC visits .

Reproductive and Child Health (RCH II)

- Institutional deliveries have reportedly decreased in the current year in the public facilities. It was due to participation of private facilities in JSY.
- Variance between plan spending occurs in Maternal Health, and is high Child Health, Urban RCH, institutional strengthening, training and IEC. There are contradictions in the level of variance in spending against plan and the documentation of high levels of expenditure for the individual funds at facility and district level under the additionalities from NRHM as facilities mostly reported 100% or less spending
- Good system of education and early initiation of new born breast feeding observed in few places
- State has 98% institutional deliveries. 2% home deliveries are concentrated at the block level.

- After discussion with ASHA it was revealed that they are referring the pregnant mothers for delivery directly to higher institutions like medical college and CHC which result in over burdening of the higher level facilities.

- Vit-A supplementation is through the school health programme and AWC

- No committee structure was found on maternal death audit during the visit.

- **Family planning services** is one of the weaker links of the delivery system; e.g. Limited IUD insertions observed; almost all CHCs have reported nil PPS in Kozhikode. Although the state has achieved its replacement level fertility, but it still needs to maintain its performance level to sustain its replacement level by providing basket of choices in contraceptives.

- Compensation for post partum sterilization (PPS) was low in 2009/10 at 40%, but in 2010/11 only male sterilization remained at this level, while female sterilization compensations indicate overachievement with a variance of -35.7% in Kottayam and a seven fold achievement above allocation in Kozhikode (699%).

Financial Management

- In the initial phase 2007-08, the spending from NRHM funds in Kerala has been reluctant 49%. This increased to 59% in 2008/09 and has already reached 66% in the current financial year 2009/10 until December 2010. It is acknowledged by the State that untied funds have brought about visible changes in the peripheral institutions, a notion that is supported by commoners in the field. Annual Maintenance Grants and untied funds are spent at block and ward levels in the CHC, PHC, SC and W(V)HSC in a decentralized manner, spending is at 80-90%.

- The system of management of accounts & finances being adopted by the different functionaries of Kerala Government under NRHM is a robust one with the mobilization of ICICI fund transfer mechanism put in practice unlike other States. However, the transfer of funds to the lowest functionaries in the hierarchy like ASHAS is still being through manual cash transactions. This in a long term can lead to not only lack of transparency but corruption and malpractices. The system of fund transfer through electronic media especially the ATM cards as said to be prevailing in Trivandrum district needs to be invariably implemented in all other districts of Kerala also.

- Overall, transparency in accounting observed even though in some institutions at block level, archaic systems still exist via single entry into cashbook and multiple documentation sources. There occurs to be some weakness in managing the balance between planning and spending, which led to high variances in implementation.

Underlying gaps were observed as: gaps in communicating identified needs within programme management, weak orientation towards PIP during implementation at district level, inadequate and slow response to training needs, lack of monitoring at state level.

- Taxes and Interests are handled as per guidelines. Knowledge gap in financial management amongst medical and paramedical staff complemented by NRHM Coordinator. Establishment of TALLY ERP 9 at block level as planned is required.

- Generally public financing mechanisms well established except in some pockets. Electronic accounting in TALLY ERP 9 at district level established. Electronic funds transfer introduced in Kerala in 2006/07 and fully operational. E-banking innovation: interface lead bank /TALLY established. System of concurrent audit established with independent agency and support of block coordinators. Statutory audit carried out and submitted last week of November to MOHFW.

- Financial Management Report: Accounts are reconciled daily, advances recorded properly. Monthly Statements of Expenditure are produced. There are quarterly FMR submissions to MOHFW. Monthly consolidation at District level with innovative mechanism like peripheral financial reporting is submitted within 1st week of each month to District Society and Conference day on the 5th of each month through participation of DPM, MO, JPHN, RCH Officer et al. to discuss peripheral financial reporting. Reporting and discussion thereof consolidated and uploaded into TALLY by DPMSU, sent to SHQ, Mission Director, et al within 15 to 20 days. High volume of FMR heads considered unnecessary, e.g. on ASHA payments for mental health, RCH incentives, etc. Requires high workload of internal control up to below district level and reporting requirement. FMR uploading to HMIS is sufficient as per FMR heads of NRHM.

Nutrition

- Overall, under nutrition is not a significant issue that the state deals with as a whole, and this was evident in the district of Kottayam as well. However, what the overall indicator has resulted in is an attitude of complacence and therefore, structured, organised programmes to promote nutrition seemed lacking. The ASHAs and ANWs all indicate that they undertake the requisite awareness and educational activities re: maternal and child health nutrition, adolescent health etc. but there is no clear evidence of the same in Kottayam. IEC/BCC materials were sporadic and not consistently visible (for e.g, all through the Taluk hospital in Vaikkom, in only one place outside the female ward did we see a poster on breast feeding health. Again, the assumption by the health workers and nurses is that this is so prevalent as a practice that they do not need more education.

- It was interesting to note that several prenatal women suffer from increased blood pressure and diabetes, thanks to the diet rich in carbohydrates and sugars (rice, coconut, etc.). This then results in an alarmingly high rate of C-sections, some seemingly because women refuse to undergo the labour pains associated with a natural birth but a large part due to complications resulting from the mother‟s health condition causing preeclampsia many a time. This naturally calls for an intervention at several levels; starting from nutritional counseling and then regular compliance monitoring during the pregnancy, regular check and control of BP and blood sugar, associated fitness activities and finally, strong and repeated IEC/BCC to choose natural birth.

- Post partum nutrition also typically tends to be low on protein and this needs to be changed. Kanji or rice porridge is part of the staple mid day meal in all the school health programmes including the right nutrient balance needs to be considered.

- Nutritional Supplementation of the Pregnant and lactating women, Adolescents and under five children is done by the Social Welfare department through the Anganwadi and Ward Health & Nutrition Days. Supplementation of the Micronutrients namely Iron, Folic Acid, Vitamin A, Zn etc are being done by the Health Department. Anganwadi Centres are mainly addressing nutrition programme and maintaining growth charts. Anganwadi worker is giving supplementary food as per guidelines.

- Low birth weight registers are not maintained properly at sub centres therefore there is no tracking of low birth weight babies at sub centre level.

- Screening of height and weight of children is performed under school health programme

- No Nutrition Rehabilitation Centres existing or planned. Almost nil cases are reported of grade III&IV malnutrition

- The district of Thiruvanthapuram however has undertaken a best practice pilot programme on Nutrition (see annexure 1) that needs to be examined and replicated across the state.

National Disease Control Programmes

(Integrated Diseases Surveillance Project (IDSP)

- It is appreciable to note that the daily communicable diseases surveillance reports are being prepared and communicated properly from almost all the subcenters and PHCs visited. However the integration of this reporting with that of IDSP was found to be lacking at health facility and district level. At the subcenter level, the weekly Form S are not being put together properly. For months together fever and diarrhoea cases are shown as nil in many subcenters. Form P is also not being prepared properly in many institutions. While in majority of institutions visited, the provisional diagnosis

is being entered properly; in some cases the OPD register shows no provisional diagnosis.

- IDSP requires weekly syndromic surveillance in all the subcenters. With the 40 and 20 day cycles of the health workers, the weekly surveillance is not happening. The Form S is being prepared based only on information generated from Anganwadi workers etc at the village level.

- The objective of IDSP is to build a decentralized monitoring and action mechanism. This is possible when the PHC medical officers analyze the Form S and Form P being submitted by their organization regularly. However it was seen that Form S and Form P are not being analyzed at PHC /CHC level and are submitted as a ritual.

- The W & C Hospital and some CHC paediatricians and physicians are not aware of the epidemiological significance of either daily or weekly IDSP formats. They are not aware of the case definitions of malaria, dengue or acute encephalitis syndrome.

- There is need to have orientation trainings of physicians, paediatricians and medical officers in various aspects of IDSP and NVBDCP.

- Under IDSP videoconferencing facilities have been provided but it was seen that they are not functional.

National Vector Borne Disease Control Programme (NVBDCP)

- The incidence of malaria in the state is less. However many imported cases of malaria are being detected. Labours, migrant workers, paramilitary forces visiting from other parts of the country have many malaria positive cases among thgem.

- It was seen that the prescribed time cycle for the visit of JPHN is once in 20 days and that of the male MPW is 40 days. In reality even this is not happening. Male workers are following 80 day cycle in many of the sub centers visited. The active surveillance is at best inadequate and mostly at a very low level. The male MPW and JPHNs are grossly underutilized. Even passive surveillance is very inadequate. It can be seen that there is a considerable delay in examination of blood smears of active surveillance.

- Most health inspectors, male and female MPWs interviewed during the visit are not aware of the treatment schedules of malaria (dosage and duration).

- There seemed to be a shortage of chloroquine and primaquine tablets in most of the institutions visited. No stock of quinine or artesunate injections in all the institutions visited. ACT is yet to be procured. Some laboratory technicians are not following the proper guidelines in preparation of blood smears and staining of smears. This is especially true of the technicians from the medical colleges working in PHCs. There is need to train the laboratory technicians.

- It is appreciable to note that the JPHNs are guiding the ASHAs regarding house to house larval survey. With better structured collection and documentation of data, very good primary data would be available.

- Dengue is definitely on the rise. The reporting of dengue through the daily communicable diseases surveillance reports is going on but needs a significant improvement.

- The Acute Encephalitis Syndrome surveillance needs to be established.

- The progress of planned activities as per PIP of NRHM NVBDCP for the year 2010-11 appeared a bit slow. Many training activities and procurement are yet to be conducted.

- Only the block PHCs, taluka hospitals and general hospitals have functional laboratories with sanctioned posts of laboratory technician and microscope. The mini PHCs does not have sanctioned posts of technicians. For health programmes like RCH, IDSP and NVBDCP the role of the laboratories at the PHC level is crucial.

Revised National Tuberculosis Control Programme (RNTCP)

- In the institutions visited it was seen that the record maintenance of the programme was good. The laboratories are working well.

National Leprosy Eradication Programme (NLEP)

- It was observed that the new case detection especially among the children and new cases being detected with deformity are still considerable indicating active transmission of the disease. The integration of NLEP activities in the general health services required strongly.

National Blindness Control Programme(NBCP)

- The spectacles were not provided free for last few months under the blindness control programme in Kozhikode

Institutional Mechanism and Programme Management

- Management systems are established till the block level; the coordination between district, district health office and block level is good.

- PRI have been assigned responsibilities for health services and manage their untied funds. All ward members of the PRI are part of the WHSC, which receive untied funds trough the PHC. Funds are used for infrastructure development and for salaries of grass roots workers, e.g. in palliative care

- HMC/RKS committees combine of the heads of health institutions and members of the PRI and voluntary organisations. They have wider administrative and financial

powers and may raise funds from user charges to further develop the facility or quality of care.

- RKS :By and large RKS meetings regular and attended by quorum; Observed excellent minutes of HMC, Palliative care committee and Rapid Response teams at Kottayam .Fund utilization is good, backed by decision of RKS and involvement of PRI is also strong.
- VHSCs meeting are not found to be regular and the minutes of meetings were not updated at all facilities. The roles and responsibilities of VHSC is not found to be very clear.
- District health mission meeting were not found to be regular.
- Supervisory schedules are not structured for facilities.

Decentralised Local Health Action

- The PRI participation was well visible right from district to village level. The selection of ASHAs were done according to the recommendations of the Panchayat. Largely governance improvement is visible from greater transparency in decision making and implementation, decentralization of functions and finances.
- The local Panchayat are extremely active in Kottayam. Several prizes are being instituted for cleanest PHC, cleanest ward etc. and funded and orchestrated by the local ward/municipal leadership. Active and sincere involvement of the Municipal chairperson with the Taluk hospital in Vaikkom was evident in our interactions.
- District health plans exist in talking with the leadership, but to what extent it is being implemented remains a question. Gaps in data exist at many places, as was evidenced by contradictory responses to several questions on the DHAPs. District health plan is exhaustive and priorities are clear (kozikode) but implementation is poor.
- No village health plans were available with most of the JPHNs (Kozhikode) but available in (Kottayam). The understanding of village health plan is not clear with JPHNs (Kozhikode)
- HMIS and IDSP data is not being utilized at district level for planning.

Progress on Institutional Framework Under NRHM

- As part of the institutional set up under NRHM the State Health Mission is constituted in the State. Meetings of State Health Mission are not held frequently. The programme is implemented through the active intervention of the District Health Missions. The participation of the elected members of the Panchayat is ensured in the

meetings. The District Collector being the Executive Chair of DHS is also actively involved in the process of implementation of NRHM. There is a well established office and staff at district level to coordinate the activities of NRHM in the district. The District, Taluk and CHCs have NRHM coordinator to coordinate the activities of the facility. The coordination of District Health Society with the State Health Society is good.

- The district level office is headed by District Program Manager (NRHM) who is assisted by Accounts Officer, Accountant etc. At block level, Block coordinators have been appointed in each health block. Their primary job is to coordinate the activities of NRHM in the concerned block. They ensure the dissemination of information from State / District to health institutions in the block.

INNOVATIONS

a) **The NRHM project of Palliative Care** has a budget of more than four crores in 2009-10. Awareness and capacity building in the general community including public and private sector medical professionals are done through this project. Outpatient facility is provided in the Pain & Palliative Clinic set up in the Medical College campus and is available to the patients needing care except on Sundays. The patients coming to the OPD are given required medicines including medicines for their pain management from here. The patients left by the medical system in case of incurable disease is incurable and requiring inpatient care for symptom management are admitted in the inpatient building set up on the land provided by Kerala Government adjacent to medical college campus. The admission of the patient here is decided on the basis of screening him in the OPD by the medical professionals in close coordination with the community volunteers and availability of beds. Thus respite care, symptom care and terminal care are being given in IPM inpatient facility. There are 32 beds arranged in 3 beds per cubicle system where the patient and his bystander are able to stay during care. Along with the care free food is also being provided to the patient.

   The doctors and nurses are being given training on Palliative care. Orientation course followed by fellowship training is offered by IPM. So far 130 doctors have been trained through this institution, which has recently been recognized as a WHO resource Centre also. The ASHA workers and the medical professionals of local Primary Health Centers along with community volunteer are participating in identification, linking up and providing care to the patients. Distribution of waterbeds, bedsore management etc., are being carried out by them.

b) **Child Developmental Service (CDS) under NRHM**

   Integrating mental health services with the primary health care system is the solution put in use by the Government of Kerala to address the problem of scarcity of mental health services in rural areas and thereby ensuring better delivery of se rvices to the community. Community mental health program of IMHANS is an attempt to incorporate mental health services in the primary health care. IMHANS could provide mental health services in the PHC/ CHC level in the 4 northern districts of Kerala, i.e., Kozhikode, Malappuram, Wynad & Kasargode through the community mental health clinics supported by NRHM and DMHP.

   Child Development Service in Kozhikode District, Kerala aims at a comprehensive care to Children with developmental disabilities like Mental Retardation, Autism, Cerebral Palsy etc. and also with emotional disorders. Programmes to create awareness, Educational and Research / teaching programs in child psychiatry are also aimed at by this institution.

The centre started functioning in the year 2007. National Rural Health Mission started extending its support to this centre in January 2008 and provided with an amount of 5 lakhs of rupees in 2008 and Rs.6 lakhs in 2009.

It is the only such centre in Northern Kerala under Government set up providing comprehensive care to not only children but also to adolescents with developmental disabilities and emotional disorders. Services of multi disciplinary professionals like psychologist, speech therapist paediatrician, psychiatrist, developmental therapist are provided through NRHM system.
Out of the total of about 4200 children (boys 2398, girls 1828) seen in the OPD of this centre majority were for the services of child psychiatrist, speech therapist, special educator, clinical psychologist & developmental therapist.

c) School Health Programme

A school Health team is constituted in the PHCs/ CHCs in the Panchayat where the school is situated. The team is lead by the Medical officer in charge of the school Health Program. Every child assigned to the JPHN undergoes a health examination and screening by JPHN and those who require further medical attention are identified. These students are examined by the doctor in charge of the school health program and students requiring specialist care are registered and referred to further specialist medical camps (as long as the condition does not require immediate care) conducted under the school Health program where, the service of a group of specialists are utilized

The pilot study was conducted at Thiruvananthapuram. The trainings for the staff implementing the project were given by the Child Development Centre (CDC). It is now being implemented in 5 Taluk hospitals directly under CDC and in 1 Taluk hospital the ARSH clinic is being supervised by CDC. Besides, ARSH clinics are conducted in 62 PHCs and 24 CHCs on weekly basis.

d) Medical Care for Victims of Gender based Violence/Social Abuses

The Government of Kerala has launched „Medical Care for Victims of Gender based Violence/Social Abuses" in selected institutions of 14 districts of Kerala on the lines of Vishakha Guidelines, funded by State Plan Fund. There are one GBV Centres in each district with a female Coordinator/Counsellor. The main objective of this centre is to provide counselling to the victims of GBV/sexual harassment and strengthen the capacity of health care providers in the hospital and also district to respond to survivors of violence against women. This also provides sensitization training to the health staff on prevention and management of GBV.

e) Floating dispensary in two districts:

Floating Dispensary is an innovative step to cater to the people of the island panchayats of Ernakulam and Alapuzha districts. The floating dispensary also works as „Bodhana Nauka‟ (information boat) creating awareness on various aspects of health. It visits an island village twice a week and caters to approximately 35 patients a day.

CHAPTER 4

RECOMMENDATIONS

Human Resource

- Introduction of a policy for rational deployment of HR
- Training needs of the HR needs to be addressed
- Clinicians may be oriented on surveillance of vector borne diseases.
- Sheer lack of interest and complacency as observed in the District Hospital can be avoided by efficient workforce allocation and process strengthening

ASHA Programme

- Monitoring and mentoring mechanism for ASHA could be put in place
- ASHAs may be incentivised for effective NCD programmes

Health Sub Centres

- Sub centers may be utilized as counseling centers for lifestyle diseases and addressing alcoholism and related domestic violence
- Register maintenance and record keeping needs to be improved. Training on importance of the same, especially to JPHNs
- JPHNs “closer group” could be formed to facilitate closer interactions amongst each other and medical officers .
- The JPHN posted in the school could undertake specific health education of teachers and students in aedes mosquito surveillance
- One-day clinic at sub centre could be held on the next working day, if closed on a particular day due to other engagements which could be communicated to the beneficiaries in advance.
- Laboratories: Laboratories needs to be strengthened in terms of equipments and human resource. The minimum laboratory services needs to be ensured from the level of primary health centre.
- Vigorous IEC/BCC needed to encourage women to opt for normal delivery
- Dietetics: Certain NGOs are providing meals to patients in Kottayam; the state may think of replicating such practices in all their facilities
- RKS funds may be utilised for facility operations such as linen, laundry, diet , minor repairs etc.

- The state may explore opportunities for strengthening blood supply by partnering with Missionary hospitals and other NGOs or community as was evident in W&C hospital Kozhikode
- External evaluations could be undertaken on ongoing best practices like palliative care and CDS
- Research studies to be undertaken, especially on ongoing best practices as well as new initiatives to be taken up by academic institutions
- Policy on interest management is required.
- Establish TALLY ERP 9 at block level as planned. Enhance orientation towards plan against implementation of activities and draw lessons for next plan to ensure sufficient funding for,
- Enhanced number of deliveries in public institutions
- Supporting upward trends in routine immunization

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CHAPTER V

STATE SPECIFIC ISSUES:

(OVERVIEW OF CRM VISIT)

The state of Kerala which is already in the league of developed nations for achieving the health indices unlike other states in the country has always been looked upon as a model example by the public health sector in the country. The state after achieving this status could have ideally worked towards making it possible for its citizens to have excellent primary health care facilities available in the public health sector as well as looked into countering and finding solutions for newly emerging lifestyle related and non communicable diseases in the state. The state has tried to take measures against lifestyle diseases but needs to systematically chart out the programmes for these. This is needed to be done urgently by working on two fronts: 1) By involving NGO"s and other organizations such as missionary hospitals in implementation of these programmes. For solid foundation of the programmes and for long term sustainability the state could look into involving other bodies in the health care. 2) State has been able to carry out pilots of pain and palliative care programme in two districts. The state must study these innovations before replicating it all over the state. The state needs to collaborate with academic and research institutions to learn from the national and international experiences and also carry out research projects to find long term solutions for these problems.

Unlike other states the subcentres in Kerala deliver only basic care. In fact the clinic at the subcentre is held only once a week. It delivers no services for delivery and immunization. The ANMs, therefore, need to be utilized for non-communicable disease programmes for counseling to have effective preventive care for problems like suicides, alcoholism and related domestic violence. The PHCs which were visited also had no impatient facility. Day care centers for aged population and counseling centres could be started in these PHC"s. The state can think of replicating the initiative taken in some of their PHC"s like PHCs Marvanthurath on lifestyle diseases.

At some places there is need for effective leadership as was seen at the District hospital Kottayam where the lack of motivation among the staff was found wanting. Such a huge facility with high demand of services has been maintained below par, record keeping was poor and there was no evidence of monitoring by district authorities etc. (In fact the facilities which are running well were found to be doing so only due to excellent personal leadership in these respective facilities irrespective of any system in place. It would be difficult to run district wide programmes in absence of sincere monitoring system in place).

State has 98% institutional deliveries. 2% home deliveries are concentrated at the block level. The state may not need pregnancy tracking to be done all over the state. It could be done in selected facilities in selected blocks. The tracking system if possible could be used for tracking aged population and for other lifestyle diseases.

In district Kottayam as against 48% cesareans in the state the percentage of cesareans is nearly 65%. The reason given by the district authority is that the women themselves go in for cesarean due to fear of pain and other reasons such as astrology. The state needs to take up programmes for creating awareness on this issue highlighting disadvantage of cesarean and advantage of normal delivery with intensive IEC campaign(in Kottayam it was told that Kerala Federation of Obstetricians and Gynaecologists has started a campaign to promote normal delivery but nothing was visible).

Medical Officers who are doing exemplary work in new initiatives could be given due recognition and awards to facilitate new inventions at other places and also to motivate other functionaries. One of the key training needs for this state health leadership is motivational and organizational behaviiour training, including leadership, management principles, NRHM programme framework and overall bridging the soft-skills gap. The state also is in need of looking into the remuneration of health functionaries which may be acting as a de-motivating factor in their work.

The state of Kerala due to its highly different health scenario and consequent needs could be treated on a differential state wherein enough flexibility is given to the state in implementing NRHM but at the same time hand holding the state in finding out solutions for different kinds of health needs. This would act as a pioneer for other states which will reach to this level in the future sometime.

Annexures:

Annexure I

District Kottayam

ACTIVITY REPORT: PHC MARAVANTHURUTH

Maravanthuruth Grama Panchayath in Vaikom Taluk, Kottayam District extends over 16.5 sq. km and is bound by tributaries of muvattupuzha rivers on tree sides and by Vembanad lake on the western side. The primary Health Centre located in Ward V of Grama Panchayath is 8 km away from Vaikom town. It caters to a population of 21, 757 in 5259 houses. It covers sub centers FWC kulasekharamangalam, FWC Maravanthuruth and FWC Main Centre Maravanthuruth functioning in own buildings and FWC Edavattom working in an Anganwadi.

The PHC has an average monthly OPD attendance of 2500 inclusive of old and new patients. The services offered include curative services, immunization, family planning services, public health activities, RCH services etc. Outpatient department has an extensive enclosed waiting area for patients, drinking water facility and separate toilets for males and females. A TV with DVD player has been provided in the waiting area displaying information regarding communicable diseases and public health issues. The patients are allowed to enter hospital only after removing the footwear. Waste bins are placed in the waiting area.

There are separate registration counters for males, females and senior citizens in OPD and Pharmacy. Drinking water is provided from Aquaguard water filter and Pure-it. (From NRHM Fund)

There are separate corners for ORT, DOTs and helpline for promoting tobacco free activities. Token system has been engaged for OP management.

NRHM FUND

The fund sanctioned under NRHM from 2005-06 onwards have been effectively and fully utilized for the infrastructure development and facility improvement. 21 ASHA volunteers have been selected and 19 of them are presently working.

Special Activities

Life style disease clinic and Health club cum Laboratory

As a part of LSG project in 2008, a health club cum laboratory was started in Jan 2008. The laboratory is equipped with a Semi Auto Analyzer and is handled by a qualified Lab technician. It has facilities to estimate blood sugar, cholesterol, urea, createnene, routine examination, SGOT, SGPT, bilirubin, IGM for dengue and Lepto. Health club volunteers were selected and trained measure Blood Pressure and draw blood samples (minimum education desired was HSC and age less than 35 years).

Initially a complete survey of the area was done by the trained volunteers using a detailed survey form. Based on the consolidation report of this survey a registry was created for life

style diseases (hypertension, diabetes mellitus, hyper choleosterolenia, Coronery artery disease etc).

Categorization was also done based on income

i. BPL> 65 years,
ii. BPL<65 years,
iii. APL

Each volunteer gets assigned two wards and has an entire list of patients in that area based on which a monthly advance tour program was prepared. Accordingly visit to the patients were made and the volunteers measured their blood pressure and drew blood samples. The collected blood samples were then brought to the PHC, tests were done and reports were collected by the respective volunteers. These reports were returned to the patients. These volunteers were provided with mobile phones, which make them more accessible to the patients.

Lifestyle disease OP is conducted twice a month. The pre-fixed dates are informed to the patients for their convenience. Costly medicines like oral hypoglycemics, insulin, several anti-hypertensives, cholesterol lowering agents, anti platelet drugs etc are supplied free of cost to all BPL patients.

Funding of the lab

Authorized rates have been fixed for all the tests. APL patients have to pay these rates. BPL patients < 65 years pay 50 % of the rates and BPL > 65 years do not need to pay.

The daily income from the lab is deposited in a joint bank account held by President Gram panchayath and Medical officer in charge. The remuneration of the volunteers and the lab technician is met from this fund.

Blood group registry & voluntary donor's forum

As per LSGD project 2009 -2010 a blood group detection camp was conducted covering the entire panchayath area. Based on this a registry and a computer database was prepared and a directory was published. A donor"s forum with phone numbers was prepared.

Palliative care

Home care is done every Tuesday. Ambulance of Grama Panchayath is being used for this visit. Pallitive care OP is conducted every Monday.

Medical Education

The PHC is a training centre for community medicines and Public health activities for B.Sc Nursing students of Bahuleyan Charitable Nursing College.

Achievements

The PHC have been awarded first place for cleanliness and hygiene (small hospital category, Kottayam district) in 2008-09 and 2009-10 by the District Sanitation Mission. This is the

only institution in the health sector with the highest rating of THREE STAR (85/100) in Kottayam district.

Moving towards convergence in Health and Nutrition: The Kunnathukal Experiment

An innovative initiative on Health and Nutrition has been launched in Kunnathukal Panchayat in Thiruvananthapuram district wherein Maternal and Child health care services of Department of Health and comprehensive mother and child health services of department of Social Welfare are being converged and implemented in association with the Village Panchayat. UNICEF, National Rural Health Mission, Department of Pediatrics, Govt. Medical College ,Thiruvananthapuram and Local Self Government Department are also part of this initiative.

Ten Point Programmes

1. Family survey to understand the family structure, health and nutrition status, morbidity and mortality.
2. Capacity building of Health, ICDS workers, ASHAs and Blue army towards delivering effective health and nutrition services
3. Assessing the quality standards of Anganawadis and subsequent measures to improve the standards towards accreditation
4. Ensuring hygiene, drinking water and child friendly toilets in Anganawadis and supply of modern study equipments with the cooperation of panchayath in oder to make them 'Model Anganwadis'
5. Improving nutrition and health status of children
6. Ensuring timely immunization
7. Assessing iodine deficiency among school children and finding out Goitre and other deficiencies due to it and consequent awareness generation
8. Making Ward Health Nutrition Days (WHNDs) more effective and ensuring services as envisaged
9. IEC/BCC activities based on the survey and project findings
10. Ensuring people‟s participation at all levels

Background

The advocacy meet on fostering convergence between health and nutrition to achieve MDGs held on 23rd,February 2010 organized by Department of pediatrics, Government Medical College and supported by UNICEF decided to form a core group towards planning and implementation of a pilot strategy towards implementing the nutritional status in a selected panchayath. Accordingly a core group was formed comprising of senior officials of Health,

Social welfare and Medial Education Department. In the preliminary meeting of the core group held on 12.3.2010 core, Kunnathukal panchayath in Thiruvananthapuram was selected for implementing the pilot strategy. The core group decided to conduct a preliminary assessment in the selected panchayath to understand the current health and nutritional status.

Planning meetings were held at Kunnathukal Panchayath office on 26.3.2010 and 7.4.2010 to chalk out the implementation strategy.The following activities were carried out

1. **Baseline survey** and data collection of demographic & health & nutrition indicators conducted by Anganwadi worker and ASHA under the supervision of JPHN.

2. **Facility survey** of Anganwadies conducted by Medical College Thiruvananthapuram with the support of NRHM

3. **Salt Analysis** in Anganwadis

Salt sample from the Anganwadies collected and analysed for iodine sufficiency. It has been observed that 90% of the salt is iodised .

4. Goiter survey

Goiter survey was conducted among students from 1st to 6th standard in 2 Government Schools in Kunnathukal panchayath.Urine sample of every 10th student was analysed on a random basis.It was observed that though iodine excretion is adequate in the urine sample analysed.Still it has been observed that there is a high prevalence of Goitre among the students.

5. Training of Anganwadi Workers and Teachers and ASHAs

Implementation Strategies

- Timely initiation of breast feeding within 1 hour of birth
- Exclusive breastfeeding during the first six months
- Timely introduction of complementary foods at six months
- Age appropriate foods for children from 6 months to 2 years
- Hygienic complementary feeding practices
- Immunization and bi-annual vitamin A supplementation with de-worming
- Therapeutic feeding for children with severe acute malnutrition
- Adequate nutrition and support for adolescent girls to prevent anemia
- Adequate nutrition and support for pregnant and breastfeeding mothers.

FACILITY ACTIVITY REPORT ,DISTRICT- KOTTAYAM

Health Infrastructure:

The NRHM activities cater to the need of nearly 16.5 lakhs rural population of the district which include 11 blocks, 75 panchayats and 1269 Wards. The health care facilities to the people of the District is provided through 330 Sub-Centres, 41 PHCs, 13 24x7 PHC, 13 CHC, 5 24x7 CHC, 4 Taluk Hospitals, 1 General Hospital and 1 District Hospital. In addition, the District has one speciality hospital and one TB centre/Sanatorium. The health infrastructure of the District is strengthened by the constitution of 1269 Ward Health Sanitation Committees, 99 Ayurveda /Homoeo Institutes and one medical college hospital.

Human Resources:

The Health Human resources are well strengthened in the District by engaging 78 doctors on contract basis under NRHM in which 6 doctors are specialists and 28 are Ayurveda/Homoeo doctors.There exist a category of Snehithan/Snehitha Doctors who are appointed under NRHM to execute the specific health care needs of the patients. The supported services also augmented by engaging 35 Junior Public Health Nurses (JPHNs) and 10 pharmacists on contract under NRHM.

Ward Health Sanitation Committees:

There are 1269 WHCs constituted in 1151 panchayat wards,118 municipality/corporationin the district. The committees conducted 4643 meetings during the year 2010-11. All of the committees submitted their Utilisation Certificates which is due for the current year. During 2007-08 to 2009-10, the committee utilised the full amount received by them in the respective financial years. However, during the current year the utilisation reached up to 78.35% as on September, 2010.

Funds Utilisation:

The percentage utilisation up to this period is on higher side as it shows 95.15% under RCH flexible pool, 80.42% under NRHM and 100% on immunisation.

Annual Maintenance Grant:

The Sub-Centres received a total annual maintenance grant of Rs.845025 during the financial year out of which 5.42% are utilised due to late release of funds by the District Health Society. Similarly the CHCs/PHCs could also utilise a meagre 17.5% of their funds due to late release of funds.

Janani Suraksha Yojana:

The total number of Institutional deliveries shows 5871 during the year 2010-11 and the total number beneficiaries figured as 3393 up to the midyear during 2010-11. There are total 38

private institutions accredited under JSY in the District which facilitated 13,699 deliveries during this year. The percentage utilisation of funds shows 93.35% during this year

Rogi Kalyan Samiti/ Hosptal Management Committee:

The funds received under this heads were fully utilised during previous years. Out of 40.5 lakhs received during the current year, 29.88 lakhs utilised which contributes 78% of the total receipt.

Tally Package:

The usage of this package is successfully undertaken by the District and it completed its account up to 19.11.2010. The State plans to extend the the system to Block level also.

Village visit:

- The team further moved on to interior village area of Kottyam District. It was a boarder of other two districts, Alappuzha, Eranakulam . The team could make an interaction with a group of 12 young people who were playing shells then and there at that time. The team leader, Rasheed ,36 yers , informed that the visits of staff from SCs are seen regularly in the area. They are also aware of the Vector bourn deceases and taking necessary precautions. The Sub Centre under their area is Kattikunnu under Chembu panchayat. However, due to easy commutation most of the villagers use the CHC located in the adjacent district ,Eranakulam.
- The team also interacted with Ms Sumathi residence of *Katti kunnu thurthu*, a small low land area surrounded by water bodies where about 150 families live. The population is around 500-600. There were not aware of ASHA worker. However, one of the villagers Ms Sumathi was well aware of ORS and use boiled water to prevent vector bourn deceases. Though the commutation to this place is little bit difficult, the villagers informed that the staff of SC used to visits at least one or to two times in three months. The team felt that the services of ASHA worker need to be mobilised more effectively in this area.
- The other villager Shobha, 45 residence of Kattikunnu informed that they have received sufficient support from nearby Government Institutions during the delivery of their daughter. However, they didn‟t comment on the JSY benefit nor they may aware of it.

Facilities Visited : District Kottayam

17/12/2010

1) **Meeting with District Officials**

   Presentation by the District leadership team
   Note: A couple of us also interacted with Dr Bindu Kumari, deputy DMO prior to the official presentation. She claimed that the human resource challenge as faced due to

lack of adequate specialists in the rural areas as one of the key impediments to the programme.

2) Visit to PHC Kozuvanal

- Catchment area of PHC is a population of about 15,000 residents where 2 sub centers and 1 PHC are present.
- Staff of the PHC is:

MBBS Lady Doctor	-	1
Staff Nurse	-	1
Pharmacist	-	1
LDC	-	1
Nursing Asstt.	-	1
Attendant	-	2
Peon	-	1
Sweeper	-	1
Health Inspector	-	1
Lady Health Inspector	-	1
Junior Health Inspector(1-Male & 1-Female)	-	2
ANM‟s	-	2

- Immunization outreach is held once in a month for 2 sub centres under this PHC on 3rd Thursday and 4th Saturday of the month respectively.
- Fixed day immunization at PHC is held on each Wednesday.
- PHC has no facility for inpatient services.
- Under school health 1103 children have been registered from 7 schools.
- Population covered by PHC is 14164.
- 95 patients have been registered under pain and palliative care programme
- OPD timings of the PHC is from 9 am to 1 pm.
- 48 antenatal cases registered in the sub centers under the PHC
- There are 2 toilets in the PHC (1 inside and 1 outside).
- Services provided in the PHCs are:
  OP
  Ante-natal
  Immunization
  DCP
  Pain & Palliative care
  Life style diseases
  School Health
  FP-IUD, OP/CC, NSV(3cases)
  Health Education
  Anti-Tobacco
  Rapid ResponseTeam
  Gender-based violence management center
  Water quality testing

- PHC officials very confident of Tobacco-free environments being maintained in public places, particularly Government Institutions. “No smoking” signs are clearly visible in Malayalalam.
- Life style disease medical camp is held on 3rd Tuesday of a month.
- The register maintenance is not very good as patients are registered at three different places like for registration, in B.P and in diabetes register.
- Positive B.P and diabetes patients are given counseling alongwith pamphlets for reading.
- The Panchayat under which these 2 sub centers function gives an award to best ASHA conducting survey on cleanliness in her villages. An Asha covers 300 -400 houses in a ward and given Rs.1000/- in award for a whole ward.
- Intersectoral committee meeting held in which discussion held on diseases out break, emergency preparedness, mobilization of funds etc. The participants in the meeting are medical officers of the PHC, Panchayat President and nearly 30 ward members.
- RKS meeting is held once in three months and pain and palliative committee meeting is held monthly.
- No malaria cases under PHC area. Mosquito-related illnesses however should be on the high alert as the agricultural conditions in the district where pineapples and rubber are major crops tends to breed mosquitoes; mutant varieties also suspected, causing the much higher incidences of Chikungunya and dengue vs. malaria
- Token distribution and display system functional in the PHC.

3) Visit to Sub-centre Kezhuvamkullam

- Staff of the Sub center consist of 1 ANM and 1 Jr. Health Inspector(MPW).
- Antenatal clinic is held from 2 to 5 pm on each Thursday.
- ORS Promotion is held on 4th Saturday of a month.
- Sub center functions on a day in a week offering clinical services from 2 to 5pm.
- ANM is on a field visit everyday from 9 am to 1 pm.
- Enough quantity of drugs such as paracetamol, bruffen and folic acid found.
- Zinc tablets were missing(transfer to PHC as it had no supply).
- Quality issues with IFA syrup and tablets
- Well maintained family health register.
- Oral pill shortage described by ASHA; said people would be willing to pay a small token amount for the pills due to the shortage; feels that the condom supply is adequate

ASHA: Ms. Sujata T.N:

- Antenatal cases register not filled in (she told that register is received only 2 months back).
- ASHA claims to visits each house and writes about the family in her diary(very difficult to trace the names of the mother and children in her diary).

- ASHA has 150 houses (42 BPL) to visits.
- ASHA does not visit all houses in a month.
- ASHA has been functioning since last three years and earns approximately Rs. 350 per month.
- ASHA has received cash for JSY beneficiaries.
- 100% immunization of children done except 1 child to whom childs parents refused to vaccinate him.
- All pregnant women registered in 1st trimester.
- ASHA has not received supply of contraceptive pills for last 1 year in a drug kit.
- People would pay for contraceptive if ASHA charges for it(she could earn this has a honorarium).
- Children under her area get food at Anganwadi center for 3 times in a day (kanji, poha and upma) and pregnant women get food once in a day (upma)
- ASHA was happy working as an ASHA but she desires to earn additional income.

18/12/2010

4) Visit to District Hospital, Kottayam

- NSV camp is held 24th of every month.
- There are only 10324 eligible couples.
- 4 camps for 4 blocks are held for laparoscopy in a month.
- Emergency ward have 4 posts of MO out of which 2 are vacant. A surgeon posted against MO post was in OPD. NRHM Contractual MO was on leave.
- In delivery room equipments were not functioning, 1874 deliveries were conducted since 1st April 2010.
- MTP register and form-"F" under PC& PNDT Act were not maintained.
- Out of 51 beds in male ward 26 were occupied.
- Breakfast of one full bread and half liter milk pack provided to patients by the hospital. Dinner is provided by NGO-Navjeevan. (lunch can be provided by hospital under RSBY).
- Waste Management practices not followed at all.
- Not well-functioning blood bank…discrepancy between number of blood supply stated in the register vs. what was actually found; lack of clinical leadership evident. Blood bank assistant on contract was very knowledgeable; needs to be more empowered and salary/remuneration needs to be revisited; Patients coming in for blood donation need to be provided with coffee etc. Technician claims that they can usually complete all the quality checks required during an emergency transfusion in 10 – 15 minutes but that seems suspect; multiple answers were being provided to the same question and there generally seemed to be some confusion re: the time.
- Resuscitation set in the labour room was non-functional; laryngoscope battery was drained; staff seemed least concerned;

- OT staff were in cleaning mode hence did not watch any procedures; infrastructure in OT needs to be upgraded; policy and protocol for central sterilization, patient safety, sedation and medication monitoring, patient communication, etc need to be strengthened
- Infection control practices gravely lacking; no hand washing soap provided; overcrowded female wards with children and mothers in the same area; neonatal care and infection issues is a big concern;
- Biomedical equipment management issues were rampant; e.g., steriliser that should have been condemned was being used as some kind of storage for several months; no coordinated process for equipment maintenance, particularly disposal of retired equipment
- Gynaec ward had 51 beds with 76 patients in it (Another ward of 50 is being repaired).
- Upgradation work costing Rs. 2 crore is on going out of which 1 crore has been provided under NRHM and 1 crore from panchayat fund.
- No generator there at present but will be provided.
- Toilets were clean but no soap kit.
- Pediatrics wards has 27 beds with 25 children.
- Bedsheets are not changed everyday as washing arrangement is insufficient. (laundry has only 1 machine)
- Lack of interest in the work by the Medical Superintendent of the hospital as well as his staff (in delivery register delivery date of the women was not mentioned). The hospital functioning is not being monitored by any authority.

Interviews with patients:

We interviewed 1 pregnant woman, one senior couple and a middle aged man (BPL) who were all waiting outside the diagnostic center at the District Hospital.

In general, they all seemed happy with the services, especially access to the hospital. The pregnant woman was able to articulate antenatal care services provided clearly and was waiting for her first ultrasound checkup in her first trimester. It is clear that the 100% literacy rate and generally raised awareness of individual rights contributes to greater health seeking behaviour in the communities.

5) Visit to CHC, Thalayolaparambu

- Drugs are plenty and maintained well with essential drug kits.
- No Biomedical waste practices followed; claim coloured bags are not available
- OPD is 9000 patients per month.; 70% BPL patients with most common diagnosis being COPD.
- It is recommended to start “old age day care centre” in collaboration with social welfare department in the CHC which has ample open space; Make it similar to a polyclinic with volunteer services, TV in the common area, geriatric and

physiological counseling services, etc. There may also be an opportunity to coordinate with the Women and Child Development services.

6) Visit to Orekkal Sub-centre

- Sub center was closed; was opened in front of the Team by the ANM who was picked up on the way.
- Place was not very clean; had the odour of birds roosting and possibly not been cleaned for a long while.
- It is a rented building by panchayat and requested to be vacated soon by the owner.
- To purchase its own land for the subcenter expenditure would be Rs.5-6 lacs approximately.
- Weekly clinic is held on Thursday.(If Thursday is a meeting day or ANM is on leave the subcenter clinic should be held on the next day as it was seen that no clinic was held for last two Thursdays).
- Villages surrounding the subcenter have safe drinking water facility but all houses have no toilets.
- Interviews with children Abhilash (11), Akshay (10) and Megha (5), two of whom are children of the local firsherman family all attested to the functional school health programme, mainly provision of breakfast and mid day meals; Children get food in the Anganwadi center which includes Upma, Kheer, Kanji, Rice & Powder nutrient for nursery children.

7) Visit to PHC, Maravanthurath

- This is the model PHC run efficiently by highly motivated Dr. G.I Sapna, Medical Officer Incharge along with a dedicated and sincere team of workers. The PHCs has undertaken outstanding initiative in the form of lifestyle diseases clinic, pain and palliative care and disease control programmes (BEST PRACTICE CASE STUDY NOTE ATTACHED).
- The PHC has Rapid Response Team to review situation in respect of prevalence of communicable diseases. The team has 7 staff members of PHC on it out of total of 15 staff members in the PHC.
- The PHC has won an award for the best PHC in 2010.
- All 21 ASHAs have been provided uniform of 2 sarees each by the panchayat.
- Out of 21 ASHAs, 2 have contested election for ward member and won
- No inpatient facilities available in the PHC except 2 beds for emergency care.
- OPD is held from Monday to Saturday from 9 am to 3 pm from Monday to Friday and from 9 am to 11.30 am on Sunday and holiday.(with MO, SN and Pharmacist present)

- An Ambulance has been provided by the Panchayat for pain and palliative care. A home care team visits homes everyday with one volunteer for two wards. The volunteer checks the BP of the patient and collects blood for sugar. These volunteers are from the village itself with education up to 10+2 and age below 35 years. A well

maintained health club cum laboratory is there in the PHC. For BPL patient above 65 years the tests are free. For BPL below 65 years half rate is charged. (rates are at ann-I)

- Clinic for lifestyle disease held twice every month in the PHC.
- The PHC has received 3 star rating by the District Sanitation Mission.
- Data base of blood group of all villagers under the panchayat are maintained in the PHC.
- Well monitored DCP in the PHC
- The key difference in this facility is the attitude of the leadership Dr Sapna and her ability to motivate and lead a whole group of highly dedicated and proud staff.

8) Visit to Sub District Hospital Vaikom

- Established in 1893
- Average OP load over 1000 each day, causing them to clear a few beds and convert an IP area into a casualty/op consultation area; Notable that even on a Sunday, the casualty was brimming with activity with pediatricians providing extra time to more than just children.
- Clinical process issues is of concern in the casualty trauma area; Unsatisfactory patient/family communication and subsequent procedures followed when a patient was brought in declared "dead on arrival"; no attempts were made to verify time of death, exact symptoms before bringing the patient to the hospital and subsequently, no resuscitation was performed; RMO was unable to articulate clear policy/protocol during such instances; Nurse/nurse sup. was unable to use the defibrillator; unaware of regular check protocols for the machine
- PPP model well functioning on campus with a 24-hr pharmacy service being provided for patients
- High demand of services with otherwise well motivated staff under the leadership of Dr. Manoj, RMO
- Extremely poor building infrastructure with equipments (like autoclave in the OT) placed at vulnerable locations due to lack of proper space and infrastructure; Procedure table ancient and rusted and single table where multiple specialty surgeries including orthopedics are being routinely performed (picture)
- Laproscopy area currently on bare-bones infrastructure, using plank support for procedure table (picture)
- Upgradation plan for an amount of Rs. 6 crore for has been submitted in the district PIP last year.
- Clinical local leadership needs to be more effective
- Meeting was held with Smt. Shrilata Balakrishnan, Chairperson, Vaikom Muncipal Council. Claimed lack of sources of tax revenue had resulted in the Municipality not even paying the electricity bills for the last two months; however, she seemed very supportive of the proposed recommendations, regarding fund utilization towards infrastructure upgrade of facilituies; assured us that once funds were released, the Municipal body would not cause any red tape and ensure the immediate release of

those funds to the hospital; She has also agreed to contribute 10% funds for upgradation work by the Municipality.

- Inspection reports by deputy DMO Dr Bindu Kumari merely obligatory in nature; no descriptive reports or comments on each inspection found;

9) Arumootimangalam, CHC-established 1962:

The in charge of CHC is Dr. Alex who is paediatrician. The total doctors: 3 including specialists. The average OP attendance is 250 per day. The new 24 bedded ward is built in 2009 using NRHM funds

- Out of Six Quarters 4 are occupied by staff. The two are remained vacant. The doctors are not staying in the Quarters.
- Equipment such as LR, Deep Freezer, IUD kits is placed in the CHC.
- The CHC needs to maintain a separate documentation on training attended by the doctors and staff nurses.
- Quality assessment of Staff nurses and lab technicians ect. are not being done systematically by the In-charge. A format needs to be devised for assessing the performance of all staff with the help of certain selected parameters in the respective area.
- The staffing /appointment are done by PSC according to the district-wise vacancies available.
- No referral records or a proper documentation of referral cases are not maintained.
- No housekeeping register
- Biomedical waste management is in place
- No display of Basic minimum standards of cleanliness.
- There are 3 computers. The data are uploaded through HMIS .
- The minutes of HMC are well maintained
- The citizen carter of HMC is not displayed.
- The cases of malnutrition are addressed by the Anganawari centres which provide counselling and other follow-up measures.
- There is lack of space in the lab of CHC, Arunootimangalam.

10) PHC, Peruva & Subcentre Keezhur:

The PHC covers 21,737 population. The cases attended 120-130 cases per day. The topics such as immunisation, breast feeding, Family planning etc are discussed in the WHND meeting.

- There are 21 ASHAs selected through panchayats.
- There are 128 cases registered under palliative care .During the last month they conducted 15 homecare vsits.
- There are 2 computers with internet connection. The HMIS data are uploaded regularly by the JPHNs. However, the monitoring of data needs to be done at the level of Medical Officer.

- **Palliative care activities**: The activities are undertaken actively in the *panchayats* with centre point as the PHC. Registers are maintained at PHC. However, it is observed that cases like respiratory problems have been included which needs to be rationalised by seeing the definition of palliative care. The most deserving patients need to be served under this care. The register needs explicit mention on the diagnosis more elaborately instead of simply mentioning respiratory problems. Specific guidelines have been issued for administrating the home care services. The homecare kits are also in place in which 58 items are included. In addition, provisions have been made for purchase of costly medicines by Local Panchayats for distributing it to the concerned PHCs where BPL patients are registered with, for which 29 medicines are included.
- All ASHAs are getting their JSY benefits .Rs. 150 received for attending training and plus Rs 100 for refreshments.

Annexe II

DISTRICT KOZHIKODE

ACTIVITY FACILITY REPORT

Day (1)

Date of Visit: 17/12/2010

Govt. Hospital for Women &Children, Kozhikode
Designated as FRU since 1960

General observation: The hospital is having sanctioned 295 beds out of which 210 are functional with average bed occupancy of 180 with 380 deliveries per month. This institution is selected for the NABH Accreditation
Operation Theatre and Labour room were kept neat and tidy. Adequate aseptic precaution is followed in all the area. In the immunization clinic the cold chain of vaccines and temperature recording was properly maintained. Training of the Medical Officers of the PHCs in the district on Pain & Palliative Care was going on in the facility. Blood was made available round the clock both to the IP of the hospital and also to the PRV Hospital. Waste management of the hospital was properly done. This is done by the IMAGE owned by IMA though Placenta is kept in labor room for 24hrs. There are no Mosquito Screens in labor room and wards. There are 8 gynecologists in the facility but the schedule ensuring one gynecologist 24 hrs in the facility is not proper. The gynecologist comes on call to the hospital during emergency. The reason for not staying is quoted as not having a residential quarter.

Availability of Services

- Facility for normal , assisted, cesarean section services and Manual removal of placenta is available in the facility
- New born care corner is also present with approximately 7 units.
- 24 hours availability of Blood Transfusion services is there , it requires approval from drug authorities
- Family Planning services (Tubectomy –Laparoscopic, Minilap and Postpartum Sterilization) are provided, though the NSV/conventional vasectomy services are not provided. Other Spacing Methods including IUD, OP , Emergency contraception are present
- Essential Laboratory Services are present including BT/CT ,Blood sugar, Blood cross-matching, Urine albumin and sugar.
- Referral Services are also present

.

Performance: 5221 Normal deliveries were conducted during last year .600 assisted deliveries and 1405 caesarean section were performed. Out of the total number of deliveries 62 % were from the BPL families. Two infant deaths and no maternal deaths have been reported during last year. 85 maternal cases were given blood transfusion. 10881 laboratory investigations were done

Gender & Equity: There is a separate toilet for female staff and separate men‟s and women‟s toilets are also present. The labor room also has an attached toilet. One doctor has quarters on the premises and stationed at the facility cleanliness.

A well structures mechanism is in place to address harassment including sexual harassment at work place the past complaints received for the same were handled by the grievance committee

Drugs and Supplies were adequate and all the drugs were well stacked. The MO I/c has the power to spend from Rogi Kalyan Samiti funds for purchase of drugs during emergency situations and for hiring transport for referral of patients to higher facilities

IEC activities as well as display of the IEC material were not proper. No special attention seems to be given to the IEC activities.

Janani Suraksha Yojana: 5221 institutional deliveries have been conducted during April to November 2010. Out of this 1131 deliveries were registered under JSY and 1171 deliveries have received monetary benefit. According to the health providers the funds received under JSY are sufficient for catering to all registered beneficiaries

Compensation for sterilization services: 1575 sterilization acceptors are recorded during April to November 2010.out of this 780 acceptors have received monetary benefit

Date of Visit: 17/12/2010

HSC Kinaloor : The subcenter (Family Welfare Centre) Kinaloor covers a population of 6864 across 4 Panchayat wards and has two staff . One Jr. PHN Parvathy K. and other Jr. HI Abdul Azeez.

- The surrounding area was not clean, hatchery for gambuzia was exiting but not well maintained
- Two ASHAs were also present in that such centre. The MCH records are well maintained. There is 1034 eligible couple in this population. 54 ANC have been registered since April. It was appreciable to note that all the ANC s is screened for anemia twice and urine examination being conducted 3 times. 3 of these ANC cases had anemia (< 10gms).
- Only 2 IUDs had been inserted in this year.
- No stock of contraceptives (IUD and condoms) was available.

- Fund registers are not well maintained and understanding of utilisation of funds requires training
- The reagent strips purchased for blood glucose estimation is found to be date expired.
- No village health plan was found and the understanding of village health plan was not clear
- VHSC meetings are held but the understanding of roles and responsibilities of VHSC was not found to be clear
- Schedule for household visits is not planned
- The immunisation cards are not displayed and the daily dairy was not well maintained

Date of Visit: 17/12/2010

Anganwadi centre Aanokundumal : The Ward Health Nutrition Day was going on during the visit. Ward Health Sanitation Committee convenor, Mr. Abdul Azeez, Jr. HI was present. The team interacted with members. 4 ASHAs, 1 lady VHSC member and AWW worker were present were present. (The ASHAs of that particular ward was not present).

- 77 children of 0-5 years are enrolled in the population of 940
- The growth chart was well maintained and there were no cases of grade III /IV malnutrition
- The ASHAs were having proper ID cards and the level of training varied from 2nd to 4th module. They were aware of incentives of JSY, immunisation and sterilization but did not seem to have adequate idea of identifying high risk pregnancies. The role of ASHA in settings of no home deliveries is perceived to be mainly of referring all cases to higher facilities. Approximate honorarium per ASHA per month ranges from 300-500 rupees
- The ASHA and other VHSC member knew the objectives of VHND, they mentioned that the household surveys are being done with registration of ANCs and checkups.

Date of Visit: 17/12/2010

CHC Balussery, , Balussery Block, Kozhikode, Kerala ,

General observation: CHC covers 6 PHCs .There are 8 doctors posted at the facility. Total number of beds is 56 out which 32 were occupied at the time of Visit.. Laboratory is accredited by NABL .The civil works done under NRHM OP Section was inspected. The civil works were up to the standard. Daily there is an average OP of 550 and IP of 30. No deliveries are conducted in December 2010 though earlier deliveries were conducted. Labor room is well equipped but it is non-functional since June 2010.Waste management of the hospital was properly done. This is done by the IMAGE owned by IMA

Availability of Services

- Only OPD and Immunisation services are provided
- No deliveries are taking place .Before December 2010 services for normal delivery were available.
- Family Planning services (Tubectomy –Laparoscopic,Minilap and Postpartum Sterilization) are provided though the NSV/conventional vasectomy services are provided. Other Spacing Methods including ,IUD, OP , Emergency contraception are present
- Essential Laboratory Services are present including BT/CT ,Blood sugar, Urine albumin and sugar
- Referral Services are also present

.

Performance: 91 normal deliveries were conducted during last year. Out of the total number of deliveries 67(73%) were from the BPL families. No infant deaths and no maternal deaths have been reported during last year. 31 Male (conventional/NSV), 18 camp for Female (Laparoscopic) 71 Female (Minilap) and 41 Female (Post partum) sterlisation have been reported last year April. 14 females were treated for RTI/STI cases.

Laboratory services: The Laboratory is accredited by NABL .The laboratory services are being provided well with 2 technicians, 1 under Tb programme and 1 general. The general maintenance of lab and maintenance of records were very good. The malaria registers show details of active and passive surveillance in sub centres /PHCs and the CHC. The male workers are not conducting adequate surveillance. It was noted that no positive cases of malaria have been detected for last 12 years under active surveillance. There is no stock of chloroquine ,primaquine, quinine etc. The health inspector does not know the schedule of radical treatment of malaria.

Gender & Equity: there is a separate men‟s and women‟s toilets. One doctor has quarters on the premises and stationed at the facility cleanliness.

Drugs and Supplies were adequate and all the drugs were well stacked. The MO I/c has the power to spend from Rogi Kalyan Samiti funds for purchase of drugs during emergency situations and for hiring transport for referral of patients to higher facilities

IEC activities as well as display of the IEC material were not proper. No special attention seems to be given to the IEC activities.

Janani Suraksha Yojana: 91 institutional deliveries have been conducted during April to November 2010. Out of this 67 deliveries were registered under JSY and 67 deliveries have received monetary benefit. According to the health providers the funds received under JSY are sufficient for catering to all registered beneficiaries

Compensation for sterilization services: 143 sterilization acceptors are recorded during April to November 2010.Out of this 143 acceptors have received monetary benefit

Day (2)

Date of Visit: 18/12/2010

Taluk Level Hospital, Perambra, Kozhikode.
Sub Divisional Hospital

General observation: It is categorized as Sub Divisional Hospital. There are 70 sanctioned beds out of which 38 are in position. This centre has 8 PHCs under it and 30 sub centres. There are 6 doctors including 1 contractual gynecologist and 9 staff nurse. The average delivery conducted per month is 50 .Separate OP section and Token system are available in the facility. Seating arrangement and drinking water facilities for patients are available in the OP.

IP wards were all neat inside, but outside of windows and corridors it was not properly cleaned. No curtains were provided to the female wards. Labour room was maintained properly. Dr. Raju Balaram, Gyanecologist provided by NRHM is conducting deliveries. No labor cases were attended in that hospital prior to his appointment. Now there is an average delivery of 20 per month. He has conducted more than 600 deliveries so far.

It is noticed that no female sterilization was done in that hospital. The gynecologist replied that the Operation Theatre is not yet made functional for want of minor repairs. The Medical Officer i/c replied that it will be made functional in a week time. Pharmacy was also inspected. No fan was provided in the waiting area of the pharmacy. The books of accounts were maintained by the concerned clerk.

Availability of Services

- Facility for normal delivery is available in the facility
- Family Planning services for NSV/conventional vasectomy services are provided. Other Spacing Methods including ,IUD, OP , Emergency contraception are present
- Referral Services are also present

.

Performance: 417 normal deliveries were conducted during the year April to November 2010. No infant deaths and no maternal deaths have been reported during last year.320 IUD insertions were done, 1354 OP cycles were distributed and 74490 Condoms were distributed during the year April to November 2010.

Gender & Equity: there is a separate men‟s and women‟s toilet. The labor room does not have an attached toilet. One doctor has quarters on the premises and stationed at the facility cleanliness.

Drugs and Supplies were adequate and all the drugs were well stacked. The MO I/c has the power to spend from Rogi Kalyan Samiti funds for purchase of drugs during emergency situations and for hiring transport for referral of patients to higher facilities

IEC activities as well as display of the IEC material were not prominent. No special attention seems to be given to the IEC activities.

ANMs	**5**	**5**	**5**
Lab technicians	**1**	**1**	
Other support staff	**1**	**1**	

Date of Visit: 18/12/2010

PHC Maruthomkara, Kunnummal Block, Kozhikode

General observation: PHC is serving to 19000 Population. There is 1 doctor, 1 pharmacist posted at the facility. There are no beds at the facility. This PHC faced an outbreak of C.G this year. The Medical Officer, Dr. Anandan, HI Mr. Chandran, Jr. PHN, Jr. HI were also present. The average OP of the institution is 140. There is no IP Facility. OP renovation, seating arrangement and drinking water for the patients were made available under NRHM fund. The Medical Officer is not well versed with the NRHM accounts. He is asked to take more interest. Form S of IDSP not being prepared properly. From S is not reviewed at PHC level. No fever and diarrohea cases are noted for months together.

Availability of Services

- Only OPD and immunisation services are provided
- Essential Laboratory Services are not present other services of family planning are not provided at the facility.

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Performance: 53 females were treated for RTI/STI cases and 44 females were given post natal visits.

Drugs and Supplies were adequate and all the drugs were well stacked**.** The MO I/c has the power to spend from Rogi Kalyan Samiti funds for purchase of drugs during emergency situations but he is found to be not well versed with the funds management and utilisation of funds

IEC activities as well as display of the IEC material was not prominent . No special attention seems to be given to the IEC activities.

Date of Visit: 18/12/2010

PHC Kunnummal, Kunnummal Block, Kozhikode

General observation: It caters to a Population of 18684 and has 2 Subcenter under it which covers almost 12 wards. The building and premises were neatly maintained Average OP is 130. IP facility is not started. Out of the three doctors posted in the institution, two are deployed to other institutions. The Jr. HI was asked about the blood collection in the field. The shortcomings noticed in his work were discussed with the District Malaria Officer. Drugs like choloroquine and primaquine are not available since last 3 months.

Availability of Services

- Only OPD and immunisation services are provided
- Essential Laboratory Services are not present
- IUD insertions are done only in camps but not at the facility
- Family planning though the NSV/conventional vasectomy services provided. Other Spacing Methods including ,IUD, OP , Emergency contraception are present

.

Performance: 3 NSV have been performed during the year April to November 2010. 29 IUD insertions were done, 4 OP cycles were distributed and 2420 Condoms were distributed during the year April to November 2010.

Drugs and Supplies were adequate and all the drugs were well stacked**.** The MO I/c has the power to spend from Rogi Kalyan Samiti funds for purchase of drugs during emergency situations and for hiring transport for referral of patients to higher facilities

IEC activities as well as display of the IEC material were not prominent. No special attention seems to be given to the IEC activities.

Date of Visit: 18/12/2010

HSC Choyimadam : Subcentre Choyimadam is under PHC Velom. It caters to a Population of 7380 spread across 4 wards. There is 963 eligible couple in the population out of which 13 had under gone PPS and 92 pregnancies were there. ANM stays in the centre and provides services for immunisation and ANC

- The subcenter premises were neatly maintained and IEC materials properly displayed in the subcentre. The Jr. PHN Smt. Rakhi, HI, four ASHAs and members of Village Health Sanitation Committee were present.
- The MCH records were maintained.
- The involvement of ASHA in Ward Health Nutrition Days is good. It is noticed that the Jr. PHN is reimbursing Rs. 150/- as incentive for mobilizing children for immunization instead of the upper limit of Rs. 100/-.

- The role of the Ward Health Sanitation committee members in the communicable disease control programme was found to be good
- ANC clinics are held every 3rd Friday of month . MO comes for ANC from VELA PHC
- ANM is not trained on IUD insertion therefore she does not perform IUD insertions
- Hb estimation is not done at the centre but at CHC kuttiadi as the equipment is not available there, ANC register does not have details of Hb percentage.
- Family planning survey was done in 2008 and thereafter no survey was done

Day (3)

Date of Visit: 19/12/2010

MCH Unit Cherupa , Kunnamangalam Block ,Kozhikode
It is designated as an FRU

General observation: MCH Unit Cherupa is also MCH training unit of Kozhikode medical college. It is 16 bedded facilities. There are 4 medical officers including 1 civil surgeon, 2 assistant surgeons. One administrative officer from medical college (PSM dept) is also posted. The hospital and premises were neatly maintained. The OP service is available for full 7 days 24 hours average of 350-400 per month and IP average is 5 per month. An exception noticed in this hospital is that the institution is giving delivery services. This is due to the committed service of the Lady Medical Officer Dr. Lizzie. Even though she is not a gynecologist, she is attending the delivery cases. 6-7 deliveries per month are reported and also PPS and Minilap are performed in the facility. Waste management of the hospital was properly done. This is done by the IMAGE owned by IMA

Availability of Services

- Facility for normal is available in the facility
- 24 hours availability of Blood Transfusion services is not available being FRU.
- Family Planning services (Tubectomy –Laparoscopic, Minilap and Postpartum Sterilization) ,NSV/conventional vasectomy services are provided. Other Spacing Methods including ,IUD, OP , Emergency contraception are present
- Essential Laboratory Services are present for only Hb and Urine albumin and sugar, No BT/CT and CBC are done in the lab.
- Referral Services are also present

.

Performance: 130 normal deliveries were conducted during last year. No infant deaths and no maternal deaths have been reported during last year. Out of 130 babies weighed at the time of birth 3 were low birth weight babies. 80 females were given treatment for RTI/STI. Under family planning services 19 Male (conventional/NSV), 16Female (Laparoscopic), 5

Female (Minilap) and 24 Female (Post partum sterlisation) have been done. 73 IUD insertions were done; 192 OP cycles were distributed, 10740 Condoms were distributed and 12 ECPs were distributed

Laboratory services: The lab is equipped well. The technician did not seemed to be aware of the guidelines regarding staining of blood smear or smear preparation. He is doing only thin smear on the glass slide and is using lieshmania stain which greatly reduces the chance of detecting the malaria parasites. No malaria positive has been detected. Blood smears are not being sent for cross checking this is very essential to maintain the quality. There was not stock of chloroquine and primaquine

Waste disposal: Placenta is disposed in a pit near the facility but the area was not found to be properly covered. The plastic garbage around the area needs to be properly maintained. There is no proper passage for worker to dispose the placenta and it is disposed in pit immediately after delivery.

Gender & Equity: There is a separate men‟s and women‟s toilets. The labor room also has an attached toilet. One doctor has quarters on the premises and stationed at the facility cleanliness.

Drugs and Supplies were adequate and all the drugs were well stacked**.** The MO I/c has the power to spend from Rogi Kalyan Samiti funds for purchase of drugs during emergency situations and for hiring transport for referral of patients to higher facilities

IEC activities as well as display of the IEC material was not proper. No special attention seems to be given to the IEC activities.

HSC Kanniparamba : It covers approximately 5825 Population Spread across 2 full wards and 4 half wards. Jr. PHN Smt. Seena was present.

- The JPHN is residing in the centre.
- The records were maintained.
- Ante Natal clinic was regularly conducted on every Thursday but ANC not happened for last one month at sub centre as the ANM is involved in PHC work
- ARSH clinics are held on Saturday classes on menstrual hygiene which covers 12-15 adolescent girls per session.
- Village Health Sanitation meetings were regularly conducted, but the minutes were not written.
- Even though one Haemoglobinometer is provided in the subcentre, the Jr. PHN is not conducting Haemoglobin estimation for want of reagents. Values of Hb of ANC are done private and the same is registered.

- Major work of VHSC is source detection for which untied funds are utilised. Household survey and chlorination is also done by VHSC members and they are paid at 2 rupees per household.
- Glass slides and lancets are available however the glass slides are very old and dirty hence unusable the lancets are date expired she is not doing any malaria surveillance form 5 is being prepared properly.
- ANM has 40 days cycle for house visits however she is not even doing this for the households with one reason being that she is often put on PHC duty.
- There were four ASHA workers. The ASHA is doing the household visits to do the larval survey.

Date of Visit: 19/12/2010

CHC Narikkuni, Chelannur Block, Kozhikode

General observation: It is a 30 bedded facility with 4 doctors and 6 staff nurses. The OP block constructed under NRHM was visited. The building and the premises are neatly maintained. . The average OP is 300 and 20 patients are admitted in the hospital on that day. There was one Optometrist available in the facility she looks after all PHCs and school health programme according to her no free spectacles are provided since 2007 under the blindness control programme. The Passive surveillance was not found to be good for malaria but RNTCP examination is good and follows up of negative patients is reported as 10%

Availability of Services

- Only OPD services are available
- No laboratory services are available.

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Performance: 56 IUD insertions were done; 180 OP cycles were distributed, 10200 Condoms were distributed. One NSV has done during the last year.

Gender & Equity: There is a separate men‟s and women‟s toilets.

Drugs and Supplies were adequate and all the drugs were well stacked. The MO I/c has the power to spend from Rogi Kalyan Samiti funds for purchase of drugs during emergency situations and for hiring transport for referral of patients to higher facilities

IEC activities as well as display of the IEC material was not prominent . No special attention seems to be given to the IEC activities.

Date of Visit: 19/12/2010

HSC Valiyaparamba : The subcenter caters to approximately 6795 population spread across 2 full and 3 partial wards. Total household are 1307 under this HSC. There is 1350 eligible couple. The premises were neatly maintained. Jr. PHN Smt. Chinnamma and Jr. HI Mr. Praveen kumar and LHI Smt. Annamma were present.

- The JPHN knows her roles and responsibilities, visits around 20 houses in a month. She maintains daily dairy with 40 day schedule
- All the records are properly maintained. The Ward Health Sanitation Committee is meeting regularly, but the agenda is incomplete.
- VHSC register and cash book were not well maintained
- Surrounding area was beautiful and properly maintained.
- Male worker showed S forms and had good understating on the surveillance
- VHSC funds are mainly utilised for source detection , new table and chair were also bought this year from the untied funds.
- Immunisation has not happened from last month

Date of Visit: 19/12/2010

Institute of Pain & Palliative care

Mr. Saif, Project Manager was present. The Inpatient ward was visited. The services provided to the terminal patients in the institution are exemplary.
The Outpatient facility is provided in the Pain & Palliative Clinic set up in the Medical College campus and is available to the patients needing care except on Sundays. The patients coming to the OPD are given the required medicines including medicines for their pain management from here. The patients left by the medical system when the disease is incurable and requiring inpatient care for symptom management are admitted in the inpatient building set up on the land provided by Kerala Government adjacent to medical college campus. The admission of the patient here is decided on the basis of screening him in the OPD by the medical professionals in close coordination with the community volunteers and availability of beds. So respite care, symptom care and terminal care are being given in IPM inpatient facility. There are 32 beds arranged in 3 beds per cubicle system where the patient and his bystander are able to stay during care. Along with the care free food is also being provided to the patient.

The doctors and nurses are being given training on Palliative care. Orientation course followed by Fellowship Training is offered by IPM. So far 130 doctors have been trained through this institution, which has recently been recognized as a WHO resource Centre also. The ASHA workers and the medical professionals of local Primary Health Centers along with community volunteer are participating in identification, linking up and providing care to the patients. Distribution of waterbeds, bedsore management etc., are being carried out by them.

Date of Visit: 19/12/2010

The Child Development Centre (IMHANS).

The Director, Dr. Krishnakumar was present. He explained various activities carried out in the centre. The centre is able to cater the needs of the patients of the adjacent districts of Malappuram and Wayanad. They have already examined about more than 5000 children with developmental disabilities and they are able to provide training to the children as well as to their parents. The funds are provided under NRHM. NRHM is also supporting the Community Mental Health Programme conducted by IMHANS.

The centre was started functioning in the year 2007. National Rural Health Mission started extending its support to this centre in January 2008 and provided with an amount of 5 lakhs of rupees in 2008 and Rs.6 lakhs in 2009. Services of multi disciplinary professionals like psychologist, speech therapist paediatrician, psychiatrist, developmental therapist are provided through NRHM system. Out of the total of about 4200 children (boys 2398, girls 1828) seen in the OPD of this centre majority were for the services of child psychiatrist, speech therapist, special educator, clinical psychologist & developmental therapist.

Annexure-III

Data received from the state

Annexure 8

Infrastructure Upgradation Checklist

A. Overview of Health Infrastructure in the State/UT

Health Facility	Required as per population norms(pl mention reference year)		Number functioning as of 31st March 2010		Gap	
	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts
District level Hospitals (DH, Gl.H & Splty)		39		39		0
Sub-Divisional Hospitals and other hospitals above CHC		65		65		0
CHCs		245		245		0
PHCs		839		839		0
Other Health facilities above SC but below block level (may include APHC etc.)		66		66		0
Sub-Centres		5403		5403		0

Building position of health facilities

Health Facility	Number functioning in Govt. Building	Number functioning in Rented Building	Gap	No. Functioning in other buildings of Panchayat/ Vol./ Social Org, etc. without paying any rent	Number of buildings under Construction		Number of buildings required to be constructed on priority
					Other Sources	Total	
District level Hospitals (DH, Gl.H & Splty)	**39**						
Sub-Divisional Hospitals and other hospitals above CHC	**65**						
CHCs	**245**						
PHCs	**839**						
Other Health facilities above SC but below block level (may include APHC etc.)	**66**						
Sub-Centres	**2956**	**981**		**1466**			

Annex 2

B. Information on Progress of New Constructions taken up under NRHM in the State (cumulative till date)

Health Facility	New Construction sanctioned under NRHM so far		Progress of New Constructions						Remarks/ Shortcomings
			Completed		Under Construction		Yet to start		
	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	
District Hospitals (DH)		10		5		4		1	
Sub-Divisional Hospitals and other hospitals above CHC		21		9		4		8	
CHCs		96		89		5		3	
PHCs		20		7		9		4	
Other Health facilities above SC but below block level (may include APHC etc.)									
Sub-Centres		2		1		1			

Information on Progress of Upgradation of Health Facilities under NRHM in the State (cumulative till date)

Health Facility	Upgradation sanctioned under NRHM so far		Progress						Remarks/ Shortcomings
			Completed		Under Construction		Yet to start		
	High Focus	Non High Focus	High Focus	Non High Focus	High Focus	Non High Focus	High Focus	Non High Focus	
District		21		9		9		3	
Sub-Divisional Hospitals and other hospitals above CHC		39		13		07		19	
CHCs		116		104		6		6	
PHCs		20		7		9		4	
Other Health facilities above SC but below block level (may include APHC etc.)									
Sub-Centres		2		1		1			

C. Status of Accommodation for Health Care Providers:

Facility Type	**Availability and Shortage of Staff Quarters**							
	Doctors/ Specialists*		**Paramedics***		**Group C Staff***		**Grade D***	
	Required	Available	Required	Available	Required	Available	Required	Available
District level Hospitals (DH)								
Sub-Divisional Hospitals and other hospitals above CHC		1413	5233	4081				
CHCs	1457	909	2228	1644				
PHCs	1917	1204	1651	1157				
Other Health facilities above SC but below block level (may include APHC etc.)								
Sub-Centres								

Infrastructure Upgradation Checklist

8. E . Sources of Funds for Health Care Infrastructure:

(Rs in lakh)

	2006-07	**2007-08**	**2008-09**	**2009-10**	**2010-11**
NRHM	0	2986	5279.39	4365.76	1244.54
Other Central Ministry Funds	0	0	0	0	0
State Budget	0	0	0	0	115.79
Donor funds	0	0	0	0	0
Financial Commission Grants	0	0	0	0	0
Other sources	0	0	0	0	0
Total	**0**	**2986.00**	**5279.39**	**4365.76**	**1360.33**

Checklist for Human Resources

1. HR status as on date: 15th Dec 2010

Category	Sanctioned	In Position			Required as per IPHS	Shortfall against IPHS
		Regular	Contractual			
			NRHM Funds	Other Sources		
Doctors	2474	2150	598			
Specialists	1611	1447	114			
AYUSH MOs			467			
Paramedics			35			
Staff Nurses	7163	7010	785			
JPHN	5571	5420	864			
ASHAs			31000			
MPW	3504	3448	1			
ANM			-			
Lab Technician	776	637	136			
Pharmacist	1612	1525	147			
X-Ray Technician	72	63	7			
Ward Staff	5481	5247	15			
Personal staff			-			
Cleaning Staff	7246	7162	-			

Availability of Training Facilities

	Category	Institutions and Annual Intake capacity				Annual Training Requirement **	Gap
		Govt.		Private			
		Number	Intake	Number	Intake		
1	ANM Schools	4	180	9	246		
2	LHV Schools	2	100	-	-		
3	GNM Schools	18	445	201	6040		
4	MPHW Schools	2					
5	Post Basic B.Sc(Nursing)-College	1	30	8	215		
6	B.Sc. (Nursing)-College	05	315	91	4086		
7	M.Sc. (Nursing)-College	3	80	11	152		
8	D.Pharm	5					
9	B.Pharm	2					
10.	Lab. Technician (DMLT)	5					
11	Lab. Technician (Degree)	1					
12	Others (Pl specify)						

Status of training of health functionaries

Type of Training	Cumulative number of functionaries trained				
	MO	**Specialists**	**ANM**	**Staff Nurse**	**others**
IUCD	**46**	**2**	**772**	**17**	**22**
NSSK	**171**	**40**	**20**	**1051**	
SBA	**-**	**-**	**-**	**-**	**-**
eOC by KFOG	**104**	**-**	**-**	**110**	**-**
IMNCI	**-**	**-**	**-**	**-**	**-**
F-IMNCI	**-**	**-**	**-**	**-**	**-**
IUCD	**46**	**-**	**-**	**72**	**17**
BeMOC	**-**	**-**	**-**	**-**	**-**
CeMOC	**-**	**-**	**-**	**-**	**-**
LSAS	**-**	**-**	**-**	**-**	**-**
MTP/MVA	**18**	**-**	**-**	**-**	**-**
NSV	**12**	**4**	**-**	**2**	
Minilap	**10**	**-**	**-**	**5**	**3**
CCSP	**-**	**-**	**-**	**-**	**-**
Laparoscopy	**14**	**-**	**-**	**9**	**6**
Communicable Diseases	**-**	**-**	**-**	**-**	**-**
Others *(NCD, IDD, ARI,Palliative care etc)	**476**	**-**	**221**	**190**	**168**
Immunisation	**126**	**-**	**1021**	**-**	**50**

Annexure 10

Formats on utilization of Untied Funds

(Amount in Lakhs)

		Utilization of Untied Fund									
Levels		**06-07**		**07-08**		**08-09**		**09-10**		**10-11**	
		Allocation	**Utilisation**	**Allocation**	**Utilisation**	**Allocation**	**Utilisation**	**Allocation**	**Utilisation**	**Allocation**	**Utilisation**
State	High Focus Districts	No high focus districts in Kerala									
	Non High Focus Districts	**737.15**	**20.37**	**2477.20**	**928.65**	**3075.20**	**1828.90**	**2741.40**	**2254.48**	**2737.15**	**693.62**
Districts Visited	D1										
	D2										
Facilities Visited	DH										
	SDH										
	CHC/BPHC (2)										
	PHC(3)										
	SC(5)										

Annexure 11

Formats on utilization of Annual Maintenance Grant (AMG)

(Amount in Lakhs)

		Utilization of AMG									
Levels		06-07		07-08		08-09		09-10		10-11	
		Allocation	Utilisation	Allocation	Utilisation	Allocation	Utilisation	Allocation	Utilisation	Allocation	Utilisation
State	High Focus Districts	No high focus district in Kerala									
	Non High Focus Districts	**455.50**	**0**	**976.80**	**259.90**	**993.80**	**666.44**	**1081**	**806.68**	**1086.30**	**83.99**
Districts Visited	D1										
	D2										
Facilities Visited	DH										
	SDH										
	CHC/BPHC (2)										
	PHC(3)										
	SC(5)										

Annexure 12

Checklist for ASHA

i. Information on ASHA

Districts	Number of ASHA required	Number of ASHA Selected	Number of ASHAs dropped out	Number of ASHAs in place	Number of ASHA trained up to 4th Module till date	Number of ASHAs with drug kits
Kozhikode	2800	2592	425	2167	2158	1690
ALappuzha	2300	2375	169	2206	0	1535
Kottayam	1965	2031	141	1889	0	1177
Palakkad	2800	2686	90	2561	0	2561
Idukki	1200	1188	115	1073	0	1073
Malappuram	4000	3740	275	3465	0	1302
Kollam	2750	2729	267	2462	0	2462
Ernakulam	3348	2201	202	1999	0	1650
Thrissur	3100	2623	124	2499	0	800
Trivandrum	3600	3527	626	2901	2901	709
Pathanamthitta	1300	1342	201	1141	1141	1232
Wayanad	839	839	40	793	718	793
Kannur	2700	2354	77	2255	2257	650
Kasaragode	1208	864	33	831	84	378
Total	33910	31091	2785	28242	9259	18012