

**FIFTH COMMON REVIEW MISSION
STATE VISIT REPORT: KARNATAKA (NOVEMBER 9-15, 2011)**

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1 . I N T R O D U C T I O N

A Common Review Mission led by Dr. S.K. Sikdar, Deputy Commissioner (Family Planning) Ministry of Health and Family Welfare, Government of India and development partners visited Karnataka during November 9-15, 2011 to review the implementation of NRHM. The team was also joined by senior officers from the Department of Health & Family Welfare, Government of Karnataka. Details of mission members are in Annex-1.

The main objective of 5th CRM was to undertake spot appraisal of the health system, reflect on success of strategies and policies, document the evidence in support/against the policy and identify course correction (if required). The team did an in-depth desk review of the documents and data available including the State PIP, Record of Proceedings of NPCC, HMIS data and variance analysis report before heading for the State.

Dr. E.V. Ramana Reddy, Secretary, DoHFW, Government of Karnataka, chaired the briefing meeting on 9th November 2011, which was attended by officers and consultants of DoHFW.

After the opening remarks by Dr. S.K. Sikdar, D.C. (Family Planning), Government of India, on the objectives of 5th CRM, a detailed presentation was made by Mr. S. Selva Kumar, Mission Director, Karnataka highlighting the progress, status of main programmes under NRHM and the new initiatives being taken by the State.

The Mission visited two districts, Bijapur and Chamarajanagar. The details of the facilities visited are in Annex 2.

The Mission had a debriefing session on November 15, 2011 chaired by Secretary DoHFW, Government of Karnataka. List of persons who were present in debriefing meeting is provided in Annex 3

The team would like to sincerely express appreciation and thank the officials of the Government of Karnataka, KHSRDP, SHS, Directorate and staff of the facilities visited by the CRM for facilitating the review, providing all the documents asked for, appropriately and very openly responding to various issues raised by the CRM members and excellent hospitality provided.

Structure of the report

The Structure of this report is as follows:

- Chapter 2 provides a summary
- Chapter 3 gives background of the State based on the desk review.
- Chapter 4 is based on the field findings of the CRM. The chapter is structured into 14 thematic areas of the 5th CRM. For each theme, the State scenario or current status, followed by team's observations in the districts, observations and findings of 2nd CRM (as applicable) and progress thereafter and issues or areas of improvement has been provided.
- Chapter 5 provides the overall recommendations.

2. EXECUTIVE SUMMARY

Karnataka has been implementing NRHM for last 6 years and has come a long way. In terms of goals and outcomes, it has achieved:

- TFR goal of 2.1 (Karnataka's TFR is 2.0 as per SRS 2009)
- MMR has come down from 228(SRS 01-03) to 178 (SRS 07-09)
- IMR of 41 (SRS 2009) has reduced from 52 (SRS 2003)
- Leprosy prevalence is less than 1
- Reduction in malaria mortality
- In TB, 12 districts have achieved the cure rate of 85%

Much more impressive than the achievement of goals/outcomes are the architectural corrections in the health system which has been brought about in the last few years, especially the last 2 years. The major path-breaking steps taken include:

- Karnataka State Civil services (Regulation of Transfer of Medical Officers and Other Staff) Act, 2011, for transfer and posting of specialists, MOs and compulsory rural posting
- Amendment in Cadre and Recruitment rules for direct recruitment of specialists
- Karnataka Private Medical Establishment Act,2009- for registering all private medical establishments with the purpose of bringing in quality, uniformity and standard in care.
- Establishment of Karnataka State Drugs Logistics & Warehousing Society (KDLWS) and automated management through electronic Drug Distribution management System
- E- procurement for all drugs, chemicals and consumables from 2010
- System for liquid and solid bio-medical waste management system
- Strong monitoring system – nodal officers from State for each district and nodal officers from district for each taluk
- SMS based tracking of Mother and new born, reliable and updated HMIS
- Financial MIS – web enabled bank independent portal for tracking fund flow and expenditure

On the anvil are three very important Act/policies:

- Revised Public Health Act
- PPP policy
- HRMIS- wherein data of all health personnel will be maintained and promotions and other HR decisions will be made on the basis of MIS

The Acts and policies are expected to provide a concrete base for better performance in health sector in the coming years and decades. The stable and focussed leadership at the State level, system of monitoring by senior officials and regular meetings of State and District Health Mission and Society has given the sector an enabling and supportive environment for systems strengthening.

Given the above background of solid policy reforms, the CRM tried to find out the causes and remedy for problems especially in maternal and child health where the other Southern States have better indicators.

Addressing the Problem of the last few miles

The desk review, discussions with the State and district officials and the field visit show:

- State has adequate infrastructure (FRUs, PHCs and SCs more than the norms of GoI)
- HR- Availability satisfactory. Since 2005 the vacancies against the sanctioned posts of MOs, SNs and ANMs have come down to 10%; shortage of specialists has been overcome by LSAS and EmOC training and higher pay. Also KPSC is recruiting 600 specialists.
- Service delivery: OPD, IPD, and Institutional deliveries have increased. Demand generation through many Central and State government schemes to attract pregnant women to institutions are being undertaken.
- Referral transport: 108 and State owned ambulances providing reliable home to facility and inter-facility transfers.

State now needs to concentrate on round the clock functioning of facilities (24x7 PHCs and FRUs), assured service guarantee and quality of health services through more systematic supervision. State should plan facilities based on accessibility rather than on the basis of population e.g. every woman in the State should be able to get to a facility with EmONC within 30 to 45 minutes.

Examples of areas of greater emphasis are:

- BPL –Pregnant women of third and higher parity who are currently not covered by any demand generation schemes
- Pockets in tribal and hard to reach areas where transport is still a problem
- Reach and adequacy of services in urban areas among BPL
- Actual availability of 24x7 EmOC services especially at night
- Review of all the maternal deaths
- Full Immunization percentage which is still low 76% (DLHS-3) and 78% (CES-2009). Coverage of urban slum area needs to be ensured; drop -out rate for BCG to Measles is almost 10%
- SNCUs with full complement of staff in all DH
- Requirement of NRCs at CHC levels
- Prioritization of HBNC in tribal areas
- Team building and closer coordination at facilities for effective treatment of patients. E.g. systematic follow up of screened high risk pregnant women

Karnataka has the experience of senior officials as well as energy and enthusiasm of young KHSDRP-NRHM officers at state, district and taluk level. Closer, result- oriented, supportive supervision is expected to show faster improvement in the health indicators.

The last CRM (2nd CRM) visited Karnataka in Nov-Dec, 2008. Observations and findings of 5th CRM when compared with the 2nd CRM show a marked improvement especially with regards to cleanliness, maintenance and service delivery. The ANMTCs which were found to be lacking in training aids and staff were found to be well staffed and vibrant. The enthusiasm of the ANM students waiting since morning to have an exposure with the CRM team and actually getting that opportunity late in the night at 8.00 pm was seen to be believed. The changes over the years prove that Karnataka is moving in the right direction. Only the pace needs to increase so that in the coming years it can compete with some of the best public health systems in the country.

3 . D E S K R E V I E W

INTRODUCTION TO KARNATAKA

Karnataka has 30 districts with a total population of 611 lakhs (Census, 2011) of which 51% are male and 49% are female. The population density is 319 per sq. km. Sex ratio is 968 (females per 1000 males). The total literacy rate is 75.60% (male – 82.85%, and of female – 68.13%).

Almost 34% of the total population in Karnataka live in urban areas.

NRHM: Goals and Achievements

RCH

The State's MMR of 178 (SRS 07-09) is the highest amongst the Southern States. The IMR of 41 (SRS 2009) has reduced from 52 (SRS 2003). With a TFR of 2.0 (SRS 2009), Karnataka has achieved the TFR target (of 2.1 by the year 2012):

INDICATOR	KARNATAKA		INDIA	
	Trend (year & source)		Current status	RCHII/NRHM (2012) goal
Maternal Mortality Ratio (MMR)	228 (SRS 01-03)	178 (SRS 07-09)	212 (SRS 07-09)	<100
Infant Mortality Rate (IMR)	52 (SRS 2003)	41 (SRS 2009)	50 (SRS 2009)	<30
Total Fertility Rate (TFR)	2.3 (SRS 2003)	2.0 (SRS 2009)	2.6 (SRS 2009)	2.1

DLHS-3 shows mixed results over the baseline DLHS-2:

(All figures are in %)

Indicators	DLHS-2 (2002-04)	DLHS-3 (2007-08)
Mothers who had 3 or more Ante Natal Check-ups	78.6	81.6
Mothers who had full Ante Natal Check-up	29.6	37.7
Institutional delivery	57.9	65.1
Children 12-23 months fully immunized	71.3	76.7
Total unmet need for family planning	15.1	15.8

National Disease control Programmes:

Parameter	Expected outcome	Outcome of the Mission in the State
Malaria mortality reduction rate	60% by 2012	11 confirmed deaths during 2010 (25 during 2006)
Dengue mortality reduction rate	50% by 2010 and sustaining that level until 2012	6 during 2010 (7 during 2006)
Cataract operations	Increasing to 4.6 million	2.1 lakhs upto Sep 2011 against 4 lakhs target
Leprosy prevalence rate	Reduce from 1.8 per 10000 in 2005 to less than 1 per 10000 thereafter	<1 (0.46)
Tuberculosis	Maintain 85% cure rate through entire mission period and also sustain planned case detection rate	12 districts have the cure rate of 85% and more, the remaining 18 districts have cure rate of less than 84%. Kodagu has the highest CR of 95%. Yadagiri has the lowest DR of 72%.

Base line of the public health system in the State

Health Infrastructure

• District Hospitals (DH)	- 19 (remaining districts have medical college hospitals)
• Hospitals	- 153
• Community Health Centres (CHCs)	- 326
• Primary Health Centres (PHCs)	- 2193
• Sub Centres	- 8870
• Urban PHCs	- 27
• Urban FW Centres	- 108
• HFW Training Centres	- 4

High focus districts

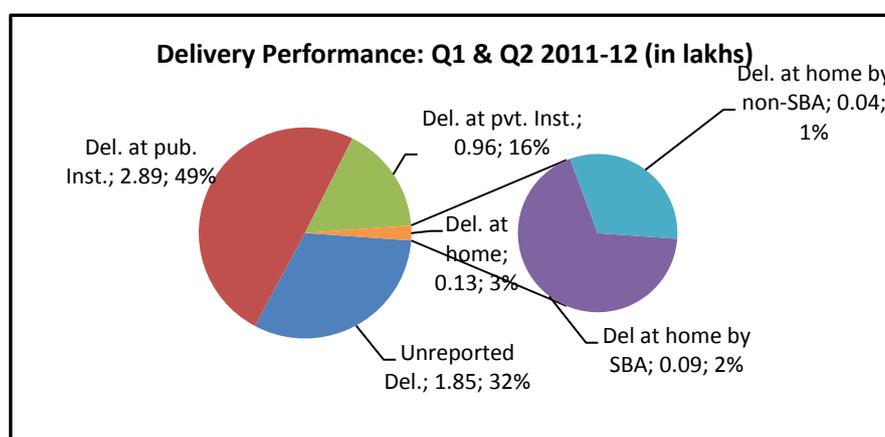
Out of 30 districts in Karnataka, 7 are high focus districts (Bellary, Bidar, Chamrajnagar, Chitradurga, Davangere, Kolar and Raichur).

The State has designated 7 'C' category districts based on vulnerability mapping: Bijapur, Bidar, Gulbarga, Yadgir, Koppal, Bagalkote, Raichur.

The CRM covered one high focus district i.e. Chamarajanagar and one C category district i.e. Bijapur.

Major Findings from Desk Review

- The analysis of HMIS data shows decrease in deliveries conducted in public facilities and an increase in the deliveries in the accredited private facilities though the % of institutional deliveries have remained the same.
- The ANC coverage is shown by the State as 130%. It was primarily because of double registration of some pregnant women at FRUs/PHCs as well as SCs. The district visited had taken corrective steps and the data is expected to be corrected in coming months.
- Of the total 3.98 lakh reported deliveries in the first six months of 2011-12, 49% were reported from public health institutions, 16% from private health institutions and rest 3% were home deliveries. 0.95 lakh deliveries in the state were unreported which constitute 32.0% of the total expected deliveries. State needs to track all the deliveries.



4. FINDINGS OF 5TH CRM IN THE STATE

Infrastructure Development

- The State is utilising budgets from various sources i.e. NRHM, KHSERP, State budget, Zila panchayat funds, 12th Finance Commission for up-gradation of facilities which doesn't have buildings as per the norms. State has a robust engineering cell comprising 4 executive Engineers, 15 Assistant Executive Engineers and 50 Assistant Engineers which monitors construction, up-gradation as well as maintenance of the health infrastructure. SDP, Land Army, Nirmiti kendras, NRHM and Zila Panchayats –all available agencies are being synergised for the construction activities:

Funding source	Type of Facility	Total no. of buildings undertaken	Building already handed over	Buildings to be handed over in 2011-12
NRHM	ANM Sub-centres	85	55	25
	PHCs/ CHCs	196	67	129
	Total	281	122	154
SICF Component	ANM Sum-centres	152	150	2
	PHCs	35	28	7
	ANM training centres	9	6	3
	Drug ware hoses	13	6	7
	Total	209	190	19
12 th Finance	District Training Centres	22	18	3
	Trauma Care Centres	137	131	6
	Total	159	149	9
	Grand total	960	617	364

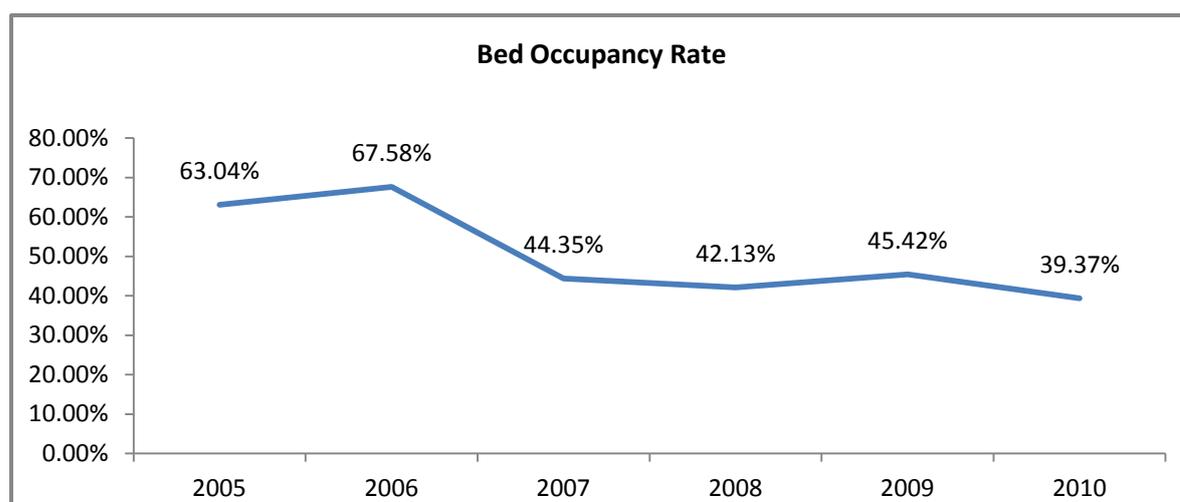
(Source: DoHFW, Govt of Karnataka)

- Most of the facilities visited by the CRM team in both the districts were found to be of good quality and well maintained. Only one facility (Thamba) had a construction flaw -a faulty pillar and is under lokayukta enquiry. Another facility in Bijapur, (at Kolhar) seemed to be constrained by space though a new building is coming up for the Kolhar PHC and is likely to be completed by the end of this financial year (i.e. March 2012), which would solve the problem.
- Many of the newly constructed facilities are disabled friendly. E.g. ramps (PHC- Vandal) and commode toilets (Tribal PHCs in Chamarajanagar) were seen.
- However, the CRM observed that the residential quarters do not seem to be part of the normal new constructions. E.g. New PHC building at Kolhar, didn't have residential quarters, the staff currently resides in quarters provided by Upper Krishna Project (UKP). Similarly the newly constructed tribal PHC (Ponachi) didn't have quarters for staff.



Karnataka has more facilities than required number as per NRHM norms:

- The State had 149 functional FRUs as on March, 2011, and the goal for 2011-12 is 192. This works out to a population of approximately 4 lakhs per FRU (assuming all deliveries take place in the public sector), whereas an FRU is supposed to cater to a population of 5 lakhs.
- Similarly the State has 2310, functional PHCs, each covering 26,000 population (as per GoI norms, one PHC caters to 30000). Moreover state has adequate number of CHCs (177), district hospitals (17) and medical colleges (10 govt and 29 private medical colleges).
- In many of FRUs (and 24/7 PHCs) the patient load is low. The bed occupancy rate in 2010 was only 39% (Source: State ppt.¹).



(Source: DoHFW, Karnataka)

In the briefing meeting, the State shared that since 2008 construction for no new facility has been taken up. Construction is only limited to renovation or to buildings which are not as per norms/requirements.

Progress against current annual PIP (2011-12)

Sl.no	Type of facility	Baseline (already existing in 2010-11)	Addition Planned during the year	Cumulative Planned	Achievement
1	Functional FRUs	149	43	192	18
2	24x7 PHC	988	62	1050	13
3	Sick New Born Care Units	33	0	33	- 33 continued
4	New Born Care Corners	762	288	1050	15
5	Stabilization Units in CHCs/ BPHCs	177	17	194	15

(Source: DoHFW, Karnataka)

¹ In 2010, total beds 25280, outpatient 1,41,15,999 and inpatient 33,92,754 .

The second CRM had commented negatively on quality of construction and had also called for efforts for optimising facilities created.

As pointed out earlier, all the facilities visited by the 5th CRM were found to be of good quality. The State has taken a decision to optimise the facilities and since 2008, no new infrastructure has been taken up.

Health Human Resources

Recruitment, Transfer and Rational Posting

Karnataka has taken up many systemic changes including enacting of few acts (e.g. Transfer Act, 2011 etc.) to improve the management of HR:

- Specialist cadre created. Cadre and recruitment rules amended; paving the way for direct recruitment of specialists (previously only GDMOs were recruited). The State informed that process has been initiated for recruiting 600 specialists through Karnataka Public Service Commission (KPSC).
- State is also in the process of building up a public health cadre and has plans to provide comprehensive training to the doctors.
- The Karnataka State Civil Services (Regulation of Transfer of Medical Officers and Other Staff) Act 2011 has been enacted which has come into effect from 2nd May 2011. It has provisions for compulsory posting in rural areas and transfer of specialists to appropriate posts.
- State has taken steps to rationalise the HR. Specialists have been redeployed in FRUs. 233 Doctors from PHCs having more than one MBBS doctors have been placed in PHCs having no MBBS doctors.
- Special remote area allowance has been budgeted in the Programme Implementation Plan wherein incentive of Rs.300-Rs.8000 has been built-in for various health personnel starting from Group D to doctors.
- The State is paying a substantially higher remuneration for specialists doctors on contract to ensure delivery of services

HR AVAILABILITY: 2005 Vs 2011

Sl. No.	Category of staff	Sanctioned strength	Status as on 2005 (base-line)		Status as on 2011			% increase over 2005
			Regular	Cont	Regular	Contractual	Total	
1.	Medical officers	2586	1104	-	2285	59	2344	52.9
2	Specialists	2600	1107	-	1557	65	1622	31.8
	AYUSH Doctors	-	-	-	-	563	563	100.0
3	Staff Nurses	7810	4965	-	7295	4264	11559	57.0
4	ANMs	10025	6795	-	8356	643	8999	24.5
5	MPW	5810	2715	-	3990	100	4090	33.6
6	LHV	1432	370	-	1162	-	1162	68.2
7	LT	2197	1345	-	2044	136	2180	38.3
8	Pharmacist	2691	1643	-	2318	-	2318	29.1
9	X Ray Tec.	568	338	-	565	-	565	40.2

(Source: DoHFW, Karnataka)

There has been an increase in all categories of HR and the gap between sanctioned strength and available HR has been fulfilled to a great extent. For many of the categories where there is a larger gap, the State is in the process of finalising the recruitment e.g. specialists.

Progress against Current year's PIP (2011-12)

The progress against the physical target given in the PIP has been satisfactory in the first six months (April-September 2011) for most of the activities:

FMR	Activity	Physical Target	Achievement
A.8	INFRASTRUCTURE (Minor Civil Works) & HUMAN RESOURCE (except AYUSH)	-	
A.8.1	Contractual Staff & Services	-	
A.8.1.1	ANMs, Staff Nurses, Supervisory nurses	-	
	ANMs (against vacant posts: Contractual /Retd./ANMs /SNs working as ANMs)	1009	733
	Additional ANM for Sub Centres in 7 C category districts	750	639
	Tribal ANMs engaged through PPP with NGO	15	15
	Staff Nurses (24 x 7 PHCs/CHCs/FRUs(NBSU)	3648	3535
	SNs (SNCU)	284	271
A.8.1.2	Laboratory Technicians, ,MPWs	145	136
A.8.1.3	Specialists	75	65
A.8.1.5	Medical Officers at CHCs / PHCs	100	59
	Medical Officers at SNCU (3 each for 22 functional SNCU's)	66	33
	Child Health Counsellors	22	9
	Integration of ICTC (salary for 83 counsellors and 83 LTs)	166	166
	One Refrigerator Mechanic to each district & one to State HQ by outsourcing	18	15

(Source: DoHFW, Karnataka)

SCs with two ANMs providing services: 8143 SCs with single ANM and 747 with two ANMs (Total 8890). The expenditure reported under incentives for various categories of staff for the first six months (April-Sept) of the year 2011-12 is up to 25% only, which means either the personnel is still not staying at HQ or their payment of incentive has been delayed.

Pre-service training

- Karnataka has adequate number of medical colleges, nursing and ANM schools run by government and private sector.
- The Nursing schools in Karnataka are under Department of Medical Education. The State has more than required number of staff nurses.
- The State has 28 ANM training schools run by the government and 30 schools run by private. Each of the Government ANM School takes up a batch of approx 30 (3 tribal ANMTCs have 40 seats) every year.



- There is good linkage between SIHFW and ANM schools. The Principals and tutors were trained in training technology for ten days by SIHFW in July-August 2011.
- Both the teams visited one ANM school each. The ANMTC had adequate staff and approx 60 very enthusiastic students. The knowledge level of students with whom the team interacted was found to be good. The school has all the infrastructure and teaching aid required. The second year students are sent to facilities for field training. Since last year, most of the students passing out from the ANMTCs are not able to get jobs in Karnataka.

In-service training

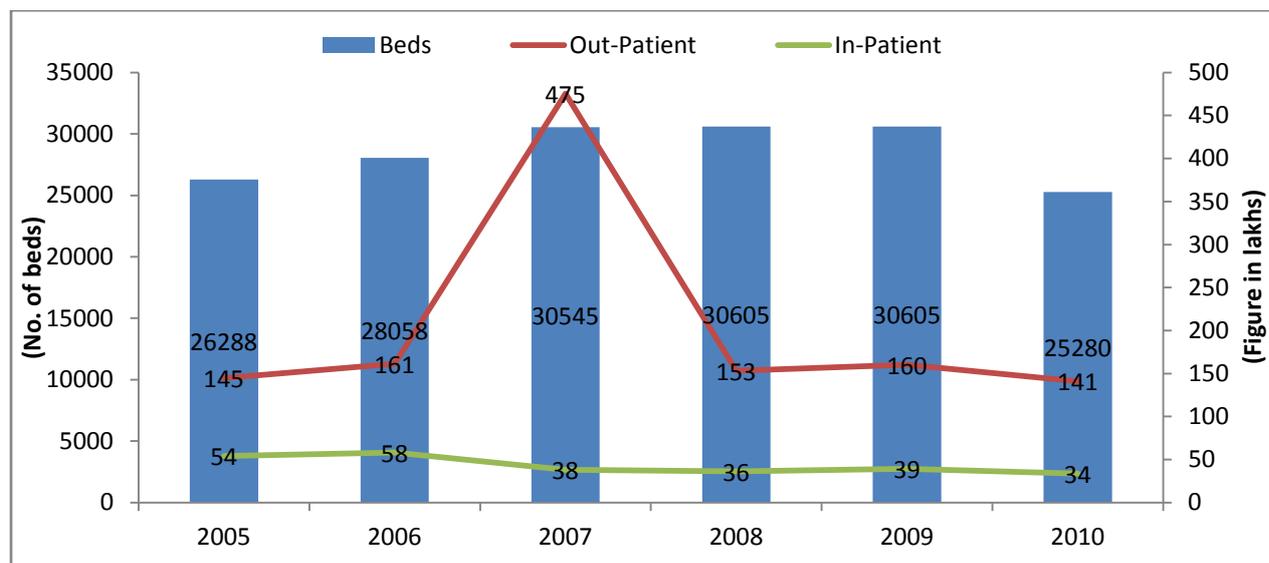
- SIHFW is the nodal agency for all the training under NRHM.
- Training is undertaken with the help of 19 district training centres and 4 Health and Family Welfare Training Centres.
- Each DTC/HWTC is attached either to a medical college hospital/DH or SDH for clinical practice sessions.
- Refresher training in SBA undertaken to bridge the gap in skills especially regarding partograph, AMSTL etc.
- Posting of EmOC and LSAS trained doctors: The State has a total of 53 EmOC and 67 LSAS trained doctors. 57 LSAS and 39 EmOC doctors who are posted in FRUs/DH are practising the skills. The non operating doctors who lack confidence may be deputed in DH under a senior gynaecologist/anaesthetist (as the case may be).

Observations of 2nd CRM

- The 2nd CRM observed that DTCs had high vacancy and there were no training plans based on district needs and there were no inputs in PIP:
 - The vacancies in DTCs remain high. The DTC at Bijapur has only one clinical trainer who is the Principal of the DTC.
 - However DTCs are now conducting training programmes as per the PIP and district needs.
- Second CRM also suggested improving the ANMTC staff availability, training aids etc., increasing intake of ANMTCs and a relook at the career path for ANMs:
 - The fifth CRM observed that ANMTCs are functioning well with enough working staff and training aids.
 - Intake of ANMs is satisfactory.
 - Batches are being admitted every year to optimise the availability of infrastructure during the field posting of the 2nd year students
 - There is still a need for charting out a career path for ANMs as most of the newly trained ANMs are not able to get jobs in the State.
 - The second CRM also pointed out that there was ‘no clear cut human resources strategy in health sector.’
 - State is yet to have a long term human resource development plan synchronised with the requirements of the skilled HR in the State.
- The HR supply for Karnataka is satisfactory. There are gaps in availability of specialists, esp. gynaecologists, anaesthetists, and paediatricians which is being overcome by in-service training of EmOC, LSAS and F-IMNCI. At places specialists are being given higher salaries.

Health Care Service Delivery – Facility Based – Quantity and Quality

OPD and IPD



(Source: DoHFW, Karnataka)

Deliveries

Year	Institutional deliveries	Public sector deliveries	%	Deliveries in private accredited facilities	%	C-sections	%
2009-10	837453	687262	82	150191	18	96685	12
2010-11	717648	650062	91	67586	9	100902	14
2011-12 (till Sept)	384869	288639	75	96230	25	65006	17

(Source: DoHFW, Karnataka)

C-sections

- Though the HMIS data for last two years show an increase in the % of C-sections, the fifth CRM found that most of the FRUs were conducting elective c-sections and were not really providing the Emergency Obstetric Care as mandated. The complicated cases at night were being referred to DH which has the same complement of staff and equipment as an FRU for EmOC. So the whole purpose of designating FRUs gets defeated. FRU Talikoti (Bijapur) has started conducting emergency C-sections as per information provided in the debriefing meeting.



Post- natal ward

Laboratory Services

- Laboratory services were available at all the facilities till PHC level. The diagnostic tests available at CHC/FRU included:

Hb, CBC, WBC, ESR, VDRL, VDAL, Blood Sugar, Hbs Ag test, Blood grouping and cross matching, urine routine microscopy, HIV, PSMP for Malaria, sputum examination for AFB, bleeding time,

clotting time, serum bilirubin, blood urea, serum creatinin etc. Diagnostic facilities included X-ray and Sonography too.

- The lab also provided test for water sampling.
- At places the ANM at SC were doing the Hb testing using strips.
- ICTCs are functional. HIV testing is being carried out for the ANC cases and followed up.
- ANC: High risk cases (e.g. severe anaemia, high BP etc.) are being screened though not followed up at some facilities in a systematic manner.
- Co-ordination between ANC, lab tests etc, required.

Quality of services

- Facilities visited were clean and maintained well. Adequate waiting area, provision of drinking water and TV for entertainment/health seen in most facilities till PHC level
- Standard treatment protocols available and displayed in OT, labour room etc.
- HR with whom CRM team interacted, were found to be adequately knowledgeable.
- Referral transport available at most places (except far flung tribal areas in Chamarajnagar), though drop back facility still having teething problems.
- The team observed Bio-medical waste management to be good at most of the places. It has been outsourced at DH. Deep burial and liquid waste management being practised at other facilities. Sharp pits seen in all the facilities. Colour-coded bins maintained in all facilities. Infection control measures: Fumigation, autoclaving, Cidex solution in use. (Though at one PHC, the team saw open incineration of waste).
- Citizen's charter including JSSK entitlements and service guarantees displayed prominently in all the health facilities.
- Record keeping is good.
- All the components of JSSK except drop back facility at some places were available. JSSK is expected to cater to and motivate all the pregnant women esp. BPL having more than 2 children for institutional deliveries.



Sharp disposal pits

Progress in JSY

- The absolute number of JSY beneficiaries has decreased from 114528 in Q1 and Q2, 10-11 to 108856 in Q1 and Q2, 11-12, a decrease of 4.9%age points (HMIS). As against a target of 215000 beneficiaries; 107499 beneficiaries received JSY incentive (negative variance of 50%age points).

Sn.	Budget Head	Physical Progress (Apr-Sept 11-12)			Expenditure (Apr-Sept 11-12)		
		Planned	Reported	Variance %	Planned (Rs. lakhs)	Reported (Rs. lakhs)	Variance %
1	JSY incentive paid for home deliveries	10000	1357	-86.4	50.00	54.10	8.2
2	JSY incentive paid for institutional deliveries						
	Rural	150000	107499	-50.0	1050.00	810.23	-22.8
	Urban	50000			300.00	156.83	-47.7
	C-sections	15000			225.00	314.04	39.6

Observations of 2nd CRM

- The second CRM had found “the facilities to be dirty and labour rooms/maternity wards in deplorable condition. There were inadequate bed sheets, poor lighting and torn mattresses. No warmer in labour rooms. Toilet in DH had no door. Open and dirty toilets in PHCs. Use of diagnostic equipments (BP instrument, weighing machine) by ANMs was found to be low. Laboratory investigations for ANC clients at PHCs not done.”
- The fifth CRM acknowledges the turnaround in the cleanliness and maintenance of the facilities. All the wards including maternity wards were exceptionally clean. Labour rooms well maintained with attached functional clean toilets (with running water) available. Adequate number of beds with mattress and clean bed sheets seen. The ANM is using the equipments and maintaining records too. Weight measured is entered in fractio indicating the actual weighing of newborns.

Outreach Services

- SCs functioning well.
- Good co-ordination between ANM, AWW and ASHA
- Immunization coverage improved from 71.3% in DLHS-2 to 76.7% in DLHS-3.
- Full Immunization (FI) coverage is still low compared to the other states.
- Due list is prepared by ANM before the session (generally a day or two before) and ASHA is asked to gather the children on due list on the day of immunization. Tickler bags being used at some places.
- Outreach services being provided on a daily basis as almost 40% of the ANMs stay in the SCs.
- The ANM is using BP instrument and weighing machine and maintaining the records.
- The viability and requirement of VHNDs in a state like Karnataka where regular services are available through SCs and outreach in most of the places needs to be revisited. The State may pilot VHNDs at some places and take decision accordingly.
- HBNC training for ASHA has been taken up in selected blocks of 7 districts. At some places in Chamarajnagar HBNC through ASHA was proving to be difficult as the families were not willing to let the ASHA touch the newborn, though such a bias didn't exist for ANM or a doctor.
- During the course of the visit the CRM team didn't come across the second ANM. The distribution of work/area between the two is not clear. The State needs to reassess if it needs the second ANM at all as SCs in Karnataka are catering to much smaller population (at most of the places) than northern states.
- Remote and hard to reach areas being covered by MMUs.
- Mobile medical units from NRHM which were at planning stage in second CRM have become operational. State has 28 MMUs under NRHM. There are 96 MMUs in the State, 28 are under NRHM and rest under KHS DRP.
- The CRM team visited an MMU in the field. Currently the NRHM MMUs are providing only OPD services (on an average 30 patient) and are not covering even the ANCs. With four staff (MO, Female SN, Male SN and pharmacist) and a driver it seems to be over staffed and under-utilized.



ANM at SC Madhbhavi



Mobile Medical Unit

- The SN or any other staffs from MMU does not seem to communicate with the villagers. There were home deliveries in the village covered by the MMU who should have been counselled for institutional delivery.

ASHA Programme

Current Status of ASHAs

- Out of a total 33750 ASHAs selected initially, 32444 are in place, all of them with Drug Kits.
- All of them have been trained up to the 5th Module
- There are 15 State Trainers for Module 6 & 7.
- ASHAs in some districts have been trained in Home Based Newborn Care but numbers are not available.

Support System

- State and district Level ASHA Resource Centers (ARC) have been established
- There is a State ASHA Program Officer who looks after the program at the state level
- ASHA Mentors have been appointed at the District and Block Levels, who are responsible for review of the program during monthly review meetings as well as support and guidance of ASHAs during field visits
- The District RCH Officer and Taluk Health Officer (THO) are part of the ASHA Support Structure at the District & Block levels apart from the DPMSU and BPMSU.
- The health workers at each level of facility work in close harmony with the ASHAs. However, ASHA Grievance Redressal Mechanism needs strengthening
- ASHA Drug Kits are being refilled at the PHCs during Monthly Meetings

Incentives and Payment Structure

- “Integrated Incentive Package” for ASHAs has been notified and 25 line items have been listed. The ASHAs are aware of the payments under each program.
- ASHA payments are made on a monthly basis. By 21st/22nd of every month the payment due is disbursed through cheques.
- The average monthly take-home amount is around Rs 600/- to 1000/-

Contribution

- A large number of functional ASHAs in the State have contributed to the major healthcare delivery achievements including increasing ANC, Institutional Deliveries, Breast Feeding Practices and Immunization Coverage.

Issues

- There has been an attrition of around 3%, attributed mainly due to more expectations & less incentives, family pressure and in some cases – delay in payments & inadequate support from the health system.

Interaction with ASHAs – A Case Study

“Happy ASHAs augur well for the Community’s Health”



ASHAs: Uma Maheshwari, Bhagyalakhmi, Mangalamma, Sumalata
Site: Gumballi PHC, Yelandor Taluka, Chamarajnar District, Karnataka
Date: 11th November 2011

Background: All the 4 ASHAs cover around 1000 population in the villages surrounding Gumballi PHC and they have been working as ASHAs for the last 3 years.

Training: Apart from the first 5 modules they have been trained in HBNC at Mysore 2 months back and are well versed with their duties. They have been provided with Drug Kits (refilled every month at the PHC during monthly meeting), Weighing Scale, Thermometers, Identity Cards and purple coloured sarees.

Their Work: A major portion of their work consists of maternal and child health activities, starting from doing pregnancy tests using “Nischay” kits during home visits and ending after the 6th Post Natal Visit to both mother and newborn. Following confirmation of pregnancy they take these women to the Sub Center for ANC registration, “Thayi” card & check-ups and to the PHC for laboratory tests. They fill “HBNC” Case Sheets for every case, detailing pre-natal, intra-natal, post-natal and home-based newborn care activities.

Support System: Monthly meetings for review of activities with Block ASHA Supervisor. Handholding and on-the-job support provided by the Supervisor during field visits.

Monetary Compensations: They get incentives under JSY (600/- for tribals & 200/- for others), PNC Visit (100/- per case for 6 visits), Motivation for Sterilization (150/-) & IUCD (100/-), Full Immunization (100/-), Record Maintenance (500/- every 6 months) & Monthly Meeting (50/-) under VHSC, VHND (50/-), PHC Monthly Meeting (100/-), Community Needs Assessment Approach (500/- every year), TB-DOTS (250/- per case), Leprosy (200 for every PB, MB Case), ICDS (50/- for identification of each malnourished case), Anaemia in Adolescence (100/- per case for administering 100 IFA Tablets), Travel Allowance (200/- per month). **Every month they get a consolidated cheque from the PHC amounting to Rs 1000/- on an average.**

The Way Ahead: ASHAs have been provided Wrist Watches & Mobile Phones from the District NRHM Chamarajanagar making it easier to “feel & count a pregnant woman’s pulse” and communicate complications to ANMs & District Official via SMS.

Sample SMS sent to DRCHO: Delivery Complication-Yes for Thayi Card No. 2299277, Name: Rathanmma at SubCenter: MM Hills/20, PHC: MM Hills/20, Taluka: KOLLEGALA, District: Chamarajanagar

Their Perception: They are very content working as ASHAs, which seems to have given them a sense of direction in their life. And of course “serving their own community” brings great satisfaction, with the monetary incentives as an added attraction

The Impact: *There have been reportedly no Home Deliveries in the villages covered by these ASHAs and the number of fully immunized children has gone up.* They have also motivated many a woman for sterilizations.

The only Wish List: Earlier they were getting 600/- for every pregnant woman under JSY, which has been altered to 200/- for general cases & 600/- for tribal women. This has resulted in a major dent in their monthly earnings...nonetheless they carry on...in the hope that the government will do something for them...

Maternal Health

- The institutional delivery % has gone up from 60% in 2004-05 to 93.3% in 2010-11(State reports). The State has taken many steps to increase the demand for institutional deliveries. Apart from Gol's Janani Suraksha Yojana, it has Thayi Bhagya (accreditation of private and public institution with incentives for institution and personnel), Madilu (a kit for mother and new born consisting of 19 items) , Extended Thayi Bhagya (cash assistance to BPL/SC/ST for delivery in private institutions) and Prasooti Araike (State incentive for nutrition and medical care) . Recently started schemes include health check-up for Bhagyalakshmi beneficiaries and Samooha Seemantha programme (Community bangle ceremony to promote ID).
- Referral transport:
 - Arogya Kavacha (108): 517 ambulances through toll free number 108, 42.4% calls were pregnancy related.
 - Janani Suraksha Vahini: 176 ambulances for inter-facility transfer, being used to shift post natal women after 48 hours stay and sick neonates
- JSY: at places there is some lag between the ID and payments. At places ready and continuous availability of cheques is still a problem
- JSSK: All entitlements, except free drop back facility is being given. Free drop back facility has been started but number of vehicles not enough to cater to all.
- Free diet till PHC level, Rs.50 for diet per day.
- Standard treatment protocols for PPH, eclampsia etc. found displayed in the facilities visited.
- MTP services being provided in FRUs. Both MVA and MA available. MTP register maintained well.
- MDR: FBMDR and CBMDR have been started. For FBMDR – State task force has been formed and 69 facilities have been identified. A workshop was conducted for all 69 FNO and Guidelines of Gol were disseminated. However, almost 42% of expected deaths as per MMR are still not being captured. The incentive planned for first informant is expected to capture all the deaths.
- Accredited private facilities: 839 institutions are accredited under JSY.
- The State also has outsourced many PHCs. The HR arrangements in the NGO run PPP were not clear and MOU showed at PHC didn't provide clear directions. E.g. nearby CHC in-charge looking after PPP PHC and SCs, whereas MO in Chamarajanagar PPP PHC is from government, but paid through NGO. Moreover, ANMs in the PPP SCs are from NGO/agency's training institute under bond only for a year, and are not able to strike much needed long term rapport with the community where she is supposed to provide the services.

The state needs to conduct a third party evaluation to get an independent opinion on the current utility of PPPs.

Child Health

- Immunization: The State reported the full immunization figures as 107% against the estimated infants. The State needs to revisit the figures.
- Karnataka is sixth in immunization performance and needs to find out the left outs and the drop outs actively. During discussion with State officials the team was informed that the Full Immunization % in urban areas especially in slums is low in comparison to rural areas.



SNCU: DH Bijapur

- SNCU: The teams visited the SNCUs in the district hospital. The Bijapur SNCU had adequate case load but only one paediatrician who has to attend to OPD, NRC, In patient ward as well as SNCU. The SNCU has many male staff nurses working round the clock. The State should ensure that their working hours are convenient to SNs and uniform across SNCUs in other districts. The SNCU staffing especially number of doctors and even nurses was found to be grossly inadequate.
- Nutritional Rehabilitation Centre: The NRC at Bijapur District Hospital didn't have enough case-load. It was started in April 2011 and even after 7 months, majority of the beds were empty. The NRCs need to be nearer to the community/villages so that children and mothers who are required to stay for 15 days can easily do so. ASHA, AWW and ANM also need to actively screen the children, counsel and refer the cases to NRC.



- Infant Death Review: is being taken up in all 30 districts of Karnataka with special package in high focus districts. An incentive of Rs. 50/- is to be given to community death informants of these districts only.

Family Planning

- The teams found many MOs in the PHCs conducting sterilizations on demand which is a welcome step.
- Unmet need of the State has increased in DLHS-3 (15.1% to 15.8%) which is corroborated by the declining performance of family planning in the State. Sterilisation and IUD performance has declined:
 - Sterilisation – from 415085 in 2008-09 to 259609 in 2010-11
 - IUD insertion – 277140 in 2008-09 to 218610 in 2010-11
 - Proportion of male sterilisation is very low (2.06%)
 - High deaths, complications and failures followed by sterilisation
 - Private sector contribution is very low (4.03%)
 - State has reported a decrease in total number of sterilisation cases in the first two quarters of 2011-12 as against same period last year (from 167440 to 146339), a drop of 11.3 percentage points. Male sterilisations account for 1% of the total reported sterilisations inspite of having trained providers, who are not being utilised. State needs to identify the underlying reasons for a drop in sterilization rates as compared to Q1 10-11 and take necessary corrective action.
- The CRM saw young clients choosing tubectomy (22-27 years). Such clients should ideally be counselled for spacing methods.
- Most of the tubectomies being conducted are conventional tubectomies and not minilap (where the incision is much smaller). The post tubectomy stay is 5-7 days which is not required in all

cases in minilap and clients can be discharged within 4-6 hours. The MOs need to be oriented in Modified Pomeroy's technique for minilap.

- The IUD training for ANMs has not been taken up. The ANMs met by the team were not aware of the 'no touch' technique.
- All the facilities had OCP and condoms, however at most places the free condom box was placed too high for a client to reach.

Adolescent Health

- Sneha- ARSH clinics: 1255 AFHS clinics have been established and are functional since March 2011, clinical services provided to 5658 boys and 8551 girls so far.
- Menstrual Hygiene Scheme (MHS): for promotion of menstrual hygiene among adolescent girls (10-19 years) in rural areas has been approved for implementation in 9 Districts of Karnataka. Sanitary napkins are being procured by GoI and will be supplied under the NRHM brand name 'Freedays' to 6 districts of Karnataka (Bidar, Raichur, Bagalkot, Gulbarga, Mysore and Belgaum) from Dec-11. Sanitary napkins will be procured by State in 3 other districts (i.e. Bellary, Chamrajnagar and Bijapur) through Self Help Groups.

A workshop was organized on 31.10.2011 at SIHFW, Bangalore regarding Implementation of MHS for the Taluka Medical Officers and RCHOs of the concerned districts. The State is also conducting ASHA training for MHS. The State has also identified the storage places at block consignee level. A flipbook designed for ASHA was seen with ASHA in the tribal Ponachi PHC, in Chamrajnagar.

- School health programme – 'Suvarna Arogya Chaitanya': Annual school health check up is being under taken and children detected with health problems are referred to PHCs, CHCs or Taluka hospitals/DH. Those requiring specialised tertiary treatment are referred to speciality and super-specialty hospitals. Almost 93% of school children are being covered under this scheme.

Quality Assurance

- State Quality Assurance Committee has been constituted under the chairmanship of Secretary Health. The last meeting was held in August 2011 which reviewed the District Quality assurance committees meetings proceedings, did Medical Audit of all death cases following sterilization and submitted the records to the Claims – Insurance Company and also took steps to settle claims.
- All 30 Districts have constituted District Quality assurance committees chaired by respective District commissioners and 9 members. First Quarter (April – June 2011) DQAC Meetings held in all the Districts. Second Quarter (July – Sep 2011) is completed in few districts. Reports are awaited.
- State Quality assurance cell - has been established under KHSDRP

Preventive & Promotive Health Services: Nutrition & Intersectoral Convergence

- The staff nurses and ANMs in the facility and ASHA and AWW in the community were found to be aware about early breast feeding, weaning, and exclusive breast feeding practices.
- Most of the facilities were maintaining data on early breastfeeding.
- VHNDs are serving as a platform for nutrition counselling to mothers.
- NRCs and its requirement in DH need to be reviewed. As the malnutrition requires long term treatment it is advisable to have facilities nearer to the community. Preferably at the CHC level.
- Karnataka State Government has launched 'Karnataka Comprehensive Nutrition Mission' to address nutritional needs of Pregnant Women, Lactating Mothers, 6-36 months children and

Adolescent Girls. It has been planned to address malnutrition by adopting intergenerational life cycle approach. The State is also seeking to involve SHG Groups and PRIs. Convergence of different departments is also being looked into. A Pilot Project is planned to be implemented through NGOs selected for Pilot blocks at Bellary Rural, Shikaripura and Gubbi Taluks.

- Intersectoral convergence especially among ASHA, AWW and ANM found to be good. At places AWW is giving the take home ration on the VHN Days.
- There is excellent convergence with NACP 3 at all levels right from the State to Sub-centre. ASHA and ANMs are engaged in ANC and HIV testing. The data shared shows that mother to child transmissions are coming down due to timely interventions.

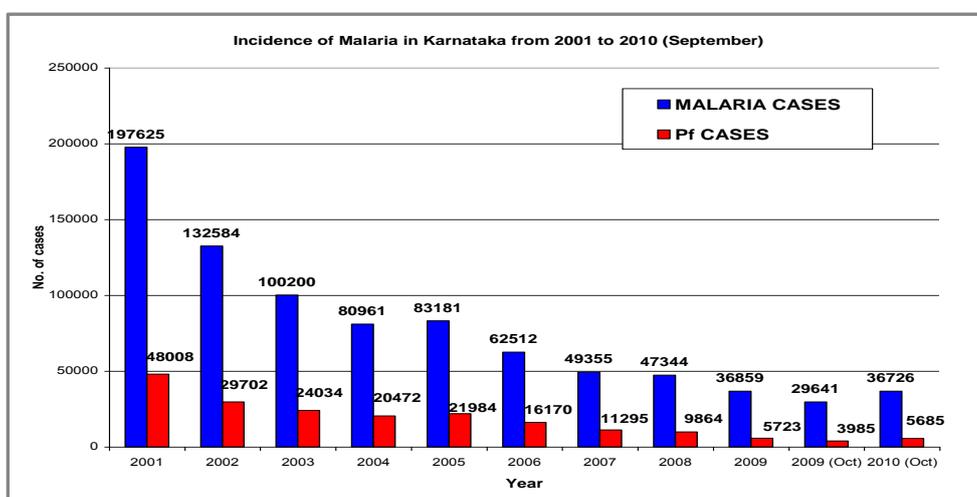
PCPNDT & Gender Issues

- There is a State level supervisory board under the chairmanship of Minister of Health and Family Welfare, Government of Karnataka. There is State level Appropriate Authority headed by Project Director (RCH), DHFWS, Bangalore. There is a special cell at the Directorate of Health and Family welfare Services monitored by Appropriate Authority – Deputy Director, Department of Health and Family welfare Services, Bangalore.
- 529 inspections have been done by the appropriate authorities totalling to 1075 during this year.
- Advisory Committee has been established at district level of Chamarajanagar, with District Collector as Chairman and District Health Officer, RCHO, Representative of 6 NGOs and the District Public Prosecutor as members. However, the committee has not been able to meet on regular basis (once in 60 days); no meeting has been held in 2011.
- An officer under the charge of the District RCHO is looking after the implementation of the PCPNDT Act in the district.
- The District Health Office has ensured that all the centres display the form B
- Screen around examination table is used to maintain privacy
- Separate screens for beds in the wards seen in one PHC

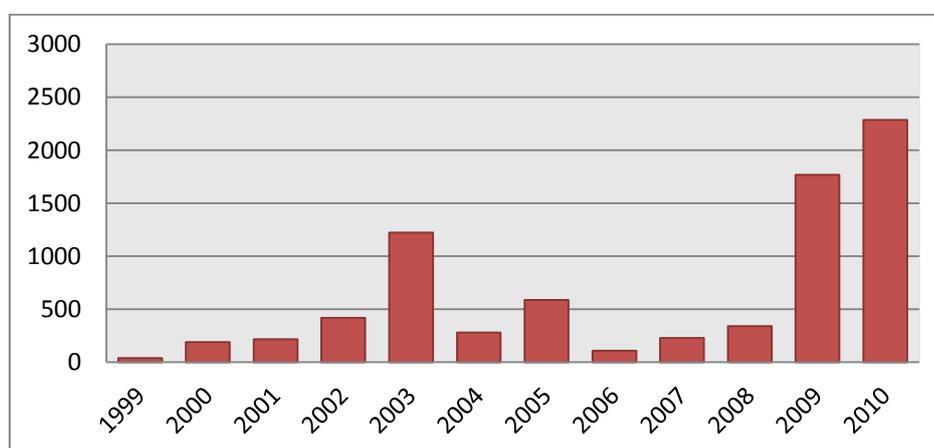
National Disease Control Programme (NDCP)

National Vector Borne Disease Control Program

- CRM has noted the effectiveness of the NVBDCP activities in the State over the years. Malaria incidence has shown a steady decline over the years since 2001 except for some increase in 2010. However during the year 2011, there has been a 40 % decline in incidence. There were some outbreaks in 2010 and deaths were also reported. However in 2011, no deaths due to malaria have been reported. The targets of NRHM are being achieved.



- The surveillance has been at a satisfactory level with high ABER being reported. The quality of surveillance has to be ensured in terms of establishing malaria microscopy centers in all the PHCs in addition to the general hospitals / CHCs /district hospitals.
- 100 contractual MPWs have been sanctioned under NRHM-NVBDCP component for the State, who are to be posted in vacant and problematic areas on priority. During 2010-11 all 100 MPWs were engaged in 20 districts. During 2011-12, 76 MPWs are working in 15 districts. The appointment of remaining 24 MPWs in 5 districts should be completed as soon as possible.
- CRM has noted the progress made for training the recently recruited MPWs. Of the 1250 recruited, about 850 are said to be trained. However it is noted that the quality of training has not been uniformly good in different districts. There is need to have a structured 2 day formal training for all these technicians. Of the 8100 ASHAs. About 5550 are said to be trained in blood smear preparation and use of RDKs. Remaining are to be trained on priority. ASHA mentors are to be oriented in conducting supervision.
- Training of laboratory technicians in malaria microscopy is to be taken up on priority.
- The process of appointment of state level consultants, district VBD consultants and other district staff including Malaria Technical Supervisor should be hastened.
- Procurement of antimalarials, insecticides (except DDT) and other NVBDCP items has been decentralized and central cash assistance is being given under NRHM to the possible extent. The procedures have to be streamlined and timely procurement ensured. CRM has noted the progress under procurement of chloroquine, Temephos, Bti, malathion, SP, dengue antigen kits and DEC. Lancets need to be procured on priority.
- There has been delay in submission of SOE and audited statements under NVBDCP to the Department of NVBDCP and ministry. Hence the release of funds for 2011-12 has been delayed from center. However with the opening balance available, the releases have been done to districts in June or so. The expenditure is about 14 % under malaria, 24 % under dengue and chikungunya, and 3 % under JE. There is need to hasten the activities and thereby expenditures. Similarly under the flexipool, the special component of Mangalore and Udupi has received assistance. Additional grants of Rs. 27.00 lakhs has been allotted for prevention and control of malaria in Mangalore city and Udupi town. Mangalore has spent Rs. 3.80 lakhs out of allotted amount of Rs. 20.24 lakhs where as Udupi has shown zero expenditure out of allotted amount of 5.84 lakhs. The grants are being utilized for engagement of workers for surveillance and anti larval measures, hiring of vehicles/transport expenses for mobility support and IEC activities in these towns. The progress needs to be accelerated.
- Dengue has shown a considerable increasing trend. There is need for a focused and priority action. It is noted that under NRHM, source reduction activities have been taken up in a campaign mode in selected village panchayats. This needs expansion to almost all village panchayats.



- Nineteen Sentinel Surveillance Centres have been established in the State for diagnosis of Dengue, Chikungunya and JE. 2963 samples have been tested for Dengue, of which 257 are confirmed while 1297 samples have been tested for Chikungunya of which 221 are positive.
- Rs. 50,000 each has been allocated to 12 Sentinel Surveillance centre to conduct sero diagnosis of Dengue, Chikungunya and Japanese Encephalitis.
- The next MDA 8th round is proposed during last week of December 2011 or 1st week of January 2012, in 9 endemic districts of Bidar, Bijapur, Bagalkote, Gulbarga, Yadgir, Raichur, Dakshina Kannada, Udupi and Uttara Kannada, depending on receipt of Albendazole tablets from GOI and DEC ordered by GMS. Rs.45,44,750/- for pre MDA activities is being released in October 2011 for the above districts out of available balance. Rs.88,56,250/- is further required to meet the drug distributor and supervisor honorarium during December 2011 – for which no funds are available under NVBDCP account. GOI has been requested for release of allocated grants for 2011-12 to the State. All efforts are to be taken up to ensure proper administration of the drugs in view of the gap between the reported coverage and actual compliance observed in previous years.
- Acute encephalitis surveillance is to be strengthened. It is observed that in most districts of Karnataka it is not up to the desired level. In those districts where the initial campaign of JE vaccination has been taken up, integration of JE vaccination in to the routine immunization is to be ensured.

Observations in Chamarajnagar:

- Surveillance is adequate and is of overall appreciable quality. In 13 PHCs where laboratory technicians are not available, there is a delay of about a week in examination of blood smears. No delay seen in other PHCs. Blood smear quality in terms of size and thickness of thick smears needs to be improved in some places. In one place, the slides were not numbered immediately after preparation.
- Record maintenance was found to be exemplary.
- Malaria incidence is on decline. Only Sattegala PHC reports a few cases. No P.f cases have been reported so far in the year in this PHC. It was good to see that rapid fever surveillance is being done.
- ACT and injectable quinine must be kept in at least Sattegala PHC and the CHCs /District hospital.
- Disposal of used lancets is being carried out satisfactorily in all the health facilities.
- Bed nets have been supplied some time back to Sattegala and other PHCs in the district. There is need for periodic impregnation of these bed nets as well as community owned bed nets. SP flow has to be procured by the district authorities / untied funds.
- There is some excess stock of ACT in the district which has to be diverted.
- Passive surveillance is inadequate in district hospital
- The fund utilization as per the PIP is only about 15 %. There is need to speed up the activities and thereby expenditure. The performance against the set objectives and activities needs a boost. The DMO has assured that the training activities would be taken up shortly. Appointment of the required 4 malaria link workers is to be done at the earliest. It was seen that the existing workers were terminated in April in view of the delayed release of budget. Now they have to be re-appointed. M & E expenditure is to be enhanced.

Observations in Bijapur:

- It was observed that the surveillance activity is going on well in the district
- Malaria microscopy is well established in the PHCs. Out of 46 Lab technician posts, 44 are in place. In the institutions visited it was seen that they are trained.
- Adequate stocks of Chloroquine tablets available.

- 6455 tablets of Primaquine Phosphate 2.5 mg and 3679 tablets of Primaquine Phosphate 7.5 mg available in the stock. Considering the current number of positive cases, the stock of primaquine especially the 2.5 mg appears to be in excess. This may be diverted to other needy places.
- It is expected that injection Artemether, injection Quinine stocks are supplied to problematic PHCs and all CHC /GH and district hospitals. However these were not in stock at the district level.
- It is observed that total malaria cases as well as P.f. have shown decline in current year.
- MF -7 & 8 registers and other registers are maintained completely and properly.
- Disposal of lancets was seen to be appropriate in all PHCs visited.
- Blood smear quality of smears needs to be improved in some places.

Revised National Tuberculosis Control Programme (RNTCP):

- The team has noted that in 8 districts the sputum positive detection rate is 70 % and above. All efforts must be made to achieve the same in all other districts.
- In 22 districts the defaulter rate is less than 5 %. In other districts where it is higher, intense activity to bring the defaulter rate down needs to be taken up.
- Only 6 % posts of STS and 3 % posts of STLS are vacant.
- In almost all the DMCs (97 %) the laboratory technicians are available. Lab consumables are available in desired quantity.

District Chamarajanagar:

- The new sputum positive case detection rates have been consistently above 70 % since 4Q06 except for 2 quarters. However the NSP cure rate has remained less than 85 % in most of the quarters. The NSP Cure Rate in 2011 (till 3q11) stands at 82.44 %, due to high default rates (6.4 %) and death rates (6.4 %)
- In the district there are 14 DMCs and 2302 DOT centers and 695 community volunteers as DOT providers. DOT decentralization can be judged from the fact that 49.33 TB patients under DOT in the district are receiving treatment from community volunteers. This is appreciable.
- The district will be covered under DOTS plus for MDR TB in the second phase after April 2012.
- The district has got 14 functional ICTCs and there is good TB HIV coordination. During the year 2011, 1046 TB cases have been screened for HIV testing. 105 of them have been found positive and put on CPT and 71 are put on ART.
- 1 STLS post and 1 senior DOTS plus & TB HIV supervisor are under recruitment.
- Maintenance of records and follow up are very good.
- Referral of chest symptomatics for sputum is to be improved.
- The medical officers in the PHCs visited, which happened to be DMCs, have been trained in RNTCP. There is a functional binocular microscope in the laboratory and trained LT is doing sputum smear microscopy. The laboratory registers are filled properly and EQA activities are being conducted regularly by the STLS. The treatment cards are complete and TB registers well maintained and up-to-date at Gundlupet Tuberculosis Unit. The PWB (patient wise boxes) are well marked and tally with the treatment cards.

District Bijapur:

- It was good to see that SOP for sputum collection and examination was displayed on the wall of lab.
- Binocular Microscopes are in working condition.
- IEC material was displayed on the wall of the facility
- TB register, TB Lab register are maintained properly, completely filling up the laboratory forms

- Availability of AKT drugs in the facility and also Laboratory consumables for Sputum examination.
- Lab Technician in the facilities are trained
- The total expenditure as on 10th November 2011 is 97%

National Program for Control of Blindness (NPCB)

- National Programme for Control of Blindness is implemented in Karnataka with contributions from District Mobile Ophthalmic Units, District Hospitals, Medical Colleges, and NGO Hospitals. More than 55% of cataract surgeries are performed by NGO Hospitals. As on the end of September, 105 % proportionate achievement has been done regarding number of cataract operations. Efforts are made to increase the cataract surgeries in Government Sector through in service advance training technique in SICS, and Phaco-surgeries. The main constraint however is large scale vacancy of ophthalmic surgeons in government sector. This is said to be as a result of the low remuneration (Rs.25000/- per month) for ophthalmic surgeons in the PIP. Hence there is need to increase the remuneration for ophthalmic surgeon considerably. 5.5 lakh school children have been screened for eye disorders. 1509 eye balls have been collected in the eye banks. 268 keratoplasties have been done. Currently the MIS reporting through email is smoothly working as all the 30 DPMs (BCD) have been provided computer systems with broad-band connectivity.

National Iodine Deficiency Disorders Control Program (NIDDCP)

- Some of the hilly and districts with high rainfall are endemic for Goiter. Goiter cases are regularly reported from Chikmagalur, Udupi, Shimoga, Kodagu, Dakshina Kannada and Uttara Kannada. During the year 2010-11 about 380 goiter cases have been reported.
- The strengths of the program are the high level of commitment seen at different levels in the department and decision taken by Government of Karnataka to supply Double Fortified Salt (with Iodine and Iron) through PDS at subsidized rate, to ICDS programme and Mid-Day Meals Programme in Schools.
- The weaknesses are the inadequate facilities in the State IDD lab, shortage of funds for carrying out IEC activities, lack of monitoring of flow of salt into Karnataka from other states for sale for human consumption, lack of strict implementation of ban of non-iodized salt for human consumption, lack of a concrete programme to unearth IDD's other than Goiter cases etc.

Integrated Disease Surveillance Program (IDSP):

- The data reporting under Form P, Form S and Form L is exemplary. There has been a steady increase from 2007 till date. The alerts being sent, weekly analysis reports and feedback have been very regular and thorough.
- Percentage of outbreaks laboratory confirmed has also increased from 57 % to 76 % (2009 to 2011)
- It is observed that a considerable number of epidemiologist and microbiologist are vacant. The efforts of the State are noted for filling up the vacant posts. There is need for more intense action.
- One entomologist and 4 DSOs need training.
- The OPD data collection from major hospitals like district hospitals, medical college hospitals, etc is very weak.
- There is need to improve the quality of Form P. In the institutions visited, it was seen that the medical officers are not writing the clinical provisional diagnosis in the outpatient register. Thereby the reporting in Form P would be unreliable.

- The districts which have no designated District Surveillance Unit include Bangalore Urban, Bangalore Rural, Chikkaballapura, Ramanagar, and Yadgir.
- Over the years there has been an increase in the number of outbreaks reported through IDSP channel. In 2011 so far 176 outbreaks have been reported. In 2008, it was 54 outbreaks, in 2009 it was 90 outbreaks, in 2010 it was 91 outbreaks.
- There has been delay in submission of SOE and audited statements under IDSP to Hq of IDSP and ministry. Hence the release of funds (Rs. 103.48 lakhs) for 2011-12 has been done in October. However with the opening balance available (Rs. 70.51 lakhs), the releases have been done to districts in September or so. The expenditure is about 6 %.
- Seeing the infrequent review of DSOs at state capital it is suggested that regular quarterly reviews be taken up.

District Chamrajnagar:

- The percentage of reporting of Form S, Form P, and Form L is more than 90 % which is appreciable. The maintenance of records and registers is very good.
- Quality of reports needs improvement. Analysis of reports and feedback to medical officers needs strengthening.
- The medical officers particularly those at District Hospital are not aware of the case definition of reportable diseases.
- District hospital is not reporting the Form P regularly. Kollegal and Gundlupet general hospitals are also not reporting regularly.
- Most of the 24/7 PHCs have been given computers and internet facility. These need to be utilized properly for online data entry of IDSP.
- There is an acute shortage of forms S, P and L in the district. There has been a request from district to state for re-allocation of budget from mobility support / savings bank interest. Similarly block health team training needs more budget.
- Community monitoring has shown only little progress. Training / sensitization activities have been taken up (426 functionaries). Only few calls have been made by community so far. Repeated sensitization may be required.
- ELISA reader is available at the DSU. However, microbiologist is not available. The technician has been trained and he/she can be engaged in testing. There is need to provide test kits.
- Video-conferencing has been done only 4 times since inception. There is need to use it more regularly.
- There are 4 physicians and 3 pediatricians in the district. However it is seen that Acute Encephalitis Surveillance has not been functioning well.

District Bijapur:

- The Form S, P and L reporting percentages are very good.

National Leprosy Elimination Program (NLEP)

- Adequate funds under NRHM and sufficient MDT drugs from Central Leprosy Division are available throughout the State. Approved PIP for the State 2011-12 is Rs 161.79 Lakhs. Funds have been allotted to all 30 districts under components G.1 to G.12. Budget has been allotted for strengthening of ASHA services, capacity building, behavior change communication, DPMR, supportive drugs, Urban Leprosy control and Special Action Plan in high endemic plan. Budget received is adequate and meets the needs of the State under NLEP. There has been a definite improvement in expenditure against sanctioned PIP amounts.

- Programme has been implemented through general health care staff & ASHAs under the monitoring & supervision of district nucleus team containing specifically leprosy trained staff. Full time state leprosy officer is needed at State Head Quarters. State Leprosy Officer post is vacant since one year.
- POD (Prevention of Deformity) camps are being regularly held in rural areas to promote self care practice. MCR is procured regularly in the districts. So for 869 MCR foot wear and 687 self care kits have been issued to needy LAPs (Leprosy Affected Person) during this year. So for 74 Reconstructive surgeries (RCS) have been done in the State. Each RCS beneficiary is given Rs.5000/- as incentive. There are 7 NGOs working for Leprosy in the state and adequately supporting state office in NLEP activities. Needy LAPs are getting pension as per provisions. Many LAPs have been brought under rehabilitation by providing houses, self employment, employment in Govt. and NGOs, issue of AAY cards.
- There is considerable decrease in new case detection in the state last 5 yrs. The state achieved the goal of elimination by the end of 2005. During 2010-11 a total of 3892 new cases have been detected as against 5307 in the year 2005-06, showing substantial decrease. Treatment Completion Rate is 97%. New cases are being diagnosed at PHC level and confirmed by DNT (District Nucleus Team). All government hospitals in the State are providing MDT on all working days. Reaction cases reported if any, are identified in time and treated. Rate of child cases among new cases detected is about 11 % over the last 5 years. The proportion of deformity cases among newly detected cases is actually increasing. It is about 4 % now against 0.8 in 2007.
- The training plan is well laid out. MPWs and ASHAs are regularly conducting IEC in the rural areas during routine field visit referring suspected cases to the nearest facility. ASHAs are being provided honorarium of Rs.300/- for (PB) and Rs.500/- for (MB) respectively for every new case detected and treated by them.
- There is a regular quarterly review of DLOs conducted at the capital.

District Chamarajnagar:

- The overall ANCDR is 13.4. The treatment completion rate is 98 %.
- District nucleus has visited 14 PHCs to validate the cases.
- 4 child cases and 4 deformity cases are seen among 67 new cases in the year 2011-12.
- In the 62 PHCs 5 MB cases have been detected. 26 contacts examined and among them 2 new cases with grade II deformity detected.
- There is an acute shortage of HR. 3 out of 4 PMW posts are vacant. Sr. N.M.S, BHE and ASO posts are also vacant. The NLCC is also having most posts vacant.
- Contractual appointments are also to be taken up yet.
- Sensitization of health workers, medical officers and ASHA is necessary.

District Bijapur:

- Leprosy prevalence rate is 0.57, New case detection rate 0.37 per lakh and defaulter rate is 2.27%.
- Out of total 88 new cases of leprosy, 13 are children, ie., 14.7% and 49% are female. RFT has done for 66%
- It is noted that 120 ASHAs are trained in leprosy in 2010-11. The team interacted with few ASHAs and it was heartening to note that they are well aware of signs and symptoms of leprosy
- Total expenditure till September is 45%

Programme Management

- All vertical disease control programmes have been unified under State and District Health Society. The Karnataka State Health & Family Welfare Society has adopted the guidelines on delegation of Administrative and financial powers provided by GOI.
- The State Health Mission, the State Health Society (both Governing Body and Executive Committee), District Health Mission and District Health Society meetings are held regularly. The minutes of the meeting shared by the State shows that they are vibrant bodies which are taking decisions to further the cause of NRHM.
- The State has SPMU and DPMUs in place. The State of Karnataka has integrated the personnel of KHSDRP and NRHM and thus has a doubly strengthened DPMU of 6 personnel.
- The DPMU is headed by the District Health & Family Welfare Officer and is assisted by the District Project Monitoring Officer (DPMO) who is responsible for implementation of the programmes under NRHM and KHSDRP. In addition the DPM, DAM and the other contractual staff work under the DPMO for effective implementation of NRHM programmes.
- The Block Programme Management Unit (BPMU) was established at every Taluka/ Block of the State during the year 2009-10. The Taluk Health Officer (THO) who happens to be a doctor under the H&FW services, is the head of this unit and supported by Block Programme Manager, Accounts assistants and DEOs.
- In addition to the above mentioned regular officers of H&FW services integrated in implementation of NRHM programmes, Nodal Officers at the State headquarters are identified for each district and assigned specific work of visiting these Districts every month for monitoring the activities undertaken in their districts against the budget released to each district every quarter. Further the districts too have appointed nodal officers for monitoring their taluks.
- The DCs have been given concise check-lists to help them review the health programmes effectively with a short time.
- The HR is also being trained in the Organization Development and leadership which is a progressive step.
- However, there is need to provide adequate infrastructure for BPMUs especially in the Chamrajanagar district.

Public Private Partnership in Karnataka: Some Areas of Concern

The 5th CRM team visited two districts of Karnataka viz., Chamarajanagar and Bijapur. Out of all the facilities visited by two teams, 5 were running on Public Private Partnership model in these districts. They were FRU Santhamarally, PHCs of Gumbally & Kannur, Sub-centre Tidagundi and MMU Chikkallapuram. Following are the areas of concern:

- During CRM's visit to the Primary Health Centre of Kannur in Bijapur District of Karnataka run under PPP model, it was observed that the doctor appointed in the PHC was from the Ayurveda system of medicines, but was prescribing medicines of Allopathic system to the patients visiting this PHC. This can endanger the life and health of the poor patients seeking treatment from the PHC and is also against the medical practice and law. The team was informed that the said doctor deployed by the Trust is drawing a salary of Rs.20,000/- per month, which is the rate of salary fixed for doctor belonging to the Allopathic system of medicine. Though the trust is free to pay a higher amount to its staff, the reimbursement claimed from the Government should be as per qualification of the staff, existing government rules and MOU.
- The ANMs working at the HSCs under Kannur PHC are trainees at the ANM training school in Mysore being run by the trust. They work at the HSCs for a year as a part of their training curriculum and return back to their native place after the completion of the tenure. This might compromise the relationship between the ANM and the villagers as the ANM may suffer from a lack of concern for the village and the villagers due to her stipulated stay in the village.
- Under Janani Suraksha Yojana money being disbursed by the Government is to be given to the mothers immediately after delivery so that it can be utilized for the welfare of the mothers as well as their babies. On a scrutiny of the JSY register of the PHC, Kannur it was observed that there are delays in payments of the JSY money to the beneficiaries as late as more than a year. E.g. the remittance of JSY benefit was done on 23.5.2011 for deliveries happened as early as in the month of March 2010, causing a delay of more than a year. This kind of undue delay in providing the benefits needs to be looked into by the Government.
- The team visited a Mobile Medical Unit when it was stationed in Chikkallapuram village. It was found that the MMU only provides OPD services. Though a lady Staff nurse was available she was not providing ANC check-ups. There is no link between the VHNDs, ANM and the MMU. The MMU is not maintaining a stock register of the medicines available and distributed by them. It is suggested that the services given should include basic lab tests, IEC/BCC, ANC and counselling for mothers/ pregnant women.. Since the MMUs are the only health points to provide some relief for the villagers in these remotest villages, effective implementation of its functioning needs to be ensured especially in view of the fact that they are run by Non-Governmental agencies, but paid from the Government exchequer.

Procurement System

- Karnataka State Drugs Logistics & Warehousing Society (KDLWS) was established in 2002 which is the single point procurement agency for procuring drugs, chemicals & miscellaneous items for the use in the hospitals in the entire State under Health sector, Directorate of Medical Education, programmes under National Rural health Mission (NRHM), Akshara Dasoha programme of Education Department and the requirements of Karnataka State Aids Prevention Society (KSAPS).
- KDLWS has 14 district level warehouses. The management of stocks and distribution is automated through the use of electronic drug distribution management system (DDMS).



Drug stocks in FRU

- Indenting is done through annual drug indent books, which are compiled by district drug house at the district level. KDLWS consolidates indents of all the districts to arrive at the state level requirements. The final quantification of drugs is done by a State Level Need Assessment Committee by reviewing the consolidated indents. Thereafter tenders are called for procurement of drugs. KDLWS has adopted unified end to end e-procurement system maintained by the State E Governance Department for all its procurements worth over Rs 1 lakh. DDMS links the warehouses to the central office and there is daily data synchronization between the warehouses and the central database.
- Thus in Karnataka the procurement is a pull system and fully caters to the need of the district as well as the facilities. Moreover the facilities have been given powers to purchase drugs from the untied funds in case of emergency and in case there is additional requirement.
 - The facilities visited by the 5th CRM teams had all the essential drugs. No stock outs were reported for the drugs supplied. The drug store and dispensing units in FRUs and DH are of transparent glass for public to see the current position of drug availability.
 - The 2nd CRM too had found the drug procurement system to be good. The State has made the system stronger over time and is now poised to go for e-tendering.

Effective Use of Information Technology

MCTS

- Karnataka started MCTS long back and now the Gol and Karnataka State platforms are in sync allowing migration of data from one to another. The State is using SMS- based systems for real time updating of the MCTS data.
- So far 5,95,889 pregnant women and 1,21,250 newborns have been registered. Till recently the uploading of registration data was being done at taluk level but now facilities too have started uploading data. As it is a recent step, many facilities do not have computer operators and many need to be oriented.
- The registration of newborns is lagging as more deliveries are at CHC, TLH and DH where data entry is yet to take off fully. The facilities are identifying person for data entry and getting him/her trained.

Health Management Information System (HMIS)

- Karnataka is uploading the HMIS data on time however it is not committing the data on time. Data entry is done at PHC level (PHCs and SCs). Facility based reporting being done from many facilities but a few CHCs left. Training of officers and staff is in progress. PHC officers and staff are trained by State officials through video conferencing. The SC staff is trained at taluka level by District and Taluka officers.
- HMIS data is being analyzed at all levels. The monthly review meetings and plans are made on the basis of HMIS data. Regular feedback is given to district authorities on HMIS data. Karnataka has achieved 97% facilities data entry on the portal right from sub-centre. Validation errors are being minimized.
- Health resource management system (HRMS), software developed indigenously for online data entry of human resources.
- The State has requested GoI to make provisions in HMIS for capturing data from private (For the time being Karnataka has created notional facilities). Speed of the central server needs to be increased. Access to back end generated reports to be given to states (At least for administrator login) Query builder to be provided on the portal so that we can generate any reports in any combination. Ready -made dashboard to be provided as provided in MCTS portal which helps in analysis

Financial Management

Status of Humans Resource

- All posts are in place at State level i.e. CFO and DCFO, and District Accounts Manager except District Data Assistant at District level. The IDSP data assistant has been made part of DPMU. At FRU/PHC level the post of Data Assistant is vacant.

Status of Maintenance of Books of Accounts

Books of Accounts are properly maintained as per Finance and Accounts Manual at SHS/DHS Level. They are maintaining books of account on Tally software and manual and updated till 9th November, 2011. Observations related to the maintenance of books of accounts based on manual accounts as follows:-

Cash/Bank Book

- Cash book is maintained in Tally ERP9 as well as manual and updated till 9th November, 2011.
- Cash book has not been closed i.e. the closing balance has not been inked on daily basis for RCH/MFP/RI.
- There are eight bank accounts (State Bank of Mysore) for RCH, RI, NRHM and rest of all for National Disease activity payments.
- There is difference in closing balance between Bank Book and Statement of Funds Position as on 30th September, 2011, the detail is given below:

Programme	Statement of Fund Position	Closing Balance of Bank Book	Difference in Rupee
RCH	52,14,521.00	47,51,524.00	4,62,997.00
MFP	64,54,921.00	59,91,481.00	4,63,440.00

Bank Reconciliation

- Bank reconciliation has been prepared by the District for RCH, MFP, and RI, the detail is given below:

Programme	Balance as per Pass Book as on 30.09.2011	Balance in BRS as on 30.09.2011 (as per bank)	Difference in Rupee
RCH	52,93,640.00	52,76,428.00	17,212.00
MFP	59,68,273.00	64,54,921.00	-4,86,648.00
RI	13,36,605.00	12,90,538.00	46,067.00

- Bank reconciliation has not been prepared by the IDSP, and NVBDCP.
- Bank reconciliation has not been prepared by the PHC-Harve, PHC Hangla, and PHC Sathyagala.

Advance Register

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

Vouchers

- The vouchers of cash/bank are properly maintained at State, Districts, FRU and PHC level. Vouchers are not serially numbered at SHS, DHS, DH, FRU and PHC.

Journal

- DHS has passed journal entries in Tally but not in manual books of accounts for the Statement of Expenditure received from CHC/PHC.
- No Journal entries are made in the manual books of accounts but in case of tally it is in place in the case of bill received from Parties.
- Supporting documents of journal entries are maintained at DHS/FRU/SHC level where the actual expenses are incurred.

Delay in Payments

There are few instances of delay in payment of JSY beneficiary and Salary at FRU, and PHC:

JSY Beneficiary Payments

- The date of delivery was 14th June, 2011 and date of payment was 24th September, 2011 to the beneficiary at PHC-Harve.
- The date of delivery was 2nd April, 2011 and date of payment was 12th July, 2011 to the beneficiary at PHC-Hangla. The PHC could not pay to any JSY beneficiary from 2nd April, 2011 to 7th July, 2011 due to shortage of funds.
- The date of delivery was 4th July, 2011 and date of payment was 22nd July, 2011 to the beneficiary at FRU General Hospital-Gundalpet.
- The date of delivery was 22nd March, 2011 and date of payment was 26th April, 2011 to the beneficiary at District Hospital Chamarajnagar.
- There was a shortage of funds during April, 2011 to 1st July, 2011 at PHC Sathyagala, therefore, they could not pay to the JSY beneficiaries.

Salary Payment

- There was delay in payment of salary to RNTCP Staff i.e. salary for April, May and June, 2011 has been paid together as on 30th June, 2011.

Single Bank Account for State Health Programme and RCH Flexipool

- Single bank account has been maintained at the District Health Society, PHC, and CHC for RCH Flexipool and Prasuthi Arayake which is Sate Health Programme. District Health Society, PHC, and CHC have opened fresh bank account separate from September, 2011 onwards.

Unspent Balance as on 30th September, 2011

- Unspent balance between DHS and State, DHS and CHC, and DHS and PHC has not been reconciled as on 30th September, 2011.

Status of e-transfer

- State Health Society, District Health Society and CHC/PHC have maintained bank account with State Bank of Mysore (SBM). The State Health Society is sending funds to DHS through e-transfer, DHS to CHC/PHC through e-transfer and down the line to PHC, it sends through cheque only.

Status of Tally ERP9

- The State Health Society and District Health Society are using customized version of Tally ERP9 and at the block level Customized version of Tally ERP9 is yet to implemented. At DHS, they have some problem in Customized version of Tally ERP9 i.e. DHS is not able to export file in excel and therefore, they are not able to take print out of books of accounts for 2011-12. However, as of now the DHS has not complained to anyone for the same.
- The funds are being released by the SHS to DHS according to ROP and activity wise, DHS to CHC/PHC according to DHAP and activity wise.

Statutory Audit and Concurrent Audit

Statutory Audit

- The State Health Society has the data related to Statutory Audit for 2010-11 whoever visited their office for Statutory Audit but the District Health Society has not maintained such records which is required as per the guidelines.

Concurrent Audit

- The Concurrent Auditors have been appointed for 2011-12 by the SHS and DHS. First quarter concurrent audit is in process at DHS. The action taken on the deficiencies of 2010-11 have been pointed out and corrected by the District but replies from some Medical Officers is still awaited.

Name of PHC	Purposes of Payments	Cash Payments in Rs. and Date
PHC-Begur	Purchase of UPS and Misc.	30,349.00 dated 22.09.2009
PHC- Harve	Building repair and maintenance to Contractor	50,000.00 dated 28.03.2008

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

Status of HMIS

- State Health Society and District Health Society are updating FMR on HMIS on time. SHS and DHS has uploaded FMR till September, 2011.

Low/Nil Expenditure during 2011-12

SHS Level (RCH)

General Observation

- Out of the approved annual SPIP of Rs.233.60 crore, reported expenditure is only Rs.70.34 crore up to the second quarter of 2011-12 under RCH Flexi pool i.e. only 30.10%.

Area of Concern

- Low expenditure has been reported by the State on core activities i.e. Maternal Health (8.80%), Child Health (7.64%) and Family Planning Services (9.71%) of the approved PIP.
- State has reported very low (i.e. less than 20%) expenditure under PNDT Activities (11.21%), Programme Management (17.28%) and Vulnerable Groups (8.77%).

SHS Level (MFP)

General Observation

- Out of the approved SPIP of Rs. 371.09 crore, reported expenditure is Rs. 85.99 crore upto 2nd quarter under NRHM Additionalities i.e. 23.17% of the approved PIP.

Area of Concern

- The State has reported low expenditure on core activities i.e. ASHA (20%), untied funds (13%), Annual Maintenance Grants (11%), and Corpus Grants to HMS/RKS (13%) of the approved PIP.
- The State has reported nil utilization of approved PIP under Research, Studies and Analysis, and support services.
- The State has reported negligible utilization of funds under Hospital Strengthening (1%) and Planning, Implementation and Monitoring (2%) and District Action Plans (including Block, Village (6%) of the approved PIP.
- The State has reported expenditure **less than 20%** under the heads New Construction / Renovation and setting up (17%), IEC-BCC NRHM (15%), Innovations (20%), New Initiatives/ Strategic Interventions (As per State health policy) (16%) of the approved PIP.

DHS Level (RCH)

General Observation

- Out of the approved annual PIP of Rs. 168.66 lakh, reported expenditure is Rs. 94.75 lakh up to the second quarter of 2011-12 under RCH Flexi pool i.e. 56.18%.

Area of Concern

- The DHS has reported nil expenditure under Child Health.

DHS Level (MFP)

General Observation

- Out of the approved annual PIP of Rs. 159.32 lakh, reported expenditure is Rs. 39.35 lakh up to the second quarter of 2011-12 under RCH Flexi pool i.e. 24.70%.

Area of Concern

- The DHS has reported low under ASHA (22.77%), and AMG (22.65%).
- The DHS has reported less than 50% expenditure under untied fund (35.61).

Pending Utilization Certificates:

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

Programme	Amount in Crores
RCH-II	32.98
Mission flexi-pool	Nil
Programme	Amount in Crores
RCH Flexi Pool	
2010-11	32.98
Mission Flexi Pool	
2007-08 to 2011	Nil

Income Tax Issues:

- It has been observed that DHS, CHC, and PHC have not followed rules of Income Tax for tax deduction at source. Some PHCs are not deducting TDS on salary of staff. TDS has been deducted by 1% instead of 10% in the case of salary to Consultant or Technical Professionals. However, return of TDS has been submitted on time as per Income Tax Rules. Some instances of pending cheques for payment of TDS are still standing in the bank reconciliation of DHS. The detail is given below:

Date of cheques	Amount (Rs.)
01.07.2011	200.00
01.07.2011	200.00
01.07.2011	598.00
08.09.2011	15,000.00

State Share Contribution

- The State share is due of Rs. 47.12 crore to be credited to SHS Account from 2007-08 to 2011-12. The break up for the same has been given below:

Year	Amounts required on basis of releases (Rs. in Crore)	Amount Credited in SHS Bank A/C (Rs. in Crore)	Short/ (Excess) (Rs. In Crore)
2007-08	52.47	-	52.47
2008-09	77.27	72.73	4.54
2009-10	77.09	140.10	-63.01
2010-11	103.48	158.20	-54.72
2011-12	108.14	0.30	107.84
Total	418.45	371.33	47.12

*State Share for 2011-12 as per ROP

Recommendations

- All vacancies should be filled up on priority basis.
- Advance Register should be maintained for all kind of advances.
- Bank Reconciliation should be prepared on monthly basis at PHC and CHC.
- Unspent balance should be reconciled on monthly basis between State and DHS, DHS and CHC/PHC.
- Journal Entry must be passed in the manual books of accounts for bills and SOE.
- The DHS should follow up to Medical Officer on reply on action taken point out of Concurrent Audit Report 2010-11.
- Budget Vs expenditure must be analyzed to know the exact variance of budget and expenditure so that proper steps can be taken to improve the utilization of funds.
- Income Tax provision for deduction of TDS must be followed by the DHS for statutory requirements.
- The reason of Low/Nil expenditure may be clarified.
- JSY payment should be made on time to the JSY beneficiaries.
- Bank account should be separate for each programme.

During the debriefing meeting the State raised some issues:

- The financial system needs to be simplified. There should be lesser heads for reporting, giving more flexibility to the State as per the spirit of NRHM.
- The heads in FMR are frequently changed. It takes a long time to get the new formats to percolate down to the facilities.
- The change in the FMR in the current year is yet to be resolved, as for the first quarter the district/facilities have booked as per the older formats.
- The Gol HMIS portal still has the older format for FMR which is causing problem in reporting.

Decentralised Local Health Action

- The District Health Action Plan is prepared in consultation with all the block/taluk officers. Requirements of all the facilities of the district were collected and it made the basis for DHAP. Financial allocation from the State is made on the basis of the DHAPs. Block health plans are basically budgets of the block and not plan per se.
- VHSCs have been formed in 25200 revenue villages out of 27481 inhabited villages. Joint A/c opened with Panchayat member and ASHA as co-signatories. Untied funds of Rs.10, 000 released through e-banking. ANM drawing the whole untied fund of Rs.10000 at one go.
- Panchayat members are involved in VHSCs as well as ARS.
- VHSCs have not got the full confidence of community. Community feels that fund utilization is not transparent.
- VHSCs/ARS capacity to spend untied funds is limited. Orientation of MOs is not done regularly.
- ZP engaged in day to day functioning of DHS/ARS, might be a reason for low utilization.



5. OVERALL RECOMMENDATION

- The State may plan to analyse FRUs' functioning in 7 C districts and high focus districts in terms of following parameters:
 - Availability of 24x7 EmOC, especially availability of EmOC at night
 - Posting of personnel (gynecologist, pediatrician, anesthetist)
 - Blood bank/storage linkage

State may also like to track referrals from the FRUs and the reasons for referral.

- The State needs to capture all the maternal deaths (almost 42% is still not being captured) through its facility and community based MDRs. A thorough review of the causes is required for each case.
- Profiling of maternal death vis-à-vis parity and BPL status (against the backdrop of most GoI and State schemes limited to BPL and first two live births) may also be taken up to see whether most of the maternal deaths are happening in 3 and 3+ births. In such a scenario the state may need to relook at the all the concessions being given upto first two live births. The State may use the funds available under research studies (in Mission Flexipool).
- VHSCs need to be transparent about the funds and utilization. This may be done by displaying the availability of resources/ funds given, names of the members, meetings conducted and work done on a black board or notice board for the general public.
- The State may look into the financial propriety of withdrawing the entire untied funds at one go in Sub-Centres. Best practices and good book-keeping may be shared with all the SC ANMs to encourage them to spend the untied funds and keep accounts properly.
- The State should aim for focussed outcome oriented supportive supervision needs at sub-district level. The officer given the responsibility to monitor a particular facility may look into matters ranging from assured service delivery (as per the level of facility) to team –building.
- The Arogya Raksha Samiti should be given proper orientation for improving utilization of untied funds. The new members (whenever there is a change) should be oriented as early as possible.
- The District Health Mission is to provide broad policy guidelines where as the Executive committee is to take the decisions about expenditure and program. The State may review the current system of monthly meetings of ZP and DHM so that it can contribute more constructively.
- The State may reconsider the deliveries at SCs to be treated as institutional deliveries or alternatively the State may consider accrediting high caseload SCs and treat the deliveries at accredited SCs as institutional deliveries. This will not only increase the percentage of institutional deliveries but also enable the ASHAs to benefit monetarily which is quite low at present.
- As the Madilu kits are meant for the mother and the new born, the State may consider providing Madilu kit to all deliveries including SC deliveries.
- State transfer policy should have a clause for exceptional Medical Officers (MOs) or facility in-charges to promote them speedily to the next level of facility (e.g. sub-taluk to Taluk, Taluk to district) and reward excellence and performance.
- Wholesale up-gradation of facilities to higher level (PHC to CHC etc) should be avoided. The decision to upgrade should be taken only after comprehensive data analysis where there is potential for more demand /case load.
- NRHM framework recommends stability of tenure for the officials. Given the background of the systemic and policy changes initiated in Karnataka, it is suggested that the government should provide the necessary three years tenure to the Secretary and the Mission Director so that improvements/gains from the changes could be consolidated.

CRM TEAM FOR KARNATAKA

BIJAPUR TEAM

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CHAMARAJANAGAR TEAM

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6	Dr. Raghuvanshi	State Programme Officer	UNFPA	011 – 42225030 raghuyamshi@unfpa.org

LIST OF THE FACILITIES VISITED BY THE TEAM

Names of district visited				
Sl no.	Name	District HQ	Name of DM	Name of CMO
1.	Bijapur	Bijapur		
2.	Chamarajnaragar	Chamarajnaragar		Dr. Ramesh Babu

Health Facilities visited: Bijapur

Sl. No.	Name	Location (Block)	Level (SC/PHC/CHC /FRU)	Name of the person in charge
1.	Balluthy,	Hanumapur	SC	Mrs. Gangu Bai, ANM
2.	Kolhar	Bagewadi	PHC	Dr. Anil Shegunashi
3.	PHC – Honaganahally	Bijapur	PHC	Dr. Dharvardkar
4.	District Hospital	Bijapur	DH	Dr.Sajjan
5.	ANM TC	Bijapur	ANM TC	Mrs. Hiremath
6.	PHC – KANNUR	Bijapur	PHC	Mr. Kumar (Administrator of Karuna Trust)
7.	Tidagundi	Bijapur	SC	Mrs. Saroja
8.	Thamba	Indi	PHC (24x7)	Dr. Y.S. Patil
9.	Taluk General Hospital	Sindagi	FRU	Dr. Sharda Kulkarni
10.	Mobile Medical Unit (MMU) – Chikkallapur Village	Indi	MMU	Rural & Urban Development Association (RUD A)
11.	Sub Centre – Madhbhavi	Bijapur	SC	Mrs. J.S. Nageshwari, ANM
12.	TALUK Hospital Basavana Bagewadi	Bagewadi	FRU	Dr. S.B.Chikale
13.	Vandal	Bagewadi	PHC	Dr. S.S. Otageri
14.	FGD with ASHA			
15.	FGD with VHSC and community			
16.	Interaction with inhabitants of Garden houses			
17.	Interaction with Gypsy population			
18.	Interaction with ex- MLA and owner of private medical college			

Health Facilities visited: Chamrajanagar

S. No	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	District Hospital	Chamrajanagar	DH	Dr. Samanpatha Kumar Dist. Surgeon
2	FRU	Santhamaralli	CHC	Dr. Krishna Prasad H.S.
3	FRU	Gundlepet Block Hospital	CHC	
4	PPP 24X7 PHC	Gumballi	PHC	Dr. K. S. Sharath
5	24X7 PHC	Ponachi	PHC	Dr. Lokesh
6	PHC	Chilakavade	PHC	MO: Dr. Sushma
7	PHC	Palya	PHC	MO: Dr. Nagaraju M
8	PHC	Sathyagala	PHC	MO: Dr. Ravi Prakash
9	PHC	:Hangla, Gundelpet Block	PHC	MO: Dr. Indu Kumar
10	PHC	Harve	PHC	MO: Dr. Mohan Kumar
11	SC	Yergamballi	SC	Ms. Mahadevamma ANM
12	Collocated SC	Santhamaralli	SC	Ms. Jayalakshmi M.S. ANM
13	SC	Mariala	SC	Ms. A.A Rukmini ANM
14	SC	Nanjadevanpura, Block: Chanrajnagar, PHC: Harve	SC	ANM: R. Gayatri; ASHA: Mahadevamma
15	FGD	AWC: Nanjadevanpura, Block: Chanrajnagar, PHC: Harve	SC	Met 11 members of VHSC and a few members from the community (this included ANM: R. Gayatri; ASHA: Mahadevamma)
16	FGD	ASHA FGD		
17	FGD	VHSC Members		
18	ANMTC			

OFFICIALS PRESENT AT THE STATE DEBRIEFING MEETING HELD ON 15/11/2011

1. Dr. E.V Raman Reddy- Secretary to Govt. H&FW
2. Sri. Selva Kumar – Mission Director, NRHM
3. Dr. Chelubaraju- Director, H&FW & In charge PD (RCH)
4. Sri Vipin Singh – Additional Director, KDLWS
5. Dr. Arundhati Chandrashekar – Chief Administrative Officer, NRHM
6. Sri. Manjunath- Chief Finance Officer, NRHM
7. Dr. P.K Srinvas – SPM
8. Sri. Nischith V.D – Deputy Chief Finance Officer, NRHM
9. Dr. Mohan Raju – ED, SHSRC
10. Dr. Naina Rani – DD, KSAPS
11. Dr. Suresh Shapeti – JD Planning
12. Dr. B.V Karoor – JD, Mental Health
13. Dr. Raju – JD, Medical
14. Dr. Saraswati – DD, Ayush
15. Dr. Suryakanth –DD, RNTCP
16. Dr. Amrutheshwari – DD, MH
17. Dr. Krishna – DD, FW
18. Dr. Geeta Nyamagowda – DD, CH
19. Dr. Narayan – DD, CM
20. Dr. Ramesh Babu – RO, RCH
21. Dr. Venkatesh – DD, IDSP
22. Dr. Parimalal Maroor – DD, Leprosy
23. Dr. Siddeshi- DD, EMRI
24. Sri. Shankar – DD, HMIS
25. Sri. Shivaram – JD, IEC
26. Dr. Selvarajan – DD, Admin SIHFW
27. Dr. Ganti Shankarappa – DD, SIHFW
28. Dr. A.V Sreenivasa – DD, Training SIHFW
29. Smt. Vasuki – PIP, Consultant
30. Dr. Ramesh Babu- DHO, Chamarajanagar
31. Dr. V.D. Galagali, DHO, Bijapur
32. Dr. K.D Gulbavadi – DPMO, Bijapur
33. Dr. Y.R Bellubi – RCHO, Bijapur
34. Sri. Ravindra – DPM, Chamarajnagar
35. Dr. Zalki
36. Doctors from Bijapur

FACILITY WISE OBSERVATIONS BIJAPUR

District Hospital, Bijapur

- It is a 400 bedded hospital with Physician, Gynecologist, Pediatrician, Nephrologists, Anesthetist along with Paramedical and Class IV staff.
- The hospital provides curative and preventive services, Laboratory, LFT, RFT, X-ray, Sonography, dialysis, ICU, NICU facilities.
- IEC material was displayed regarding Breast feeding, JSY, JSSK etc.
- Overall cleanliness maintained in the hospital.
- The average OPD is 40-50 per day.
- Only one Gynecologist available though more than 50 C – sections are conducted in this hospital. Two more Gynecologists required for this facility.
- The team interacted with a mother Jyoti Karuti (20) with normal delivery and LBW baby (1kg). she told that she took pre-partum TT but her mother in law prevented her from consuming IFA tablets for the myth that such tablets increase baby weight.
- The nephrology unit has 6 dialysis machines. However there is no separate dialysis machine for HIV/AIDS patients.
- Nutrition Rehabilitation Centre is available, but is underutilized. Only six children were admitted in a 10 bed NRC. Awareness generation is needed to create awareness for optimal utilization of the services in the facility.

TALUK Hospital (FRU), Basavana Bagewadi

- It is 100 bedded hospital with 6 Doctors (Anesthetist, Pediatrician, EmOC trained doctor, General Surgeon, Orthopaedic), 19 Staff Nurse, 2 X-Ray Tech, 4 Pharmacist, 3 Lab Technician, a refractionist and a cleaner.
- The lab conducts HIV tests, Water sampling, Hb, CBC, WBC, ESR, VDRL, VDAL, Blood Sugar, HbS Ag test, blood group cross matching, urine routine microscope, Sputum examination for AFB, Bleeding time, clotting time, serum billirubin, blood urea, serum creatine, urine routine microscopy etc. PS for MP is done for 40 to 50 slides per day.
- Food is being provided for delivery patients
- On an average, 150-180 deliveries takes place in this centre per month, of which 39 are through C-Section, however emergency obstetrics service at night is not taking place despite of availability of Gynecologist and Anesthetist.
- Provisional diagnosis was written on the prescription and IPD/OPD registers were maintained properly.
- The JSY registers did not have photographs of the beneficiaries as was seen in other health facilities in the district.
- The Malaria register was maintained properly and the hospital was sending forms P & L form regularly to District.
- LT was trained under RNTCP programme, but Pharmacists are not trained under RNTCP
- LT practically showed slide preparation for AFB. Thick and thin Malaria slide was not up to the mark.
- Medical and paramedics were well aware of the revised Anti Malaria policy.
- Anti Malarial drug, Tuberculosis DOT drugs were available according to category.

- There is no blood storage facility at this FRU.
- Facility charging pregnant women for lab investigations
- The facility was also Rs.50 for X-Ray.
- Diesel charges in the case of referral cases from FRU to other hospitals.
- Drop back facility for delivery cases was not available
- HMIS & MCTS: Though computer and internet connection are available, the data is being sent to Taluk Health office for uploading. The reason given was that there was no person trained for uploading the data.
- Sterilizer is available in the hospital, but is said to be non-functional since last one month.
- On interaction with a patient admitted in the male ward, it was found that he had to purchase Omnigel and Diclopin from outside. When inquired at the pharmacy, it was found that Omnigel was not available but Diclopin was available.
- Generator for power back up was not in working condition.

Taluk General Hospital (FRU), Sindagi

- It is 100 bedded hospital 8 Doctors (Gynecologist, Physician, Dentist -2, Dermatologist)
- 11 Staff Nurses, 3 Lab Technicians (one each for RNTCP, Malaria and ICTC), a Pharmacist, Driver & Class IV staff.
- The Medical officer trained in IDSP and 2 staff nurses are trained in SBA.
- The facility has 200-250 OPD per day. It conducts 130 deliveries per month which includes 3 to 5 C sections.
- All cesarean are elective and done during day time due to unavailability of Anaesthetist.
- The lab conducts HIV tests, Water sampling, Hb, CBC, WBC, ESR, VDRL, VDAL, Blood Sugar, HbS Ag test, blood group cross matching, urine routine microscope, Sputum examination for AFB, Bleeding time, clotting time, serum billirubin, blood urea, serum creatine, urine routine microscopy etc. PS for MP is done for 40 to 50 slides per day.
- Dental OPD average 1 -3 patients per day, average 50 per month, with 2 dentists (1 regular and 1 contractual) posted in the CHC. Rational distribution of HR is needed. Similarly, RNTCP LT examines 1-2 sputum per day with 3 LTs posted in the CHC.
- JSY: No backlog of payment seen.
- The team interacted with 3 ASHA viz., Madhavi (7th Std), Mallamma (10th Std), Sasikala (10th Std). All of them are working since last 3 years. They are earning average Rs.1000/- per month.
- RKS meeting conducted once in a month and also as and when required.
- MTP, referral, IPD, OPD registers maintained properly.
- IDSP – P & L forms are maintained completely and sent to districts regularly.
- NVBDCP - MF 7& 8 register for Malaria are completely filled. MDA for Filaria elimination programme till date is not conducted in the State. LT examines 30 slides per day.
- RNTCP - TB registers are maintained properly. Sputum examination 60 per month (average 2 per day)
- Anti malarial drugs like AKT available.
- HMIS and MCTS data is brought in to the Taluk health office from all the 11 PHCs and 1 Taluk General Hospital for uploading on 27 or 28 of every month except Aski & Kalker PHCs where MCTS data is being uploaded directly.

PHC, Kolhar

- This PHC has 6 beds with Lab, Minor OT and caters to population of 25000. The PHC has a Medical officer (working since two and half years & staying in quarters), an Ayush doctor, a LHV, a Lab Technician, a driver, pharmacist, 4 ANM, 3 Staff Nurses (staying at quarters) and a counselor for ICTC centre.
- Medical officer is trained in all National programmes and Staff Nurses are trained in SBA.
- Average 60 – 80 OPD per day and Ayush facilities are provided by doctor with Ayurvedic medicines. Provisional diagnosis was not written on the prescription of the patient.
- PHC conducts 45- 50 deliveries per month. Post delivery women are kept in hospital for 48 hours.
- Water facility and toilets available and found to be hygienic. Accommodation available for staff.
- Anti rabies vaccination (ARV), Laboratory facilities for Hb estimation, HIV testing available.
- For Dengu and Chikungunya cases, the blood samples are sent to District Surveillance Unit lab for investigation.
- Integrated Counseling and Testing facility for HIV is available at PHC.
- RKS meetings held 1-2 in a month as per requirement. Untied fund utilized for solar heater, baby warmer and for one night watchman.
- IDSP – P & L forms are maintained completely and sent to districts regularly.
- HIV – 1534 general population tested, 40 positive till date, for ANC- 1300 tested, 4 found to be positive.
- NVBDCP -Malaria cases on average 1-2 per month
- Leprosy – 1 Leprosy case found in a 5 year old child in the current year.

PHC, Honaganahally

- The PHC has 6 beds and caters to population of 3500. The PHC has a Medical officer, (Dr. Dharvardkar), 3 Staff nurse, a pharmacist, an ANM and a class IV staff. Only ANM has quarters.
- Tubectomies are performed by the doctor.
- EMRI vehicle (108) available which is mainly used to transport the pregnant women to Bijapur District Hospital.
- Curative and preventive facilities, Laboratory facilities for Hb estimation are available.
- For Dengue and Chikunguniya cases, the blood samples are sent to District surveillance unit lab for investigation.
- Provisional diagnosis was not written on the prescription of the patient.
- Neither doctor nor staff was not aware of the revised Malaria Drug policy
- ACT & RDK were not available in the PHC.
- MF 7 & 8 registers were filled completely and maintained properly.

PHC, Thamba, Block Indi

- The PHC has 6 beds and caters to population of 20,000. The PHC has a Medical officer, an AYUSH doctor, 3 Staff nurse (1 contractual), a pharmacist, 6 ANM (1 contractual), a FDC, and a class IV, and a night watchman.
- Water facility and toilets available and found to be hygienic.
- Medical officer is trained in all National programmes and Staff Nurses are trained in SBA.

- For Dengu and Chikungunya cases, the blood samples are sent to District surveillance unit lab for investigation.
- Average 50-60 OPD cases per day and 70 deliveries per month. Post delivery women patients are kept in hospital for 48 hours.
- JSY: 52 births during October 2011. Payment of 77 JSY cases which include patients from Sub Centers. No backlog found in payments.
- RKS meetings held regularly
- PNDT Act has been displayed prominently in the hospital.
- No laboratory tests available as the post of Lab technician has not been sanctioned.
- IDSP – P & L forms are maintained completely and sent to districts regularly.
- NVBDCP - MF 7& 8 register for Malaria are completely filled.
- RNTCP - TB registers are maintained properly.
- A prominent crack was seen on the wall of PHC which cannot be repaired due to a pending Lokayukta case. However, it is strongly suggested that necessary actions should be taken immediately to avoid accident.

PHC, Vandal

- The PHC has 8 beds and caters to population of 3000. The PHC has a Medical officer, 3 Staff nurse, a LT and 5 ANMs.
- PHC conducts 45 deliveries per month.
- OPD load of the facility is 50 to 70 patients per day.
- The lab conducts HIV tests, Water sampling, Hb, CBC, WBC, ESR, VDRL, VDAL, Blood Sugar, HbS Ag test, blood group cross matching, urine routine microscope, Sputum examination for AFB, Bleeding time, clotting time, serum billirubin, blood urea, serum creatine, urine routine microscopy etc. PS for MP is done for 40 to 50 slides per day. LT is trained in Malaria program under NVBDC program.
- IDSP, Malaria register maintained properly and sending forms P & L form regularly to District.
- Anti Malarial drug, Tuberculosis DOT drugs according to category available.
- Sputum examination slides 15- 20 per month under RNTCP Programme.

PHC, Kannur (Karuna Trust PPP Model)

- The PHC covers population of 55,584 and has 11 sub centres with 15 villages
- PHC has Medical officers (working since 1.11.11), a Staff nurse, a LT, LHV, Administrator, LHV Incharge, Health Male worker, Class IV, Pharmacist, 11 ANM (posted in the community), JHA - 6 (posted in the community)
- Medical officer is not trained in National programmes who is an Ayush doctor posted by Karuna Trust.
- State Government has given additional charge to a medical officer (25 kms from this PHC) for MLC and post partum cases.
- Government hospital building with toilet and water facility maintained in good condition with overall cleanliness.
- Average OPD 100 and 25 to 30 deliveries per month.
- PHC receives all the medical equipments, medicine & diagnostic kits under National disease control program from State Government. PHC also receives maintenance grant and untied fund from NRHM.

- Vehicle available, but no driver. Vehicle driven by administrator as and when required.
- LT is trained for 1 day in Malaria slide examination. Retired Sr. Sanitary Inspector is doing active and passive surveillance in the field drawing smears. ACT drugs are available. Chloroquin 2000 tablets available.
- HIV: 448 cases tested of which 5 positive.
- TB: collection of sputam and sent to District TB office.
- IDSP – Provisional diagnosis not written on OPD register & prescription
- anti malarial, anti leprosy drugs available.
- Maintaining IDSP & NVBDC registers complete in all respects.
- As per MOU, MBBS doctor is supposed to be posted by Karuna Trust but Ayush doctor is posted in this PHC @20,000/ salary which is the salary of an MBBS doctor. All the expenditure is being reimbursed from NRHM.
- ANM posted in sub centre for 1- 2 years maximum and go back to their own native place on completion of bond with trust. They are from ANMTC, Mysore run by Karuna Trust.
- Ayush doctor prescribing Allopathic medicines.
- JSY: Delayed payments of JSY. Delivery done in March 2010 have been paid JSY benefit on 23.5.2011.

Sub Centre Tidagundi, Kannur PHC (PPP)

- The Sub Centre caters to the population of 4500.
- The sub centre has an ANM (paid Rs.10500/- pm) residing at SC.
- No deliveries are conducted in this SC.
- Vaccination is carried out at this facility.
- ANM was well versed with national programmes including MCTS.
- Labour table is available, but no delivery. Hence suggested that the same can be shifted to PHC Kannur where delivery takes place

Sub Centre, Madhbhavi

- The Sub Centre covers the population of 7000. It has an ANM and 3 ASHAs. It is a Government building with water & toilet facility maintained in good condition.
- Deliveries are conducted at this SC and the ANM is trained in SBA. Family Planning, immunization services are provided from this SC.
- ANM is conducting 30 delivery per month. ANM Mrs. J.S. Nageshwari has received award for her work of 12 years & staying in the same premises.
- She calls 108 ambulance for emergency cases. In case of its unavailability, she calls an autorikshaw driver to take patients to the nearest Bannuti PHC.
- She purchases medicines from untied funds when they are not available in PHC.
- During November 2011, she had already conducted 19 deliveries out of which 7 were night deliveries.
- She is maintaining Tracking Bag for immunization follow up.
- Due list for immunization beneficiaries is also being prepared.
- Syndromic register under IDSP and sub Centre level are maintained with complete information.

Sub Centre, Balluti

- The Sub Centre caters to population of 5190 (1229 households)
- SC has MPW, ANM, 5 ASHA and 3 Anganwadi workers
- ANM has been trained for 3 days in IUD insertion, however untrained in SBA. DHO informed that preference for SBA training is given to staff nurse from 24x7 PHC.
- Sub centre is in Government building with toilet facility but without water and maintained in unhygienic condition.
- MPW stays in the same premises.
- ANM stays in Hanumanpur Sub Centre.
- 5- 10 OPD load per day at Sub Centre.
- Immunization, ANC check up, Family planning services, passive surveillance for Malaria etc. are done from the SC.
- ANM inserts average 3 IUD per month. VHND – Every second Saturday, VHND is conducted in Anganwadi Centre in coordination with ASHA, Anganwadi worker and ANM. The activities conducted are ANC check up, HIV test, Blood testing, BP examination, Provision of giving IFA tablet, to give health education on nutrition and other aspects of health.
- During VHND average 1-2 HIV tests are conducted per month and positive patients are referred to ART Centre if CD4 <350.
- Refer the patient for UPT to Kolhar PHC.
- Anti Malarial drugs available
- Required records are maintained completely.
- No stock of OC Pills & condoms.
- Cheque book was not issued to ANM and she withdraws money with withdrawal slip.
- District is not releasing untied fund to Sub centre if balance of previous year is available with Sub centre.
- The villagers are not aware of the activities & entitlements of VHNC and there is a communication gap.

Discussion with ANM, MPW, AWW

- Average number of children per family is 2 to 3 children.
- 75% of population belongs to Hindu community.
- ANM & MPW were not aware of Emergency Contraceptive pills.
- The health services like immunization and curative services are being provided to the migrant labour population coming from adjacent Maharashtra State for 6 months mainly for sugar cutting.
- The day of visit was a vaccination day. 12 children were vaccinated on the day and a due list was prepared well in advance.

Discussion with 3 ASHAs

- They were proud to work as ASHA
- They are gaining knowledge regarding health and related issues.
- Completed Module 5 of ASHA training.
- Average monthly earning Rs.800 to 1000.
- Along with social mobilization for ANC, immunization etc, they also prepare slides for Malaria.

Discussion with VHSC Members

- 11 - 14 members are part of VHSC, two of them were present during interaction.
- Money mainly spent on Purchase of water tap, weighing machine, cleaning of community water tank, Purchase of uniforms for ASHAs, Purchase of first aid boxes for schools etc.

ANM Training Centre

- The training centre has 6 tutors, one vice principal and one principal
- There were 27 students in first year and 30 students in the second year.
- The ANMTC has 30 rooms comprising rooms for Principal, class rooms, student rooms etc
- All Teaching materials including computers was available.
- 2nd year students are attached for field practice area to Tikota and Bagleswar
- CRM team interacted with the students to assess their knowledge by asking certain questions on immunization, family planning, nutrition etc. and found to be good.
- Practical exposure to IUD insertion needs to be included in the syllabus
- A watchman on night duty and a cook are required for the institution.

Mobile Medical Unit (MMU) Chikkallapur Village

- The MMU is a PPP model with participation of an NGO viz., Rural & Urban Development Association (RUDA) and functional since last 1 year & 3 months.
- This MMU covers the Population of 400.
- The MMU has a doctor (at 25000 per month), Nurse (at 9000 per month) a pharmacist (7000 per month) and a driver.
- Curative OPD services for 1-2 hours on every Friday are provided by MMU in villages.
- For lab Services, patients are referred to the nearest PHC at 8 km.
- The OPS load is 50 – 60 patients
- Criterion for selection of village is said to be the distance from main stream area and lack of easy accessibility.
- The MMU does not have any stock register for medicines.

Village Visit

- 20 year old Renuka Nagraj who delivered at home (second girl child). The reason for home delivery was said to be more safety.
- Presently there are 6 pregnant women in this village & 7 ANC cases.

Interaction with MLA and owner of private medical college

- The Team also had an opportunity to meet an MLA who also happens to be the owner of BLDE institutions which includes medical college too in addition to other educational institutes.

FACILITY WISE OBSERVATIONS CHAMRAJANAGAR

- Almost all the visited facilities had IEC posters, Citizens charter, Drugs status, Performance data, RKS, Labour room protocols, color coded bins.
- Free services to pregnant women and newborns up to 30 were being given. However, drop back facility was not available.
- Indoor service utilization at PHC was low.
- Data operators were not present at all the facilities.

District Hospital Chamrajanagar

- It is a 150 bedded hospital. The work for the new block consisting of 100 beds is complete. The equipment are being procured and contractual appointment of SNs done. The facility will shortly be functional in the new block.
- The hospital has surgeon, pediatrician, O&G specialist, and anesthetist. There is a blood storage unit. There are 7 CCU beds, X-Ray facility, USG, ECG, NBCC, Residential Quarter for 4 MO, 4 SN and 4 Group-D.
- Labour room had protocol displays. New Born corner was present. SNCU has not been operationalised.
- Total OPD and IPD cases increased between 2006 and 2010 (from 149475 to 159699 for OPD and from 4759 to 6069 for IPD).
- Institutional deliveries fluctuated between 1900s and 2100s between 2006 and 2010 with numbers little low in 2010-11 (1784). However, cesarean sections drastically improved from 33 in 2006 to 136 in 2010-11 (also in nights).
- MTP increased from 32 to 80 between 2006 and 2010-11.
- Sterilization (particularly tubectomy and laparoscopy) went up from 76 to 1088 during the same period. However, IUCD insertion fluctuated between 160s and 180s.
- There was a separate RI room
- There was an operational blood storage unit. There were 2 units and the feeder point was Mysore Blood Bank.

ARSH Clinics

- Against a target of 63 Sneha clinics, 58 clinics were established in the district.
- On average 20 adolescents visit the clinic. The number of adolescents using the facility increased from 5565 (2711 boys and 2854 girls) in 2010-11 to 9821 (4239 boys and 5582 girls) in 2011 up to Oct 2011. The heartening observation was that girls were using the clinics more than the boys.
- The mothers after delivery did stay for 48 hours. However, only medicines given to the mother were being recorded. The comprehensive general condition of the mother and child was not recorded. This makes 48 hour stay futile if the condition of the mother and child is not monitored.
- The discharge cards had information on personal hygiene, nutrition and immunization. At the time of discharge, SNs gave limited information about danger signs, breast feeding etc.

FRU Santhemarahalli

- The facility covers a population of 68,750 and has 3 PHCs & 21 SCs under it.
- This health facility work under PPP Scheme. The MCH services have been outsourced to Karuna Trust.
- Government provides infrastructure support (Labor Room, OT, 14 bedded Obstetric ward, NBSU with 3 beds. Karuna Trust provides human resource (O&G, Anesthetist, Pediatrician, 3 SN) & Services (ANC, USG, Normal Delivery, LSCS, PNC, New Born Care). The post of the pediatrician is vacant Anesthetist is on call for LSCS and paid 750/- per case by Karuna Trust.
- For every delivery, Government pays Rs. 3000/- to Karuna Trust out of which Karuna Trust pays 750/- to the "ArogyaRakshya Samiti" as infrastructure Fund. Karuna Trust pays an extra Rs. 100/- to ASHAs per case.
- There is no functional Blood Bank or Storage Unit. Currently the Center is linked with FRU Yelandor (5 Kms) & DH Chamarajanagar (14 Kms)
- The facility has OPD Block with 5 rooms including Dental Services. There is 14 Bedded O&G Ward. The FRU has X-Ray, USG, NBSU (Radiant Warmer + Phototherapy Unit), automated laundry Machine services.
- The dietary services are outsourced. There are 2 residential quarters one for MO and one for SC ANM.
- There are Burial Pits for waste disposal and a private Agency has been hired for BMW disposal.
- 3 SNs posted in MCH division has been given SBA training and Partographs are being used.
- No maternal death has been recorded in the last 10 years.
- The facility does not have AYUSH Services and there is no Quality Assurance Committee.

FRU Gundlepet Block Hospital

- It is a 100 bedded hospital, with 10 specialties with 10 specialists. (Pediatrician, O&G specialist, anesthetist, general surgeon, orthopaedician, dental surgeon, general medicine specialist and ENT specialist). The hospital has 20 SN and 12 other staff. The hospital does not have pharmacist and OT assistant. There was acute shortage of group D staff.
- On average, 200 deliveries, 160 sterilisation and 5 IUCD insertions are carried out every month in the hospital. Between 8 to 10 C-Sections were conducted a month including during night.
- The OT and the labour rooms were clean and functional. There were 3 labour tables. There was a functional new born stabilization unit. Partographs were being used but there were some gaps in understanding.
- Power back up and ambulance services were available.
- There was no blood storage unit.
- The MOIC mentioned that the drugs were inadequate and RKS fund was being used to purchase drugs.

PHC, Chilakavade

- 10-15 deliveries and 1-2 IUCDs insertion a month are conducted at the facility.
- Partograph was being used though there is need for training.
- OT was not in use as no procedures were performed. Patients were referred to the Block PHC.
- IEC display, charter display and cleanliness were as good as for other facilities.

- Understanding of case definition under IDSP and recording the cases in L and P register was poor.
- VHSC meetings were not being conducted.

PHC, Palya

- 10-15 deliveries and 2-3 IUCD insertion are conducted at the facility per month. Partograph was being used.
- No sterilization was being conducted.
- RKS fund was utilized for IEC, UPS, Oxygen cylinder, water facility and cleanliness as per the DHO directives.
- HMIS consolidation for the PHC area was not being done in standard format.

PHC, Sathyagala

- It was a PHC with a separate maternity hospital. The labor room was with a new born corner. On average 15–20 deliveries and 2-3 IUCD insertion were conducted every month. No sterilization was performed at the PHC.
- Sneha clinic was attended by about 35 adolescents a month (about 50% boys and 50% girls)
- No consolidation of PHC area report was being done in the standard format.
- There was repetition in reports. ANM prepared more than 16 reports every month. There were formats reporting same information on different formats.

PHC, Gumballi

- The PHC is working under PPP with Karuna Trust.
- It covers a population of 22,436 in 13 villages. There are 5 SCs under the PHC.
- Infrastructure of the PHC consists of OPD, 6 bedded IPD, Laboratory, X Ray, Labor Room with NBCC. Power Back-up available in the facility.
- The PHC has a Medical officer, a Pharmacist, 3 SN (including 2 under NRHM), 5 ANMs & 4 MPW-M for SCs. However, there is no AYUSH service at the facility.
- Difficult Area Incentives being given to MO (Rs.2000/-), SN (Rs. 1000/-), ANM (Rs.750/-)
- The PHC had a Mobile Dental Clinic and 1 Ambulance from the Karuna trust
- Free Diet is provided under JSSK to institutional delivery 3 meals per day for 2 persons for 2 days.
- Number of Cases have decreased since the last 3 years after CHC Santhamaralli was operationalized (8 Kms away)

PHC Ponachi

- The facility has 1 Medical Officer, 3 Contractual SN, 1 ANM, 1 LT, 1 Pharmacist and one FDC. MO has been trained in IMNCI and RTI/STI. All 3 SN are trained in SBA & 1 in NSSK. The facility has OPD, 5 Beds and labor room with suction machine and oxygen cylinder. The laboratory is well equipped.
- The facility OPD has increased over the years. Deliveries are conducted at the PHC and 48 hour stay is ensured. Food is provided to the mothers for 2 days.
- There is a First Division Clerk at the facility who was not managing accounts and records of NRHM related activities.
- There are no quarters for the MO and the staff. The MO resides 3 km away from the PHC and Staff nurses reside in a room in the PHC building.

- There is no ambulance provided for this tribal PHC. Since the PHC is situated in hilly remote area, there are no alternatives for the referral except the 108 service. However, 108 can not cover 30 km area adequately in this remote hilly area.

PHC Harve

- The PHC has functional OT, labour room and new born care corner. 10-15 deliveries were conducted a month; 1-2 IUCDs were inserted and about average 10-15 sterilisation were conducted.
- Liquid and solid waste disposal mechanism in place. Colour coded bins were being used.
- The laboratory was also functional and the records were well maintained.
- The PHC had power back up.
- Snesha clinic was functional with average 10-15 adolescents visiting the clinic every month.
- The cold chain was well maintained.
- The facility reports were in standard formats. The entry was being done at Block PHC. The consolidated PHC area report was not maintained in the standard format. Monthly HMIS review was conducted every 24th of the month. MCTS entry was also happening at Block PHC.
- VHNDs happened on 3rd Saturday, in which ANMs, AWWs and Male Health Workers participated.

PHC, Hangla

- The facility has OT, Labour Room, New Born Corner, laboratory, power back up and ambulance service.
- On average 10 sterilizations, 2-3 IUCD insertion and 10 deliveries were conducted every a month. Partograph was being used.
- Consolidated HMIS report for the entire PHC areas was not being created in standard portal format. MCTS report was computerized. The PHC had computer but data entry was not being done at the facility.

Sub Centre Nanjadevanpura

- Government building of SC had 3 rooms, a verandah and toilet block. There was both running and drinking water facility.
- All required furniture, labour table, almirah, instruments were available. No delivery was being conducted. The BP machine and weighing machine were available.
- IEC materials, figures and other information were neatly displayed.
- The ANM has stopped conducting deliveries .Each day, ANM visits field between 9 – 2 PM for PNC. She covers 50 houses a day during the field visit.
- IFA was not supplied for 4-5 months. Kit A and B not supplied this year.
- No Hb estimation and Urine examination instrument and reagent available. For Hb and urine examination, ANM refers ANC case to PHC.
- 8 IUCDs insertions were done last year and currently, 6 women from her area were using OCP. Condoms were put in the free distribution box in front of the SC.
- The ANM was maintaining due list and conducting RI on fixed days a month at SC.
- All registers and records were properly maintained by the ANM. No printed registers were provided.
- ANM had MCTS ID but she was not using the facility as it was not fully functional. However, ANM had the list of the beneficiaries which she regularly forwarded to PHC for uploading.

SC Yargumballi (PPP), SC Santhamaralli (co-located with CHC) & SC Mariala (Govt.)

- All 3 Sub Centers visited are located in government buildings, a majority of which are occupied by the ANMs as residential facility and a very small portion being utilized for SC activities
- The Co-located SCs does not have any equipment and its activities are linked with the CHC
- As with the rest of the district, the SCs have a single ANM
- The service delivery at the Sub Center is minimum and limited mainly to registration of Pregnant Women and treatment of minor ailments
- Immunization Sessions are held at the Center on the 17th of every month
- The ANMs' main activities mainly comprise of field work and record maintenance
- The fieldwork is mostly a duplication of the ASHA activities and consists of follow-up of registered ANC Cases and counseling them to complete their ANC visits, PNC visits and new born visits to educate them on immunization.
- These household visits are utilized for motivation to adopt FP methods including sterilization.
- Afternoon halves are mainly for updating the registers and reports. Since service provision is mainly at the PHC and higher centers, the ANC records at the SC is a compilation of the data collected by the ANM during her field visit.
- The VHNDs is all about IEC and BCC and service provision is limited. Even immunization is given only at the SC and not during the VHNDs.

Focused Group Discussion with VHSC Members

General Perception

- With the advent of NRHM, the access to health care and provision of free medications has improved to a great extent.
- The beneficiaries including pregnant women feel that they will be provided with good care at the facilities and hence their visit to these center have increased.

VHSC Meetings

- VHSC meetings are held on the 1st Monday every 2 months. Emergency meetings are held if required. These meetings are attended by the ANM and discussions involve areas for utilization of funds.

Utilization of Funds

Some of the activities include:

- Provision of Slippers for every Pregnant Woman
- Cleaning of the Village
- Cleaning of Water Tank
- Procurement of Bleaching Powder
- Transportation of sick patients

Other Contributions

- VHSNC members have recorded incidents where VHSC members have collected donation for this purpose. They attend VHNDs whenever possible to motivate the participants to increase utilization of government health facilities for mother & childcare and for their illnesses as well.

Concerns of VHSNC

- After the Obstetrician at nearby FRU Yelandur has left, the pregnant women of their villages have to travel a longer distance to DH Chamarajanagar or FRU Senthamaralli.
- Lack of range of range of specialty services at the District Hospital is another concern.
- They also feel that with a larger allocation to the VHSC will enable them to undertake more activities related to sanitation as well as help poor patients in whatever way they can.

FGD with VHSC Members

AWC: Nanjadevanpura, Block: Chamrajnagar, PHC: Harve

- Eleven persons including VHSC members, ASHA, Gram Panchayat President, ANM, AWW and a few local women participated in the discussion.
- It was informed that both VHND and VHCS meetings were primarily the forums of interaction (no health service delivery happens on VHND days).
- It was said that VHSC meetings and VHNDs happen regularly. During VHSCs mainly discussion on health and sanitation took place. Not much planning and local health programme were discussed.
- It was mentioned that the VSHC fund was used for purchasing ASHAs dresses. The group was broadly satisfied with the health service availability and accessibility. However, the women said cervical and breast cases were on rise and adequate diagnostic and treatment services should be made available for these through SC, PHCs with linkages to higher levels.
- The group was not aware of Sneha clinics.
- The Panchayat president mentioned that the fund available with Gram Panchayat Fund (Rs. 3000) was insufficient for latrine construction in the villages.