



7th Common Review Mission – Karnataka

9-15 November, 2013

***Ministry Of Health & Family Welfare,
Government of India***

CHAPTER 1 - INTRODUCTION

The Common Review Mission team of 14 members consisting of professionals from the MOHFW, Government of India, Planning Commission, Development Partners, NGOs and NHSRC visited Karnataka during November 9-15, 2013 to review the implementation of NRHM..

The main objective of 7th CRM was to Review progress of National Rural Health Mission/National Health Mission with reference to the functioning of NRHM vis-à-vis its goals and objectives-Identify the changes that have occurred in last eight years and reasons for the current states and trend. The process involved assessment and seeking comments on detailed terms of references (TOR) in 10 broad areas, with sub activities subsumed within it. The State briefing workshop was held under chairmanship of Mission Director and presentations were done by the Mission Director, NRHM and other NRHM key functionaries highlighting the progress, status of main programmes under NRHM and the new initiatives/best practices being taken by the State.

From 10th November to 13th November both teams visited two Districts namely Gulbarga & Haveri, interacted with Chief Medical Officers, District Program Management Unit Staff, Medical Officers, Doctors, Specialists, Staff Nurses, ANMs, Community Members, ASHAs, PRI members, District Collector. List of the facilities visited by CRM team in both the districts is given below in table.

The overall review process included various methods, apart from examining the presented data as the background, extensive discussions with the state and district level health team officials, extensive field visits to facilities, parallel to observations of the objective conditions of services delivery, examining the registers & records of documentation available, consultations with functionaries of facilities, consultations with stakeholders including beneficiaries of various programs such as JSY, JSSK, interactions with community, local body leaders at villages, Committee members such as VHSC/ RKS etc.

On 15th November CRM debriefing session was held at Bangalore under the chairmanship of Secreary, DoHFW, GoK and the CRM team made the presentations on the observations made during the visit.

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/discussing to various issues raised by the CRM members and excellent hospitality provided.

Structure of the report:

- Chapter 2 Background
- Chapter 3 Best Practices & Innovations
- Chapter 4 Overall Recommendations
- Chapter 5 TOR wise Observations, Areas for Improvement & Recommendations
- Annexure Facility wise Findings

TEAM COMPOSITION

Team Haveri	Team Gulbarga
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Dr. Balaji Naik. R, WHO-RNTCP	Dr. Raghunath Prasad Saini, RCH
Ms. Chhaya Pachauli, Prayas CSO	Dr. Shashikala, NHSRC
Dr. Nikhil Utture, Consultant, NRHM, MoHFW, GOI	Mr. Yogesh Kumar Singh, Planning Commission
State Representatives	
Dr. B.G. Prakash Kumar, SPM, SHS, Karnataka	Dr. Shridhar, SHS, Karnataka
Dr. Rahat-E-Shaik, SHS, Karnataka	Dr. Narayana, SHS, Karnataka

Facilities Visited:

Type of Facility	Gulbarga	Haveri
District Hospital	Gulbarga	Haveri
Taluk Hospital	Jewargi, Sedam	Shiggoan, Byadagi
CHC	Mudhol, Malkhed, Gundagurti	Rattihalli
PHC	Mandewal, Jeratgi, Aurad, Mahagaon, Ambalga, Madbool, Kadganchi UHC: New Rahmat nagar, Ghazipura Urban PHC, Gullar Gali (Slum)	Tadas, Attigeri, Kaginele
SC	Khanadal, Kattisangavi, Mandeval, Aurad, Sindigi, Madaki, Dhottargaon, Ranjol, and Goturu	Neeralagi, Kuruba gonda, Attigeri
Villages	Khanadal, Kattisangavi, Mahagaon, Madaki, Neeloor, Chandapur, Sindgi, Kanasur, Dhottargaon, Bennur K , Goturu	Neeralagi, Tadas, Kuruba gonda, Attigeri
Others	ANM Training Centre-Gulbarga; District Training Centre and R.F.W.T.C.-Gulbarga; Regional Drug Warehouse-Gulbarga; Schools: Sindgi, Kadganchi; Anganwadi centre : Kanasur	Ayush Hospital: Shiggoan; ANM/GNM training center Haveri; District Vaccine stores; Schools - Attigeri and Tadas; Mobile medical unit: Sheelavanta Somapura, Shiggoan Block; Anganwadi center: Devagiri; SIHFW, Karnataka drug logistics and warehouse.

CHAPTER 2 - BACKGROUND

Karnataka State is the ninth most populous State in the country with a population of 6.11 Crore (Census, 2011) of which 51% are male and 49% are female. The population density is 319 per sq. km. Sex ratio is 973 (females per 1000 males). The total literacy rate is 75.36 % (male – 82.47%, and of female – 66.01%). Out of total population of Karnataka, 38.67% people live in urban regions. The State has 30 districts, 176 blocks, 775 Hoblies and 29340 villages.

GULBARGA is one of Northern, backward and high priority districts of Karnataka. It was a district of Hyderabad Karnataka area and became a part of Karnataka State after re-organization of states. The district is spread across 7 taluks - Afzalpur, Aland, Chincholi, Chittapur, Gulbarga, Jewargi & Sedam.

HAVERI is one of the Central, economically better performing districts of Karnataka and has, for decentralized administration, two sub-divisions namely Haveri and Savanur with seven taluks namely Hanagal, Shiggaon, Savanur, Haveri, Byadagi, Hirekerur, and Ranebennur.

Indicator	Karnataka	Gulbarga	Haveri
Total Population	611 Lakh	25.66 Lakh	15.97 Lakh
Female Population (in percentage)	49	49.27	48.72
Area (In square Kilometers)	191,791	10,954	4,823
Population Density	319	234	331
Sex Ratio	973	971	950
Female Literacy Rate	66.01	55.09	70.46
Urban Population (in percentage)	38.67	32.56	22.25

Source: Census 2011

HEALTH INDICATORS:

Sl. NO	Indicators	Karnataka	India
1	Infant Mortality Rate (SRS 2012)	32	42
2	Maternal Mortality Ratio (SRS 2007-09)	178	212
3	Total Fertility Rate (SRS 2011)	1.9	2.4
4	Under-five Mortality Rates (SRS 2011)	40	55
5	Institutional Deliveries (During 2013-14 upto June)	214861	3303609
6	Full immunisation (In thousands) (During 2013-14 upto June)	267	4863

PROGRESS OF NRHM: (As on June 2013)

Sl. No	Activity	Status
1	24x7 PHC	Out of 2310 PHCs, 1018 (44.06%) PHCs are functioning on 24x7 basis
2	Functioning as FRUs	147 Health Facilities (37 DHs, 96 SDHs and 14 CHCs) are functioning as FRUs.
3	ASHA Selected	Out of 34860 selected ASHAs and trained up to 5 th Module, 28291 ASHAs have been trained in round 1 & 2 and 21958 ASHAs in round 3 & 4 of 6 th & 7 th modules.
4	ANMs at SCs	Out of 8871 SCs, none of the Sub Centre is functioning with second ANM.

5	Contractual appointments	81 Doctors (GDMOs), 52 Specialists, 625 AYUSH Doctors, 60 AYUSH Paramedics, 3965 Staff Nurses, 128 Paramedics & 812 ANMs are positioned.			
6	Rogi Kalyan Samiti	2639 facilities (27 DHs, 180 CHCs, 146 Other than CHCs & 2286 PHCs) have registered RKS.			
7	Village Health Sanitation & Nutrition Committees (VHSNCs)	Out of 29340 villages VHSNCs has been constituted in 26084 (88.9%) villages.			
8	ERS	517 ERS (108-Type) vehicles are operational.			
9	VHNDs	18231 VHNDs were held during 2013-14 (upto June).			
10	Infrastructure Strengthening	Facility	New Constructions		Renovation/Upgradation
			Sanctioned	Completed	Sanctioned
					Completed
		DH	3	1	8
		SDH	-	-	69
		CHC	6	6	-
11	New Born Care Units established	PHC	275	186	58
		SC	802	382	-
		Sick New Born Care unit (SNCU)			33
		New Born Stabilization Unit (NBSU)			178
		New Born Care Corner (NBCC)			1390

Action taken on recommendations of 5th CRM:

Recommendations	Action Taken
<p>1. The State may plan to analyse FRUs' functioning in 7 C districts and high focus districts in terms of following parameters:</p> <ul style="list-style-type: none"> – Availability of 24x7 EmOC, especially availability of EmOC at night – Posting of personnel (gynecologist, pediatrician, anesthetist) – Blood bank/storage linkage <p>State may also like to track referrals from the FRUs and the reasons for referral.</p>	<p>State is facing acute shortage of specialists. To overcome the shortage, a versatile manpower hiring (gynecologist, pediatrician, anesthetist) through 1. Contract 2. case to case 3. retainer basis is practiced. Short-course, specialists training of MBBS Doctors in EmOC (53) and LSAS (67) and posting to FRUs after counseling is also done</p> <p>The reasons for referrals are categorized as follows: Lack of specialist services, lack of confidence among the service providers, societal reasons, personalized preferences</p> <p>The referrals from PHCs to higher facilities and from FRUs will be further strengthened. Referral slips are provided to all the 24x7 PHCs and instructions given to track each referral.</p>
<p>2. 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.</p>	<p>The State is capturing all the facility and community based Maternal Deaths. It may not be correct to say that 42% of Maternal Deaths are not captured. The capturing is almost complete in rural areas, but urban areas is a problem. There is no established human field based infrastructure like ASHA, ANM, MPW in Urban areas. Hence the data collection is</p>

Recommendations	Action Taken
	relatively difficult in the urban areas though the effort from the State is there continuously through involvement of local bodies and private providers.
3. 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).	It is a good suggestion by GOI. The State will act upon it.
4. 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.	About 3,50,925 VHSCmembers have already been trained for capacity building through the NGOs under PPP mode. All VHSC members have been sensitized about the concept, role, functions of the VHSC, Untied Fund, its purpose and method of spending and maintaining accounts & also about the monitoring of VHSC functioning. Untied Fund sanctioned to the VHSC and its expenditure will be displayed at all sub centres, gram panchayat offices on black boards/notice boards.
5. The State may look into the financial	Strict guidelines will be sent to all the

Recommendations	Action Taken
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.	subcentres not to draw the entire untied fund at one go. ANMs have been trained to maintain the details of expenditure and book-keeping in the VHSC members training. This will be again reiterated in the guidelines issued to Untied Fund utilization.
6. 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 State has already recognized the need of productive & supportive supervision. It has reviewed the supervision structure of District Advisors to review all the National Health Programmes and concentrate on assured service delivery including the improvement of accessibility to the poor and marginalized section of the society.
7. 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.	Capacity building of VHSC & ARS members is taken up through PPP from 2010-11. So far 19734 committees/samitis throughout the State are trained in planning & Functioning of VHSCs & ARS.
8. The District Health Mission is to provide broad policy guidelines whereas 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 present system of monthly scheduled prefixed agenda meetings are working well. However the State keeps an open mind about review of the current system as and when necessary.
9. The State may reconsider the deliveries at	State has already taken steps to treat the

Recommendations	Action Taken
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.	deliveries occurring in SCs as Institutional Deliveries.
10. 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.	Madilu Kits are provided to the eligible beneficiaries who deliver in SC also
11. 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.	The Govt. has enacted the transfer act & rules which govern the transfers of officers and staff of the department through a transparent computer generated counseling system. The suggestion for rewarding excellence of performance is good which will be kept in mind during counseling and postings
12. 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.	With effect from 01.11.2011 the govt. has put on hold the sanctioning of new hospitals/health centres & upgradation for a period of 3 years
13. NRHM framework recommends stability of tenure for the officials. Given the background of the systemic and policy	No comments

Recommendations	Action Taken
<p>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.</p>	

NRHM Conditionalities and Incentives Status:

(not yet provided by State)

CHAPTER 3 - Best Practices & Innovations

- **Innovations in Transfer & Postings:** The Karnataka State Civil Services (Regulation of Transfer of Medical Officers and other staff) Act, 2011 was passed in 2011. This Act provides the regulation of transfer of medical officers and other staffs of the Department of Health & Family Welfare so as to ensure their availability in government health facilities in rural areas. It gives provisions for compulsory posting in rural areas, posting/transfer of MO/Specialists to appropriate posts, rationalizing the cadres/posts and need-based HR restructuring of the department.
- **Human Resource Management System (HRMS):** The Karnataka Government in collaboration with the NIC has developed a web enabled HRMS system for collection, compilation and updation of information/data related to institutions and the individual with respect to contact details, employment & types, deployment, service details, transfer & promotion, vacancy positions, trainings/deputations, payrolls, retirement and performance review etc..
- **Maternal Health:** Karnataka has launched many State initiatives like Prasoothi Araike, Madilu, Thaiy Bhagya and Thaiy Bhagya Plus which has dramatically increased the institutional deliveries in Public Health facilities.
 - ✓ **Prasooti Araike:** Financial assistance for the SC, ST and BPL pregnant women and mothers for the first and second live births, in two instalments. - First instalment of Rs 1000/- during the second trimester of pregnancy and Second instalment of Rs. 1000/- given after delivery (including Janani Suraksha Yojana amount i.e. Rs. 300 for Rural & Rs. 400/- for Urban beneficiaries)
 - ✓ **Madilu Kit:** Post natal care kit for mother and new-born containing 19 useful items like, Jhamkhana, Bed sheets, Mosquito nets, Abdominal belt, soaps and detergents, Sweaters for Baby etc... is provided to BPL, SC & ST beneficiary, 1st two live births and who deliver in Government Institutions.
 - ✓ **Thaiy Bhagya & Thaiy Plus:** To overcome the shortage of specialists in rural areas, totally cashless delivery services is being provided through Public Private Partnership in accredited private hospitals in 7 backward 'C' districts (i.e.

Gulbarga, Yadgiri, Bidar, Bijapur, Bagalkot, Koppal, Raichur district) and Chamarajanagar for SC, ST and BPL women. A cash assistance of Rs. 1000/- for a private hospital delivery is paid to rural SC, ST and BPL women for the first 2 live births in all other districts in accredited private hospitals

➤ **Karnataka Internet Assisted Diagnosis of Retinopathy of Prematurity (KIDROP):**

It is India's first PPP in Infant Blindness ROP. The National Rural Health Mission (NRHM) takes of the entire infrastructure costs and Narayana Nethralaya Foundation (NN) – (funds as a part of her social responsibility) takes care of the cost of the doctors and trains technicians for effective project implementation. The programme aims to provide provides retinal screening and surgical intervention for premature infants in underserved areas of rural Karnataka.

➤ **ASHA initiatives :**

- ✓ Rs. 400 for reporting infant deaths from State budget.
- ✓ **Matching Grants for ASHA:** First of its kind in the Country, each ASHA will be given an additional amount equal to the incentives earned by her under NRHM, which will be funded by State Government.
- ✓ CUG SIMs to all ASHAs.
- ✓ Mobile Handset for ASHA from KHSDRP.

➤ **MCTS:** MCTS software is customized by NIC according to the State needs and started from 2011.Data entry through mobile SMS is introduced and it has been recognized in the international forum and awarded the 'Top 11 in 2011, innovators challenge award' instituted by Rockefeller foundation.

➤ **RNTCP:** Nutrition Support from the State to all TB patients (Nikshaya); State funding & Support for C/DST (DR Lab); TB Mela (active surveillance) arranged by NGOs; TB awareness to corporate sector; Cash incentives by elected representatives..

➤ **Civil works:** Karnataka has got a separate Engineering Wing under Department of Health & Family Welfare which looks after the construction of all health infrastructures and best constructions practices are adopted.

- **Integration of ICTC with NRHM:** Various initiatives were taken up by the Government of Karnataka to integrate PPTCT services with the existing RCH and other components of primary health care. As a result of successful integration of both the programmes, pre Test counseled ANC mothers have increased almost ten times since 2000. Almost every ANC cases registered in the district are counselled and tested for HIV during last 10 years.
- **Diploma of Public Health (DPH) course** has been started in Karnataka and first batch of 32 DPH candidates completed the course.
- **Dialysis Units:** In 1 taluka hospital of all 30 Districts a Dialysis Unit is established with all facilities and treatment is provided free of cost.
- **AYUSH:** Pancha karma units functioning at District Hospital; PPP mode yoga Naturopathyunits established; AYUSH Nutrition programme in Two taluks; 7 AYUSH Doctors deputed for DPH.
- **NVBDCP-**Involvement of ASHAs as Domestic Breeding Checkers to facilitate source reduction.

CHAPTER 4 - Overall Recommendations

- There is a need to optimize utilization of lower tier facilities to reduce burden on higher facilities like TH/SDH & DH. While planning for new facilities, due consideration to be given to terrain underserved population and travel time to reach the facility. Standards of equitable distribution of existing health facilities within the blocks in the district should also be maintained.
- SCs potential needs to be fully explored. Additional plans for service provision and screening of non-communicable diseases can be tested at sub-Center to counter the changing disease profile in the State.
- State should progressively shift towards providing free laboratory & radiological investigations and must abolish the practice of user fees for all patients utilizing public health facilities.
- IEC-BCC activities in facilities and community needs more visibility, especially prominent visible display of IEC material on JSSK entitlements is needed across facilities. Coverage of it as part of mass media campaign, through hoardings, wall paintings etc, apart from other mass media modes, are adequately needed for the delivery of the message of free entitlements. Grievance Redressal System needs to be strengthened.
- Completion of pending infrastructures is essential to address infrastructural disparity. It may be important to make these facilities fully functional. If the lower tier facilities can be made fully functional pressure on the higher facilities and that too for normal deliveries can be addressed adequately.
- There is a need for monitoring & technical supportive supervision for quality ANC services and for adequate maintenance of records and reports. Hb estimation services through line list of anemic women needs to be provided at each service delivery levels.
- Each infant death needs to be reviewed along with maternal death and surrounding community to be made aware regarding causes of death. Discussion on causes of death should also be taken place during VHND session.

- The Thai card number can be used as UID across the ANC register, 108 network, labour room record and HBNC so that quantum and quality of service entitlement delivered to individual woman can be accessed.
- Family planning, especially PPIUCD and availability of Spacing methods at door step through ASHAs, should receive attention and closely monitored. Safe Abortion Services in public Health system may be made available.
- RBSK implementation in the districts to be planned according to the RBSK guidelines for timely roll out of the scheme as per RoP conditionality.
- The accreditation of SNCUs by reputed agencies like NNF could help to improve and maintain the Quality of Care in SNCUs. State should go for SNCU software so that the reports could be child based and will help better monitoring
- Decreasing the dropout rate and increasing the full immunization coverage needs strengthening by preparing due lists and tracking the beneficiaries and mobilizing them for vaccination.
- Improving MCV 2 coverage and decreasing measles outbreaks, Training to ANM's, Regular review of the coverage and feasibility of ***measles campaign in high risk blocks of northern districts*** with consistent measles outbreaks over the years need to be explored .
- Immunization field volunteers recruited for RI monitoring can be assigned with role supportive supervision, capacity building of frontline health workers, training, components of the Immunogram pilot of chikballapur in order to reduce the drop outs.
- State specific Effective vaccine management (EVM) study to be conducted to find the gaps in cold space for the vaccines at every level, vaccine logistics management, temperature maintenance, equipment maintenance, stock management etc. *An operational research* to find the difficulties in coverage review at sc/phc/taluka and district and mechanisms to evade the disparities between facility wise and area wise reporting

- IDSP: Vacant regular positions need to be filled up to strengthen the programme. Ayush facilities should also report using the IDSP portal. Private sector reporting under the portal needs strengthening.
- NVBDCP:
 - ✓ IEC activities need to be focused to reach the correct target population. Visibility of the programme need to be intensified through social mobilization and sensitization activities at all level including ASHAs, Village Health & Nutrition Day, sub-centre, Rogi Kalyan Samithi, Taluk and district level meetings.
 - ✓ Priority for VBDs should be given especially on source reduction, implementation of NVBDCP strategy and targeted disease for elimination i.e. Lymphatic Filariasis in the state.
 - ✓ Entomological surveillance needs strengthening and entomologist located at district under IDSP needs to perform the activities according to the need of NVBDCP and submit the monthly report to VBD officer. Vacant entomologist posts have to be filled on priority.
 - ✓ The revised guidelines of malaria management are to be disseminated and monitored for effective implementation.
- RNTCP: State has to have micro-plans to reduce death and default rates. Efforts to increase the smear negative and paediatric case notification to be intensified. Programme managers should conduct sensitization workshops for pediatricians and doctors regularly to increase case notification and better case-holding. Programme should be reviewed regularly by the THOs/ BHOs and CMOs/ DHOs. State should think of some innovative strategies to ensure monthly TB notification from private health establishments.
- NPCDCS: NPCDCS activities to be scaled up to all the districts phase wise. NCD cells have to be fully functionalized and effective collaboration to be established with other programmes such as RNTCP, social support schemes wherever applicable.
- NTCP: Tobacco control activities have to be implemented by the state and districts as suggested by the national programme guidelines. Tobacco cessation centres (TCC) should be functionalized in the districts to cater to the needy population.

- Mechanism should be evolved for regular re-orientation and updating of knowledge of Specialists & MOs. E.g. Regular access to magazines on recent developments in health field can be a good initiative to bring awareness about recent developments in medical science and its practices.
- GDMOs should be appointed at THs/SDHs as they will reduce the burden on specialists. In addition they can act as a gate-keeper by initial screening of OPD patients and then referring the needy ones to specialists.
- State needs to take steps to expedite full compliance to HR conditionalities laid down by GOI.
- Empowerment of VHSNCs by involving them in “community based monitoring of health services”. Appropriate tools and formats can be developed for this purpose and capacity building of VHSNCs be carried out around this
- ASHAs: System of ASHA payments may be simplified by making whole of the amount paid at one go. ASHA kits to be made available to all the ASHAs and robust system for their regular replenishment be placed. Establishment of ASHA restrooms at all the facilities up till PHC level must be ensured
- Specific VHND sites can be identified where service delivery is most required at the periphery and VHNDs to be organized as per the MoHFW norms delivering most essential health and nutrition services (including ANC, immunization, PNC etc) at these points.
- HMIS: State has to relook in their recruiting process and remuneration payment via the third party HR agencies and ensure that the DEOs get their due.
- MCTS: Timely registration of pregnant woman on MCTS portal needs to be given due importance. Sukshema may also be rolled out to other districts of the State.
- RKS meeting should be regularly held for monitoring the funds and further planning. Funds of RKS should not be used for JSSK scheme at the District Hospital, Gulbarga.
- Timely payment to JSY beneficiary to be monitored from DHS level. Cash Payment/Bears cheque of JSY and FP is to be avoided.

- Director Finance and State Finance Manager must visit at least two Districts in a month for monitoring and improving the financial management system. District Accounts Manager/Accountant may also plan to visit at least two blocks in a month for supervising the working of the Accountant and submit his report to the CMHO and a copy to the concerned BMO
- Monthly meeting of DPMs/DAMs along with CMHOs may be held for monitoring the physical and financial progress of the programmes.
- Computerization of drug distribution counters and IT based inventory management should be introduced. “Dual prescription practice” may be initiated in the state for strict monitoring and audit purposes.
- Standard guidelines must be issued to health facilities for ensuring efficient drug storage/maintenance of storehouse and adherence to rational prescription practice.
- Mechanisms for social audit such as Janvamsad, public meetings at villages and accountability measures for health need to be put in place and made effective.
- Data from various sources needs to be analysed and utilized for effective monitoring and supportive supervision. Monitoring and supportive supervision and action taken report on observations mechanism in the DPMU and SPMU needs to be structured in line with GOI recommended Supportive supervision guidelines.

CHAPTER 5 TOR WISE OBSERVATIONS, AREAS OF IMPROVEMENT & RECOMMENDATIONS

TOR 1 – SERVICE DELIVERY

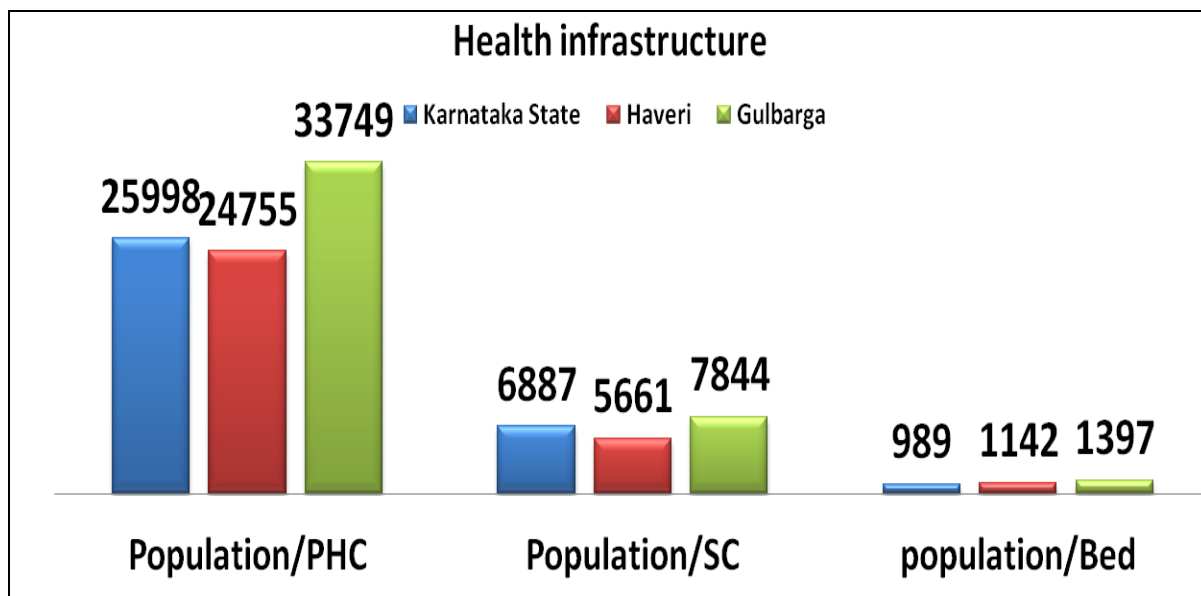
OBSERVATIONS:

Adequacy of facilities:

- Overall as per the population norms there are adequate number of facilities in Karnataka and Haveri district, except for few SCs and PHCs shortfall in Gulbarga district.

Facilities	As on 2013	Projected facilities as per population (Census 2011)	Shortfall
KARNATAKA			
SC	8871	7494	-
PHC	2350 (+27 UPHCs)	1873	-
CHC	206	374	-
SDH (Taluk Hospitals)	146		-
DH	20+10 GOV. Medical College Hospital	20+10 GOV. Medical College Hospital	-
HAVERI			
SC	307	248	-
PHC	67	62	-
CHC	5	4	-
SDH/TLH	6	6	-
DH	1	1	-
GULBARGA			
SC	327	346	19
PHC	83	86	3
CHC	16	16	-
SDH/TLH	6	6	-
DH	1	1	-

- In Gulbarga District, there is inter-block disparity in terms of distribution of facilities. State should emphasize for making facilities operational in difficult areas.



- Over the years under NRHM, Karnataka has strengthened the primary care infrastructure by adding large numbers of SCs and PHCs. Under NRHM, Karnataka has added 728 numbers of SCs, 671 numbers of PHCs and 29 numbers of CHCs.

	In 2005	In 2012	Change in Numbers
SC	8143	8871	+ 728
PHC	1679	2350	+ 671
CHC	159	188	+ 29
SDH	146	146	-
DH	30	20	-10 (Shifted to Government Medical College Hospitals)

Infrastructure:

- Overall the infrastructure development in visited districts is satisfactory. Infrastructure in most of the facilities visited in the district were found to be of good quality and well maintained with adequate waiting area, provision of drinking water seen in most facilities till PHC level and are well located within the approach of the villagers.
- However, in many facilities Staff Quarters were not found or were not in proper condition and sufficient in numbers. Due attention should be given by state administration on residential facilities especially for the staff of 24x7 functional PHCs in the district.
- Karnataka has got a separate Engineering Wing under Department of Health & Family Welfare which looks after the construction of all health infrastructures.
- In Gulbarga district, the Maternity home in the SDH Sedam is retained in the old location, 2.5 km away from the new Sedam TH, which also houses the blood storage facility.

	Major Construction taken up under NRHM (2005-12)	Major construction completed (2005-2012)	Minor Construction taken up under NRHM (2005-12)	Minor construction completed (2005-2012)
Karnataka	905	395	133	109
Haveri	25	25	0	0
Gulbarga	19	19	2	2

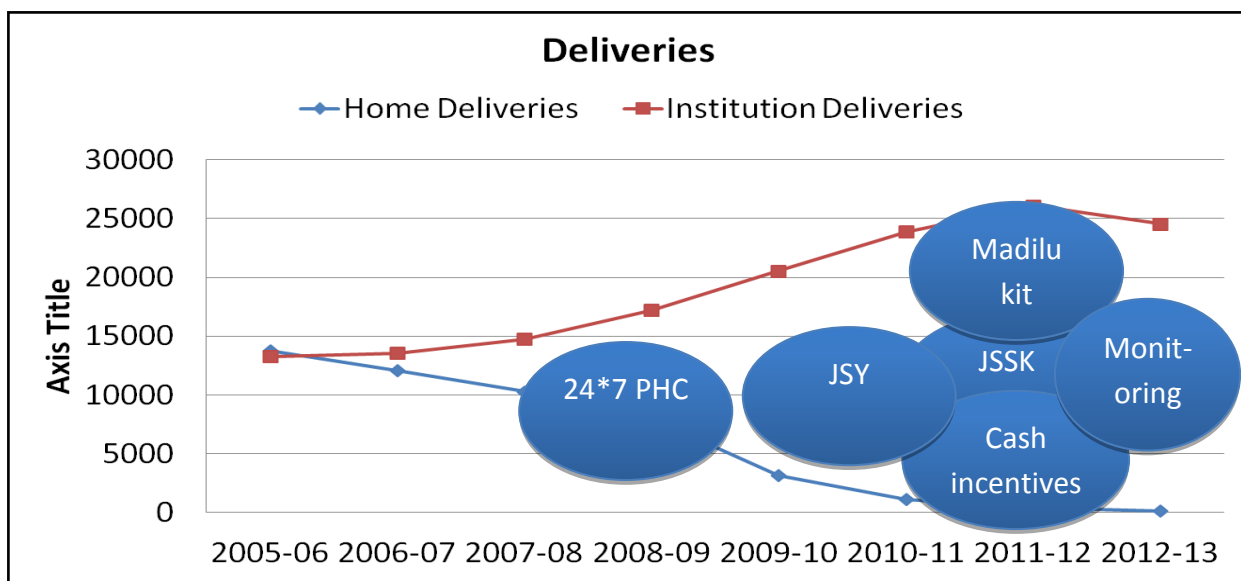
- Overall in Karnataka, around 56% of major construction works undertaken under NRHM are yet to be completed. For Haveri & Gulbarga districts all the major construction works supported under NRHM are completed.

Utilization of facility based services:

- Utilization of services in Public Facilities has increased progressively over 5 years.

Indicator	2005	2012	% Increase
Institutional Delivery	63%	98.02%	+ 35.02%
OPD	54.59%	74.5%	+ 19.91%
IPD	3.68%	6.8%	+ 3.12%
Sterilisations	368975 (2008-09)	394526 (2012-13)	25551

- The highest service delivery improvement has been seen in the institutional delivery followed by OPD services. The improvement in IPD services is marginal indicating that Karnataka needs to improve inpatient and emergency care service availability in the government facilities.
- Wide range of services are provided in the facilities - RMNCH+A, disease control programmes and Primary, secondary and tertiary facility based care.
- However, in Gulbarga District it was found that many of the health facilities visited including CHCs and even the Taluka level FRUs are conducting only normal deliveries. Provision of full range of services as per facility norms is poor in facilities visited in both of the districts. (E.g. CHC visited in Haveri District)
- There is a lot of variation among same category of health facilities in terms of case load or utilization. E.g. PHC-Awarad is attending 372 patients per month i.e. 12 patients per day only while some other PHC like PHC- Kadaganchi is attending 1588 patient per month i.e. more than 52 patient per day. The situation for CHCs is also found same.



- Wide range of interventions like 24x7 PHCs, JSY, JSSK, State initiatives like Madilu Kit, Cash incentives and better monitoring has drastically improved the number of institutional deliveries. However, mothers' not staying for 48 hours after delivery in the health facility is a cause of concern.
- As service delivery from the sub-Center has reduced to a great extent and the ANM is mobilizing pregnant women to the PHC, the role of SCs needs to be reassessed and explored.
- In Gulbarga District, except for the District Hospital, none of the facility is conduct major surgeries. Minor surgeries were also not happening in majority of the health facilities in the district.
- **Dialysis Units:** In 1 taluka hospital of all 30 Districts in Karnataka has a Dialysis Unit established with all facilities and treatment is provided free of cost.

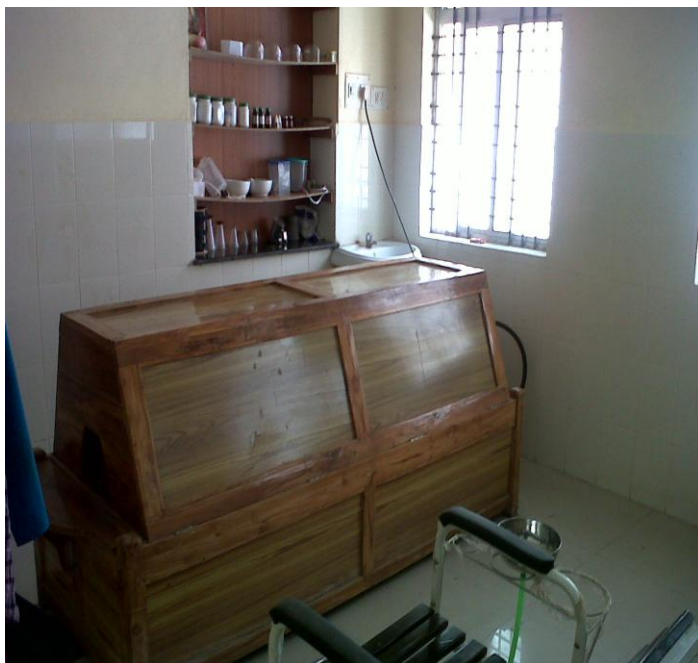


Dialysis Unit in Taluka Hospital

Mainstreaming of AYUSH:

- The State of Karnataka with large number of AYUSH educational institutions and traditionally strong AYUSH practices has co-located AYUSH facilities at District Hospital, Taluk Hospitals and PHCs.
- 602 AYUSH doctors including 40 Homoeopathy, 36 Unani doctors have been deployed in 12 District Hospitals, and 590 PHCs/Taluk Hospitals. 60 AYUSH Para-medical staff is also working under NRHM.
- Apart from these facilities 10 Yoga & Naturopathy units are running under PPP mode in Taluk Hospitals.
- AYUSH doctors are providing the AYUSH services apart from participation in National Health programmes like school Health programmes, and ARSH progrmmae - Sneha Clinic particularly the PHC level doctors. Many of them are trained in SBA, IMNCI, and NSSK. Generally AYUSH medicines were found available. However, the regular availability of AYUSH medicines was an issue in facilities visited.

- The **DH, Haveri** with two regular Ayurveda doctors including district Ayurveda Officer, one NRHM contractual Unani and one NRHM contract Homoeopathy doctors are running the facilities in their respective disciplines. Shortage of AYUSH medicines was noticed. The average OPD attendance/ day for Unani & Homoeopathy are 20-25 respectively. Separate treatment rooms with Panchakarma equipment are also available. The Panchakarma treatments are said to be done on day care basis.



Panchakarma Center in District Hospital, Haveri

- At **Taluk Hospital Shegaon** also one Ayurveda doctor was available. He is yet to receive the Ayurveda medicines in the Ayurveda facility. An average OPD attendance of 20 patients/ day was reported and it was mentioned that these patients were provided with Allopathic medicines.
- **Govt Ayurveda Hospital, Shegaon, Ashraya Plot, Hulugur Road:** The hospital in the sub-urban area is well inhabited by the people of poor social status. A new building was constructed out of Department of AYUSH funds. There is space for treatment room, wards consultation room, dispensary room, and patient waiting space. There was water supply and electricity connection. 2 PG Ayurveda doctors, 2 masseurs, 1 pharmacist were deployed out of department of AYUSH funds apart from 1 regular

AYUSH Doctor. An average 30 number of patients are attended in the OPDs. IPD is yet to be started for want of equipments and furniture. 30 IMPCL machines are available. Total constructed area is 211. Sq. meter, as per the information provided by Medical Officer in Charge.

- **PHC Attigere:** 1 Ayurveda M.O. appointed on the strength of the PHC is working in another PHC where there is no other doctor.
- **Taluk Hospital, Bydagi:** 1 Homoeopathy doctor is appointed under this co-location in the hospital. Department of AYUSH provided Rs. 10 lakhs to this facility for co-location during 2008-09. However, it appears that no modification/alteration was done in the existing building for AYUSH Unit, even though a separate room was provided for Homoeopathy consultant in the Trauma care centre. It was assured that sufficient space will be provided to AYUSH unit in the newly constructing unit. Medicines were available in the Homoeopathic clinic. Since no supporting dispenser/pharmacist was available the medicines were kept in the consultation rooms. Sufficient furniture for Homoeopathy unit was available. The doctor was SBA trained and the patients of Asthma, Skin disorders and arthritis are reported in the OPD and maximum 20-25 patients are reported per day.
- The State Government also rolled out an **innovative nutritional supplement for children** of Anganwadi Centres – **AYUSH Biscuits** on a pilot basis.
- The contractual doctors deployed in the facilities informed that they were paid Rs.13,000 p.m. which is grossly inadequate. It was also observed that there is a need to provide AYUSH medicines regularly in the facilities.
- In Gulbarga District, there are 7 Hospitals and 33 Dispensaries providing AYUSH services in the district. AYUSH facilities are made available at District Hospitals and co-located at Taluka Hospital levels. PHC Medical Officers are being supported by AYUSH MOs in various health care activities.

Ancillary services:

- All ancillary services such as laboratory and radiography investigations, medicines and equipments are available in almost all facilities. The patients were provided medicines

free of cost but the practice of user fees was found prevalent in Haveri District for laboratory and radiological investigations. All facilities visited by the CRM team found adequate equipments and diagnostics services.

Blood Bank and Blood storage centre:

- The blood bank facility is available in district hospitals. Blood storage Centres are available in Taluk Hospitals but are generally not functional. In Haveri District, out of 4 BSUs only 1 in Rani Benoor is functional

	No. of Blood Bank – Govt.	No. of Blood Storage Units – Govt.	No. of blood Bank - Private
Karnataka	42	147	102P + 34 Voluntary BB
Haveri	1	4	0
Gulbarga	1	5	3

- Blood bank was found to be maintained properly with adequately trained staff & records. Temperature monitoring charts were maintained properly and monitoring of expiry date of each unit of blood was done meticulously by the staff.
- It caters to both government & private hospitals of district. Charges are: Rs. 300 for govt hospital , Rs. 700 for Private Hospital , free for BPL.
- In Shhiggaon Taluka Hospital, BSU establishment is in process. Necessary equipments and other requisites being available but process of actual operationalization is delayed (8 months) due to tardy processes and paper work.
- None of the CHC and FRU is conducting C-sections in Gulbarga district. Blood storage unit at CHCs are not available.

Supportive Services:

- Overall the supportive services and amenities like laundry, diet, toilets, drinking water etc. were found to be available.

- Diet is being provided in all facilities. In PHCs/ CHCs food was not cooked in-house but arrangement was made from nearby hotels. In the SDH/DH food was cooked in-house and was distributed to all patients. In facilities visited the kitchens were found in clean conditions.
- However, interaction with in-patients in few facilities revealed that food was not served in the hospital and patients had made self-arrangements. Moreover, it was found that delivered mothers are provided food from 2nd day after delivery.
- Signage's-All rooms in the facilities were well marked with signage in local language.
- A patient help desk was found operational in District Hospital, Haveri which is run in PPP mode.



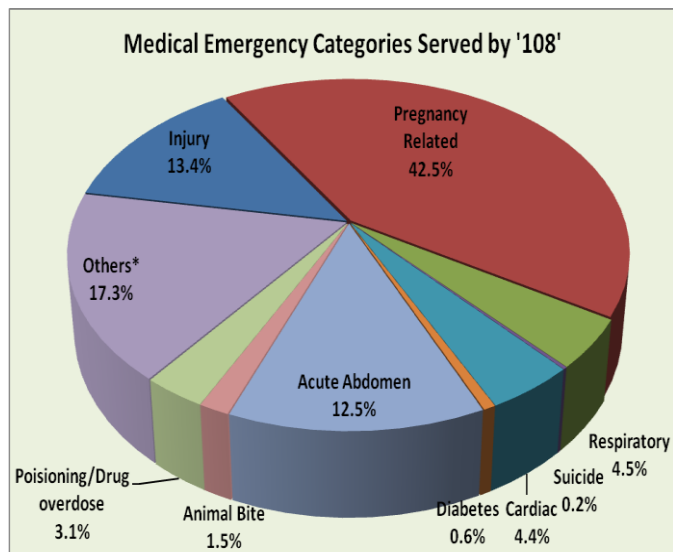
PPP run Citizen Help Desk in DH, Haveri



In-patient ward in DH, Haveri

Quality of Care:

- State Quality Assurance Cell exists and District level Quality Assurance Committee has been constituted in both of the districts.
- **Privacy concerns-** In many of the facilities visited in Haveri District the Injection rooms were not separate for male and female and also there were no curtains/screens utilized.
- In some facilities there was no segregation of male & female in-patient wards.



- In some facilities, patient amenities like waiting rooms & attached clean toilets were found inadequate.
- Standard treatment protocols available and displayed in OT, labour room, etc.

BMW Practices:

- Bio medical waste management services for DH, SDH, Taluka

Hospital and CHC level have been outsourced in the district.

- New color coded bins for Bio medical waste segregation exists at all levels. Protocols were being displayed. Orientation on BMW segregation to all the health functionaries at all level is being done.
- However, the waste segregation at source was not done properly in both of the districts.
- Needle cutters were available at all the health facilities.
- The State of Karnataka has employed one bio-medical waste management consultant in each district who is responsible for management and monitoring of bio-medical waste management practices in all the facilities of the district. It is one of the innovative & best practices followed in Karnataka.

Ambulance & Referral Services:

- 108 Emergency Patient Transport System is used in the state for referral transport. A total of 517 EMRI ambulances (BLS – 387 and ALS – 130) are available. Overall one ambulance is available for 1 lakh population in Karnataka with some district specific variations. In Gulbarga district, one ambulance covers on an average 116,651 population in the district.
- As per the data available with EMRI central unit- A total of 37,869,526 calls were made to the EMRI call centre during November 2009 - October, 2013.

- After making call to EMRI Call Centre, the ambulance reaches the scene/place in 20 minutes in urban area and in 20 to 25 minutes in rural area.
- Beneficiaries (mothers admitted in post natal ward) are generally not aware about free drop back facility.
- Cleanliness and BMW management in 108 vehicles is cause of concern. Some vehicles do not maintain the stipulated daily quality check of essential equipment.



108 Emergency Ambulance Service

- In terms of total deliveries reported in public facilities (19216 public institutional deliveries in 2013-14 till October 2013) the number of pregnancy related cases transported by the 108 network is only 37.61%. The percentage of mothers supported by 108 is even lower (25.25%) when compared to total institutional deliveries (28624) till October, 2013
- Number of Instances of “deliveries in-transit” (14,659 during November 2008 to October 2013) is an area of concern and needs attention.
- 108 ambulance service is adequately utilized for transport of pregnant women from home to facility in Haveri District.
- Drop-back service is not provided by the 108 services and is being done in the state separately using hospital ambulances. However the utilization of drop-back is low in the state.

- The ambulances are not bearing the National Ambulance services logo of NRHM.
- State is in process of adding a fleet of 102 type vehicles in all hospitals to strengthen the drop back.
- Private vehicles are called in case of delayed response of 108 to transport women from home and between facilities for which payments are made from Untied Grants especially for BPL clients.

Mobile Medical Units (MMUs):

- MMU services are provided through KHSDRP under PPP mode throughout Karnataka and different NGOs run it in Districts.
- MMUs are manned by one medical officer, one staff nurse, one assistant and one driver.
- Each MMU's visit schedule is fixed in advance and the MMU conducts field visits as per the schedule. Each MMU covers 12 Villages/week, i.e. 2 villages per day provides health care services to unreached, under served, tribal, Tandas & Remote areas in the district with service guarantee to the population living in these areas.



Mobile Medical Unit, Shhigaon Block

- Services provided include – OPD, laboratory investigation, medicine & family planning consumables distribution, follow-up, counseling, referral and screening.
- Monitoring: NGOs submit monthly reports to District Health Officer.
- Cost per month per MMU is around Rs.1.50 Lakh.

IEC/BCC:

- Mostly IEC displays were put up inside the hospitals/Centres. Putting these displays near targeted beneficiaries can attract more number of the patients.
- Visibility of IEC-BCC activities in facilities and community was poor, especially prominent visible display of IEC material on JSSK entitlements was found not available across facilities. In addition, display in general public areas such as main roads, critical junctions is rudimentary.
- The Karnataka Guarantee of Services to Citizens Act-2011 is displayed prominently in most of the health facilities in both of the districts. However, prominent display of Grievance Redressal System and Citizen's charter is not seen in most of the facilities.
- For grievance redressal 104 system exists for registering complaints and feedback but needs awareness amongst the masses. A patient help desk was found operational in District Hospital, Haveri which is run in PPP mode and caters to grievances of DH. But the grievance redressal system at other facilities was found to be generally inactive.
- Facility based essential drug list were not displayed at all level. Although, a list of general drugs which are available at the facility was displayed.
- During the discussion with the patients and people in the districts/blocks/villages, it was reported that there was no activity related to informative skits or other awareness generation practices for the betterment of the villagers preventing them from common diseases. However, the role of ASHAs cannot be overlooked in terms of BCC.

AREAS OF IMPROVEMENT:

- Inter-Block Disparity in distribution of facilities and variation in utilization of same category facilities.
- Residential Facilities in facilities especially at 24x7 PHCs needs to be strengthened.
- Delay in completion of major construction works undertaken under NRHM is a cause of concern.
- In-patient and emergency care services needs to be strengthened.
- Service Delivery at SCs needs to be reassessed and explored.

- CHCs & FRU THs needs to be made fully functional with special focus on under-utilized facilities.
- The Blood Storage Units in both districts needs to made functional.
- Salary of contractual AYUSH Doctors is low and regular availability of AYUSH medicines in facilities needs to be ensured.
- Dietary provision to in-patients in facilities needs improvement, especially to mothers.
- Privacy needs to be given adequate attention.
- Waste segregation at source needs improvement.
- Number of Instances of “deliveries in-transit” is an area of concern.
- Drop back services need strengthening.
- Bill boards outside facilities not present across all facilities and Grievances Redressal mechanism has to be made functional in facilities.
- Facility based EDL needs to be displayed at each of the facility.

RECOMMENDATIONS:

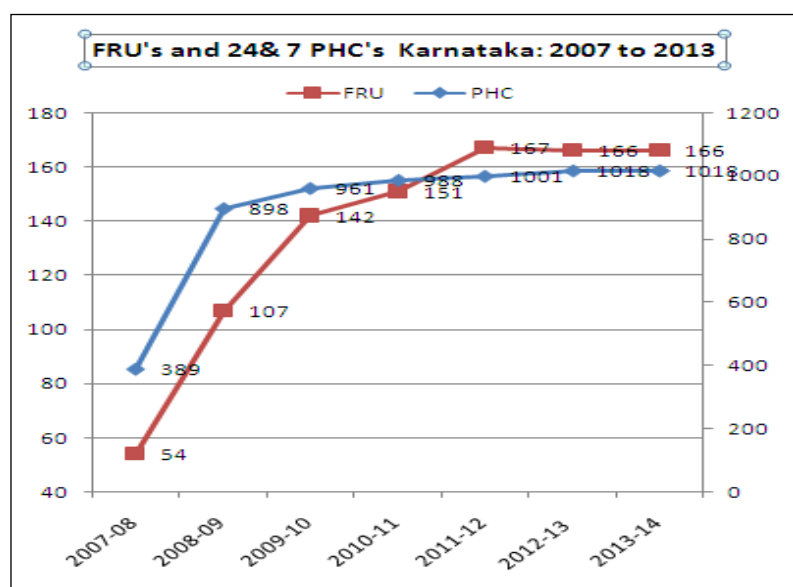
- There is a need to optimize utilization of lower tier facilities to reduce burden on higher facilities like TH/SDH & DH.
- While planning for new facilities, due consideration to be given to terrain underserved population and travel time to reach the facility. Standards of equitable distribution of existing health facilities within the blocks in the district should also be maintained.
- Due importance should also be given by state administration on residential facilities especially for the staff of 24x7 functional PHCs in the district.
- SCs potential needs to be fully explored. Additional plans for service provision and screening of non-communicable diseases can be tested at sub-Center to counter the changing disease profile in the State.
- AYUSH doctors may be increasingly involved in National Health Programmes after required training while practicing their own systems of medicine.
- The AYUSH patient data may be included in the facility data separately.

- The regular supply of AYUSH medicines is required to be provided to the co-located facilities and remuneration of AYUSH doctors under co-located facilities required to be enhanced.
- State should progressively shift towards providing free laboratory & radiological investigations and must abolish the practice of user fees for all patients utilizing public health facilities.
- Blood storage units and C-sections facility needs to be made functional in CHCs, THs.
- Diet provision to in-patients must be improved, especially diet for pregnant and delivered mothers must be ensured.
- Privacy of patients needs to be taken care.
- The bio medical waste segregation at source needs improvement. Sensitization on waste segregation needs to be enhanced among health functionaries and deep burial for disposal of sharp waste need to be given due importance at all levels.
- Improve awareness about the referral transport and drop back facility among ASHAs and beneficiaries.
- Need to do extensive IEC for increasing the awareness of the JSSK entitlement amongst the beneficiaries.
- IEC-BCC activities in facilities and community needs more visibility, especially prominent visible display of IEC material on JSSK entitlements is needed across facilities. Grievance Redressal System needs to be strengthened.
- Coverage of it as part of mass media campaign, through hoardings, wall paintings etc, apart from other mass media modes, are adequately needed for the delivery of the message of free entitlements.

TOR 2: RMNCH+ A

OBSERVATIONS

- **Delivery points and First referral units:** Continued efforts to increase the number of delivery points and functional first referral units is seen in the state as depicted in the graph below. 54 FRUs in 2007 to 166 in 2013 and 389 PHC's (24*7) in 2007 to 1018 in 2013. The expansion and inputs from NRHM are very much visible in the state. Labor room nurses are SBA trained, Partographs are being maintained, good visibility of



Operationalization of delivery points

Technical protocols, and emergency obstetric drugs were available in Labor room.

Continued thrust on the institutional deliveries in the state due to various national and state initiated schemes has brought IDs to the level of reported 98% deliveries in institutions, increased from 63% in 2005-06. Apart from Govt's **Janani Suraksha Yojana**, **Janani shishu suraksha karyakram**, Govt of Karnataka instituted programmes namely, **Thayi Bhagya & Thai plus** (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 Thai Bhagya** (cash assistance to BPL/SC/ST for delivery in private institutions) and **Prasooti Arai ke** (State incentive for nutrition and medical care) . **Samootha Seemantha** programme (Community bangle ceremony to promote ID)

- **Institutional deliveries:** Continued thrust on the institutional deliveries in the state due to various national and state initiated schemes has brought IDs to the level of reported 98% deliveries in

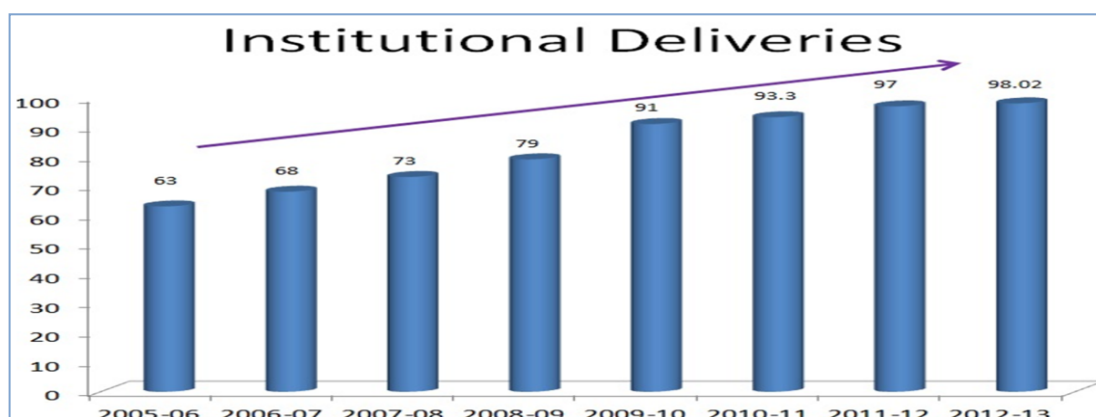


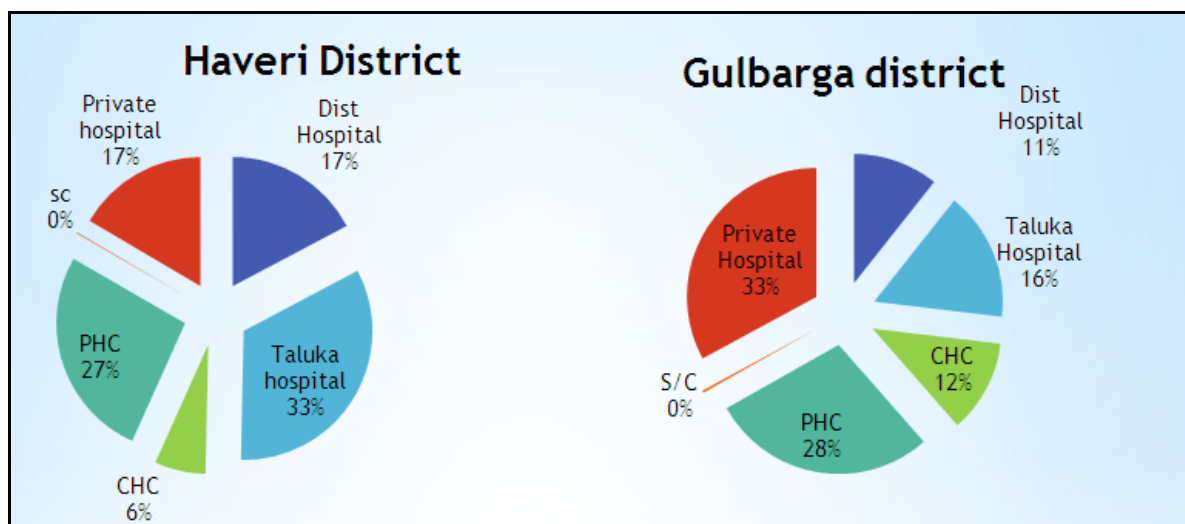
Figure 1: Trend of institutional deliveries, Karnataka
2005-06 to 2012-13

- District Gulbarga caters to a total 2566326 population, out of which 1730731 rural and 835596 urban. As per IPHS norms, there is a need of 2 CHCs, 7 UHCs and 19 SCs more health facilities in the district.
- There are 68 (1 DH, 6 FRUs/THs, 15 CHCs, 42 PHCs and 4 SHCs) designated delivery points in the Gulbarga District. Although, district has made all the PHC 24x7 health facility, but some (12%) of the PHCs not achieved the norm of delivery point, which needs attention.
- There are 49 designated delivery points at Haveri district 37 are PHC's. Only two 24* 7 PHC (Aralashwar and Shyadaguppi) have consistently less than 10 deliveries per month; rest are performing well.

Delivery points										
Name of the District	SC	PHC	24x7 PHC	CHC	CHC-FRU	SDH	DLH	DH	MC	Total
Haveri District	0	2	35	4	1	6	0	1	0	49
Gulbarga District	6	0	40	15	0	6	0	1	0	68
State	50	35	594	113	13	136	8	20	10	979

- In Gulbarga district out of total reported deliveries, 67.13% deliveries are in Public facilities. Of the total institutional deliveries in public system, 0.45 % are reported in the sub centres. 42.17 % of total institutional deliveries in public system are reported at PHC level. Of the total deliveries in public facilities 17.36% are at CHC level, 24.12 % are at Taluka level and 15.9 % are at DH level. Further the inter block variation in access of delivery facilities is far and wide table below.

Figure 2: % Deliveries at different institutions, 2012-13



- In September, of the total deliveries of 3011, 652 deliveries (21.65 %) were through Ceseurian sections. The LSCS rate is in higher side. Ceseurian sections. During October at DH Gulberga of total 459 live deliveries, 96 was through C sec (20.91%) , 11 birth was reported as Intra uterine deaths(IUD). The two FRUs Sedam and Jewargi conducted 2 and 4 Cesarean sections respectively in Apr-Oct, 2013. On the other hand in the same period 3325 Cesarean sections were conducted in private accredited facilities in the district.
- Of the 76 24X7 PHCs in the districts – 52 are performing more than 10 deliveries per month, range of 66-10. Moreover 24 are performing less than 10 deliveries per month, range 9-4.
- Blood used in the District is from the District hospital. Of 1389 blood units collected, 1274 were issued, and out of these 590 units used for ANC & PNC. In SedamTaluka Hospital 2 units were used for LSCS, 5 for PNC, 18 ANC at JewargiTaluka Hospital– 2 used for LSCS, 9 PNC, 11 ANC.

- ANC care: In Gulbarga district, 55.28% of women receive ANC care. Of them, 58.73 % received 3 ANC checkups. There are Block variations. *Available ANC register records do not reflect provision of either the service delivered in each ANC visits nor the 3 ANC details. Monitoring and supportive supervision for maintaining ANC needs attention. Tests for mother and newborn at facility are not universally available.* Line list of severe anemic women is not maintained at the PHC and SC level
- Maintenance of labor room records needs improvement e.g. Indication for c-sections not mentioned in all facilities.
- The labor room beds do not have mattresses and privacy in some facilities is an area of concern.



Labour table without mattress

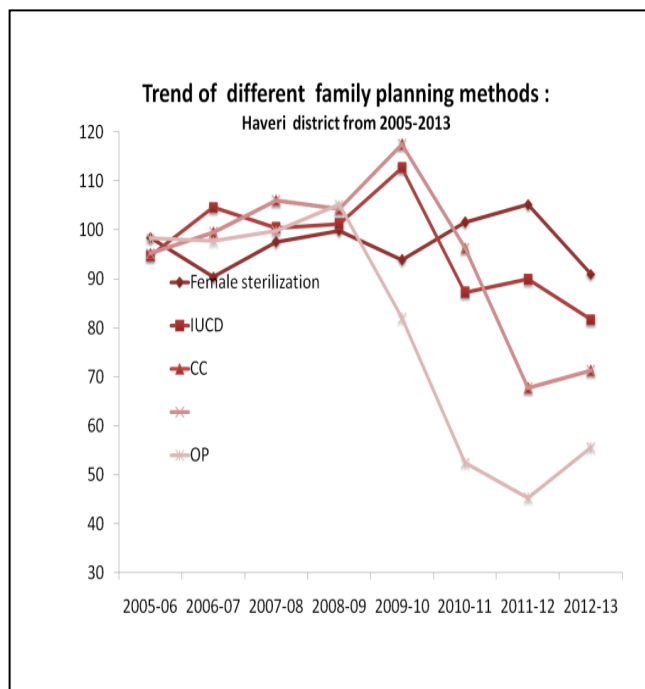
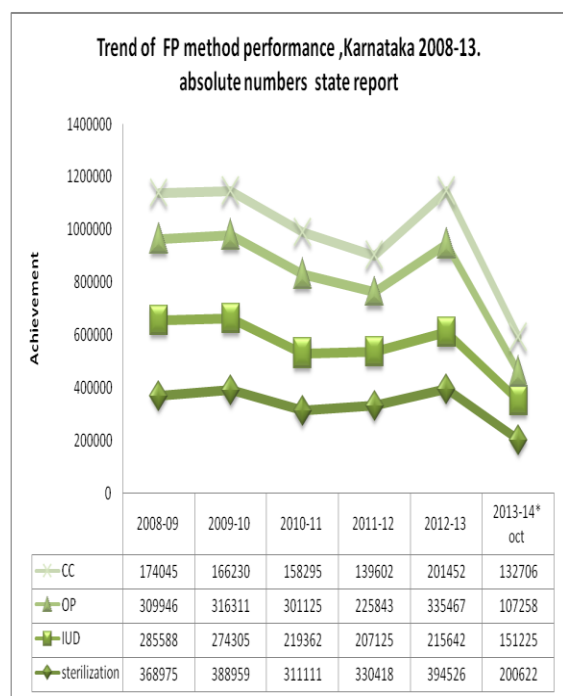


Emergency protocol in LR above eye level

Family Planning

- Facilities for sterilization and IUCD are available through fixed day approach once in a month at PHC level and weekly basis at FRU's. As per DLHS 3 contraceptive prevalence rate of the state is 62%.The trend as per state reported coverage the IUD and sterilization performance declined in 2010-11 and 2011-12 improved in 2012-13 and shows low performance 2013-14 till October.
- Proportion of male sterilization is very low (< 2%). 98% are female sterilization. Only 1 Vasectomy is done out of total annual target of 96 cases in Gulbarga district and 2 cases in Haveri district against the target of 1450.
- Acceptance of spacing methods is poor in both districts.
- PPIUCD not taken up for implementation. Apparently training in PPIUCD has been initiated by the State.
- OBG specialists are not oriented towards counseling /providing services for post-partum methods(PPIUCD/PP sterilization)

Trend of FP method performance ,Karnataka 2008-13. absolute numbers state report



- RMNCHA+ counselors are not available at DHs.
- **Safe abortion services** is a weak area-Medical abortion drugs not available at any level.OBG specialists are using outdated technology(E.g. D& C) Safe abortion Services are only in FRU by specialists, Safe abortion services are not available at 24*7 PHCs.

Child health

- The state had established 1386 newborn care corners in all the delivery points. 178 NBSUs at FRUs mainly at the taluk hospitals,33 SNCUs at District level .
- These are functional in both the districts where team had visited. In district Haveri a SNCU in the district hospital,NBSU's in all 7 FRU's and 37 NBCC's in all delivery points are functioning.
- Equipments for essential newborn care e.g. radiant warmer available.

SNCU in district hospital Gulbarga

- In the District Hospital, 14 bedded SNCU is functional divided in 2 wards (6 bedded + 8 bedded) headed by a Pediatrician, who is supported by 12 Staff Nurse, and these SNs were specially trained for 3months to care the sick newborns at Indira Gandhi Institute of child health Bangalore during May 2010 to Aug. 2010.
- At the time of visit 10 new born were admitted. On an average 100 to 120 sick children per month were admitted. In the month of July and August 128 and 152 sick newborn admitted respectively. During the month of Oct. 2013, there were 97 (63 inborn and 34 out born) total admissions and 11 deaths. 15 children were also followed up during the same month.
- In SNCU of 804 total admission, in April to October, 2013 (62.18 % is inborn admission). In October 2013 of the 97 children were admitted (59 male 38 female) show gender discrimination in admission. 30 admissions were reportedly due to birth Asphyxia.



Sick newborn care unit, Gulbarga



RoP screening at SNCU

- District Hospital is equipped with 10 bedded **NRC** headed by a trained medical officer and support staff which includes 4 staff nurses, 1 nutrition counselor (part time), 2 attendants, 1 cook and 1 sweeper. The nutritionist was previously full time but this year it is converted into part time. During the month Oct. 2013, total 30 children were admitted and 20 children were discharged after gaining target weight.
- **SNCU Haveri:** Infrastructure as per guidelines, 12 SNs, 2 trained MOs, 1 pediatrician. Supplies and consumables were adequate. No central oxygen supply, AMC is available but from State level. Large number of admissions are inborn (60-70%), and of NBs with birth asphyxia (1/3rd). 10- 12% mortality in SNCU. Universal ROP screening is in place.
- NBSU's were visited at Shiggoan and Byadagi taluka hospital were functioning, trained pediatrician and stays in head quarters. Phototherapy units, Embrace kit radiant warmer Ambu bag, laryngoscope, ET tubes, infant feeding tubes, emergency drugs are available
- staff were SBA trained. High risk pregnancies are handled here Community follow up. (Total number of deliveries in the last month in Shiggoan Taluka hospital were 102. Eleven were admitted and treated in NBSU, Cumulative in the year 74/539).

- NBCC at PHC TADAS: It is delivery point (24*7PHC) catering 19530 population 18 villages, 4 sub centers. Labour room was well maintained partographs were being used. protocols are being maintained NBCC is functional and Nurses are SBA trained.
- NRC at the district hospital been set up in 2012-13, 20-25 children per month gets admitted. average stay is around 15 days. 4 SNs , No MOs , pediatrician in District hospital taking care of NRC. The parents of the admitted children conveyed to team that they have been referred from Anganwadi worker. Diet chart present. Nutrition counselor position is vacant

State Innovation RoP at SNCU

- SNCU's are covered under the PPP service delivery with Narayana Netralaya.
- Till September 2014 871 new borns were screened – (1414 sessions, 205 child found with RoP, 44 of them treated).
- In October 81 new born were screened (272 sessions, 17 were found with RoP, 2 treated).
- Weekly visit plan resulting in 40% dropout in first contact.

ARSH & School Health

- Adolescent health counseling services is being provided in the district with the honorarium given to ICTC counselors for ARSH activities.
- Counseling to adolescents, who are visiting the OPD, is being provided at ICTC or in the general OPD.
- Biannual de-worming and weekly supplementation of Iron tablets under WIFS (not the blue tablets) is reported on every Monday to school going children.
- Sanitary Napkins under Menstrual Hygiene is initiated to school girls.
- School Health Programme in its new shape i.e. RBSK is still to be implemented in the district.
- Recruitment of RBSK mobile health teams for screening teams is partial and setting up of District Early Intervention Centers (DEIC) is still to be conceptualized.
- Trainings of the RBSK teams not yet planned because recruitment of teams is not completed in the district.

- Sneha Clinics (ARSH): The adolescent service provision is not up to the mark in health facilities. E.g. In CHC, Rittihali Sneha clinic is not at all conducted.
- RTI/STI: Combikits for syndromic management only available at STI clinic of DH, not available at Sub District level health facilities.

Care of mother and child:

- Most facilities visited in the district had provision of laboratory services which offered a range of bio-chemistry, pathology and micro-biology tests based on the level of facility. LTs from different programmes have been oriented and multi skilled for conducting all types of lab tests. Routine investigations such as Hb, blood sugar, urine are being conducted in most facilities designated as delivery points.
- The quality of ANC was poor, in the MCH register all the details related to weight and BP of pregnant women were entered but scrutiny of these registers showed many discrepancies. First, the weight gain over three ANC visits for most registered women ranged from 0-1 kg. Second, for pregnant women the BP was recorded uniformly as 120/80 mm Hg for all cases. All the health facilities (including sub centers) where ANC was being provided were having functional equipment's for measurement of both weight and blood pressure.
- The interaction with the pregnant women revealed that during their ANC visits they are given inj. Tetanus Toxoid (TT) and 50-100 tablets of Iron Folic acid; and weight. All these women said that BP measurement, Hb and abdominal examination were not done during their ANC check-up.
- Equipment for Hemoglobin estimation, urine albumin and blood sugar testing kits, delivery equipment are found unutilized at some of the SHCs in the district.
- Line listing of high risk mothers especially for hypertension, gestational diabetes needs to be monitored by the immediate supervisors.
- As far as maternal health is concerned, all PHCs in the district are providing 24x7 delivery services and staffed with 3 Staff Nurses. 40 PHCs are conducting 10 – 25 deliveries per month while 7 PHCs are conducting more than 25 deliveries in a month

in the district. The emergency drug trays too were found to adequately and appropriately stocked with all emergency drugs.

- Labour rooms equipped with functional new born baby corner up to PHC level.
- Partographs were available at all labor rooms and they were attached for labor case sheets. However, protocols related to Active Management of the Third Stage of Labor (AMTSL), Eclampsia management, and New-born resuscitation needs to be displayed properly.
- Interviews with post-natal women at the facilities revealed a high degree of satisfaction with the quality of services received.
- C-sections are taking place at District Hospital only. No C-sections are taking place at FRUs/CHCs at Gulbarga district because of non-availability of specialist at these facilities. In Haveri 2 talukas dont have LSCS facility
- Blood bank found to be maintained properly with adequately trained staff & records. Temperature monitoring and monitoring of expiry date of each of blood was done meticulously by the staff.
- Blood Bank is functioning at the District Hospital Gulbarga and Blood Storage Unit at SDH/GGH Jewargi only in the district no other public health facility have BB/BSU. There is a need to establish more BSUs especially up to FRU/CHC level with sufficient no. of blood bags in the districts.
- The coverage for postnatal care was poor. During postnatal period ANMs were conducting any home visits for care of the delivered woman and her newborn. While scrutinizing the records maintained by ASHA it was noticed that ASHAs were keeping the record of all the children immunized, type and number of doses of vaccine received and due, but such a record for home visits for postnatal care was not available with her.
- *HBNC visit has started in some SCs. The KIT of the HBNC visit does not comply with the ASHA HBNC kit guidelines. The equipment in the HBNC are battery operated however the ASHA coordinator at the district does not have a stock of button cells for these equipment. Record maintained for HBNC however indicate many women are not staying for 48 hours in facility especially in PHC level.*

- Delivery points except District Hospital Gulbarga, providing just midwifery services in the district, but the entire range of RCH services as appropriate to that level, with a focus on services for MTP, family planning and care for the newborn and sick child was missing.
- MCTS implementation is poor, timely registration of a pregnant woman on MCTS portal needs to be given due importance. Child data entry maintained in the B section of Thai card is less than the percentage of delivery data entry.

Janani Suraksha Yojana (JSY)

- The women delivering at the health facilities are provided with JSY benefits and they are aware about JSY benefits.
- Most women stayed 48 hrs. after delivery at the District Hospital and FRUs. Payments to the beneficiaries being given to mothers immediately after delivery to the mothers. However, on the scrutiny of the JSY register at PHC level health facilities, delay in payment was observed in some of the PHCs.
- Blank cheques signed by the Medical officer at CHC/PHC level for payment of JSY were also found in some of the facilities.
- It is also observed that bearer cheques are still being issued to beneficiary for payment of JSY in most of the facilities in the district.
- Aadhar number based Direct Benefit Transfer (DBT) in bank account of the beneficiary is not implemented in the visited districts. However it is been started in few districts in the state.

Janani Shishu Suraksha Karyakram (JSSK):

- JSSK guidelines have been provided to all the health facilities in the district and concerned health functionaries have been made aware about the JSSK entitlements. However, interaction with beneficiaries and their attendants revealed that they are less aware about JSSK entitlements.

- JSSK entitlements are largely available to all the beneficiaries at all the health facilities except the drop back facility and diet in some of health facilities.



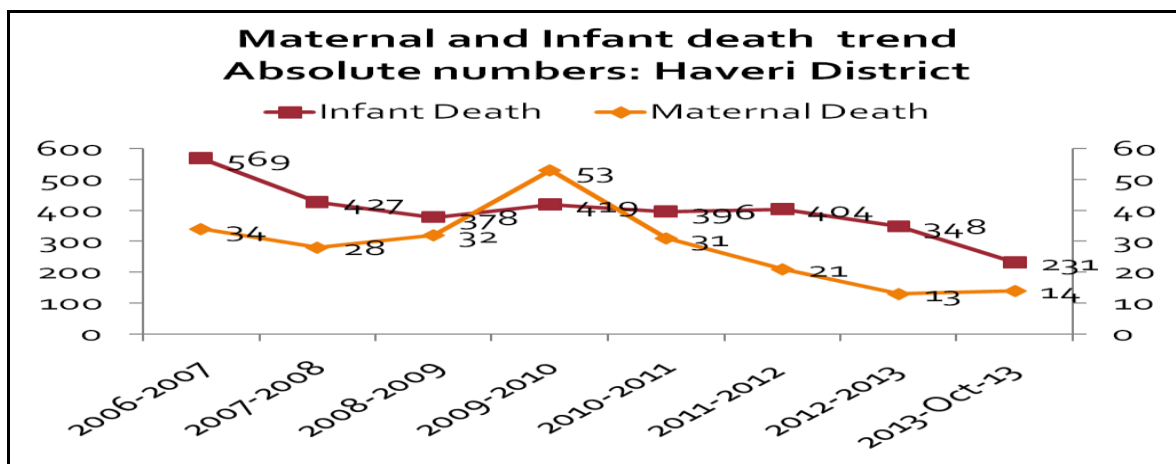
- Community level interactions with slum women in Gulbarga district revealed discrepancies in the free entitlements related to diagnostics, where payments are charged to JSSK women, who displayed copies of receipts.
- There is limited IEC material found on JSSK entitlements in the facilities visited in the district.
- There is a need to make available of grievance redressal systems for JSSK with other public grievance redressal mechanisms at all the health care facilities in the district.
- Drop-back availability and awareness is poor.

Prasuthi Araiike Programme is a state initiated scheme and very popular among the beneficiaries.

Maternal and Infant death review

- State had initiated incentive for reporting maternal death hence the reporting improved since 2008-09
- In the month of September there were 3 maternal deaths in Gulbarga district all are from Chittapur taluka and due to PPH and with Multiple referrals and tendency to avoid risk.
- Orientation of service providers and frontline workers on community based MDR needs to be implemented.
- Quality of review at district level needs improvement in identifying and addressing systemic gaps than creating a fear of punitive action in service providers and frontline workers
- Documentation related to Maternal Deaths as per the Standard MDR formats is of poor quality.

Figure 3: Maternal and infant deaths trend, Haveri district 2006-2013



- In the state 32% of deaths in Infants are due to Birth Asphyxia and 23% are due to low birth weight in infant deaths in 2013-14 (till Oct).
- In the year 2013 till October district Haveri had 231 infant deaths and Gulbarga had 500. Out of 500 infant deaths in Gulbarga 471 were delivered in Institution. 372 deaths took place at Hospitals. 141 deaths was due to birth asphyxia.

- Use of corticosteroids in preterm labour is not yet universalized. Vitamin K is not given at birth in all facilities

AREAS OF IMPROVEMENT:

Infrastructure ,HR ,Services	Quality
Non-functioning FRU s at Gulbarga, EMOC services	Quality ANC, PNC, HBNC. (E.g. Maintenance of labor room records needs improvement)
Unavailability of Safe abortion services/MTP services in PHC level. (Close to the doorstep of women)	Line listing of high risk pregnancies
FP coverage.PPIUCD post-partum methods(PPIUCD/PP sterilization)	Drop back facility and diet in JSSK
SNCU central oxygen supply, repair of equipment	User charges to BPL beneficiaries
NRC : Less admissions.no nutrition counsellor	Quality of Maternal and Infant death reviews
RBSK –Recruitment,Training and DEIC	MCTS

RECOMMENDATIONS:

- Filling of vacant posts of specialists especially OBG, Pediatrician and Anesthetist at CHCs and GGH/THs level needs to be given due preference. Amendment of Article 307 J may be helpful; however contractual staff recruitment may be the short term measure under NRHM to make facilities operational.
- Completion of pending infrastructures is essential to address infrastructural disparity. It may be important to make these facilities fully functional. If the lower tier facilities can be made fully functional pressure on the higher facilities and that too for normal deliveries can be addressed adequately.

- Monitoring & technical supportive supervision for quality ANC services and for adequate maintenance of records and reports. Hb estimation services through line list of anemic women needs to be provided to each service delivery levels.
- PNC care needs to be strengthened with appropriate supervision and monitoring.
- Each infant death needs to be reviewed along with maternal death and surrounding community to be made aware regarding causes of death. Discussion on causes of death should also be taken place during VHND session.
- Monitoring and supportive supervision and more importantly action taken report follow-up needs strengthening in line of GoI guidelines from SPMU, DPMU and BPMU levels. Monitoring visits at all levels should be made mandatory and to be made part of District and Block action plans and reviewed regularly. Monitoring visits would also help in ensuring that PIP action plans are being properly implemented. The Zone level programme management infrastructure under public health personnel may be reinstated which would address the geographic spread of the State of Karnataka.
- The Thai card number can be used as UID across the ANC register, 108 network, labour room record and HBNC so that quantum and quality of service entitlement delivered to individual woman can be accessed.
- Sukshema may also be rolled out to other districts of the State for data.
- The delivery record in duplicate as being piloted by Sukshema project in the Gulbarga District can be mainstreamed as delivery room record. One copy of the record can then be handed over to emergency referral vehicle personnel who without the record, as at present do not have many details on the condition of the mother. Further such a system would also help the receiving facility about the patient condition upfront.

- Family planning, especially PPIUCD and availability of Spacing methods at door step through ASHAs, should receive attention and closely monitored.
- Action plan should be prepared for creating awareness and motivating clients both at community and facility level about spacing methods as well as terminal methods especially in high TFR districts.
- Fixed day services may be extended up to Sub Health Centre (SHC) level.
- Safe Abortion Services in public Health system may be made available.
- Community involvement in planning, implementation and monitoring needs to be encouraged.
- Adolescent health services needs to be strengthened with creating separate Adolescent Friendly Health Clinics (AFHC) and ARSH counselors.
- RBSK implementation in the districts to be planned according to the RBSK guidelines for timely roll out of the scheme as per RoP conditionality.
- The accreditation of SNCUs by reputed agencies like NNF could help to improve and maintain the Quality of Care in SNCUs
- State should go for SNCU software so that the reports could be child based and will help better monitoring

Immunization

OBSERVATIONS

- **Status:** As per CES 2009 full immunization coverage (FIC) for Karnataka state is 76.7% placing Karnataka at the 6th position in Immunization performance in the country. As per DLHS 3 there is disparity among the Full immunization coverage(FIC) between

northern and southern districts. As per HMIS, Full immunization coverage in the state for the last three years are 96.80 %, 94.93 % and 91.86% during the years 2012-13, 2011-12 and 2010-11 respectively.

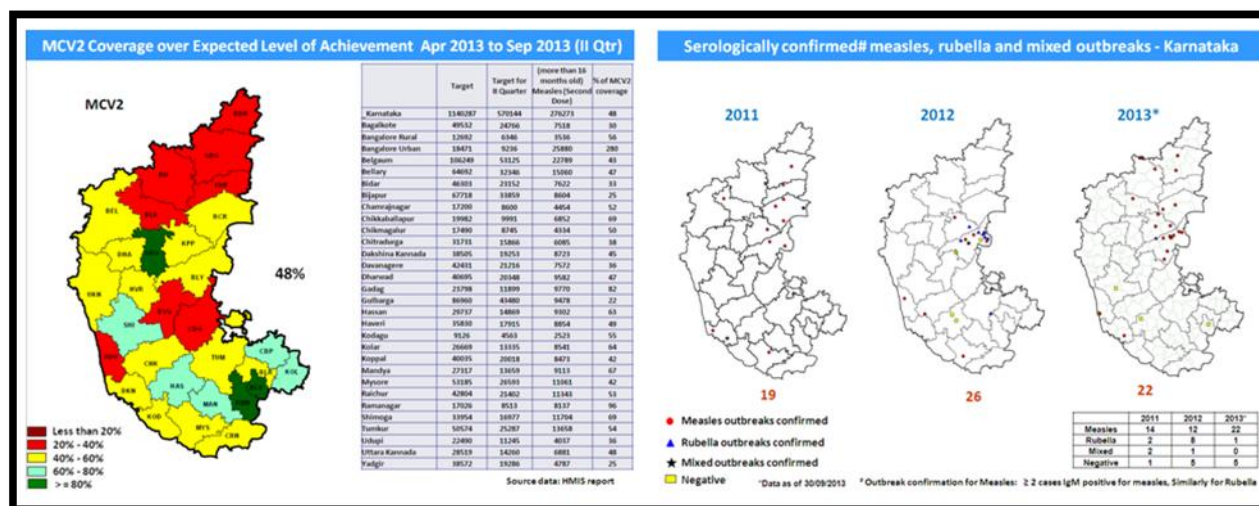
- **Cold chain system:** There are 2419 cold chain points in the state. Each cold chain caters for an average population of 24000. Cold chain space is adequate at the peripheral level; there is a need of more space at state vaccine stores. As per EVM study report the available cold space at state vaccine stores Bangalore for the immunization schedule is only 58% adequate. Sickness rate found to be 2%.
- NCCMIS: National cold chain MIS not getting updated regularly, last date when website accessed by the state was on 25th August 2013 (source: website). Cold chain technicians' vacancies still exist in the state. Cold chain technician tool kit is not available with 80% of CCTs.
- Cold chain handlers training are incomplete in the state.
- Micro planning exists at every level, Health workers are trained ASHA's are involved in community mobilization. Incentives for mobilization are being given to ASHA's. Immunization sessions are being held on every Thursday at PHC HQ and outreach, Monday and Thursday at CHC/TH and every day at District hospital. Immunization sessions planned vs. held is > 100% for the last year. Birth dose of OPV Hepatitis B and BCG been given for the institutional deliveries the team observed which are being given on 2nd to 4th day of the birth.
- Open vial policy being followed the team noticed the date of opening the vial is not written on the vial which needs to be mentioned to discard the vial after one month.
- State had taken initiative to recruit 41 Immunization field volunteers (IFVs) for RI monitoring. The concurrent monitoring and feedback will facilitate the improvement of the programme components.

AREAS OF IMPROVEMENT:

- **Dropout rate:** As per HMIS data presented by the state depicts +30% to -30%. More than 10% of dropout rate is a concern, Negative dropout rate (DPT3 more than DPT1) raises the question on HMIS data quality. The due lists preparation and usage of the

same to track the beneficiaries needs further improvement. **Duelists** are not available in 70% of sessions monitored by external monitors. All vaccines were not available in 16% of the sessions. MCTS registration is only 39% in the state.

- **MCV2 coverage** : Although the MCV2 introduced in the RI in the state in 2011 the coverage is 48% .Considering continued measles outbreaks in the state as shown in map below ,there is need of improvement of MCV2 coverage or considering catch up campaign in the northern Karnataka.



- **Review of the immunization programme using HMIS data:** Program officers at every level are finding a difficulty in reviewing the program performance using HMIS data as the data is not consistent and comprehensive. Numerator does not represent denominator and gives invalid indicators like negative drop-out. Program managers are relying on area based RCH reporting which is also used for KDP review meetings. There is disparity between the facility wise and area wise reports even at the district level. HMIS does not capture the data completely from private sector immunization and children immunized in neighboring districts. Area wise reporting helps in review as the denominator is clear. Hence state need to plan for an operational research to easy facilitation of the monthly/quarterly review at PHC level / Taluka / district level program managers and identify the low coverage areas.
- **Immunization in Private sector:** Districts are giving vaccine to the private pediatric clinics/hospitals and collect the data and incorporate in their reporting, but it is not

uniform and consistent. Quality of cold chain maintenance, and data capture are the areas needs attention in the private sector.

RECOMMENDATIONS:

- Decreasing the dropout rate and increasing the full immunization coverage needs strengthening by preparing due lists and tracking the beneficiaries and mobilizing them for vaccination.

Chickballapur pilot (Immunogram): Improves the coverage, addresses the drop outs, helpful for weekly/monthly RI review and monitoring and ensures the quality. It gives child specific drop-out rates hence there is no chance of getting negative rate, thus the indicator is valid and can be used for programme review and improvement. It helps in rapidly closing the immunity gap. It is a good initiative from the state.

- Improving MCV 2 coverage and decreasing measles outbreaks, Training to ANM's, Regular review of the coverage and feasibility of ***measles campaign in high risk blocks of northern districts*** with consistent measles outbreaks over the years need to be explored .
- Immunization field volunteers recruited for RI monitoring can be assigned with role supportive supervision, capacity building of frontline health workers, training, components of the Immunogram pilot of chikballapur in order to reduce the drop outs.
- State specific Effective vaccine management (EVM) study to be conducted to find the gaps in cold space for the vaccines at every level, vaccine logistics management, temperature maintenance, equipment maintenance, stock management etc.
- *An operational research* to find the difficulties in coverage review at sc/phc/taluka and district and mechanisms to evade the disparities between facility wise and area wise reporting
- Develop mechanisms to monitor the quality in private sector immunization and data capture.

TOR 3: Disease Control Programme

I. Communicable Disease Control Programmes **(IDSP, RNTCP, NVBDCP, NLEP, Others)**

Integrated Disease Surveillance Programme (IDSP)

OBSERVATIONS

- State surveillance and district surveillance units are functional in the state. Reporting percentage across the state has shown an increasing trend over the years with more than 85% (S-form), 90% (P-form) and 87% (L-form) reporting in the latest available data. IDSP data is being regularly used for action plan preparations at district and state level. Regular outbreak alerts are generated and in-place rapid response teams are acting as per the protocols. Key contractual positions have been filled. IT infrastructure with trained manpower is available for data analysis and dissemination. State and district public health laboratories are functional. Programme is reviewed regularly by the concerned officials.

AREAS OF IMPROVEMENT

- Some regular posts like microbiologist and senior laboratory technicians are vacant in the districts visited by the team. Ayush facilities are not reporting under IDSP. Reporting from private facilities is less than expected.

RECOMMENDATIONS

- Vacant regular positions need to be filled up to strengthen the programme. Ayush facilities should also report using the IDSP portal. Private sector reporting under the portal needs strengthening.

National Vector Borne Disease Control Programme (NVBDCP)

OBSERVATIONS

- Malaria and JE cases have shown declining trend in the state whereas Dengue & Chikungunya cases have shown increasing trend during last two years. Total malaria cases detected in 2012 were 16466 whereas till October 2013, it is 10,613 with no deaths during these years. Similarly, confirmed JE cases have reduced from 23 in 2011 to 1 in 2012 and 3 in 2013 till October with no mortality. Dengue has increased from 3924 cases in 2012 to 5961 cases in 2013 (till October) whereas Chikungunya cases from 2382 in 2012 to 4585 in 2013. Lymphatic Filariasis is targeted for elimination from the country and 8 districts of Karnataka are endemic in which the elimination strategy of annual mass drug administration with DEC + Albendazole is being implemented since 2004. The coverage of population covered under MDA has increased to around 90% which has resulted in reduction of microfilaria rate from about 1.9% in 2004 to 0.6% in 2012. Three districts have qualified for validation test to stop MDA. The remaining districts have been targeted for MDA in 2013-14 rounds and will prepare for validation test subsequently. The validation is through Transmission Assessment Survey (TAS) as per WHO guidelines.



AREAS OF IMPROVEMENT

- District VBD officer post is vacant in the districts visited. Urban malaria control is currently not addressed in totality. IEC activities concentrated in hospitals. Cross checking is regularly done and feedback from state lab is received but sometimes delayed. Most of the times only negative slides are picked owing to a large number of negative slides examined to reach targets. In the districts visited, the practice of given giving chloroquine as presumptive treatment was found. The revised guidelines for management of malaria are not yet followed.



RECOMMENDATIONS

- Programme manager for VBDs is a crucial position currently run by the district surveillance officer. A dedicated full-time officer for VBDs should be in place and trained in districts with vacancies.
- IEC activities need to be focused to reach the correct target population. High risk districts for Malaria where Pf percentage is more need focused attention. The Problem of urban malaria has to be tackled for which the local body and municipal corporations need to be thoroughly and regularly sensitized. The activities need to be monitored on monthly basis.
- Visibility of the programme need to be intensified through social mobilization and sensitization activities at all level including ASHAs, Village Health & Nutrition Day, sub-centre, Rogi Kalyan Samithi, Taluk and district level meetings.
- Priority for VBDs should be given especially on source reduction, implementation of NVBDCP strategy and targeted disease for elimination i.e. Lymphatic Filariasis in the state. Three districts qualified for validation should finish TAS in this year as per ROP.

- Some mechanism needs to be developed to cross-check a proportion of positive and negative slides.
- Entomological surveillance needs strengthening and entomologist located at district under IDSP needs to perform the activities according to the need of NVBDCP and submit the monthly report to VBD officer. Vacant entomologist posts have to be filled on priority.
- The revised guidelines of malaria management are to be disseminated and monitored for effective implementation.

Revised National Tuberculosis Control Program (RNTCP)

OBSERVATIONS

- RNTCP in Karnataka is performing moderately. Treatment success rate is showing an increasing trend with 83% success rate among new smear positive case in the latest report. New case notification and total case notification rates are on a declining trend mainly owing to low number of smear negative and paediatric TB cases. Default rate of 6-7% and death rate of 5-6% are the reasons for the state not reaching the minimal expected target of 85% success rate. Proportion of paediatric cases of the new cases is 6%. Nikshay case based web based data entry of treatment cards more than 90% but some districts are not updating all the sections of the treatment cards. TB notification order has been disseminated to all the stake-holders. Nearly 60-70% of the private health establishments have been registered but very few practitioners are notifying TB cases. PC-14 and PC-16 paediatric drugs and Isoniazid 100 mg were found to be inadequate in the districts visited. State has scaled up MDR-TB/ PMDT services and covered the whole state with DR-TB services. RNTCP is heavily dependent on the contractual staff (STS/ STLS/ TBHV). General health staff ownership is lacking. Currently the programme is reviewed seriously by DTO only and not given due priority in THO/ DHO meetings. TBHIV coordination is excellent. Nutrition scheme to provide free nutrition to TB patients approved by the Chief Minister in the state budget but not yet executed. Most of the key RNTCP staff are in place and trained. RNTCP account is

merged with NRHM account. The number of laboratories and technicians were found to be as per norms. Laboratory consumables supply was adequate except for some procurement delays in Haveri district.

AREAS OF IMPROVEMENT

- High death and default rates need to be addressed by the state on priority. Low paediatric and smear negative case notifications leading to low total case notification. The programme is heavily dependent on RNTCP contractual staff with lack of ownership among the general health system staff. RNTCP is not reviewed on priority by the THO/ DHO and wholly done only by DTO. TB notification from private health establishments is minimal in spite of disseminating the TB notification order to most of the stake-holders.

RECOMMENDATIONS

- State has to have micro-plans to reduce death and default rates. Efforts to increase the smear negative and paediatric case notification to be intensified. Programme managers should conduct sensitization workshops for pediatricians and doctors regularly to increase case notification and better case-holding. Programme should be reviewed regularly by the THOs/ BHOs and CMOs/ DHOs. State should think of some innovative strategies to ensure monthly TB notification from private health establishments.

National Leprosy Elimination Programme (NLEP)

OBSERVATIONS

- In the year 2012-13 3368 new cases of leprosy were detected. Among these 369 were children. 3354 were declared as cured with 95.5 % treatment completion rates. Grade II disability was recorded for 132 new cases. Nearly 158 patients underwent reconstructive surgeries in referral centres attached to the districts. Deformity rate of 3.8% was recorded for the latest reporting year. There is a decreasing trend of new case

detection rate and prevalence rate over the last 5 years. Almost all the districts have reached elimination status. District leprosy officers are in place and trained. District nucleus has adequate staff. Endemic blocks are identified and intensive activities undertaken. Regular trainings are conducted as per PIP. Activities at block level are managed by the area health workers and ASHA. Adequate drug stocks were in place. The recording and reporting are happening on time as per guidelines.

AREAS OF IMPROVEMENT

- Leprosy consultant and physiotherapist posts are vacant. There is delay in supply of MCR footwear to peripheral institutions due to communication gap.

RECOMMENDATIONS

- Vacant positions have to be filled at the earliest for effective programme implementation. The communication from peripheral institutions to district and state has to be timely and correct for regular supply of MCR footwear and its usage by the patients.

Other communicable diseases

- Following are the statistics for the year 2012-13. Appropriate measures need to be taken to reduce the incidence of cases. Special efforts need to be made to prevent deaths especially from snake bites and gastroenteritis.

Name of the disease	Incidence	Death
Gastroenteritis	74663	40
Cholera	237	2
Viral hepatitis	3913	7
Leptospirosis	441	10
Dog bite	207388	13
Snake bite	9534	136
Kyasanur Forest Disease	66	0
Typhoid fever	47216	1
Handigodu syndrome	555	9

II. Non-Communicable Disease Control Programmes **(NPCB, NPCDCS, NTCP)**

National Programme for Control of Blindness (NPCB)

OBSERVATIONS

- NPCB is functioning effectively overall with established network of public and private eye operation theatres with support from hired services of private eye surgeons. State is showing an increasing trend in cataract surgeries, school eye screening, free spectacle distribution and eye ball collection. In the year 2012-13 nearly 388210 cataract surgeries have been conducted with over 22766 free spectacles distributed and 4073 eye balls collected in the state.

AREAS OF IMPROVEMENT

- Lack of specialist in the Hyderabad-Karnataka districts is a concern. There is a shortage of refractionists leading to sub-optimal involvement of schools in the programme. State expressed an issue that there is an acute shortage of ophthalmic surgeons but as per GOI directives, private doctors cannot be contracted for performing surgeries etc at the public health facilities.

RECOMMENDATIONS

- Measures need to be taken to hire services of ophthalmologists in the northern districts of Karnataka to provide timely services. Reimbursement for private doctors has to be streamlined to avoid delays in payment. Vacant refractionists' posts should be filled at the earliest.

National Programme for Prevention & Control of Cancer, Diabetes, CVD & Stroke (NPCDCS)

OBSERVATIONS

- The programme is implemented in 5 (Chikmagalur, Kolar, Shimoga, Tumkur and Udupi) out of 30 districts of the state covering a population of 8.3 million. State and district NCD cells are established and most of the contractual positions are filled and adequate training provided. Hypertension and DM screening are going on as prescribed in the protocols. For cancer screening, 3 major hospitals have been roped in under MOU.

AREAS OF IMPROVEMENT

- In the districts visited, there are no focused activities for NCDs. Management of non-communicable diseases is through tertiary centres and referral to higher centres.

RECOMMENDATIONS

- NPCDCS activities to be scaled up to all the districts phase wise. NCD cells have to be fully functionalized and effective collaboration to be established with other programmes such as RNTCP, social support schemes wherever applicable.

National Tobacco Control Programme (NTCP)

OBSERVATIONS

- The Cigarettes and Other Tobacco Products (Prohibition of Advertisement & Regulation of Trade and Commerce, Production, Supply and Distribution) Act - COTPA Act 2003 has been disseminated to various stake holders.

AREAS OF IMPROVEMENT

- No visible activities seen with respect to tobacco control programme. No tobacco cessation centres were available in the districts.

RECOMMENDATIONS

- Tobacco control activities have to be implemented by the state and districts as suggested by the national programme guidelines. Tobacco cessation centres (TCC) should be functionalized in the districts to cater to the needy population.

III. Other programmes

OBSERVATIONS

- National Programme for Prevention and control of Fluorosis (NPPF) is implemented in 18 endemic districts of Karnataka with special focus on 6 high prevalent districts. National Programme for the Health Care of the Elderly (NPHCE) is operational in the 5 districts which have NPCDCS programme. Geriatric clinics have been established in these districts with OPD facilities and 10 bedded geriatric wards in 3 districts for in-patient care. Geriatric camps are conducted in district hospitals and CHCs. Under the National Mental Health Programme (NMHP) the district mental health programmes are operational in 4 districts (Gulbarga, Karwar, Shimoga and Chamarajanagar) of the state

AREAS OF IMPROVEMENT

- Poor visibility of these programmes in the districts and low priority in the programme reviews.

RECOMMENDATIONS

- Scale up activities to cover the whole state with these services to be attempted in phase-wise in line with the national plans. Due priority has to be provided to all the programmes in performance review meetings at various levels.

TOR 4: Human Resources & Training:

OBSERVATIONS

- In order to address the shortage and availability of health human resources, Karnataka has taken up many systemic changes and innovations including enacting of new acts like the Karnataka State Civil Services Act 2011, the KPME (Karnataka Private Medical Establishments) Act 2007, development of Human Resource Management Systems (HRMS), Incentives for deployment & retention of HR, Pre-service and In-service training for HR, Human Resource Development Program.

Human Resources in Karnataka: A, B, C Cadre

Sl.No.	Cadre	Sanctioned	Working	Vacancies
1	Sr. Specialists	1351	1141	210
2	Sr. Medical Officers	383	256	127
3	Specialists	1124	266	858
4	Taluk Health Officers	176	116	60
5	Sr. Dental Health Officers	15	15	-
6	Dental Health Officers	297	242	55
7	General Duty Medical Officers	2586	1995+298	293
8	Pharmacist	2691	2009	682
9	Jr. Lab Technician	2197	2005	192
10	X-Ray Technician	568	564	4
11	Refractionists	658	570	88
12	Staff Nurse	7810	6319	1491
13	Jr. Health Asst. (Female)	10025	8035	1990
14	Jr. Health Asst. (Male)	5937	3332	2605
15	Jr. Chief Medical Officers	120	65	55
16	Programmer Officers	206	132	74

- However, due to Article 371-J which gives special status to Hyderabad Karnataka- filling up vacancies is temporarily suspended.

Contractual Human Resource under NRHM

Category of Satff	In position
MBBS Doctors	67
Outsourced specialists	47
AYUSH doctors	602
Staff nurses total under all activities	3989
ANMs	770
Laboratory technicians	134
District Programme Managers	28/33
District Accounts Managers	26/33
Block Programme Managers	175
Other supportive staff (Accounts Assistants, DEOs etc)	262

- Doctors, Nurses, and ANM are adequately trained but some of the MOs and Specialists need re-orientation for updating knowledge & skills on new technology and programmes
- All nurses and ANMs in the Health Facilities are SBA trained and are using their skills.
- Majority of T.H. and D.H do have specialist doctors but OBG specialists appear to be overworked. There are no MBBS doctors (GDMOs) at high case load facilities especially in Taluk Hospitals to support the specialists especially gynecologists in handling the work load.
- Nutrition counsellor and M.O. are not available at Haveri DH NRC.
- ASHAs are available and are adequately trained and motivated.
- Good initiative of CPHN training of LHV's at SIHFW – to fill vacancies of District Nursing Officer/District Nursing Supervisor Post

- State has rationally deployed SNs. It should ensure rational deployment of other manpower - specialists, lab technicians, ANM/Nurses to ensure optimal utilization of skills.
- From inception, a total of 70 doctors have been trained in EmONC and 74 in LSAS. Of these 21 and 26 respectively are conducting C-Section and administering life saving anesthesia. Around 35% LSAS/EmOC doctors are not performing and is a cause of concern.
- There is a dire need of training needs assessment of service providers at delivery points and rationalizing training plans at District & State level
- Physical Infrastructure of SIHFW is impressive. However there is a need to train and orient the faculty and consultants appointed by NIHFW on the latest strategies & interventions to enable them to conduct training programs for service provider.
- A number of ANMTCs have been upgraded to GNMTCs which would function under Medical Education Department.
- Selection of LHVs for training is based on certain criteria related to seniority, service left, willingness etc.
- The creation of separate public health cadre is under process.

AREAS FOR IMPROVEMENT:

- Re-orientation of Specialists & MOs for updating of knowledge and skills on new technology and programmes.
- Appointment of GDMOs in THs/SDHs needs to be ensured.
- Filling-up of vacant positions needs to be expedited once legal impediments are done with.
- Rational deployment of manpower - specialists, lab technicians, ANM/Nurses needs to be ensured.
- Training needs assessment of service providers at delivery points and rationalizing training plans at District & State level.
- Training and orientation of the faculty and consultants appointed by NIHFW on the latest strategies & interventions.

Compliance to key HR Conditionalities:

Rational Deployment	<ul style="list-style-type: none">• Partial Compliance-SNs• 35% LSAS/EmOC doctors not performing.
Facility wise audit and Corrective action	<ul style="list-style-type: none">• Partial Compliance- State is doing facility wise reporting.• Facility wise rating not done yet and has not been uploaded.
Performance measurement system	<ul style="list-style-type: none">• Yet to be fully complied with.• Baseline performance targets not uploaded on website.
Baseline assessment of Competencies of SNs, ANMs	<ul style="list-style-type: none">• Partial Compliance-Action plan shared• Baseline assessment of SNs, ANMs, MOs not yet done.
Filling up of vacancies of regular posts of MOs, SNs etc.	<ul style="list-style-type: none">• Not complied due to legal impediments

RECOMMENDATIONS:

- Mechanism should be evolved for regular re-orientation and updating of knowledge of Specialists & MOs. E.g. Regular access to magazines on recent developments in health field can be a good initiative to bring awareness about recent developments in medical science and its practices.
- GDMOs should be appointed at THs/SDHs as they will reduce the burden on specialists. In addition they can act as a gate-keeper by initial screening of OPD patients and then referring the needy ones to specialists.
- State needs to take steps to expedite full compliance to conditionalities laid down by GOI.

TOR-5: Community Processes and Convergence

Village Health and Sanitation Committees (VHSNCs)

OBSERVATIONS

- VHSNCs exist at village level and are largely active
- Trainings of VHSNC members carried out
- Regular monthly meetings of VHSNCs being held and minutes duly recorded in registers
- Untied funds seen being utilized on various activities such as cleanliness, maintenance of health facilities, providing financial support to poor/marginalized members of the community in seeking health care services, buying ASHA sarees etc.

AREAS FOR IMPROVEMENT

- Structuring of VHSNCs with due membership
- VHSNCs are not involved in monitoring of health facilities and services delivered
- At places untied fund seemed insufficient taking into account the fact that a large part of it was being utilized in buying ASHA sarees (e.g. Buying 18 ASHA sarees from the untied fund of just one VHSNC in Tadas)
- Convergence with water and sanitation department needs attention.

RECOMMENDATIONS

- It should be ensured that the VHSNCs are properly structured as per the norms issued by the state govt. so that adequate participation of women, SC/ST and minorities can be observed

- Further empowerment of VHSNCs by involving them in “community based monitoring of health services”. Appropriate tools and formats can be developed for this purpose and capacity building of VHSNCs be carried out around this
- Should be ensured and monitored that the untied funds are timely disbursed and appropriately utilised
- Coordination between the signatories (ASHA and Panchayat member) of the VHSNC needs to be improved. At some places ASHAs have been facing issues with regard to spending of untied funds.

ASHA

OBSERVATIONS

- ASHAs found to be very vibrant and active
- Online system of ASHA payments is quite appreciable
- ASHAs have been receiving orientation/trainings on different subjects pretty regularly and have completed training till Module 6 & 7
- Their role in mobilizing community members for ANC, institutional deliveries, immunization etc looked great
- ASHA reporting formats are in place
- ASHA monitoring based on 10 indicator-based performance monitoring system is taking place
- ASHA I-cards were found with all of them
- ASHAs found very active in facilitating VHSNCs functioning
- ASHAs’ involvement in disease control programme is for Blood Test for Malaria, Larval Survey, MDA for Filariasis elimination, Morbidity Management Demonstration, ensuring complete treatment of T.B.
- Payments to ASHAs are based on budget line items, this makes it pretty cumbersome and ASHAs at times do not receive whole of the months payment at one go but in parts. This often creates confusion among them

- Most of the ASHAs have not received ASHA kits. ASHA kits replenishments were found poor. Many of the ASHAs did not have medicines.



AREAS FOR IMPROVEMENT

- ASHA payments
- Filling up ASHA positions where vacant
- ASHA kits and their replenishment
- ASHA incentives on distribution of OCPs and condoms (ASHAs do not sell OCPs and condoms to community members as community members do not take it if they are asked to pay for them)
- ASHA restrooms

RECOMMENDATIONS

- Regular payments to be ensured (At Tadas ASHAs had not received payments for past two months Sep-Oct)
- System of ASHA payments may be simplified by making whole of the amount paid at one go
- ASHA kits to be made available to all the ASHAs and robust system for their regular replenishment be placed.
- Establishment of ASHA restrooms at all the facilities up till PHC level must be ensured

Village Health and Sanitation Days (VHNDs)

KEY OBSERVATIONS

- VHNDs are supposed to take place every 1st Saturday of the month
- Although VHNDs take place they are not being organized as per the MoHFW guidelines, no comprehensive service delivery taking place. The only service delivered is nutrition supplement and counseling.
-

AREAS OF IMPROVEMENT

- Shaping VHNDs to provide comprehensive health and nutrition services

RECOMMENDATION

- Specific VHND sites can be identified where service delivery is most required at the periphery and VHNDs to be organized as per the MoHFW norms delivering most essential health and nutrition services (including ANC, immunization, PNC etc) at these points.
- Frontline workers be oriented on the significance of organizing VHNDs and services which must be delivered on the day.

TOR 6: Information and Knowledge

Health Management Information System (HMIS)

OBSERVATIONS

- Facility wise HMIS data is fed online up to Sub center level. Districts have IT infrastructure with dedicated data entry operator. HMIS data is used for programme review, monitoring, formulation of plans and execution.

AREAS FOR IMPROVEMENT

- Contractual data entry operators hired for HMIS and MCTS are paid very low.

RECOMMENDATIONS

- State has to relook in their recruiting process and remuneration payment via the third party HR agencies and ensure that the DEOs get their due.

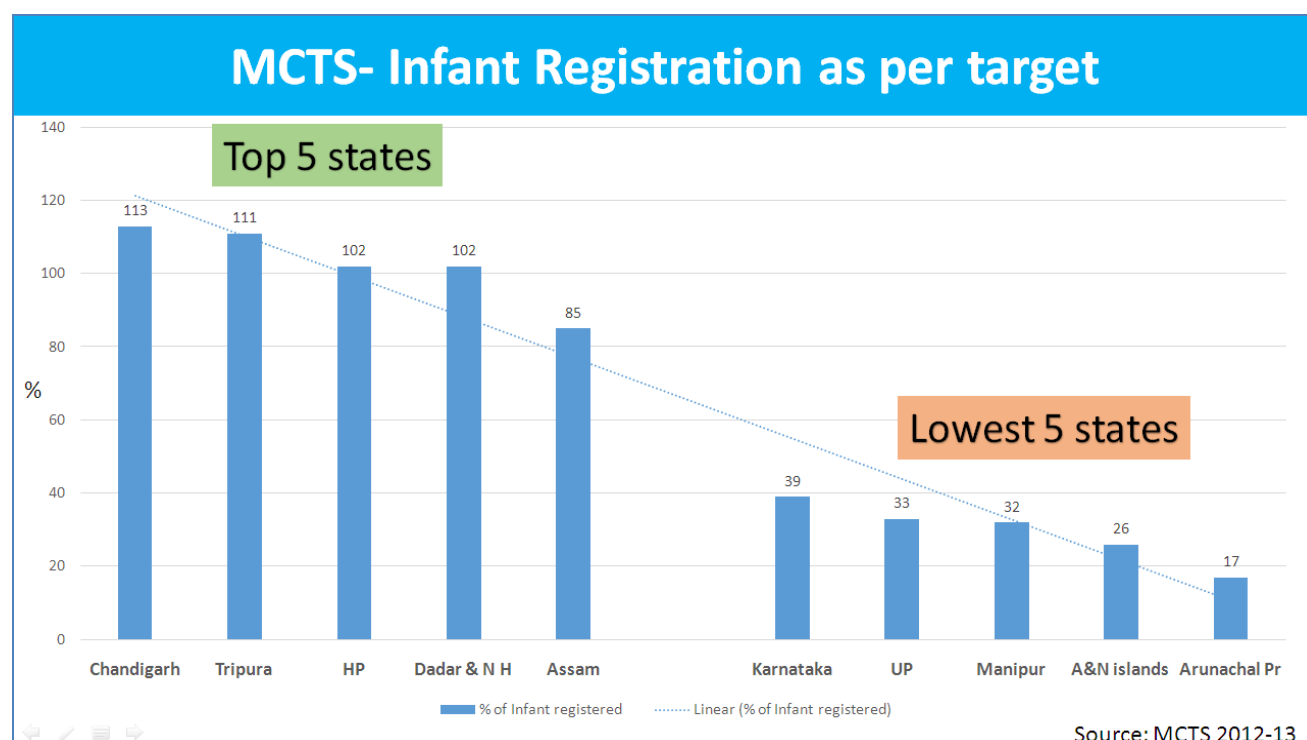
Maternal and Child Tracking System (MCTS)

OBSERVATIONS

- MCTS software is customized by NIC according to the State needs and started from 2011. Data entry through mobile SMS introduced and it has been recognized in the international forum and awarded the 'Top 11 in 2011, innovators challenge award' instituted by Rockefeller foundation. Under Sukshema, KHPT is roped in for 8 HFD of State for helping district to monitor monthly outcome. Block/District level CNA based monthly estimated target in 8 thematic areas including disease control programme has been developed. Population based monthly targets is fixed for Staff - ASHA SN for outreach. Block level achievement based on CNA target reviewed in monthly DHQ/CMHO meetings.

AREAS FOR IMPROVEMENT

- MCTS is implemented in the districts; however, there is delay in registration of pregnant mothers. Child data entry maintained in the B section of Thaiyi card is less than the percentage of delivery data entry.



RECOMMENDATIONS

- Timely registration of pregnant woman on MCTS portal needs to be given due importance for making the pregnancy and delivery safe and for securing the survival of the mother and the new born by preventing premature death of women and children. Data entry of all the sections of the Thaiyi card has to be up-to-date in MCTS. The Thaiyi card number can be used as UID across the ANC register, 108 network, labour room record and HBNC so that quantum and quality of service entitlement delivered to individual women can be accessed. Sukshema may also be rolled out to other districts of the State. The delivery record in duplicate as being piloted by Sukshema project in the

Gulbarga district can be mainstreamed as delivery room record. One copy of the record can then be handed over to emergency referral vehicle personnel who without the record, as at present do not have much detail on the condition of the mother. Further such a system would also help the receiving facility about the patient condition upfront.

State Health Systems Resource System (SHSRC)

- A functional SHSRC is present in the state. It provides support in formulation of state and district action plans, conducting and monitoring research, training and quality assessment. SHSRC supports the state in analyzing the data from checklists filled by state nodal officers and based on them suggests corrective actions to be taken by the concerned departments.

SIHFW and RHFWTCS

- SIHFW has adequate capacity, infrastructure and equipment in place. SIHFW assists the state in drawing up training calendars and conducting them on time. Adequate trained staff available in the centres.

TOR 7 FINANCIAL MANAGEMENT

GOOD PRACTICES

- ✓ Books of accounts were properly maintained in Tally ERP-9 software at State/Districts level.
- ✓ Manually Cash Book maintained at all level.
- ✓ No shortage in state share contribution.
- ✓ Bank Reconciliation Statement was prepared at State/DHS levels.
- ✓ Timely reporting was observed from Block level to District health society.
- ✓ Uniform accounting practice is being followed by District Health Society.
- ✓ JSY registers is properly maintained and all the JSY records and photographs of beneficiaries maintained properly at CHC/ PHC level.
- ✓ NDCPs accountant are properly maintaining books of accounts at District Health Society level.
- ✓ Smooth Electronic transfer of funds up to PHC/CHC level. No shortage of funds at all level.

OBSERVATIONS

Budget Vs Expenditure

The total approved budget of the State for financial year 2013-14 Under NRHM is Rs. 1073.61 crore against which the expenditure has incurred by the State up to September 2013 is Rs. 210.01 crore equivalent to 19.56% of approved PIP. The State has only 41% expenditure under RCH flexible pool against the approved SPIP of Rs.202.45 crore and only 47% expenditure reported under Mission Flexible pool against the approved SPIP of Rs. 228.88

crore. The committed liabilities are Rs. 22.57 crore in RCH and Rs. 112.23 crore in Mission Flexi Pool for FY 2013-14.

Pending Utilization Certificate

(Rs. in Crore)

Programme	2010-11	2011-12	2012-13	Total
RCH	0	32.73	186.83	219.56
Mission Flexi Pool	0	33.30	174.10	207.40

15 % State Contributions

State has excess contributed of Rs.7.11 crore for State Share up to financial year 2013-14. State has using State contribution in NRHM activities. Overall excess State share contributed by the state is as under:

(Rs. in Crore)

Year	Amounts to be contributed	Amounts Credited	Excess Contribution
2007-08	48.86	69.89	-21.03
2008-09	71.88	72.73	-0.85
2009-10	71.65	140.10	-68.45
2010-11	97.40	85.28	12.12
2011-12	111.84	115.00	-3.16
2012-13	217.94	180.36	37.58
2013-14	175.24	138.56	36.68
Total	794.81	801.92	7.11

Human Resource (Finance)

There is no financial manpower shortage in the State. One post of State Accounts Manager is vacant at the state level. Out of 30 districts 4 positions of District Accounts Manager is vacant. However there is a need of full time Chartered Accountants is seems for financial compliance of Concurrent Audit and Statutory audit at state level. State informed that the appointment of 4 vacant post of District Accounts Manager is under process.

Concurrent Audit

State has implemented the concurrent audit system in 2012-13 and 2013-14. They state has implemented quarterly concurrent audit. Appointment of Concurrent audit is under process District Health Society, Gulbarga for FY 2013-14. State should implement the concurrent audit timely to ensure the double entry system at all the level. Reason for the delay appointment of concurrent auditor at the District Health Society that the DHS has sent the proposal of appointment of concurrent auditor for State Health Society for concurrence after tendering. The concurrence of appointment of concurrent auditor was not yet received at the district level at the time of district visit.

Statutory Audit

State has not submitted the statutory audit report for the year 2012-13. State is required to submit the audit report for FY 2012-13 to settle the pending Utilization Certificate for FY 2011-12 and 2012-13. There is delay for four month as state is required to submit the audit report before 31 July 2013. The reasons behind the delay of statutory audit vacant positions of District Accounts Manager and the auditor has started his audit in the month of August 2013 due to late appointment. The State has ensured that the audit report will submit on 30th Nov 2013.

Funds Flow Mechanism

Electronic funds transfer system is being used in the State up to CHC/PHC level. Activities wise funds transferred under NRHM to District Health Society /CHC/PHC level. ASHA incentive payment is delay for two months at District Hospital Gulbarga and CHC/PHC level. Funds of VHSCs have not been transferred in visited facility and Bank Pass book was not updated at the time of visit of team. Bears cheque was issued for JSY payment and Family Planning payments. Funds are being utilized at VHSCs and sub centre level. The funds of National Disease Control Programme transferred from State Health Society in Sub Group bank accounts of concerned disease control programme at the District level.

Accounts Training

Training to accounts personnel is provided at District level and State level. CHC/PHC accountants are maintained books of accounts on double entry system. They need the accounts training on keeping books of accounts as per the double entry system.

Tally ERP9 Software

Tally software ERP9 procured and training has been conducted up to district level. Tally software is working properly at State and District level. Print out of tally ERP9 accounts (Cash Book) are not seen at District level and state level. Consolidated FMR was not prepared at the state level through tallyERP9. Districts Health Society sending their accounts in excel sheet to state health society.

Delegation of Financial Power

The State has issued delegation of financial powers up to Sub centre level.

Advances outstanding position of State Health Society as on 30-09-2013:

S.N.	Programme	Outstanding Advances 30/09/2013 (Rs. in Crore)
1	RCH	66.02
2	Mission Flexi pool	78.22

3	RI and PPI	4.66
4	NDCPs	20.27
	Total	169.17

Age -wise advance should be monitor from and advances should not be booked as expenditure.

Bank Balance as on 30-09-2013

S.N.	Programme	Bank Balance as on 30/09/2012 (Rs. in crore)
1	RCH	146.32
2	Mission Flexi pool	119.78
3	RI and PPI	16.24
4	NDCPs	19.47
	Total	301.81

Funds are available in Bank accounts of State Health Society. State has not monitored the pendency of JSY, Family Planning and ASHA incentive for funds transfer to District level.

Integration of Financial Management process with NDCPs

It was observed that the integration of finance staff at State /District Health Society level is done for reporting of expenditure purpose.

Diversion of Funds

At the District Hospital Gulbarga the funds of RKS has been used for payment of JSSK expenditure .The funds have been transferred from one scheme to another scheme at District Hospital level FY 2013-14.

Implementation of Model Accounting Hand Books

State has not implemented the Model Accounting Hand books. The State has not sent the books to District Health Society and District Health Society has not sent the books to CHC/PHC /SHC /VHSNC level for implementation the Model Accounting Hand book as issued by Government of India.

TDS provisions

State and District level are following the rules of TDS deduction. But they are not timely filed the TDS return through NSDL agencies.

RKS Audit

The RKS auditors for the year 2013-14 have not been appointed at SHS and some of DHS. RKS meetings are regularly held at District Hospital, Gulbarga. RKS audit should be implemented as per ministry guideline.

Unspent Balance:

Unspent balance under NRHM is Rs. 470.98 crore as per the statement of funds position as on 30.9.2013. Unspent balance available at State Health Society, District Health Society, District Hospital, Sub Health Centre and Sub Health Centre level. Financial Monitoring was not done for monitoring the unspent balance. Advances should be properly adjusted in books of accounts of State and District Health Society.

Main Group Bank Account and Sub Group Bank Accounts

Bank Accounts has not been opened as per the ministry guidelines for opening of Bank Accounts in Main Group Bank accounts and Sub Group Bank accounts for integration of Bank accounts at State and District level.

Singed Blank Cheque:_____

Singed Blank Cheques were found at the PHC and CHC level for payment to JSY beneficiary at Gulbarga District.

Delayed in ASHA incentive and JSY payment:

Delayed payment to ASHA incentive was observed at PHC and CHC level. JSY payment cheque issued at all level but the cheque was not issued to the beneficiary.

Bank Reconciliation Statement:

Bank Reconciliation statement was not prepared at the CHC/PHC level. Pass book also not updated at the district below units.

AREAS FOR IMPROVEMENT

- State should timely submit the statutory audit report for financial year 2012-13.
- RKS audit should be done as per guidelines of the Ministry.
- Full time Chartered Accountants is to be appointed for monitor the financial compliance of Concurrent Audit and Statutory audit at state level.
- GOI guidelines for operational guidelines for financial management, Booklet for RKS, Block, Sub centre and VHSNC should be circulated to all concerned.
- Accounts training calendar should be prepared from State Health Society to provide accounts training to District Accounts Manager, CHC/PHC accountants.

RECOMMENDATIONS

- RKS meeting should be regularly held for monitoring the funds and further planning. Funds of RKS should not be used for JSSK scheme at the District Hospital, Gulbarga.
- Taluka Accountants and Taluka Health Officer should monitor the funds of VHSNC.
- Timely payment to JSY beneficiary to be monitor from DHS level.

- Hard copy of financial report generated from Tally ERP-9 should be kept at all level duly signed.
- Cash Payment/Bears cheque of JSY and FP is to be avoided.
- Display/sign boards with NRHM logo about the medical and health care facilities and incentives available under various programmes of NRHM such as RCH, JSY Immunization and NDCPS may be erected at CHCs/PHCs at the earliest for general public information.
- Director Finance and State Finance Manager must visit at least two Districts in a month for monitoring and improving the financial management system
- District Accounts Manager/Accountant may also plan to visit at least two blocks in a month for supervising the working of the Accountant and submit his report to the CMHO and a copy to the concerned BMO
- Monthly meeting of DPMs/DAMs along with CMHOs may be held for monitoring the physical and financial progress of the programmes.
- Physical and financial progress of work should be monitored and also report in FMR.
- Civil works expenditure should be properly accounts for in books of accounts of State Health Society.
- Bank Reconciliation statement should be timely prepared at all level.

ToR 8: Medicine and Technology

OBSERVATIONS

- Karnataka currently has a similar system of drug procurement and supply of free drugs at the facility as TNMSC/RMSC but still has a long way to go to meet the same efficiency
- Karnataka Drug Logistic and Warehouse Society (KDLWS established in 2003) works as the dedicated agency to facilitate procurement and supply of drugs and establishment of warehouses
- State has its own Essential Drug List (EDL) and is currently supplying about 500 drugs/items
- Quality of supplied drugs is ensured through three tiers of quality check which is much appreciated. Three empanelled private labs facilitate quality checks (a govt. lab to be established is in the pipeline)
- 14 drug warehouses exist right now and 13 more are in the pipeline
- Robust system of indent of drugs and passbooks were found to be in place at all the facilities. Waiting time between placing the demand for drugs and receiving them was very brief which is great
- Drug availability and supplies were found to be regular at the facilities.
- There's provision for facilities to purchase drugs at local level in case of irregularity in supply or in case of abrupt demands. Most of the facilities were utilizing this provision.
- Patients were only being prescribed drugs out of those under supply; No branded drugs or those unavailable at the facility were found to be prescribed in the prescriptions (Although cases where drugs were prescribed in plain chits for medicine to be bought from outside were evident in some places especially in case of women who had delivered)

AREAS FOR IMPROVEMENT

- Prescription practices: Some of the sites were found to be using plain chits and pieces of paper as prescription slips

- Display of list of drugs outside drug dispensing counter needs to be adhered to at all the facilities
- There were few cases evident where women who had delivered were asked to buy certain tonics from outside medical shops
- Drug storage at health care facilities was found poor (lack of space, racks, shelves, ventilation at the store houses, no systematic arrangement of drug storage e.g. alphabetical ordering, labeling etc)
- Record keeping was found weak. Poor update of stock registers (this is most probably because of heavy patient load and poor human resource availability to cater to it)

RECOMMENDATIONS

- Karnataka already has quite a good system of free drug, the govt. may now like to plan ahead to move towards free diagnostics as well
- Computerization of drug distribution counters and IT based inventory management should be introduced
- More human resource needs to be deployed largely to maintain proper records and to facilitate efficient drug storage
- “Dual prescription practice” may be initiated in the state for strict monitoring and audit purposes
- Periodic prescription audits and monitoring visits must be carried out to ensure that patients are not forced to buy medicines from private outlets
- Monitoring and supervision to assess drug storage systems, record keeping etc must be carried out regularly by the state at all levels of facilities
- Standard guidelines must be issued to health facilities for ensuring efficient drug storage/maintenance of storehouse and adherence to rational prescription practice (e.g. most of the prescriptions did not have any diagnosis mentioned)
- KDLWS must come up with a web site of its own for bringing in more transparency
- District drug ware houses must be established at all the districts

TOR 9 National Urban Health Mission (NUHM)

State level structures of Urban Health

- Under **NRHM**, 48 Urban Health Centres are functioning in cities and town of karnataka having > 50000 Population.
- OPD, MCH and Out-reach services are provided
- Each UHC has 1 MO, 1 SN, 3 ANMs, 1 LHV, 1 LT, 1 Clerk, 1 Attender and 10 Link Workers
- Under NUHM, BBMP, Mysore & Mangalore City Corporations, Bagalkote City and Ullal Town in Dakshina Kannada have been taken up during 2013-14
- Stake Holders Meetings were held during June and July 2013 with BBMP, and District Health Societies of Mysore, Dakshina Kannada and Bagalkote Districts.
- PIP Workshops were held for the District teams to prepare PIP
- GO issued by State Govt. for launching NUHM
- State Health Mission and KSH&F Welfare Society have been reconstituted by adding new Ministers and New Officials from Urban Development, Housing, Municipal Administration and BBMP (GO No: HFW/134/ FPR 2013/ Date: 28-09-13)
- 25 % State share for 2013-14 NUHM implementation has been approved by Cabinet and GO issued (GO No: HFW/108/FPR 2013 Date: 28-10-13)
- Benguru Metropolitan City, Mysore, Mangalore, Bagalkot, and Ullal town were included in PIP process for 2013-14 (for 4 months) with a Grand total budget of Rs. (In Lakhs) 13241.
- The CRM districts of Gulbarga and Haveri are not represented for the NUHM PIPs as yet.

Major observations related to Urban health Program

- Total slums in Gulbarga urban are 57, out of which notified are 51 and unnotified are 6. The population of 55845 of which the notified slum population is 55309. 62 percent of (34316)of total slum population is SC category, 32.6% (18079) is ST population and 11.4% is others (source: Municipal corporation of Gulbarga).
- Mapping of vulnerable population is not yet completed.
- Women's self help groups exists in the slums for Micro finance/ Credit purposes, with whom large group & FGDs meetings were held in the slums to understand the health care situation and needs and priorities
- There are no special initiatives for providing health care to the most vulnerable populations i.e. homeless, street children, migrant workers etc. other than through the two Urban PHCs and minimal outreach program attached to them that exist.
- Urban health care Infrastructure in the Gulbarga city consists of

No. of Urban Health Centres (IPP Estb.): 6

No. of Urban Maternity Centres : 2

No. of Urban Health Centres under NRHM: 2

- The Staff position of each of the above is as follows:

UHC(IPP) have 1 MO, 2 ANM.

Urban maternity centre has 1MO, 3Staff Nurses.

UHC (NRHM) have 1MO, 1Staff Nurse, 1LHV,3ANMs, 1 Lab Tech, 1 A/c assistant cum DEO and 1Grp D.

- There is one Urban Health Centre under PPP Model that caters to a population of 52000, where in structure consists of 1 Medical officer, 1 SN,3 ANMs and one (Male)

Health Assistant, 1 store keeper cum clerk. At present 2 ANM caters to the outreach services to the slum populations.

- Facility operates through the PPP model by which staff salaries are paid from the Government and while the equipment is carried over from the previous Urban R.Ch project, rest of the items, such as building rent, Drugs etc are through partnership model.
- Second UPHC (Khanapur) under NRHM caters to a Population of 52,500, with a lean staffing pattern of 1 MO, 2 ANMS, 1 lab technician (deputed from malaria department of malaria) and 1 Assistant/ helper and a minimum equipment.
- Services include apart from general OPD, OPD for ANC, PNC, immunization done both in the PHC and outreach mode, National program coverage such as school health (Health checkups are conducted monthly once for the 40 schools in the catchment area), RNTCP where in while the lab tests are done at the PHC, DOTS workers operates from the Centre on specific three days from the Centre and for follow up. At present there are 40 cases of TB attached to the PHC.
- Deliveries performed, ANC and Immunization services provided at most urban centers, except two centres (as per the data provided for period April to October 2013 by DHO) are far below the set targets. This needs improvement.
- FP: sterilization cases are referred to UFWCs in the city depending upon the convenience and locations and to the DH. Even IUDs are not inserted, but referred.
- In both UFWC and UPHC, ARSH/ SNEHA clinic carried out once a week. Counseling is carried out by the ANM as there is no sanctioned post of a counselor. Average turn out of girls is 6-7 per session i.e. weekly once, and Iron & sucrose tablets and sanitary accessories are provided.
- While the average turn out per session is about 6-8, it is mostly Girls (in the UFWC clinic) and both girls and boys in the case of UPHC.

- In the case of UFWC generally OPD turnout consists of, common ailments coughs, fever, malaria, dengue etc., are treated, apart from cases of BP, arthritis, and acute/ chronic cases are referred to the tertiary care units.
- In UPHC, general OPD cases consists of white discharge, UTIs and PIDs, other than the ANCs. Out of the total OPD load, about 20 % are Neurotic/ psychosis related patients, apart from cases of arthritis, BP and diabetics.
- Drugs are supplied from the General medical stores (GMS). In UPHC there is no shortage for medicines in general and even for some of the NCDs such as Hypertension/ BP, Diabetes. Etc.
- **NCDs** : In the UPHC There is no special focus on NCDs other than coverage in the OPD for BP, diabetes etc.
- To the UPHC, untied funds are released from the DHOs office, in installments, but not exactly as per the needs, were stated by the MO. A system needs to be initiated for release of funds.
- Fund support: Allocation from Municipality funds is only for urban water and environmental Sanitation programs. Budget for existing health Centres from two sources, Government of Karnataka and for existing Urban PHCs from the NRHM
- UPHC MO brought up before the team, the issue of lack of support from locals & community ownership, value attached to the facility and problems encountered in the process such as facility's compound being used as a waste dumping ground by neighbourhood and the goons using it for illicit activities such as liquor consumption etc. local health administration, including RKS committee should leave apathy and be accountable to take stern actions. Photographs is given below.



UPHC ground as a dumping ground

- 48 hours stay at DH level only. No other institution is followed the JSY guidelines
- Payment for JSY beneficiaries is not made in time at some of the PHCs, through check only, pending cases also found.

Gaps and Areas of improvement of UHP in Gulbarga district

- A mechanism for referral linkages to tertiary and other facilities needs to be strengthened.
- Service component at UFWC and UPHC should be strengthened so as that they perform atleast normal deliveries and to reduce load on tertiary centre.
- Existing UFWC are needed to be converted and mainstreamed into the NUHM and along with the existing UPHCs need to be strengthened in terms of coverage of service delivery, staff, and equipment. To this effect a situational assessment of epidemiological profiles of slums are needed to be conducted to match the direction of strengthening of service components. [For instance, in the UPHC covered, it was unfolded that 20% OPD turn out is neurological patients. Similarly interactions with the community SHG

women revealed that there is a gap of unmet need for health care services of senior citizens such as arthritis, BP , other needs of infertility treatment etc.]

- Coverage of the NCDs in terms of for example early detection, diagnosis and referral as well as OPD case referrals of NCDs and other ailments related senior citizen population.
- In line with the above mentioned, strengthening the tertiary hospital and at the same time effective referral linkages will follow logically, as per the NUHM framework.

TOR 10. Governance and Management

OBSERVATIONS

Program Management

- The PMU is well integrated with the Directorate
- At District level separate District Programme Managers with Medical and Management background
- NRHM Contractual posts appointments are decentralized
- DPM & BPMU units with a total of 24 recruited staff, consists of district Program manager, Accounts manager , Program Assistant and Accounts assistant and at Block level Block Program manager, Accounts manager and Block data manager.
- The financial powers has been delegated to District Hospitals, PHC medical officers and Taluk Health Officers
- Staff training included areas of Induction, HMIS & MCTS, E learning management, DHAP preparation and accounting & Tally training. Similarly Block level staff received in similar training.
- State deputed doctors and programme officers for Masters/Diploma/short courses in Public Health
- State commissioned a committee for creation of public health cadre (Dr.Haligi committee the proposal is under consideration of the govt.)

Institutional Mechanisms

- Besides the District Health Mission, with Governing body, Executive committee, District Health society with Governing body and executive Committee, other committees such as District level Vigilance and monitoring committee, Quality assurance committee, IEC

committee, ASHA Grievance committees, PC& PNDT advisory Committee and ARS Committee are available.

- District Health Society and District Health Mission convenes regular meetings
- District Health Action Plans are prepared with a bottom up approach
- At taluk level ASHA grievance Committees, ARS/RKS Governing body and executive committees at Taluk level, CHC, PHC level are available, besides sub centre level VHSCs.
- Documentation for VHSC s is available, however needs improvement in terms of regularity and quality
- Each district has been assigned to one officer of State who acts as Nodal officer for district
- Important decisions on convergence with WCD, Utilization of Zilla Panchayat Funds to construct toilets borewells etc.

Supportive Supervision & Monitoring

- Monitoring and supervision is done by State as well as District officials as per monthly schedule.
- Visits to the CHCs, PHCs including 24x7, SDH and subcentres revealed that there are no monitoring registers/ diaries kept for recording the priorities & suggestions through supportive supervision.
- When particularly enquired about documentation of the visit of a monitoring officer, signatures were shown in the attendance registers of the staff. They are at random signatures, without a date, without any notes/ comments. Even among the few signatures, program management from District or Taluk are significantly missing.
- Information on any existing tools such as supervision checklists at SPM or at District Program management office for supportive supervision not available, even on enquiry.

- Systems for monitoring and Supportive supervision to all levels of facilities need to be strengthened on a priority basis in the districts including follow up action taken reports.
- Review and feedback mechanisms needed to be strengthened including their documentation.

Accountability & Regulations

- Social audit in the forum of community meeting done twice in a year by the community members
- Though there is a mention of district level vigilance & committee, no details including documentation of details were provided.

AREAS FOR IMPROVEMENT

- Supervision & Monitoring needs to be strengthened especially in terms of planning of monitoring activities and documentation (Field Report and Action Taken Reports)
- Mechanism for social audit and other accountability measures for health
- Functioning of District Level Vigilance & Monitoring Committee.

RECOMMENDATIONS

1. Mechanisms for social audit such as Janvamsad, public meetings at villages and accountability measures for health need to be put in place and made effective.
2. The District Vigilance and Monitoring Committees needs to be made functional.
3. Implementation of Public Health Cadre needs to be expedited (already initiated)
4. Norms and systems for Monitoring and supervision are needed to be put in place and strengthened.
5. Data from various sources needs to be analysed and utilized for effective monitoring and supportive supervision.

6. Monitoring and supportive supervision and action taken report on observations mechanism in the DPMU and SPMU needs to be structured in line with GOI recommended Supportive supervision guidelines.

Annexure:

Facility Wise Findings

HAVERI DISTRICT

District Hospital - Haveri – Observations

- 250 bedded hospital , all major specialties are present (OBG , paed , surgery , blood Bank , SNCU , NRC , Dialysis Unit , PPTCT , ART Center , ICTC , Citizen Help Desk
- **Physical Infrastructure:** Overall adequate infrastructure exists , District hospital accessible , govt building , and in good condition, electricity with generator , running water supply , Overall cleanliness there is a scope of improvement particularly toilets , Staff Quarters present.
- **SNCU:**
 1. Infrastructure as per HBNC guidelines is available
 2. No central oxygen supply
 3. 12 SNs , 2 trained MOs , 1 pediatrician
 4. AMC is available but from State level
 5. Supplies and consumables were adequate
- **NRC:**
 1. Separate toy area , separate kitchen
 2. 20-25 patients per month (get report)
 3. 75 cases treated from 2012-13 to October 2013
 4. Patient Interview: Case referred by AWW.
 5. Diet Chart present ,
 6. Nutrition Counsellor post is vacant
 7. 4 SNs , no MOs , pediatrician in DH runs the NRC
 8. Avg stay: 15 days

- **Blood Bank:**

1. Functional , caters to both government & private hospitals of district (1:3) , Rs. 300 for govt hospital , Rs. 700 for Private Hospital , free for BPL ,
2. 4 camps per month , extra camps whenever needed ,
3. Blood is collected without screening and is later screened and stored.
4. Temperature chart was maintained , equipments well maintained
5. JSSK patients reimbursed for blood by hospital
6. 4 BSUs in District but only 1 in Rani Benoor is functional

- **BWM:**

1. Out source for waste disposal
2. Color coded bins maintained, Charts maintained but segregation was not as per the guideline and needs improvement.

- **HIV detection & treatment:**

1. ICTC , PPTCT , ART centre are all placed in DH and are as per guidelines with sufficient space
2. Staff is adequate and is well trained
3. ART Centre HR: 1 SMO , 1 MO , Counsellor , 1 lab technician , 1 community care co-ordinator

- **Laboratory:**

1. All equipments available , pathologist and micro-biologist both present
2. Reagents are also available

- **Injection Rooms:** Separate rooms for male and female patients but no privacy (no curtains) , no patient waiting facility available outside injection rooms

- There is a Help Desk run in PPP mode by an NGO

- Functional SNCU , OT well equipped (3 OTs) ,

- Radiology apparatus adequate but radiologist is contracted in for fixed day services (weekly twice)

- **AYUSH OPD:**

1. OPD functional with 1 Unani & 1 Homeo Doctors , 2 ayurveda doctors providing ayurveda services with panchkarma services on day care basis

2. Ayurveda , unani and homeo medicines available and approximately 25-30 patients for OPD per day
 3. Panchakarma equipment available in separate rooms but supporting staff was not adequate
 4. AYUSH doctors are involved in school health program only for AYUSH interventions along with allopathic team.
- **JSSK:**
 1. Interaction with patients show that many are not aware of JSSK entitlements
 2. Few cases of OOPE on medicines was also reported/informed
 3. Drop back facility is very poor
 4. Citizen charter was not there and JSSK entitlements needs to be placed clearly in front of hospital
 - **Kitchen:** Clean and food was prepared , but delivery patients informed that food was brought from outside

Shhiggaon Taluka Hospital:

- 100 bedded hospital
- Govt Building and is in good condition (original building is old maternity home started in 1940)
- Quarters for MOs and SNs available and is satisfactory
- Electricity with power back up , regular water supply
- Newly constructed 2nd floor yet to be occupied and does not have provision for attached toilets
- **BSU: Establishment** is in process. Necessary equipments and other requisites being available but process of actual operationalisation is delayed (8 months) due to tardy processes and paper work. Currently blood is transported from hubli medical college or district hospital Haveri.
- **Wards:** Separate Male & Female wards , ANC , PNC , Post op patients were randomly assigned in the same ward

- **Labour Room:** Critical equipments like Ventouse/vacuum extractor for assisted delivery were not available .
- **Pharmacy & Store Room:**
 1. Infrastructure is sub-optimal and storage is done in haphazard manner
 2. Inventory Management inappropriate
 3. EDL available , medicines were mostly available
 4. Absence of rational prescription practice (There was no diagnosis no doctor signature)
 5. They have got pass book system
- **Human Resource:** No GDMOs post sanctioned for Taluka Hospitals. (Needed to assist specialists) , only 9 SNs in position (6+3) , OBG must be assisted with BeMONC MOs
- **Case Load:** OPD- , IPD - , Delivery - , C-sections , FP ,
- MCH wing has not been proposed for this hospital
- No services for PPS / PPIUCD. Tubectomy (Minilap) camps held periodically.
- Colour coded combi packs for syndromic treatment of RTI/STI not available (Not being supplied)
- No maternal deaths have happened in the recent past (1 maternal death of patient with PPH who had been referred from this hospital to hubli medical college due to lack of blood availability)
- **Financial Management:**
 1. All account books properly maintained but there is lag in updation particularly cash book.
 2. No training to the staff for managing accounts.
 3. Other registers like Asset register , payment register in respect of JSY including Cheque issued maintained upto date
 4. ASHA payment register properly maintained and are paid online (DBT)
 5. CMO not aware of proper Accounting practice
 6. BAM not trained
- **AYUSH:** AYUSH GDMO working in the hospital on contract even though he was posted in the hospital during 2012 he was not provided with any AYUSH medicines till date.

However an average 20-25 patients per day is reported in the OPD as per the records and these patients were managed with allopathic drugs. No other medical systems or medicines are available. The doctor is also not trained in National Health Programmes

- **JSSK:**

1. JSSK entitlements in place but more visibility required.
 2. OOOPE incurred by few patients on drugs
 3. Diet given in hospital ,
 4. Grievance Redressal mechanism not evident.
- No citizen charter , no NRHM Posters display , no complaint/suggestion box ,

Attigeri 24x7 PHC:

- Building in good condition even though it was old , no staff quarters ,power back up and water facility available , toilets were clean ,
- HR: ANM shortage (1 ANM looking after 3 Sub Centres) , all SNs are SBA trained (partographs being maintained) and SNs alongwith Labour room look after casualty , MO needs training (BeMonC).
- BWM: With deep burial pit available , waste segregation done , staff was well trained , needle cutters available. There is a Bio Medical Waste Management Consultant for each taluk. Based on each taluk he is monitoring each facility in the taluk.
- VHND needs to be more structured to cater the needs of community
- FP activities more focused on limiting methods (all female sterilization and NSV not acceptable) , services offered through camp approach
- Financial Management: All registers well maintained but cash books not updated till date , no training to account handlers ,
- Patient Transport & Referral System: 108 used and if not available private vehicles hired and reimbursed through ARS funds
- Pharmacy & Drug store room: All registers maintained along with short expiry drugs register ,
- JSSK: No grievance redressal mechanism , suggestion box present

- ASHA Interview:
 1. No drug kits given (HBNC kit available)
 2. Trained up to 7th module
 3. Take drugs from PHCs , perform all activities
 4. Avg incentives per month: Rs. 800 (700 to 1200)
 5. After regular follow up of ANC , patients deliver at PHCs without informing ASHAs and they loose the incentives . There must be a mechanism to account for ASHAs efforts

Sub-Centre Attigeri: Located very vlosely to PHC

- Not conducting delivery
- 1 ANM for 3 SHCs (5 villages)
- ANC immunization services provided at PHC
- Out reach services mainly conducted by ASHAs and AWW

Taluka Hospital , Byagdi

- Hospital currently functioning in old building , a separate new building designated for trauma care but is utilized currently for conducting OPDs. From 2007 30 bedded hospital was upgraded to 100 beds.
- New building (100 bedded) is under construction
- Staff Quarters: Available for 2 doctors , 2 SNs and 1 grp D employee which was also old. It was informed that in the new building provision has not been made for staff quarters
- Same injection room for both males and females and there is no curtains , no patient waiting arrangement.
- Laboratory: 2 LTs (1 regular and 1 under NRHM) , semi-auto analyzer was not available (will be approved only when new building is approved) ,
- **Human Resource:** Only 1 Senior GDMO in position and MOs are not sanctioned. Atleast 2 to 3 MOs may be sanctioned so that all OPD patients are screened primarily by MOs

and then if necessary may be referred to Specialists. NRHM DEO is getting only Rs. 4000 for full time job (HMIS-MCTS data entry plus all computer work)

- **Service Delivery:** 60-70 deliveries per month , C-sections- 8 to10 per month , 55% bed occupancy , Minilap & Tubectomy – Fixed day clinic
- **AYUSH:** Homeopathy unit is collocated with one MO in the hospital with average patients of 25 to 30 per day. There is no pharmacist to assist the dispensing of medicines so that the medicines are kept in the consultation room itself. The doctor is trained in MCH & SBA training. The patients reported are mainly with asthma skin diseases and arthritis. Medicines are procured from private companies and are in short supply. Even though Rs. 10 lakhs was provided to this facility for collocation by GOI no addition/alteration/modification to provide required space for AYUSH made so far. However it was informed that in the new building being constructed adequate space will be provided.
- **Bio Medical Waste Management:** Even though color coded bags were available no scientific segregation of BMW was adopted. One agency was contracted to carry the waste.
- **Finances:** All registers maintained and separate books are maintained for NRHM and HFW. Entry is lagging in the cash book for 3-4 months. Vouchers are not properly maintained in respect of untied fund utilization even though usage is 100 %. Asset register maintained in respect of NRHM. Strict accounting guidelines have to be issued to the staff dealing with accounts after providing training.
- **IEC BCC** activities on various programmes under NRHM has not been done properly in facility location.
- **Governance & Programme Management:** RTI information board , Citizen Charter prominently displayed
- **Diet:** It was informed by few patients that no diet was provided in the hospital.

Non FRU - CHC Rittihalli:

- 30 bedded hospital, huge new infrastructure existing but underutilized due to acute shortage of manpower (only 30% filled).
- No pharmacist available.
- 250 opd per day , 30 deliveries per month
- Radiographer posted but no X ray machine. 1 ambulance but no driver available. Hence rational deployment of HR is suggested.
- Sneha Clinic (ARSH): Not being conducted.
- Finance: All registers maintained for various schemes, 100 % utilization of UFs , ARS

24 x 7 , PHC Kaginelle:

- The PHC is functioning in 65 years old building with one M.O. and one AYUSH Doctor 6 ANMs and 3 NRHM staff nurse. The facility caters a population of 44675.
- The PHC provides for ANC care Delivery and also conducts eye camps and runs a sneha clinic.
- There is no ICT councillor. The Lab Technician post is vacant. However the contractual Lab Technician does 60-70 tests.
- The staff nurse and ANMs are SBA and IMNCI trained.
- Sneha Clinic is also functioning. Diet is reported to be provided from outside.
- The Bio-Medical waste care management with colour coded segregation of Bio-medical waste is found. Deep burial pit was also recently established behind the PHC.

ASHA:

The ASHAs are vibrant. The ANC care and Immunization are done in the facilities resulting in the VHND is doing the activities like IEC and awareness activities. The drug kits available with ASHAs consists of HBNC. Some of the ASHAs expressed their difficulties in getting the signatures of PRI representatives fo VHSC funds.

AYUSH:

The Ayurveda doctor available in the facility is providing Ayurveda services as well as running the sneha clinic. She is oriented in SBA RNTCP NSSK and Leprosy programmes. 13 medicines are available and 20 cases are reported in the facility.

It was informed that the remuneration provided to the contractual AYUSH doctors are too less considering the work output.

District Gulbarga – Facility wise Findings

District Hospital Gulbarga: Major observations

- District hospital is large with existing 400 beds in many different wards and consists of specialties of Medical (including T.B, and dialysis), Pediatrics, Genic & Obstetrics, Ophthalmology, Psychiatric, skin, and ENT. There is also an ESI ward, as the facility has a tie up with the ESI and specialists from the ESI facilities visit here on specific days.

Help Desk Vis-à-vis Grievance handling mechanism:

- There is a help desk, which is supported by the KHSDRP World Bank support, at the entrance consisting of a manager, 3 assistants, including one assistant for night shift. This is supposed an interface between in patients and providers and for helping the in patients and out patients, solving their issues and problems. In terms of the functional processes of the help desk, monthly meetings are reported to be held between help desk unit and the facility management and reported issues are taken for resolving. No documentation of the complaints registered, meetings held and resolutions was provided to the visiting team. For a question on grievance handling mechanism at the facility, the district Program management units reports the help desk as a grievance handling mechanism. Only one complaint box is observed at the hospital. Although 'Help desk' can be construed as grievance handling mechanism, it requires to be made popular amongst patients with IEC and systems to be put in place for addressal of grievances received, which should be taken on priority basis for immediate resolution, and with adequate documentation.
- **Psychiatry In-patient ward:** Ward is common for both males and females, without separator screens, including the washrooms, with a separating corridor space. It is reported by DH Supdt that these patients are admitted in this ward only in the non-violent stage of the ailment. 3 patients are there at the time of visit.
- There are support structures such as IPD admission counter, Arogya Mitra counter to help in patients in the claims, out post police station for MLCs and Orphan baby ward.

- A separate ward for treatment of rape victims: It is reported as present, however other than the fact it is a separate room, it is observed by the team that no other specific features present over there, for instance a separator, IEC for sensitization, person/staff with counseling skills or gender sensitization training. The same was suggested to the officials.
- **Laboratory** : A huge one with 13 sanctioned positions of technicians attached to all different units such as PPTCT lab, general lab, blood bank attached etc is available in the DH.
- ANC tests are done in the laboratory. Examination of registers revealed that there is no system for maintaining separate registers for ANC tests particularly HB counts, to focus on High risk pregnancy data.
- **NRC**: Started in the DH in 2011. Staff includes nutritionist, and other support staff. There is no counselor since 3 months and KSAPS counselor was deputed and she went back. There are around 10 children, referred from the AWC centres. Both cooked and dry food is given to children and follow up is reported done.
- **NCDs in DH**: No special focus on NCDs. Only those who approach through the OPD are basically treated and all chronic cases are referred to tertiary care mostly outside Gulbarga, as DH is the highest tertiary care in the city.
- **ARSH**: ARSH clinics are reported held at the centre in DH, but no data was provided by the DH nor DPMO.
- **Mandatory Displays**: Citizen Charter exists at the main entrance of the facility. But contents of the chart reveal essentially the various wings/units of the facility and no other normative information citizen rights etc. The rest of the contents of a citizen charter are needed to be furnished to make it complete.
- Display of the status of drugs available at facility is available. But EDL is not displayed.
- RKS member's list is not displayed. Grievance handling board is not available.

Areas of improvement in DH services:

- Laboratories attached to DH and other units should maintain separate, systematic registers for ANC data such as HB count etc to easily access and track High risk pregnancies.
- ‘Thai maternal health card’ which is quite elaborate with its columns of data related to high risk pregnancies is an innovative measure. However it needs to be filled in systematically to reflect on high risk indicators for timely preventive action. Senior management has to sensitize staff on this matter and ensure that Thai card data is systematically maintained.
- PNC care of delivered women needs to improve at the DH and also particularly about the hypothermia of new born. Emphatic awareness generation among pregnant mother on the critical new born care such as hypothermia and post natal care aspects through the already initiated ‘Baby shower’ platforms of the state.
- Policy focus needed on prioritizing pregnant women for BPL card or make the ‘Madilu kit’ free for all delivered women be ensured to
- Mandatory displays are needed to strengthen in DH and other facilities also with proper fashion for instance, citizen charter should contain besides all details of facilities, citizens’ rights over the facilities; ARS members list, EDL.
- Initiation of grievance handling mechanism in proper spirit and form is needed, other than merely being a complaint box in a vague corner of the facility, which is found in few facilities, and to be displayed in full its substance.
- DH is reported as having a help desk, which actually is positive feature. However, as already mentioned, it needs to be proactively transformed to act as a grievance handling mechanism with necessary popularization and putting in place desired processes.
- Focus on NCDs is required at the DH and other prominent facilities such as CHCs, & SDHs.

