KERALA

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

1. State Profile:

Rural Population (In lakhs) (Census 2011)	174.56
Number of Districts (RHS 2011)	14
Number of Sub Division/ Talukas	63
Number of Blocks	152
Number of Villages (RHS 2011)	1018
Number of District Hospitals (RHS 2010)	14
Number of Community Health Centres (RHS 2011)	224
Number of Primary Health Centres (RHS 2011)	809
Number of Sub Centres (RHS 2011)	4575

2. Status of Health Indicators

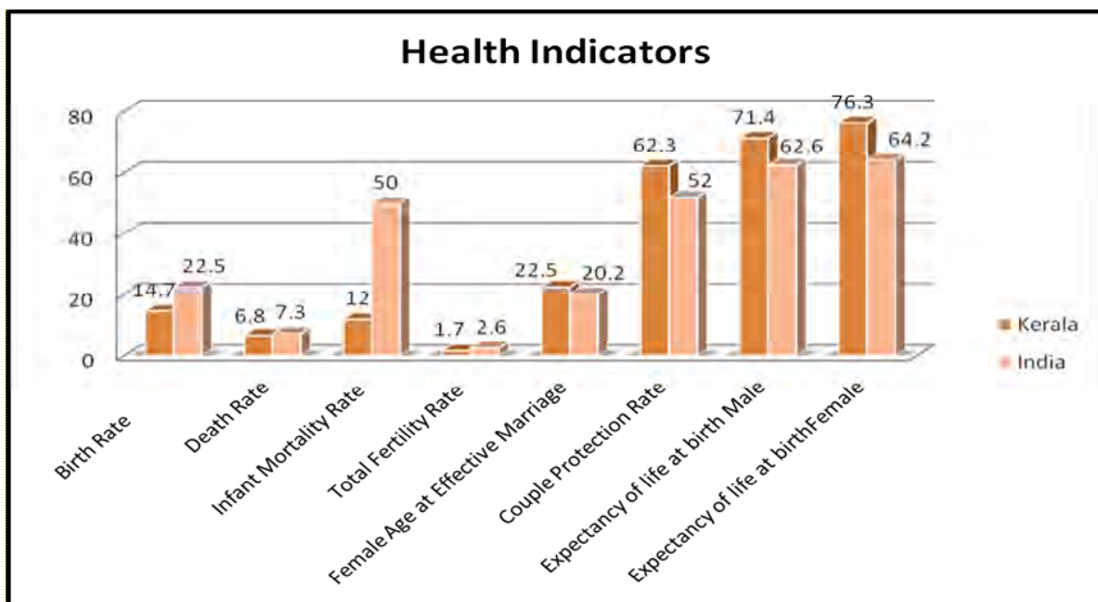
Sl. NO	Indicators	Kerala	India
1	Infant Mortality Rate (SRS 2010)	13	47

2	Maternal Mortality Ratio (SRS 2007-09)	81	212
3	Total Fertility Rate (SRS 2010)	1.8	2.5
4	Under-five Mortality Rate (SRS 2010)	15	59
5	Institutional Deliveries (2011-12) (Upto March)(MIS)	498165	16305423
6	Full Immunization (In lakhs) (2011-12) (Upto March) (MIS)	461	22332

3. Dmographic Profile

Indicator	Kerala	India
Total population (In crore) (Census 2011)	3.33	121.01
Decadal Growth (%) (Census 2001)	4.86	17.64
Crude Birth Rate (SRS 2010)	14.8	22.1
Crude Death Rate (SRS 2010)	7.0	7.2
Natural Growth Rate (SRS 2010)	7.8	14.9
Sex Ratio (Census 2011)	1084	940
Child Sex Ratio (Census 2011)	959	914
Schedule Caste Population (In crores) (Census 2001)	0.31	16.66
Schedule Tribe Population (In Crores) (Census 2001)	0.03	8.4
Total Literacy Rate (%) (Census 2011)	93.91	74.04
Male Literacy Rate (%) ((Census 2011)	96.02	82.14
Female Literacy Rate (%) (Census 2011)	91.98	65.46

Table showing comparison of Health Indicators:



Kerala has best health indicators in the country and has already achieved the MDG goals related to TFR, IMR and MMR.

Health Infrastructure of Kerala

Total population of Kerala is 33387677 out of which population in rural areas of kerala is 1, 74, 55,506.

Particulars	Required	In-position	Shortfall
Sub-Centres	3525	4575	NA
PHCs	586	809	NA
CHCs	146	230	NA
ANMs or JPHNs at Sub-centres and PHCs	5384	4173	1211
Health Workers (Male) at Subcentres	4575	1285	3290

Health Assistant(Female)/LHVs	809	795	14
Health Assistant (Male)	809	633	176
Doctors at PHCs	809	1122	*
Obstetricians and gynaecologists	224	NA	NA
Physicians at CHCs	224	NA	NA
Paediatricians	224	NA	NA
Total Specialist at CHCs	896		
Radiographers	224		
Pharmacist	1033	1013	20
Lab technician	1033	268	765
Staff nurses at PHCs and CHCs	2377	2014	363

(Source RHS Bulletin 2012, GOI)

Health Infrastructure Health Services Department

INSTITUTION	NUMBER	BED
Total Govt. Allopathic Institutions	1255	37021
1. General Hospitals	10	4312
2. District Hospitals	16	4168
3. Speciality Hospitals	18	5390
4. Taluk Hospitals	80	9988
5. Community Health Centres	230	7146
6. 24X7 Primary Health Centres	175	3437
7. Primary Health Centres	660	2206
P H Cs Total (6 + 7)	835	5643
8. T.B.Centres / Clinics	17	176
9. Other Institutions	49	198
Specialty Category Wise		
1. W & C Hospitals	7	1436

INSTITUTION	NUMBER	BED
2. Mental Health Centre	3	1342
3. TB	3	608
4. Leprosy	3	1916
5. Others	2	88
Total	18	5390
Other Institutions Category wise		
1. Govt. Hospitals/Health Clinic	8	116
2. Mobile Units/Mobile Clinics	17	0
3. Government Dispensaries	24	82
Total	49	198

Details of posts of Medical and Paramedical staff in Health Services Department

(Regular)

Sl. No	Category	No. of Posts
I. MEDICAL		
1	Director of Health Services	1
2	Addl. Director of Health Services	14
3	DD/DMO/Superintendent	46
4	Dy. DHS Dental	1
5	Assistant Director	119
6	Jr. Administrative medical Officer	21
7	Chief Consultant	16
8	Senior Consultant	50
9	Medical Consultant	603
10	Junior Medical Consultant	1017
11	Civil Surgeon	815
12	Dental Civil Surgeon	18
13	Assistant Surgeon	1586
14	Dental Asst. Surgeon	62
15	Dist. TB Officer	7

16	State Nutrition officer	1
17	RCH Officer	14
TOTAL		4391
II. PARAMEDICAL		
1	Number of Nurses	7303
2	Health Supervisor	168
3	Lady Health supervisor	157
4	Health Inspector	876
5	Lady Health Inspector	955
6	Junior Health Inspector	3504
7	Junior Public Health Nurse	5575
8	Other Para-Medical Staff	24453
9	Total Staff(Medical & Para Medical)	42991

Delivery Points Status (State and Districts visited):

	State	Malappuram	Allapuzha
No. of SCs conducting >3deliveries/ month	NA	NA	NA
No. of 24X7 PHCs conducting >10 deliveries/ month	NA	NA	NA
No. of any other PHCs conducting >10 deliveries/ month	NA	NA	NA
No. of CHCs (Non -FRU) conducting >10 deliveries / month	9	3	NA
No. of CHCs (FRU)conducting > 20 deliveries / month	NA	NA	NA
No. of any other FRUs (excluding CHC - FRUs) conducting >20 deliveries/ month	58	5	3
No. of DH conducting > 50 deliveries / month	14	2	1

No. of District Women And Children hospital (if separate from DH) conducting >50 deliveries / month.	5	NA	2
Total	**86**	**10**	**6**

Observations and Issues : (Diet , laundry need to be added, citizen charter)

- Out of 4575 Sub-centres, 2128 are in government buildings, 981 are in rented buildings and 1466 are in rent free or panchayat buildings. Out of all PHCs, 12 are in rented buildings and 7 are in rent free or in Panchayat buildings. All CHCs are in government buildings.
- The Public Health infrastructure in the State shows nearly an adequacy in terms of numbers but needs improvement especially for sub-district hospitals. A well structured infrastructure development wing is present.
- Funds for infrastructure up gradation are drawn from different sources like state plan funds, NRHM and other sources e.g. PRI system .Construction of health facilities is carried out by different agencies like PWD, HLL, HPL, KHRWS, KSCC etc.). The up gradation of health institutions are carried out with the participation of local authorities, hospital authorities and other stake holders.
- More than 50 % Sub-centres, 90 % PHCs and all CHCs are in government buildings. Public Health Infrastructure is adequate in numbers as per population norms but there is an urgent need of improvement in the infrastructure of District Hospitals and especially in Sub-district hospital where there is a huge load of deliveries. Despite the fact that particularly in Malappuram district the major part of delivery case load is going to the private sector, the public sector facilities from Taliqua hospitals upwards are overloaded and require up gradation in terms of physical infrastructure including equipments, supplies and manpower.
- Overall, the infrastructure was found to be good in terms of buildings and at many places community has donated land and buildings for health facilities. This is highly appreciable. However, despite having good infrastructures, most of the facilities visited are not optimally utilized especially CHCs and 24 x7 PHCs, there is a general preference to access private sectors. The District Hospital in Mallapuram and the CHCs required major strengthening.

- Primary level facilities i.e. non-FRU CHCs, PHCs are underutilized as in Kerala women do not prefer to access these institutions for delivery care. No In-patient were found in PHCs visited. However, it is a case in point that one of the PHCs visited PHC-Thiruveli in Malappuram was bustling with activities in spite of the fact that no deliveries take place here. Utilisation of this PHC was in terms of high case load of 150-200 OPD attendance per day, regular medicines for non-communicable diseases, Immunisation coverage >99% , convergence activities involving PRI members e.g. Nutrition Interventions- Demonstration of using locally available food etc.
- Different health seeking behaviour of the community unlike many other States has resulted in non utilisation of Sub-centres for deliveries; However, Utilisation of Sub-centres and involvement of JPHNs for other health care activities e.g. palliative care, screening of non communicable diseases, Ante-natal registration, and immunisation activities were more than visible. Sub-centres are effective hubs for out-reach activities related to these areas.
- Convergence of AYUSH systems and Allopathy under the umbrella of NRHM was primarily envisaged as a strategy to provide choice of treatment to the patients; strengthen facility functioning and strengthen the implementation of the National Health Programmes in the country.
- Kerala has 29945 registered AYUSH practitioners (as on 01-01-2011). It has 23 under-graduate and 6 post-graduate institutes of AYUSH systems. Each year these institutes provide 1120 AYUSH graduates and 56 AYUSH post-graduates.
- Co-location of AYUSH services with allopathic services has not yet been achieved within the public healthcare delivery system in Kerala. AYUSH system is functioning as a parallel system of service delivery. It may be noted AYUSH services are extremely well developed and well utilised in the private sector. There seems to be no cross-referral of patients between AYUSH and allopathic systems.

  A separate detailed write up on AYUSH services in the State is at Annexure 1
- Government of Kerala has initially selected 15 hospitals for National Accreditation Board for Hospital & Health Care Providers (NABH). Out of this 3 hospitals- General Hospital Ernakulam, THQH cherthala and WC Thycaud are already NABH Accredited. WC Kozhikode is under Final assessment and DH Kollam, DH Kottayam, THQH Thodupuzha, DH Palakkad, DH Manjeri, THQH

Sulthan bathery, DH Kanhangad, THQH Chavakkad are under Pre assessment stage. However, GH Pathanamthitta, DH Kannur are still under preparatory phase.

- Since NABH is difficult to achieve and expensive, Government of Kerala has decided to introduce accreditation standards for all government hospitals. The aims is to enhance the patients' quality of care by providing better medical treatment and preventive healthcare medical care services with the state of art technology with easy accessibility, affordability & equity. 70 hospitals were selected for the implementation of Kerala accreditation standards for Hospital (KASH).Two PHCs, two CHCs and 1 THQH were initially selected for the implementation. KASH will be implemented in a time-bound manner and the NRHM has earmarked the funds for the first phase in this year's allocation.
- The lack of residential accommodation for the health staff was visible in almost all the facilities visited in both the districts visited. If present, their condition was found to be poor in some. The few residential accommodations found in liveable condition were not inhabited by medical and Para medical staff. There is a scope for proper planning of infrastructure for accommodation. According to RHS data only 55.3% of the Sub centres have accommodation facilities for ANMs and among these 65.3 % of Sub-centres are actually utilising it.
- Planning process (PIP) did not universally reflect rational allocation of funds for upgrading health facilities e.g. No funds for CHC (FRU) Edappal (40-45 deliveries per month) vs. CHC Valavannur (no case load of deliveries) for which up gradation had been planned, although none were ultimately sanctioned in PIP.
- In most of the facilities drugs are available as per EDL and there is no shortage of drugs. Kerala has initiated project to supply free generic drugs of 952 medicines including Anti cancer Drugs to BPL and non taxpaying APL patients through government institutions.
- Essential equipment and drugs are generally available in most of the health facilities visited. There is underutilization of health facilities at CHC and PHC level. However, there is a lack of ownership and monitoring to ensure equipments are in working order.
- In both the district there was shortage of items like linen and mattresses particularly in the high case load facilities at Taliqua and District level.

- Infection management is being implemented by PPP and outsourced to IMAGE a private organisation. However, even in the secondary care facilities, Infection control practices are unsatisfactory ; e.g. no hand washing soap provided;; colour coded bins were present in Malappuram but the lids were not covered; protocols related to segregation of Biomedical waste and disposal not being followed . There is no segregation of highly infected patients who can be a source of hospital acquired infections. GOI Infection Management & Environment Plan (IMEP) Guidelines were not available, there was no display of protocols and guidelines are not being followed. Knowledge of the staff was highly limited as far as segregation and disposal of Biomedical Waste is concerned. Further, there is no mechanism for storage before disposal. Sharp and burial pits were available only at some places. Intensive training is therefore required regarding IMEP.
- THQH Cherthala of the district is the first NABH accredited Taluka Hospital in India. The whole process of getting NABH Accreditation of Cherthala THQH took 4 years and lots of resources. Final assessment for the same accreditation of few more selected hospitals is almost completed. In order to improve the quality of care across all public health facilities in the state in a shorter time frame, Govt of Kerala has developed its own standards "Kerala Accreditation Standards for Hospitals (KASH)". As on now, 14 hospitals are KASH (Kerala Accreditation Standards for Hospitals) accredited, 2 laboratories are accredited by QCI Essential Laboratory Programme.
- Outsourced to IMAGE across the State. However, the segregation at facilities was not as per GOI Guidelines
- Awareness of the staff regarding BWM of final dispersal processes undertaken ("what and how' segregation of waste, storage and disposal of sharps and placenta etc) was not up to the mark as services for disposal were being outsourced.
-
- It has been noted that Staff was not wearing protective gears like gloves while handling needles and syringes.
- Collection of anatomical waste like placenta was not done in closed bags/covered bins at the source of generation and during disposal of the placenta secure deep burial pit no disinfectant was used.

- Although there was sufficient arrangement for cleaning the premises of the hospital and patient areas were generally clean and sepsis rates were reported to be low by hospital authorities, the overcrowded female wards with children and mothers in the same area, the lack of shelter arrangement/stay arrangements for the accompanying relatives of patients seemed to be extremely important risk factors for potential nosocomial infection.
- No action plan has been developed in district for quality assurance interventions in the facilities.
- No Managerial and technical guidance is provided at the District level on implementation of action plan for improving the quality of services in the facilities.
- Out of pocket expenditure being incurred other than user fees were found to be negligible.
- Free Drugs need to be added

Recommendations

- Periodic assessments were not being done in Districts to identify gaps and to find solutions for improving quality of services in the facilities.
- Prioritization of works for up gradation of infrastructure should be based on the requirements at the local/district level and not based on top down approach which seems to be the case currently.

- Construction of residential quarters as well as ASHA waiting room should be taken up on top priority.

- In order to ensure better maintenance and timely repair of life saving equipments in health facilities annual maintenance contracts may be signed.

- It was recommended that guidelines on monitoring these services need to be issued from the state to district officials for strict enforcement of standards.

Besides this, the state urgently needs to provide training at all levels on infection prevention practices and waste management specially segregation practices

Out-reach and patient Transport Services:

- There is no shortage of sub-centres in term of numbers and all Sub-Centres are equipped with one JPHN (ANM) and JHI (junior Health Inspector/Male worker) and unlike other states the Sub-Centres in Kerala do not conduct deliveries but provide other basic care e.g. palliative care, screening of non communicable diseases, Ante-natal registration, and immunisation activities.
- Second JPHN is not present at any sub centre and none of the JPHNs are SBA trained. However, Male health workers (JHI) are attached with every sub centre and play a major role in surveillance and house hold visits for source reduction for communicable and non communicable diseases.
- Sub centers visited had adequate space and were well maintained clean facilities.
- Availability of drugs at SCs was satisfactory but in some of the Sub-centres there has been shortage of Vitamin A solution and IFA syrup. However, other medicines were available.
- ORS packets were generally available but not with Zinc.
- Record keeping was found to be reasonably good but there were gaps in follow up and documentation of PNC. Work plan for ANMs including outreach activities calendar was available. OPD attendance was found to be good in sub-centers.
- Schedule of Immunization at Sub-centres is once a month. In outreach i.e. WHSND 1 session/ward/month.
- Registers like Stock Register for routine medicine, Immunization clinic register, Weekly ANC Register, MCH Register, Condom Register, Death register, Eligible Couple Register, IEC register on Awareness for NCD/CD & personal Hygiene etc are well maintained.
- NCD clinic is organized on 2nd Friday of every month. NCD Clinic Camp Register available.

- WHSNDs are organized as per schedule, attended by ward member. Minutes of the meetings are up-to-date.
- There was no electricity connection in one of the sub centre (Mararikulam) of Allapuzha District due to nonpayment of electricity bills by Panchayat.
- There is no piped water connection. Water is drawn from a well found within the premise.
- Good co-ordination and Active involvement of JPHN, AWW and ASHA and PRIs.
- There is a conflict in data on full Immunization (FI) coverage from the following two sources i.e. HMIS and data from Immunization division of the ministry based on the yearly reports from the State

Indicator: Full Immunization coverage	HMIS (2011-12)* (in percentage)	Immunization Division (2011-12)# (in percentage)
Kerala	92.1	73.9
Malappuram	66.3 ⟷	53.4
Allapuzha	122.5 ⟷	73.9

*Infants fully immunized to reported live births

Infants fully immunized to target population

- Due list is prepared by ANM before the session (generally a day or two before) and ASHA is asked to gather the children on due list on the day of immunization.
- The JPHN is using BP instrument and weighing machine and maintaining the records.
- Provision for joint accounts of JPHN and ward member for WHSC is there. However, although in Malappuram there is provision for a separate account at Sub centre level for untied funds, this provision was not there in Allapuzha District, where Untied funds for the SC are received as cheque from the concerned block MO in charge and deposited in the WHSC account. Funds are withdrawn from this account as per requirement with combined signature of ward members and JPHN. Another issue was that the money received on account of untied fund in cheque

form had not been deposited into the bank account for two months in Ward no. 26 to 29 in Malappuram District.

- The main activity performed by ANM is to conduct immunization session (every Wednesday) ANC and PNC. Sub-Centre micro plans for immunization were available at all the facilities visited. However, alternate Vaccine delivery system not in place. Either ANM/ ASHA have to go nearest PHC one day prior to collect the vaccines. This affects their service delivery.
- The RKS has been set up at all levels. In the DH meetings the RKS meetings take place, and members have been drawn from PRI, NGOs, and beneficiaries. There is an increasing confidence in making expenditures although more systematic planning and comprehensive understanding of possible investments of RKS funds. Most expenditure is on repair and maintenance, have appointed a plumber and electrician for services to the DH. Audits of RKS are not taking place at any level. An evaluation of the RKS is required at this stage to understanding key constraints in operation and enabling more effective use of the funds.

Referral Transport and MMUs

- Government ambulances were available at district level only while none were available at sub-district level facilities. State has not developed a call centre based network of Emergency Medical Response System except in Trivandrum and Allapuzha districts.
- In some of the tribal areas of the Malappuram district home deliveries still persist for which apparent reason is lack of transport facilities.
- Floating Dispensary is an innovative step in Allapuzha to cater to the health needs of the population living in geographically isolated riverine areas which are comparatively inaccessible. There are three such floating dispensaries. Each dispensary consists of 2 doctors, 1 staff nurses and pharmacists recruited on contract under NRHM. They report to CHC medical officers. Cost of one dispensary is almost Rs.49, 000.The boat, diesel, maintenance and drivers are to be provided by the agency. Day of visit and place are fixed in advance by the district.
- Camps are organized at regular intervals by these dispensaries. Each camp will be attended by 50 -70 patients.

- There are total 16 functional MMUs in seven districts of the State, all in tribal areas. These provide facilities for basic lab tests like blood sugar, hemoglobin; malaria etc. and also fitted with generators. These specially designed units are manned by two medical officers, two nurses, a lab technician, a radiographer and a pharmacist.

Recommendations:

A callcentre based Ambulance network catering to the basic emergency needs of the population including pregnant women and sick newborns services is the need of the hour

State needs to ensure that deployment of ambulances must be done rationally on the basis of the population and load of emergency cases.

Every district to have a call centre based system of referral transport

Nos. of ALS /BLS ambulances need to be planned based on nos. and types of caseloads at different levels and different geographic areas.

Ward Health and Nutrition Days (WHND):

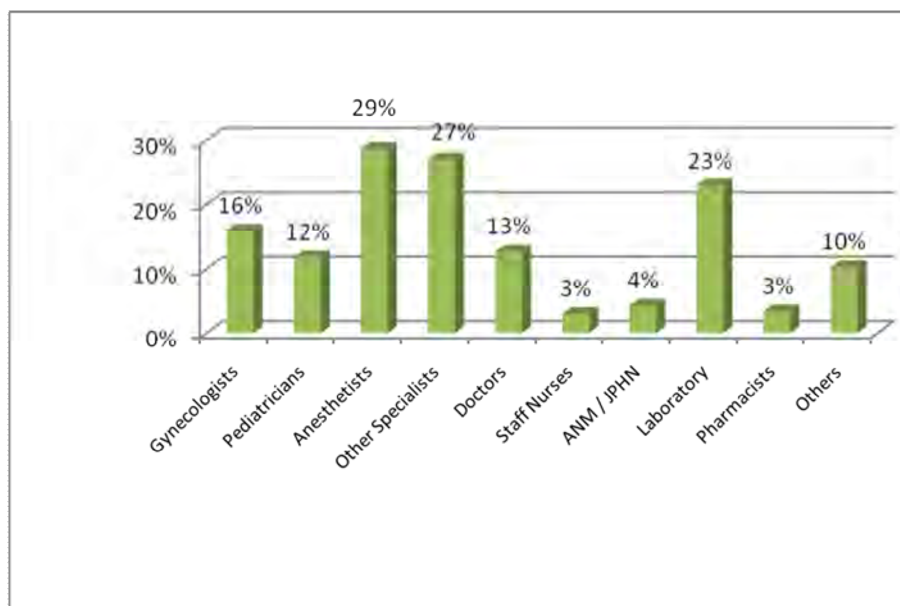
- WHNDs are organized through ANM/JPHN & AWW on every 2nd Saturday either at AWC or in the village. ANMs were giving counseling on Immunization, nutrition, breast feeding, ANC, PNC & Family planning. Nutritional supplementation (Take-home Rations) was given to less than 3 years old children & pregnant and lactating women.
- Involvement of ASHA, LHV/ Public Health Nurse & male supervisors was good at WHNDs. VHNDs were being monitored by VHSNC members and MO-IC. Village Health Nutrition Days and immunization activities are planned through common micro plans of ANMs, AWW and ASHAs. There is good inter-sectoral linkage with ICDS.
- ASHAs play a key role in conducting the nutrition day by mobilizing the people to attend the program. Agenda for WHNDs are decided in advance, based on the need of the area during the monthly conference at the PHCs. Junior Public Health Nurses keep the record of all the activities in the register and the consolidated reports of the block is prepared by the Block Coordinator.

- WHSCs are working mainly for source detection and chlorination during household visits. Chlorination is also done by WHSCs members during house visits.•

TOR III

Total Health Staff under Directorate of Health Services

Category	Number of Sanctioned post	Number of vacant post against sanctioned
Gynecologists	283	45
Pediatricians	203	24
Anesthetists	136	39
Other Specialists	1062	287
Doctors	2702	342
Staff Nurses	7303	218
LHV		
ANM / JPHN	5575	235
MPW	397(field worker)	129
Laboratory Technicians	776	178
Pharmacists	1514	51
Others	27431	2820



- Incentives, Special incentives for Difficult areas: Doctors are given incentive for working in Difficult Rural areas (Rs.3000/-) and Most Difficult Rural Areas (Rs.5000/-). This encourages the doctors to work in the backward areas and as a result, presence of doctors is ensured in these areas.
- Performance Appraisal against Benchmarks, renewal of contract based on performance: Under NRHM, initial appoint is given for a period of three months. Based on the performance of the individual, the appointment is extended for further period. Benchmarks are fixed for each category of post and the performance is appraised based on the same. Further, each employee is appraised based on their annual performance appraisal report and is linked to increment.
- As a motivation measure a separate cadre for specialists has been set up. Residency
- System has also started in the state.
- At block level no BPMU has been established. No ARSH counselor
- JPHNs appointed in Urban RCH as well as School Health Programme have been appointed on contract basis.
- Capacity of SPMU is not satisfactory.
- In Kerala, 4232 JPHNs are sanctioned as compared to 5384 required JPHNs out of which 59 positions are vacant as per RHS 2011.
- 1399 positions for Health workers (Male) are sanctioned out of which 114 positions are vacant.
-

Status of Contractual Staff

Category	Appointed	Vacant
MBBS Doctors	275	94
Ayurvedha Doctor	153	10
Homoeo Doctor	268	20
Specialist Doctor	81	28
Staff Nurse	1025	4
JPHN	973	25

TOR IV

Reproductive and Child Health

RCH Indicators of the State:

SN	RCH Indicators	Kerala
	Maternal Mortality Ratio (MMR)	81 (SRS 07-09)
	Institutional deliveries	99.4% (DLHS 3), 99.5% (SRS 2010)
	3 + ANC Coverage	95.2% (DLHS 3), 90.8% (CES, 2009)
	Safe Delivery	99.4% (DLHS 3), 99.9% (CES 2009)
	Infant Mortality Rate (IMR)	13 (SRS 2010)
	NMR	
	U5MR	
	Children under 3 years breastfed within 1 hour of birth	64.6% (DLHS-3)
	Fully Immunized children	79% (DLHS-3), 81.5% (CES2009)
	Children (age 6 months above) exclusively breast fed	22.3% (DLHS-3)
	Children with diarrhoea in the last 2 weeks who received ORS	45.6% (DLHS-3)
	Children with diarrhoea in the last 2 weeks who were given treatment	78.8% (DLHS-3)
	Children with acute respiratory infection/fever in the last 2 weeks who were given treatment	89.8% (DLHS-3)
	Total Fertility Rate (TFR)	1.8 (SRS 2010)
	Crude Birth Rate	14.8 (SRS 2010)
	Any modern method for family planning	55.9%(DLHS-3)
	Unmet need of the state	15.8% (DLHS-3)

	CPR for any methods	64% (DLHS-3)
	Post Partum Sterilization	74.66%
	Male Sterilisation (NSV)	2.93%

Health Infrastructure in Alappuzha & Malappuram:

SN	Health Infrastructure	Alappuzha	Malappuram
	Medical College	1	
	General Hospital	1	
	Women & Child Hospital	1	
	Delivery Points (where deliveries take place), all are FRU & have PP Unit	7 (1 Med College, W&C, 5 THQH)	
	District Hospital, Mavelikara	1	
	Taluk Hospital-	7	
	CHC	16	
	24*7 PHC	39	
	Total PHC	39	
	Total Sub centres	366	

RCH Indicators (HMIS 2011-12)

SN	RCH Indicators	Allapuzha	Mallapuram
	Total Population	21,29,262	
	Sex Ratio	1100	
	Sex Ratio 0-6 years	947	
1	Expected pregnancy	34,664	
	Expected delivery	31,513	

2	Total number of pregnant women registered for ANC	25,831	
	ANC registration against expected pregnancies	75%	
	ANC Registration against reported pregnancy		
	ANC Registration in 1st trimester (of total ANC registered)	78.8%	
	Mothers who had at least 3 ANC check ups (of total ANC registered)	83.3%	
	TT2/Booster given to pregnant women against ANC registration	98%	
	100 IFA tablets given to pregnant women against ANC registration	35%	
	Total reported deliveries	20,570	
	% of total reported deliveries to estimated deliveries	65.3%	
	% of total un-reported deliveries to estimated deliveries	34.7%	
	Deliveries at public facilities to reported institutional deliveries	49.6%	
	Total number of C-Section (Pvt & Public)	9827 (47.8%)	
	Abortion (spontaneous/induced)	1187	
	Abortion rate against expected pregnancies	7.8%	
	Live births reported against estimated live births	65.8%	
	Newborns weighed against reported live births	99%	
	Newborns weighed less than 2.5kg against newborns weighed	11%	
	Newborns breastfed within one hour of birth against reported live births	86%	
	Fully immunized children against reported live births	122%	
	Female sterilization to total sterilization	97.8%	
	Male sterilization to total sterilization	2.2%	

KEY FINDINGS, ISSUES AND RECOMMENDATIONS

a. Delivery Points:

- Alappuzha: As per the GOI Guidelines, 7 (1 Med College, Women & Child Hospital, 5 Taluka Hospitals) are functional delivery points in the district.
- Deliveries are not taking place at sub-centers, 24x7 PHCs, non-FRU CHCs resulting in concentrated case loads at higher health facilities.
- The midwifery services by JPHN (ANM) of Sub Centers are limited to ANC Checkups. However, the sub centre staff e.g. JPHN & JHI (Junior Health Worker) are extensively involved in promotive & preventive activities under various other public health programmes and Non Communicable Diseases surveillance e.g. screening for cholesterol, screening for diabetes, screening for hypertension etc;, Pain & Palliative care, School Health Programme etc. Besides ANC etc, the JPHN's focus is substantially on other outreach activities related to counselling for nutrition to adolescents, immunization etc. The workload on the JPHNs is therefore substantial in spite of actual deliveries not being conducted at Sub centre.
- ANC registration within 1st trimester is 80% in Kerala and it is taking place with the help of JPHN. They are also tracking the pregnant women for subsequent ANC checkups although these checkups may be done at higher public health facilities or in the private sector.

b. JSSK:

- JSSK with all the entitlements has been implemented across the state on 15th Aug 2012 and on 25th Aug 2012 in Allapuzha. Under the scheme, "Near to NIL" out of pocket expenses if a pregnant woman delivers in the public health facility and for treatment of sick neonates till the age of 30 days for drugs & consumables, investigations (blood & urine tests, ultra sonography etc), blood transfusion.

- Rs 45.5 lakhs of allocated budget of Rs 91.17 lakhs for JSSK to Alappuzha has been received, and Rs 24.38 lakhs have been disbursed to the institutions which have started the JSSK.
- An effective system of referral transport for inter-facility referral was seen in the districts through "108" ambulances with state level call centre for pregnant women and sick newborns. However, each pregnant woman receives a cash payment of Rs 500/- against the transportation for coming to hospital and drop back under JSSK. The same facility was available for treatment of sick neonates in public health facilities.
- There was a provision of diet to pregnant women for 3 days and 7 days for normal delivery & C-section respectively in Women & Child Hospital, Alappuzha. However, Rs 100/- per day has been earmarked for diet wherever kitchen facility is not available e.g. medical college hospital, Alappuzha and similar provisions are there in Malappuram.
- Essential laboratory services were available at most of the facilities visited
- Front line health workers e.g. ASHA and ANMs in the district were aware of the newly launched JSSK scheme.

c. Normal Delivery v/s C-Section:

District Alappuzha: Service Utilization for ANC, Institutional Delivery (ID) and MTP (Attached with Annexure)

SN	Year	ANC	IDs	MTP

	06-07	30645	29267	2793
	07-08	34371	36077	1025
	08-09	35405	23462	1152
	09-10	27490	21281	1083
	10-11	25423	20392	962
	11-12	25062	20480	1348
	12-13 (up to Sept 2012)	13119	10221	378

- ----------- supportive data
- Proportion of institutional delivery : private to public hospitals is around 60:40 across the state. In Malappuram district, it is 6:1. However, the scenario is different in Alappuzha where two third of the deliveries are taking place in the public institutions because of less number of private institutions and because public institutions (W&C Hospital, Medical College Hospital etc) are easily accessible (located in the middle of the city). One of the private hospital visited in Malapppuram , Malabar Insitute of Medical Sciences (MIMS) was NABH accredited and handling heavy case load.
- Out of pocket expenditure incurred on normal deliveries by women accessing private sector facilities was in the range of Rs 4000-5000.
- C-sections rate as a proportion of total deliveries is high in both public and private sector ranging from 32.5 % in Medical College hospital Allapuzha to 59 % at DH Mavelilkkara in the same district.On an average approximately 40-50 % of the deliveries end up in c-sections. Two probable causes of this are the high rate of practice of augmentation of labour with Syntocinon, many times unindicated and the demand by fairly literate women for surgical interventions in order to cut short the labour.

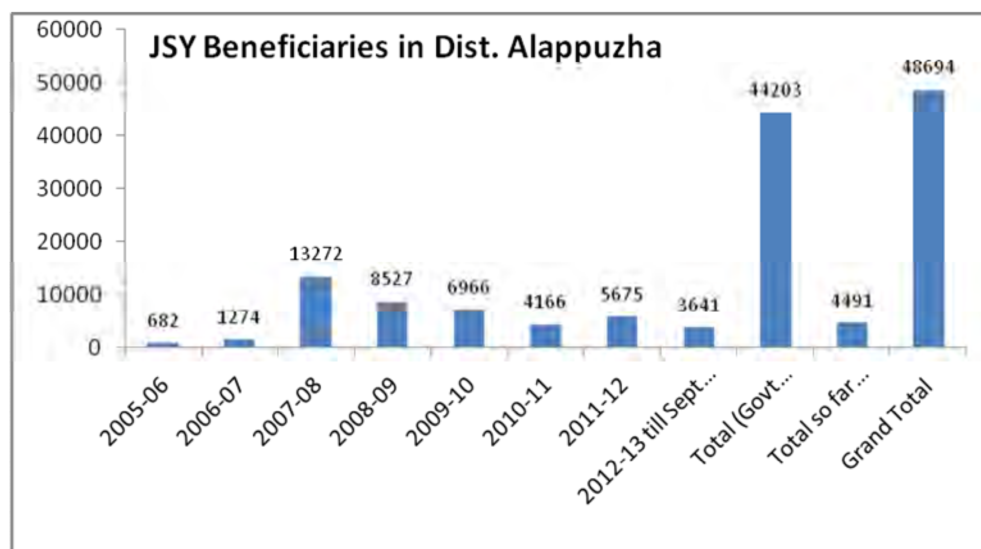
- With JSY and JSSK implementation and infrastructure improvement, the number of institutional delivery in public hospitals shows a marginal increase (supportive data). However, the social culture for delivery in private hospitals is overall still persisting in the state.
- In district Malappuram, home deliveries are still taking place in few tribal pockets.
- Elective labour induction was seen in most of the cases admitted in Women & Child Hospital and Medical College hospital, Alappuzha resulting in adverse outcome e.g. increased prevalence of C-Sections, PPH, foetal distress.

d. Janani Suraksha Yojna (JSY)

Alappuzha: Facility of JSY benefit available at all the 7 delivery points & 26 private accredited hospitals since Oct 2007

SN	Year	**JSY Beneficiaries**	
		Alappuzha	Malappuram
	2005-06	682	
	2006-07	1274	
	2007-08	13272	
	2008-09	8527	
	2009-10	6966	
	2010-11	4166	
	2011-12	5675	
	2012-13 till Sept 2012	3641	
	Total (Govt Hospitals)	44203	

	Total so far (Accredited Private Hospitals)	4491	
	Grand Total	48694	



- Well functioning in both the districts visited. There was no APL/BPL demarcation, no age bar for PW and no bar on nos. of children/pregnancy for JSY benefits.
- Timely disbursements of incentives under JSY were being practiced and it was linked to 48 hour stay in the facility.
- There was no shortage of JSY fund in the any of the HFs. Incentive was being issued through cheque at the time of discharge.
- Inactive Grievance Redressal mechanism in the districts.
- List of JSY beneficiaries were not being displayed publicly in health facilities, however the list was available with the staff
- No informal payment to any of the staff reported by the beneficiaries to get JSY payment.
- Beneficiaries were satisfied with the facilities provided them in hospitals.

e. Tracking of severe anaemic pregnant women:

- Diagnosis of severely anaemic women through Hb testing is taking place at health facilities free of cost but the line list of these women was not seen at the HFs visited for tracking of treatment due to insignificant number of severely anaemic women e.g. only 18 severely anaemic women in Alappuzha district as on Nov 2012.

f. Labor Room (LR):

- Alappuzha: sufficient space in maternity wing including labor room, separate demarcated areas for 1st stage of labor and recovery room (post-labor room before sending to post-partum ward). However, there was inadequate physical infrastructure in LR of District Hospital, Mallapuram.
- Round the clock dedicated staff (OBG and nursing staff) for LR in Alappuzha, however, absence of gynecologist specialist during out of routine hours was cited as a reason by clients opting for private services in Mallapuram.
- Partographs were being used in most of the facilities visited to monitor the progress of labor and timely identification of complications of delivery.
- All the routine and emergency drugs and consumables were available in the labor rooms.
- Colour coded dustbins were found in the LR for biomedical waste.
- Over all good record keeping in labor room of the facilities visited but it was excellent in Medical College hospital, Alappuzha,
- All the women admitted for delivery in public hospitals (Women & Child Hospital, Medical College Hospital, Alappuzha) were dressed in white sarees found in white dress.
- No use of referral slips when refer cases to higher health facilities
- Elective/ irrational labour induction was seen in most of the cases admitted in Women & Child Hospital and Medical College hospital, Alappuzha resulting in adverse outcome e.g. increased prevalence of C-Sections, PPH, foetal distress.

- There was no display of standard technical protocols for management of labour and complications in the LR of the HFs visited.
- Service providers posted in maternity wing have not been trained in RMNCH skills e.g. SBA, F-IMNCI, NSSK etc. Similarly, most of the service providers were not exposed to in service training (CMEs) to upgrade their skills

g. Blood Bank/Blood Storage Unit:

- Available at all the FRUs of both the districts.
- Well equipped blood banks at Women & Child Hospital and Medical College Hospital, Alappuzha.
- There was no dedicated Medical Officer for Blood Bank, Women & Child Hospital, Alappuzha and one of the two paediatricians was handling the additional charge. It was suggested to the State to relieve him of this additional charge as there were only 2 paediatricians in the hospital for 24x7 services.

h. **Mother & Child Protection Card**:

- Staff was still using the older vaccination cards for immunization of children and expected mothers.
- As per the state officials, MCP cards were under printing and training of paramedical staff on MCP cards was going on simultaneously.

i. Child Health, SNCU, NBSU & NBCC:

- Designated Newborn Care Corners (NBCCs) were found in labour rooms and operation theatres; however some of these were without functional radiant warmers. Where ever available, some of these were not placed at the appropriate sites in the labour room/OT. Staff nurses posted in labour room and obstetric OT staff have not been trained on essential newborn care - specifically NSSK. The staff using this equipment had little information on usage, maintenance and troubleshooting . Whatever skills are there have probably been required on the job.
- Higher level of Special New born care specific for different levels was not available in the facilities visited e.g. DH Thirur only had New Born Care

facilities of the level of NBSU. There are NBSU at district/sub-district level in Women & Children Hospital, District Hospital, and Medical College Hospital. State is currently in process of expanding the newborn care bed capacity through establishing SNCUs using NRHM funds. The plans are developed and agencies are finalized for renovation/civil work; however the number of proposed newborn beds in upcoming SNCUs appears lower than the expected (including future projections).? (No. of SNCUs if any to be confirmed)-Dr Sanjeev's Inputs

- Newborn beds are not included in the bed strength at some places and are not given indoor registration number (ID) – hence the resource are not proportionately allocated to health facilities, though the newborns require larger attention and resources.? Dr Sanjeev's Inputs
- FBNC Training for operationalizing SNCUs initiated at Regional Collaborative Centre, based at ICH Chennai through UNICEF support, where a group of MOs and staff nurses were trained as trainers. Dr Sanjeev's Inputs Also copi in Knowledge management
- ORS was seen available at various levels, however Zinc not available any facility. None of the front line service providers were aware of doses and schedule of Zinc for childhood diarrhoea
- State has not started infant death review (IDR) as yet. ? Dr Sanjeev's Inputs

j. Immunization & Cold Chain:

- There was an active participation by representatives of panchayats & political parties and as a result PHC Thiruveli of district Malappuram has achieved almost 100 % immunisation coverage and has been organising a number of convergent activities for nutrition and other health parameters.
- Routine immunization was good in general; however there are pockets/districts of low to medium coverage.
- Almost all vaccines were found in usable condition; however the staff was not fully aware of standard cold chain methods in Alappuzha District.
- Measles 2nd dose has been introduced under Routine Immunization in the entire state.

- Pentavalent vaccine has been introduced in the state from 14th December, 2011. This vaccine which was available everywhere
- Many of the health staff responsible for RI and cold chain was not trained recently, so they were not aware of latest guidelines.
- The state was still using the old immunization cards and record registers. The records were kept neat and clear.
- One of the recently studies, "*Uptake of Child Immunization: Barriers and Challenges - A Qualitative Assessment in Malappuram & Palakkad Districts*" conducted by HLFPPT cites instances of vaccine stock-out, lack of monitoring and lack of IPC for routine immunization

k. Drugs:

- Most of the essential drugs under JSSK were available in the visited health facilities.
- Drug stores in most of the facilities were in good working condition
- Drugs for MMA are not included in EDL.

l. Maternal Death Review (MDR)

- Excellent civil registration system in the state, system of on-line reporting for each birth and death. Each woman gets provisional birth certificate for her newborn child from the hospital at the time of discharge.
- There is a system of lodging FIR immediately if any maternal death takes place.
- All the hospitals including private hospitals are bound to report each birth and death within the stipulated time. Heavy fine to be paid by the hospitals in case of failure or default.
- A system for Maternal Death Review exists in the state, however, it is not as per GOI protocols and Guidelines. Officials use different formats for reporting and analysis. Although teams from District level go down to facilities to conduct reviews , an in house facility based review was not visible. Deaths were not observed to be classified into the designated medical causes. Private sector facilities did not have Committees for FBMDR.

- There also exists a system of "**Confidential Enquiry of Maternal Deaths**" in the state since 2004 with the support of Kerala Federation of Obstetricians & Gynaecologists (KFOG). The review under the system takes place quarterly. However, there is no sharing of their analysis with the Central Ministry. It was also observed that the review & analysis of reported deaths is mainly limited to identification of medical causes.
- Health staff including field functionaries was aware of immediate reporting of maternal and infant deaths. However, there was no awareness on submission of "NIL" death reporting to district HQ and further to state HQ.
- District MDR Committee has been constituted in both the districts to review and investigate maternal deaths reported by the health facilities. However, there was no constitution of Facility Based MDR Committee at the facilities with high delivery case loads to investigate deaths.
- Review of reported deaths has not been taking place under the chairmanship of District Magistrate.
- No proper record keeping at district level for MDR particularly line listing for "NIL" death. Similarly, documentation (filled formats) for the reported deaths were not found at the health facilities.
- Minutes of each meeting of District MDR Committee of CMO to be kept to take corrective action and follow up.

m. Safe Abortion Services (CAC- Comprehensive Abortion Care)

- There was inadequate safe abortion services in both the districts. The health providers are still using outdated technology. They were neither aware of or using MVA, which equipments were not available.
- Drugs for MMA have yet not been included in Essential Drug List (EDL).
- Alappuzha: In most of the MTP cases at tertiary level hospitals, women adopted sterilization after MTP.
- Malappuram: OBG at FRU was reluctant to perform induced abortion due to fear of the community in case of any complications. Tendency was there to refer all patients to medical college. Many women appear to be seeking abortion services from private health facilities.

- KVM Hospital, accredited private hospital under PCPNDT was providing USG services with expired license in Alappuzha district. At Malappuram District hospital in the absence of radiologist, the OB gynae specialist was USG but was not aware of the documentation required under PCPNDT
- Poor IEC for CAC (about the availability of SAS in the health facilities free of cost, MTP Act etc) both at health facilities and in community.
- The documentation for induced (MTP) and spontaneous abortion was not in the standard formats in district Alappuzha.

n. RTI/STI & HIV/AIDS:

- Functional ICTC clinics with dedicated staff, equipments and drugs at district hospital and medical college hospitals, Alappuzha.
- All the pregnant women are advised to visit ICTC for HIV/AIDS testing by Rapid Test and for pre & post investigation counseling.
- Treatment facility for RTI/STI was available at most of the facilities visited.

o. IEC:

- Good IEC about the various government schemes particularly JSY and JSSK etc across the districts.
- Lack of IEC for newly emerged thrust areas of RCH e.g. safe abortion services, adolescent health, RTI/STI etc
- Displays of IES messages were mainly limited and concentrated to the HFs.
- Visibilities of various IEC/BCC messages through mass media like buses, hoardings in prominent places of city etc. was lacking.
- IEC/BCC activities are going on to encourage women for normal delivery.

p. MCTS: In IT Section

- JPHN have been made responsible to up load MCTS data at PHC level as there are no DEOs at PHC level to upload this data.
- Mis match between HMIS data and MCTS data (M. Puram) however not so in Alappuzha.
- Lack of capacity for analysis of HMIS data for planning, programme monitoring and management.
- Up-dation of data in the MCTS web portal and utilisation for tracking of service delivery is a challenge.
- Telemedicine unit established in Malappuram but not functional because of lack of staff
- The due lists of beneficiaries from MCTS have been generating and used by ANMs for providing RCH services mainly vaccination.
- Verification of MCTS data (contact nos of beneficiaries, ANMs, ASHA's etc) was taking place.
- The utilization of available data for monitoring and planning by the district officials was not very evident.

q. Family Planning:

District Alappuzha: Service Utilization under Family Planning (as an Annexure)

Year	NSV	Lapro	Mini	PPS	IUD	Condom	Oral Pill
06-07	38	597	503	5375	2535	753447	12131
07-08	28	459	427	4552	2589	466045	10071
08-09	395	522	343	4695	2532	18915	621629

09-10	518	951	356	4667	3351	252543	10581
10-11	467	738	273	4654	2614	95602	19700
11-12	373	771	319	5415	2895	132751	1832
12-13 (up to Sept 2012)	209	298	101	1111	1560	177633	2525

- FP acceptance and service delivery good in Alappuzha but acceptance by community poor in Malappuram
- In Alappuzha, post partum IUCD/ligation and post placental IUCD insertion etc was seen in significantly high numbers.
- Fixed Day camp approach for sterilization in most of the health facilities visited.
- The practice of pressurizing women seeking abortion services, to adopt contraception compulsorily was noticed in Allapuzha.

- All health facilities visited in the two districts have their own buildings and were well maintained.
- Cleanliness in the health facilities particularly in labor rooms in-spite of over-crowing were appreciable.
- Attached toilet in LR. Separate toilets for women were available in all the facilities.
- Good display of signage’s for available services in most of the facilities.
- Janani Shishu Suraksha Karyakram (JSSK) guidelines were displayed in the facilities.
- No process of internal monitoring through PRI, RKS etc. as a part of quality control.

r. Floating Clinics in Alappuzha (Mobile Medical Unit)

- There are three floating clinics Kuttanadu, Kuppapuram and Perumbalam covering 12 panchayat and are to provide health care services to water logged areas. Each clinic is staffed with two MO, one Staff Nurse, and one Pharmacist. The schedule for the month is prepared in advance and publicized through news papers and other media modes. Each boat covers 2 boat jetties per day. ASHA of the area is responsible to mobilize the patients to the clinic.
- Substantial case loads with an average 1600 patient per month per boat.
- There was no privacy for female clients visiting these floating clinics.

s. Menstrual Hygiene Scheme:

- Only in Malappuram as it is one of the 7 districts of the state where the scheme has been started. The supply of the sanitary napkins under the scheme is from HLL.
- The uptake of sanitary napkins was reported to show a decreasing trend because of the poor quality of the napkins.

t. **ASHA in Alappuzha & Malappuram**

SN	ASHA	Alappuzha	Malappuram
	Total nos of ASHA allotted	2300	
	Total selected	2375	
	Nos of ASHA currently working in the district	2297	
	Trained up to	5th Module of 2054 ASHA	
	Nos of ASHA who have received Drug kit	1585	

- ASHA are poised to play a major role in palliative care in non-communicable disease management in the state.
- Breastfeeding practices are reported to have improved due to presence of ASHA in field.
- Their numbers were found more than the expected nos.
- Average monthly payments to ASHA reported range from as low as Rs. 350 per month.

u. School Health Programme

- Launched in Sept 2009 in district Alappuzha:
- 27 JPHN have been appointed on contract basis for the programme
- The scheme is for all the Govt and aided school (745)
- Progress under the programme:
  - Screening medical camps conducted in 2010-11- 86
  - Special Medical Camps conducted- 32 (12 in 2010-11, 20 in 2011-12)

v. Adolescent Reproductive & Sexual Health (ARSH) Programme

- In district Alappuzha, 5 colleges have been selected for ARSH Activities. Fixed ARSH clinic at General Hospital and one mobile ARSH clinic for the district have been allotted in the District PIP 2012-13. Currently, training of the staff is going on.

w. Arogyakerlam Pain & Palliative Care Programme

- Objective of the programme is to provide palliative care to elderly people where conventional health care services are of little use, at their home. It is a nurse led home care system with community participation and supervision by a doctor.
- The programme has been started in Sept 2008 in all the 41 Panchayats & 1 Municipalities of the district Alappuzha. Staffs under the programme are 1 Field Coordinator, 1 Doctor, 8 Staff Nurses. In addition, 41 more palliative Care Nurse have been appointed through LASGI for Pain & Palliative care programme.

Recommendations:

- No cash payment under JSSK is permissible; therefore, the State should speed up the process of setting up a network of ambulances to provide transportation facility (from home to hospital, inter-facility and drop back home). Similarly, provision of diet could be done through SHGs (Self Help Group) if the facility of kitchen is not available in any of the delivery points.
- Consider revising SNCU development plans in order to address the current and future needs of district
- Cascading of FBNC trainings and mentoring to make ensure trained human resources in existing and upcoming SNCUs/NBSUs
- Develop State Perinatal Resource Centre at state level to plan, train, monitor, mentor FBNC services for sustainability
- Ensure training and supplies of Zinc
- Identification of low coverage pockets and develop plans/micro-plans to reach-out the unreached and periodic review of the micro-plans
- Trainings and refreshers of health functionaries on RI and Cold Chain Management. Further the State Government may consider undertaking an Effective Vaccine Management (EVM) Assessment in order to understand the gaps in immunization and cold chain.

- District/state level training centers can be strengthened using external agencies/professional associations/ medical colleges in clinical and program management
- Capacity building needs to be strengthened at State and district level (SIHFW and setting up DTCs, Nursing Training institutions)
- Strengthening of skills in Basic life support/Advanced Life support for doctors/nurses is needed.
- Provide training in PIP preparation and program management to AYUSH district officers along with DPMs and other district level officials.
- Skill up gradation of OBGs and other service providers on latest updates and GOI Guidelines on various health subjects through CMEs.
- Intensive IEC BCC activities for adopting normal deliveries rather than un-indicated C-sections, for full immunization etc.
- Closer monitoring and regulation of private sector to reduce un-indicated C-sections
- Ensure display of technical treatment protocols for complications during pregnancy and delivery which have been disseminated by GOI
- MDR process to be institutionalized as per GOI guidelines, ensure orientation and training of health functionaries, including private sector.
- Improving Infrastructure and quality service delivery in public sector facilities.
- The Grievance redressal mechanism needs strengthening at all the levels to improve the quality of care in public sector.
- Considering the substantial work load at grass-root workers (JPHN), the state is recommended to place their demand for hiring District Data Manager/DEOs at least up to block PHC level to upload MCTS data with the support of JPHNs.
- The state is suggested to conduct orientation/training sessions for service providers including private sector in data management and utilization.

TOR V. Disease Control Program-Communicable and Non Communicable

1. Is reporting for IDSP adequate and complete, and is information used for appropriate action? What are the gaps that limit its functioning? Is IDSP data used in district planning for control of communicable diseases?

- Daily reporting from all institutions before 3 P.M. and weekly consolidated report is being prepared.

2. National Vector Borne Disease Control Programme (NVBDCP): On each of the following Malaria, Japanese Encephalitis, Kala-Azar, Dengue and Chikungunya) disease control programmes, note whether the district has seen in change in incidence?

- Yes there is a change in the incidence reported. More dengue cases are reported. Especially in costal areas.
- Leptospirosis: a reduction in incidence has been observed among the reported cases indicating low prevalence .

(a) To what extent are specific public health strategies under each programme being implemented in the district?

- Suspected and affected Case detection , Awareness programs , reporting and campaigns.

(b) To what extent is implementation responsive to disease prevalence patterns?

- Multi-sector approach has been formulated to control the disease prevalence.

(c) To what extent are facilities able to provide the support required for illness management?

- Secondary and tertiary level care centers are over utilized and primary level care centers have to be strengthened to meet the support required for illness management.

3. Revised National Tuberculosis Control Programme (RNTCP):

(a) Analyze and comment on achievements with respect to targets and constraints.

- Total case detection and sputum positive Tb cases is Static and not crossing 50% expected .
- Suspected examination is doubled. Case detection is not double. Right side skewness.as 50% cases are low positive, less than 50 % scanty, prevalence is in grey area. However, no reports from private Sector.
- RNTCP started, Since 2008, 64 cases diagnosed, 36 cases on treatment.
- 3 HDR diagnosed .

(a) What is the status of roll out of new programmes, such as MDR-TB?

- Malappuram is the first district where MDR-TB program started.

4. National Program for Control of Blindness (NPCB):

(a) What is the progress on establishment of Eye Operation Theatres and increasing Eye Surgeons in rural areas;

- OT at Gen. Hospital Tirur and one post of Ophthalmologist.

(b) What is the performance on cataract programme, including IOL supply and on: monthly once screening at CHC level

- Total IOL : 615

Govt	Pvt	NGO	Total
91	226	298	615

(c) Checking of refractive errors among school children? yes in association with SHP.

(d) Note constraints: Lack of facilities at Sub Center & PHC level

5. National Iodine Deficiency:

(a) Is iodized salt in universal use in the district? Yes.

(b) Are test kits in use? : Test kits are used by ASHAs.

(c) Is the state laboratory functional? Yes.

6. National Leprosy Elimination Program (NLEP):

(a) What is the change in disease prevalence by type of disease and age group? :

- Total Reported cases : 127 MB: 72, PB :55 , (SC -4)
- 25 out of 127 cases are Children. Among the 25 cases, 24 are PB and one is MB.
- In 2005 total cases were 157, MB : 98 and PB : 59.

(b) What control and rehabilitation measures are being undertaken? Rehabilitation by DPMR . distributed :

- MCR Chappals -60, Wheel Chair -1, cretches 1

7. Non Communicable Disease: Is there any data on the prevalence of NCD at state and district levels? :

Yes

(a) What efforts are underway at state and district levels for NCD?

- Weekly screening for diabetes hypertension at sub-center level.
- Distribution of Glucometer and strips to all the sub-center.
- Referral to district hospital.
- ASHAs are involved in helping for screening.

8. Comment on involvement of AYUSH doctors in national health program specially NCDs. What preventive and promotive services are available in AYUSH facilities?

9. At what level in the state are screening programs available for conditions such as Thalassemia, Sickle Cell Anaemia, and Genetic Disorders? Comment on the programs to provide curative and follow up treatment for such cases. :

- Sickle Cell screening programe for all Tribal people.
- Genetic Dosorders : this programe has not been implemented as Training is going on.

Integrated Disease Surveillance Project:

IDSP is being implemented throughout the state. There is well laid out structure at state, district and sub-district level as per IDSP guidelines. There are reporting units in public as well as private sector. At district level, the data is gathered from peripheral units through telephone every day. Timeliness of reporting was observed 90 percent or more.

Disease conditions like Leptospirosis, Dengue, Malaria, Chickenpox, Measles, Typhoid, Cholera and Diarrhoeal Diseases, Acute Encephalitis Syndrome (AES), Hepatitis etc. are being reported since IDSP started in the state.

Observations:

- Disease like Dengue and Leptospirosis are continuously showing high incidence and disease related mortality.
- First half of 2012 has reported all time high14 disease outbreaks in Alappuzha district in last five years. These include Cholera, Acute Gastroenteritis, Chickenpox, JE/AES, and food poisoning.
- There is an apparent surge in Dengue and Hepatitis cases in 2012
- State is doing surveillance of Influenza like Illnesses (ILI) for H1N1 and stockpiling of anti-viral drug Oseltamivir for suspected and confirmed cases of H1N1.
- Almost all health facilities in public sector are reporting disease and related conditions under on P, S or L-Form regularly to IDSP. However only fewer private sector health institutions are reporting these diseases and related conditions to IDSP.

- There is no mechanism to gather data from outpatient departments (OPD) to IDSP of large hospitals like Medical Colleges and Corporate Hospitals – only indoor data is collected and reported. This is a big missed opportunity for strengthening disease surveillance.
- Most of outbreaks are first picked by the local media before health system. This shows weakness in disease surveillance system – both in terms of quantity and quality.
- AYUSH System is quite popular in the state and a large number of people visit AYUSH health facilities for various health problems. Homeopathy health facilities have a computerised data collection system and a large data set. There is an opportunity to use data from AYUSH to strengthen disease surveillance.
- Remuneration of IDSP staff has remained same since its beginning. The project has not factored-in the current inflation rate. Equipment like computers and peripherals provided under IDSP has become more than five years old – so some of them are now outdated and non-functional.
- IDSP is considered a vertical programme

Recommendations

- Further strengthening of data collection: expand the reporting units in private sector and AYUSH health facilities
- Ensure out patient data collection from large health institutions in public and private sector, which is valuable source of information
- Consider revising remuneration of IDSP staff to keep them motivated. New computers and peripherals wherever needed
- Apart from collecting data at local level, enhance efforts to analyze and interpret and convert it in to information, in order to take remedial action on time.
- Augment control measures for control vectors of Dengue, malaria and leptospirosis
- In-migration from MP, CG, Orissa, West Bengal, TN to Kerala calls for targeted interventions

TOR VI- Community Process Including ASHA, PRI, VHSNC, CBM and NGO

In Kerala, Lowest administrative unit is ward which is apparently considered as a village in terms of Village Health and Sanitation and Nutrition Committee.

Constitution of VHSNC:

Chairperson : Elected representative of the concerned ward

Convenor :JPHN/JHI/LHI/HI

Members :Medical Practitioner, School Teachers, Ayurveda, Unani, Siddha, homeopathic Medical Practitioners, Anganwadi Workers, Kudumbasree members, Residence Association Representatives, SC/ST representatives, NGO, Women SHGs

The main domain of the committee is to monitor the health, nutrition and sanitations status as well as to address the issues pertaining to the well being requirements of the concerned village. Concerned ward member and the JPHN

or JHI will jointly operate the financial aspects (accounts) of the Committee. The meetings of VHSNC are convened every month in consultation with the members of the committee and the president of the Grama Panchayat.

Hospital Management Committee:

RKS which is known as Hospital Management Committees representation of Panchayat President and other elected representatives is a mandate. Other than this, most of the hospitals have made it a point that the committee should have the representation of all the political parties so as to address the issues with the support of different school of political ideology.

Chairperson : Panchayat President
Vice Chairperson : Health Standing Committee Chairperson
Members :
Members of the Health Standing Committee (Maximum 5 Nos),Officials (Engineers) from the Electricty Board, Water Authority in Village Panchayats – Engineers/Asst.Engineers or officials who are in similar ranks.3 people nominated by the PRI and Representatives of Political parties.

Convenor : Medical officer

District Health Society

District Health Mission and the District Health & Family Welfare Society
On the lines of the State Health Mission, every district will have a 'District Health Mission' comprising of the District Panchayath President as chair person and the District Collector as the Co-Chair person and District Medical Officer (H) as the Convenor & Member Secretary.

To support the District Health Mission, there is the integrated District Health & Family Welfare Society. All the existing societies (except AIDS and Cancer) as vertical support structures for different national and state health

programmes were merged in the District Health & Family Welfare Society. The District Health & Family Welfare Society is responsible for planning and managing all health and family welfare programmes in the district, both in the rural as well as urban areas.

The District Health & Family Welfare Society may also be viewed as an addition to the district administration's capacity, particularly for planning, budgeting, budget analysis, development of operational policy proposals, and financial management etc. Because it is a legal entity, the District Health & Family Welfare Society can set up its own office, which has adequate contingent of staff and experts and can evolve its own rules and procedures for hiring staff and experts both from the open market as well as on deputation from the Government. In other words, the District Health & Family Welfare Society is not an implementing agency; it is a facilitating mechanism for the district health administration as also the mechanism for joint planning by NRHM related sector

District Health Mission

Governance Structure

Chairperson : District Panchayath President

Co-Chair & Executive Director : District Collector

Convener& Member Secretary : District medical Officer (H)

Member :MPs, MLAs, from the district, Chair-persons of the Standing Committees of the District Panchayath, Project Officer (DRDA), Chair-persons & Convenors of the District, General & W & C Hospital Development Societies, District Programme Officers for health programmes, PHED, ICDS, AYUSH, Education, Social welfare, Panchayati Raj, representative of State Mission Director, representative OF MNGO etc.

District health & Family Welfare Society

Governance Structure

Governing Body

Chair : District Panchayat President

Co-Chair & Executive Director :District collector

Convener :District medical Officer

Members : District Programme Manager (NRHM), Project Officer (DRDA), District Programme Managers for Health, AYUSH, Water and Sanitation [under Total Sanitation Campaign (TSC)], DPMSU, PHED, ICDS, Education, Social Welfare, Panchayati Raj, a representative of State Mission Director, representatives of Medical Association/MNGO and Development Partners

Executive Committee

Chair :District Collector

Co-Chair : DMO (H)

Vice-chair : District RCH Officer

Convener : District Programme Manager

Members

District Superintendent of Police, Superintendents - General, W & C and District Hospitals, All District Programme Managers for health, ICDS, PHED, Water and Sanitation, Education, Panchayati Raj RDOs/ Sub Collectors, CHC In-charge, Project Officer (DRDA), District Programme Managers for AYUSH.

Participation of the PRI representatives is almost 100% as per the minutes and attendance sheet. Level of participation of PRI is good team has observed that ASHA are also elected as PRI members team found that where ASHA are member in Panchayat health and nutrition issues are in priority.

All the wards (Urban and rural) across the state have formed Village Health and Sanitation and Nutrition Committees (VHSNC) in the state VHSNC called as WHSNC, Therefore WHSNC are getting 10,000/- per annum.

In the state composition of VHSNC is not as per revenue villages so that denominator is numbers of ward.

Sl.No.	Districts	No. of Wards	VHSNCs formed
1	Trivandrum	1546	1546
2	Kollam	1431	1431
3	Kottayam	1321	1321
4	Pathanamthitta	910	910
5	Alappuzha	1372	1372
6	Ernakulam	1812	1812
7	Thrissur	1789	1789
8	Palakkad	1692	1692
9	Kozhikode	1501	1501
10	Kannur	1593	1593
11	Malappuram	2211	2211
12	Idukki	850	850
13	Wayanad	487	487
14	Kasasragod	776	776

All the VHSNCs across the State has got bank accounts, Major Expenditures & pattern

- Financial assistance to destitute women for medical checkups, VHSNC can also provide financial help for further medical treatment of the person.
- Observance of Ward Health Nutrition Days – Awareness classes on various health topics

- During the outbreak of diseases, special day observances are the major times where the committee makes use of the fund as food, spray etc.

- Ward Member & the Convenor are the joint signatures of the VHSNC fund
- Convenor is responsible of maintaining the expenditure details

Role of the ASHA in the VHSNC-

- ASHA is working as member of the Village Health & Sanitation Committee .of the Gram Panchayat to develop a comprehensive village health plan. She will mobilize the community for taking part in the awareness classes.

- ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services. She also plays an important role in mobilizing the community members for NCD clinics at the sub centre

People are actively involved in the activities of VHSNC. This is very evident from the attendance sheets and reports that are available with the Sub centre.

There is no as such information at the field level we have observed on training of VHSNC to frontline worker in the state.

- ASHA will take part in the planning meeting of the ward level Health programme and assist the JPHN, Anganwadi teacher and the Panchayat members towards the effective implementation of the programmes.

- ASHA will have to maintain a healthy relationship with the Anganwadi Workers, JPHN, and JHI for the betterment of health aspects in her area of work (Jurisdiction).

- ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.

- She will counsel adolescents on health, women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.

- ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.

- She will work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan.

- She will arrange escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre-identified health facility i.e. Primary

Health Centre/ Community Health Centre/ First Referral Unit (PHC/CHC /FRU).

- ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.

- She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.

- Her role as a provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.

- She will inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.

- She will promote construction of household toilets under Total Sanitation Campaign.

  - ASHAs are involved in registration of eligible mothers, motivating pregnant women for ANCs, institutional deliveries, immunization, post antenatal and neonatal care.

- Involved in child tracking, identify childhood diseases, ensuring proper breast feeding & complementary feeding practices, immunization follow up etc.
- They are also involved in salt testing in 12 endemic districts.
- They mobilise women and adolescent girls for WHSCNC meetings where the issues pertaining to nutrition, RCH, sanitation & hygiene, breast feeding, menstrual hygiene, age at marriage, contraception, etc are discussed.
- They make possible efforts for the publicity of the meeting to ensure wider participation of women and adolescent girls of the village.
- They also mobilise men and women for attending NCD camps.

c. Monitoring is based on the monthly report submitted by the ASHAs to the JPHN.

- The register of claims made by ASHA and the amount paid are maintained at the Sub centre level along with an aquittance roll as proof proof payment.
- Monthly SOE is submitted to the District Programme Manager before the 3rd working day of the next month.

Districts	Total target	Total Selected	Currently working ASHAs	Total Trained - Module I	Total Trained - Module II	Total Trained - Module III	Total Trained - Module IV	Total Trained Module 5
KASARGOD	1377	1285	990	978	937	779	710	654
KANNUR	2500	2431	2185	2431	2374	2063	2057	2100
WAYANAD	839	839	776	928	825	819	727	681
KOZHIKODE	2800	2592	2048	2048	2048	2045	2041	2033
MALAPURAM	4000	3991	3626	3948	3774	3747	3585	3425
PALAKKAD	2800	3306	2701	3233	3097	3035	2933	2647
THRISSUR	3205	3205	2777	2983	2727	2644	2444	2144
ERNAKULAM	3100	2683	2413	2511	2327	2212	1908	1900
IDUKKI	1200	1188	1137	1188	1116	1065	1073	1137
KOTTAYAM	1965	2031	1732	2031	1965	1836	1685	1590
ALAPUZHA	2300	2375	2297	2375	2300	2225	2150	2054
PATHANAMTHITTA	1340	1340	1212	1340	1244	1189	1141	1086
KOLLAM	1729	1729	1618	1729	1641	1481	1320	1189
TVM	3600	3901	3399	3901	3419	3178	3006	2646
TOTAL	**32755**	**32896**	**28911**	**31624**	**29794**	**28318**	**26780**	**25286**

Training Status of ASHAs

a. Number of ASHA in place/number to be selected, look for shortfalls in blocks/districts with high SC/ST/minority populations,

Selected : 32896

Now working: 28911

Shortfall : 3844

b. Number trained district wise, adequacy of training institutions in state, district and sub block levels,

c. Mechanism for training of new ASHAs

In the first level SHSRC trains the District programme Managers, RCH Officers, DMOs, MCH Officers and DPHN in the ASHA Modules, these officials in turn train the ASHAs at district levels.

d. Quality of ASHA training, existence and conformity with training plans/calendar, Training Evaluations- quality of information and whether updated

ASHA trainings are inconformity with the training plans /training calendar . 25320 ASHAs have been trained in Module 5. Due to lack of training infrastructure and manpower in training institutions, training evaluation are not taking place.

e. Do the ASHAs have communication kits, drugs and equipment kits?

8450 drug kits - 2008-09

14900 drug kits - 2009-10

8450 drug kits to be refilled

F . During a FGDs with ASHA, it has been mentioned that ASHA workers do not get incentive for pregnant mothers who are not of the locality. (for eg. married women coming back to native place for delivery) .Further ASHA workers expressed that the incentives are less as compared to the services provided by them.

ASHA payment through Bank account and there is grievance redressal mechanism at facility level particularly at the PHC level. Average take home money is 1000-2000 per month , 500/- additional money has been provided by state.
Grievance redressal mechanism is not effectively managed by respective service provider.

G. ASHA drop-out data based is maintained at district level and district officials are updating it properly. Selection of ASHA is conducted by Panchayat and there is no as such conflict we have observed on selection because number of candidates are less.

H. There is no specific ASHA monitoring mechanism exist in the state, however Public relation officer who are responsible for implementation of all NRHM programme in the Block he/she also looking after ASHA programme also. There is no ASHA mentoring group exist in the state.

I. Community monitoring programme is not planned in PIP. It is observed that community is aware about health need but there is no as such opportunity has been available where community as a hole can discussed or analyse the performance of health facility . In the state like Kerala where political participation is very visible in health facilities community monitoring could be effectively implemented .

J.State has mentioned about MNGO programme but we have not observed at the field level. (what about Malappuram??)

TOR:VII Promotive Health care

6. Is there a state and district specific BCC strategy at state and district level, which helps identify key health behaviors to be addressed? Comment on extent, reach and quality of IEC activities (including method mix-) including capacity building workshops.

Yes, SPMSU has developed a state specific IEC/BCC strategy.

- Under the JSSK, the State has launched IEC activities at district level._Two paper advertisements quarter page and half page- released in all the major dailies
- State level workshop held for district level officials and hospital superintendents
- 50000 posters and 10 lakhs leaflets printed and distributed /displayed in connection with state launch
- Standees on JSSK developed and displayed
- Display boards installed in all major hospitals

- Displayed a float on JSSK in the onam grand finale procession
- Campaigns done through TV channels and FM

<u>IEC activities as part of Breast feeding week</u>

- Kavyanjali – A Poetic rendition on significance of breastfeeding -Poets meet conducted at state level, Thrissur and Pathanamthitta as a part of week observation attended by renowned poets
- District level and block level functions held
- Awareness classes held at CHC/PHC levels
- Healthy baby contests held
- 30 sec spots on Breast feeding promotion aired for one week at the rate of 8 spots per day in 6 pvt channels and in AIR
- 50 seconds TVC on breast feeding promotion 4 times per day released in 6 major pvt TV channels and DD
- Quarter page ad on Breast feeding promotion released in all the leading dailies

BCC/IEC activities for FP

<u>World Population Day activities</u>

Population Mobilization Fortnight- From 27th June – 10th July 2012

Population Fortnight - From 11th July – 24th July 2012

- District Level Inaugurations were held in 13 districts
- Block level inaugurations were held in all the districts
- 440 Awareness Classes were held across the State.
- 12 Rallys
- 4 Quiz programmes
- 6 Essay Competitions
- 6 Streetplays/Puppet shows
- 4 Exhibitions – Thrissur, Alappuzha & Ernakulam
- Video Spots were aired in all the Health Institutions with TV/DVD Facilities
- RJ Cuts were aired in major FM channels

- Counseling Corners in all the PHCs in Palakkad District
- IUD & NSV Mega Camps
- Family Health Mela
- Awards for NSV promoters in Idukki & Thrissur
- Mobile Publicity Van
- Magic Show

School Health Programme has been scaled up from 3337 schools to the rest of 8950 schools. Micro planning is done for the programme. Health cards have been distributed to all schools. Manual for health workers is being revised and module for child abuse and nutrition has been prepared and will be printed.Training of JHIs are on going. Establishment of electronic data base and related trainings are under progress. ARSH seminar 52/district are in progress. Health club Monthly activity going on in schools with programme in place

Innovations- RADIO HEALTH

- In- House Radio Production unit
- Broadcasting health awareness programme through all Kerala Network of All India Radio
- So far broadcasted 681 thirty minutes programmes and 305 fifteen minutes programmes
- Number of Programmes broadcasted (April to October 2012)

<Ananthapuri FM: 213> <All Kerala Stations : 151>

RADIO HEALTH

All Kerala Broadcast: Programme Timing

NO	AIR STATIONS	TIMING	FREQUENCY
1	Kannur - AM	9 - 9.15 am	Monday to Friday
2	Kozhikkode - AM	9 - 9.15 am	Monday to Friday

3	Trissur - AM	2.30 - 2.45 pm	Monday to Friday
4	TVM - ALP - AM	9 - 9.15 am	Monday to Friday
5	Mancheri - FM	9.30 - 9.45 pm	Monday to Friday
6	Devikulam - FM	5.30 - 5.45 pm	Monday to Friday
7	Cochin - FM	9.45 - 10 am	Monday to Friday
8	Ananthapuri – FM (Tvm)	3 – 3.15 pm	All Days

h. What are the key areas of focus for BCC interventions?

1. How to Reduce Maternal Mortality and Child Mortality
2. How to Improve the nutritional status of children, women and adolescents
3. How to make Reduction of Mortality and Morbidity on account of Communicable and Lifestyle Diseases.
4. Issues on Adolescent Reproductive Sexual Health
5. Increasing male participation in family planning and promoting IUCD

• 86% of the population prefer TV as the medium of information. 68% of the population has got the information about the ad on preventive vaccination through this media.

• Celebrity endorsement plays a major role in the ad as 83% of the population who have seen the ad recalls the celebrity. 58% have recalled the scene of the child protected from the rain by an umbrella in the ad whereas only 17.8% of viewers have recollected the information on the seven fatal diseases likely to affect children.

• 90% of the population is aware of preventive vaccination for children from sources other than mass media such as health workers, hospitals/health card, anganvadis, public messages, pamphlets and other IEC materials.

• Hospitals / health card are the leading source of information at 49.6%. Health workers and Anganwadis are also instrumental in reminding to take vaccination.

• 90.5% of the respondents, who have children below 5 yrs, take timely vaccination for their children. The major reasons for not vaccinating (9.5%) include lack of

awareness of place of vaccination; fear of side effects; resistance from others and forgetting to take.

• 52% of the people who have seen the ad has reminded others to take timely vaccination for their children.

Following a campaign to promote normal delivery for a period of 6 months, a marginal decline in the rates of C-sections was noted in the districts were the campaign was initiated.

Immunization rates have also gone up following local specific BCC interventions.

j. Are field functionaries (ASHA, ANM) effective in communication, and what additional inputs are required?

ASHAs, JPHNs are effectively made use in communicating messages to the grassroots. Specialized Communication training to ASHAs shall be planned enabling them to do effective FGDs, how to make effective of IPC tools etc.

e. Do the ASHAs have communication kits, drugs and equipment kits?

8450 drug kits - 2008-09

14900 drug kits - 2009-10

8450 drug kits to be refilled

NRHM QUIZ competition Sahil will add

TOR VIII

- Managements unit is established at the district level and there is a good co-ordination between State, District and Block level management unit. Head of the State Programme Management unit is an IAS officer called as Mission Director of NRHM, and the Additional Director of Health Services (FW) is functioning as the State Program Manager (NRHM). Similarly, Additional Director (TB) is the State Nodal Officer for RNTCP under NRHM and Additional Director (Public Health) is the State Nodal Officer for NVBDCP and IDSP. This method has resulted in very good coordination between SPMSU and Kerala State Health Services Department. A professional and dedicated team has been put in place at the SPMSU for effective management of the activities under NRHM Management System and is operational at the block level. At the District level DPMU unit is working very efficiently and DPMs are the permanent staff of Kerala State health services department and unlike other States all DPMs are doctors having good knowledge of Public health.

SPMSU has been assigned the key result area of providing effective management, project monitoring, providing assistance in policy and strategy formulation, and supporting implementation of the project components. In the context of emerging needs and the complexity of the programs, the SPMSU is also periodically strengthened with enhanced number of personnel and capacity building of the skills of the personnel. This capacity has equipped the SPMSU with a strong support system to implement projects and components, and to manage a comprehensive MIS at programme level and tracking physical and financial progress of various projects. SPMSU is also a knowledge repository to provide support with a

central pool of support resources, to generate cross-project and cross-district synergies, avoid inefficient overlaps, and take advantage of comparative benchmarking based on a Common Management, Monitoring and Evaluation (M&E) frameworks. The SPMSU also provides a dashboard and other critical information needed by key stakeholders. It also serves as a unit to compare service quantity and quality metrics and specify impact of the project in terms of improvements in the quantity and quality of public health services. Work description of various sections is detailed below:

Implementation of NRHM in the districts depends on the management capacity of District Programme Support Unit under the District Health and Family Welfare Society. District level Program Support Units are headed by District Program Managers (NRHM), assisted by Accounts Officers, Assistant Bio Medical Officers, Assistant Quality Assurance Officers, Junior Consultants (Communication & Documentation), Accountants etc who oversees implementation of Public Health activities in the District especially in the context of re-emergence of communicable diseases. The Society acts as a pivot in coordinating the public health activities as well as ensuring that there is no lack of actions in carrying out the various activities under different Disease Control Programs. The District Program Manager (NRHM) collates the data received from the health blocks and draw inferences for planning out remedial activities, as and when necessary.

PRO cum Liaison Officers have been appointed in all the 234 health blocks of the state. Their primary job is to coordinate the activities of NRHM in the concerned block and also facilitate SOE/UC Collection. They ensure the dissemination of information from State / District to health institutions in the block. They act as catalyst in implementation of various NRHM activities. Further, PROs have also been appointed to install professional PRO functions in the hospitals. PROs act as a link between general public and staff of the hospital. PRO is also the nodal officer for RSBY activities in the concerned institution.

- There is a lack of coordination between Disease Control Programmes and DPMU in Allaapuzha District.
- The State has committed Doctors at District level, both in the Health Department and PMUs. This commitment has realised the full potential of these officers.
- DPMs have a central role in District level planning and have demonstrated considerable skill. However bottom up planning is not taking place with Village Health Action Plans often absent and VHSCs not performing.

Additionally BPMs are not in place, further hindering evidence based planning. The CRM tram recommend that the State expedite the recruitment of BPMS and provide further support to bottom up needs based planning in the Districts.

- This is a weak link in overall implementation and monitoring and supervision of programmes of NRHM in secondary care hospitals.
- The Programme Management structures are well established at both state and District level. There were no major vacancies at the DMPUs in the State. District data Mangers posts are not there.
- Good coordination between the Health Directorate and the Programme Management Unit was seen in both the districts. This may prove helpful in bringing about balanced dynamics between the District Health Directorate and DPMU. The State of Kerala has integrated the personnel of Kerala Directorate of Health Services and NRHM.
- All vertical disease control programmes have been unified under State and District Health Society in Mallapuram district. The Kerala State Health & Family Welfare Society has adopted the guidelines on delegation of Administrative and financial powers provided by GOI.
- The State Health Mission, the State Health Society (both Governing Body and Executive Committee), District Health Mission and District Health Society meetings are held regularly. The minutes of the meeting shared by the State shows that they are vibrant bodies which are taking decisions to further the cause of NRHM.
- The Block Programme Management Unit (BPMU) was not full established at every Taluka/ Block of the State. The Block Health Officer who happens to be a doctor under the H&FW services, would the head of this unit and supported by Block Programme Manager, Accounts assistants and DEOs.

- In addition to the above mentioned regular officers of H&FW services integrated in implementation of NRHM programmes, it is recommended that nodal officers at the State headquarters can be identified for each district and assigned specific work of visiting these Districts every month for monitoring the activities undertaken in their districts against the budget released to each

district every quarter. Further the district also can have appointed nodal officers for monitoring their taluks.

- The DCs have been given concise check-lists to help them review the health programmes effectively with a short time.

TOT IX

- Kerala State Institute of Health & Family Welfare is the apex training institute under the Kerala Health Services, conducted different types of training for various categories of health staff under different schemes-Plan, NRHM & State training Programme of the IMG. The trainings conducted are pre-placement Trainings, Induction Trainings, In service trainings, skill development like supervisory, Administrative, management, computer trainings, and training of trainers. Training is given to Medical Officers including the senior officers and to the newly recruited Assistant Surgeons.
- Part of the old building of Kerala State Institute of health and family welfare accommodates the Kerala Medical Services Corporation Ltd. (KMSCL). Food Safety Commissionrate had been established in vacant quarters of the institute. New Initiatives
- Pre placement Orientation Training to newly recruited Medical Officers. 380 Newly recruited Medical Officers trained.
- Orientation training to Office Staff of health and Family Welfare Department of kerala Government Secretariat
- 12 days Induction training has given to 94 Medical Officers in the Health services by two phases
- 20 Administrative cadre Medical Officers given training on Health System management at ASCI, Hyderabad.
- One Medical Officer (Training Coordinator/consultant) and one training coordinator posted on contract basis for coordinating the trainings at Ernakulam region.
- Plan fund through KSIHFW_ Trivandrum has been transferred to health and family training centre, Kozhikode for conducting trainings.

HMIS and MCTS

	Sub Facilities (PP Units/Sub centres)	PHCs and other than CHCs at or above block level But below district level	Health Block including Municipalities
No. of data entry points	5658	1351	270
Number of facilities reporting to MCTS portal	5560	1351	270
Number of facilities where Data Entry Operators are deployed for data entry	0	0	0
Number of facilities where ANMS/DEOs are trained for data capturing on MCTS formats and uploading on MCTS portal.	5658	324 Urban health Centres	270
Number of facilities where Computer with internet connectivity available	0	973	270
Number of facilities generating and using work plan for MCTS	Work Plan Generation has been started in all facilities where 100 % registration achieved		
Number of facilities doing verification of data to reduce error and anomalies occur at the time of data capturing and data entry.	Trainings were recently initiated for Monitoring and verification of data by Medical Officers in charge of all facilities. Training in 5 districts completed.		

Status of Implementation of Mothers registration as compared to HMIS in 2012-13

S.No	District	Total Mothers registered	Total Mothers registered HMIS	Percentage of ANC registration
1.	Alappuzha	14,012	13166	106.43
2.	Pathanamthitta	7,646	7397	130.37
3.	Kollam	19,346	18752	103.17
4.	Malappuram	49,061	47814	102.61
5.	Kasargod	12,571	12276	102.4
6.	Wayanad	7,815	7889	99.06
7.	Kottayam	10,614	11053	96.03
8.	Kozhikode	24,725	25889	95.50
9.	Thrissur	19,487	21379	91.15
10.	Trivandrum	18,353	20801	88.23
11.	Ernakulum	17,573	20274	86.68
12.	Palakkad	19,227	22961	83.74
13.	Kannur	17,929	22360	80.18
14.	Idukki	5,330	7906	67.42
Kerala		2,24,011	259917	86.19

Status of Child registration 2012-13 in MCTS

S.No	District	Total Children Registered MCTS ‘A’	Total Children registered HMIS ‘B’	Percentage of registration as compared to HMIS i.e. A/B*100
1.	Alappuzha	10437	10306	101.27
2.	Pathanamthitta	14976	16102	93.01
3.	Kollam	35678	45799	77.90
4.	Malappuram	7341	10554	69.56

5.	Kasargod	5306	7739	68.56
6.	Wayanad	4650	7098	65.51
7.	Kottayam	17750	27771	63.92
8.	Kozhikode	12333	22340	55.21
9.	Thrissur	6721	12920	52.02
10.	Trivandrum	10070	19584	51.42
11.	Ernakulum	7374	19573	37.67
12.	Palakkad	2567	6841	37.52
13.	Kannur	7468	21355	34.97
14.	Idukki	3417	23617	14.47
Kerala		146088	251599	58.06

In Kerala registration of Mother and children is done directly by the ANM herself. Since they are in experienced when compared to data entry operators. are slow in registration in the initial Stages. more over registration in the urban areas have only been started during 2013-13 only. The shortage of registration of health blocks, facilities and sub-facilities are from the urban area.

It initiatives of NRHM kerala

ASHA Software: Software is being used to make online incentive through bank. Implemented in Thrissur district (pilot project), 2700 ASHAs gets the benefit and planning the State level roll out.

Biometric Attendance System implemented in state office

Non Communicable Diseases Software for data analysis and reporting

Digital Documentation filing system implemented in State office and 14 district offices.

New Initiatives

Project is aiming to facilitate palliative programmes in Government sector in three levels

1. Primary level - Basic homebased palliative care for the bedridden patients in Gramapanchayats, municipalities and corporations with the help of Govt. hospitals. 50 more lsg's have initiated home care programmes this year making the total no. to about 700. Each primary unit is providing regular homebased care to about 50 patients at a time. Preparatory works have completed in all the remaining lsg's which are expected to start home care progamme by December. The project is offering support for the LSG's in the following areas

a. formation of the project
b. organising the initial training
c. three months training for community palliative care nurses identified by each lsg . More than 700 nurses have already completed training.
d. provision of case sheets, registers and reporting forms
e. ensuring training and support of health staff.
e. review and monitoring

2. Secondary level

Secondary level specialised palliative care units with the following activities are being initiated in 78 major hospitals of the state this year

a. Specialised homecare service led by staff nurse - started in 12 units
b. additional palliative support for the patients admitted in the wards- started in 26 units
c. special palliative care op for the referred patients - started in 27 units
d. monthly review and monitoring of the primary level programmes assigned to the unit - stated in 58 units

3. Tertiary level - training and co-ordination unit in each district.

One of the secondary unit is being upgraded as tertiary unit this year in each district. Co- ordination activities have started in all the units and structured professional trainings have started in 13 units.

Other activities

a. Project is facilitating the elderly and palliative care programme of Director of Health Service.
b. Project is facilitating palliative care projects of Block panchayats and District panchayats
c. Project has good links with about 200 community based palliative care initiatives in Kerala and is complimenting their activities.
d. Project has links with vayomithram palliative care programme run by Social Security Mission.

Overall expenditure of the project till October is about 30 %.

TOR X

Financial Management- Kerala

1. **HR Under Financial Management**

Name of the Post	In Position	Vacancy
Director Finance	1	NIL
State Finance Manager	0	1
State Accounts Manager	1	0
Consultant (Accounts)	1	0
Junior Consultant (Finance)	1	0
District Accounts Manager	13	1
Block Accountants/ Block arogyakeralam Co-ordinators*	202	0

*At present Block arogyakeralam Co-ordinators given additional responsibility for account keeping.

2. State/District on the absorption of funds provided Factors responsible for low and high utilization

The State/Districts are using the funds released for the approved activities by GOI. The state is not able to so far utilize the amount allotted under the head 'Training' to the optimum extent.
JSSK scheme was started in the state only in August 2012. Consequently no significant expenses have been incurred so far. However the scheme has attracted the attention to community due to spirited BCC/IEC activities.

3. Mainly three kinds of auditing in State and district

- Statutory audit
- Concurrent audit and
- AG Audit

- Statutory auditors are appointed in state level as per detailed procedures laid down by GOI. They are visiting in all districts and covering 40% of total number of blocks in each district. Statutory audit up to 2010-11 completed and 2011-12 is going on and will be completed by November 2012.

- Concurrent Auditors are being appointed at the state and district Level. Here also state is issuing detailed guidelines for their selection based on the guidelines issued by GOI. They are auditing district society and are covering all institutions in the districts with in the financial year. Regarding the audit for 2011-12, the Executive summary furnished up to March 2012 to GOI. The Concurrent auditors for 2012-13 appointed in all districts and status is follows:
-

Status of Concurrent Audit, Kerala for 2012-13	
Districts	**Status**
Trivandrum	First Quarter completed
Kollam	Second quarter completed
Pathanamthitta	First quarter started
Alappuzha	First & Second quarter completed and report will submit this month
Kottayam	Second quarter going on will complete before 15.11.12
Idukki	First Quarter started
Ernakulam	In progress up to second qtr and report will be submitted shortly
Thrissur	Second quarter completed
Palakkad	Completed up to August 2012
Malappuram	First and Second quarter will be completed next week
Kozhikode	Completed up to August 2012
Wayanad	First Quarter started
Kannur	First quarter completed
Kasrgod	First quarter completed

Head Office	First Quarter started

- CAG audit up to 2012 completed and ATR submitted. 5th CRM report is also submitted with ATR report.
- **Compliance with Income Tax**: TDS returns are being filed in time. 12 A registration of State and district level are going on.
- **Unspent Balances under RCH-I and EAG schemes**: Unspent Balances under RCH-I **has already been** refunded to GOI.
- **Interest Earned**: - Being utilized for the approved activities under NRHM
- **Diversion of funds**:- Funds are being utilized for the approved activities by GOI. Since state having separate accounts for part A/B/C/D, reallocation has been done if required in case of shortage of money in any bank account and later recouped when funds are received from Ministry for the programme.

4. Delegation of Financial & Administrative powers

District programme managers are authorized to release of fund to facilities as per PIP and further approved by Executive committee of the District health society.

Procurement of goods, repairs and minor civil works and procurement of services for specific tasks including outsourcing of support services.-	District panchayat president /Chairperson of Governing Body	More than Rs 5.00 Lakh
	Chair-Person, Executive Committee and District Programme manager	More than 2 lakhs and upto Rs 5 lakh per case . Upto Rs 2 lakhs per case.
Miscellaneous items not mentioned above such as hiring of Taxi, Hiring of auditor, meeting and workshop, training , purchase of training material / Books and magazines, payment of TA/DA allowances for contractual staff and /or non –official	District Panchayat president /Chairperson of Governing Body	Upto Rs 1.00 lakh at a time a time subject to a maximum of Rs 10 lakhs per annum.
	District collector and Chair-person of Executive committee	Upto Rs 75,000 at a time a time subject to a maximum of Rs 5 lakhs per annum
	District programme manger	Upto Rs 50,000 at a time a time subject to a maximum of Rs 4 lakhs per annum

invitees to DHS meeting and /or official deputed to meeting outside the district.		

At the CHC/PHC level There are two bank accounts are operational one is for Hospital management committee (HMC) and other is for NRHM . HMC account is jointly operated by president and member secretary and NRHM account is operated by in- charge Medical officer.

At the Health Sub center level two type of bank account is being kept one is for Health sub center level untied fund and other is for Ward Health and Sanitation Committee. Under one Health sub center there are four to five wards so one JPHN(ANM) is signatory of four WHSC account with ward member that is in rural and urban area both.

For Untied fund of HSC as per direction respective ward member and GPHN (ANM) /JHI (Junior health inspector)will be the signatory of Account but practice varied from place to place. Some place in Alappuzha district MOIC are keeping funds with them and as per need they are purchasing article or giving money to respective ANM .

Electronic funds transfer

- Receipts and payments of funds are regulated using "I-Check Pay software " of Ministry of Health and Family Welfare, GOI through ICICI bank in the State and 14 districts and payments are done electronically to the bank account of party concerned. It is software for NRHM, and full details of fund receipts, payments with transaction number date, proceedings/order number beneficiary name etc. are available on an online basis.
- Customized version of the Tally ERP 9 is being used at the state and district level. Full transactions of I-Check Pay software is importing to the tally software as HTML file. Importing is doing on a weekly/monthly basis. Tally is customized in such a manner that all reports needed by GOI such as FMR, SFP all are available in tally software.
- Below the district level accountant are not using any software for accounting purpose that is why CHC and PHCs are not able to generate uniform online FMR. State is planning to introduce CPSM upto PHC level.

5. **Pendency of UCs up to 2011-12**

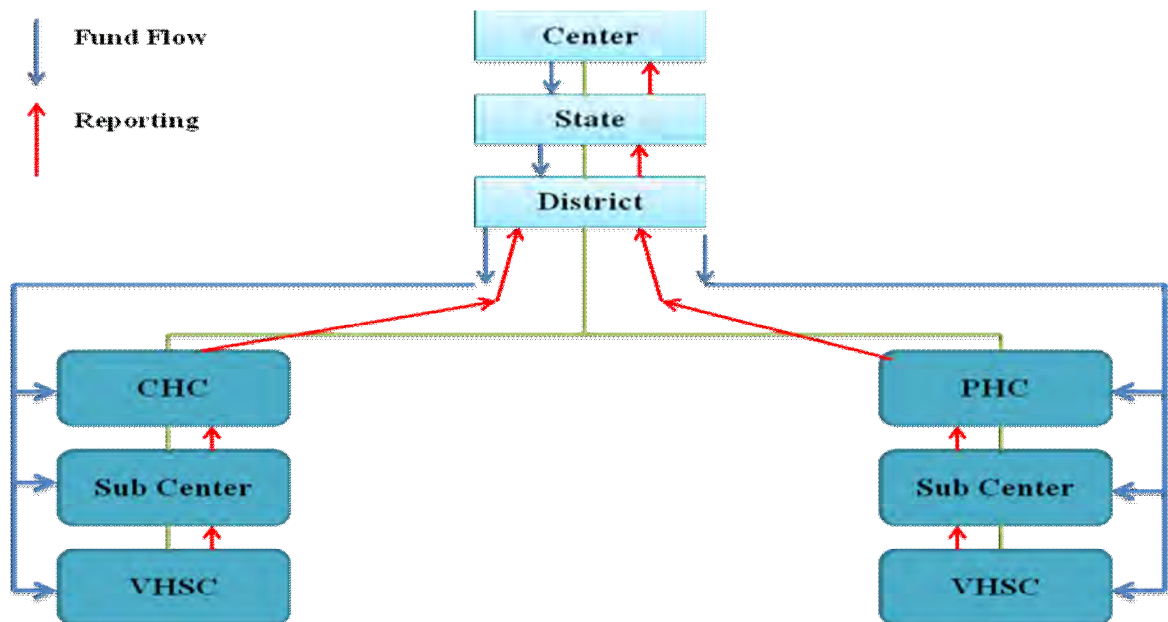
It may be kindly noted that Utilization Certificates for 2005-06, 2006-07, 2007-08, 2008-09, 2009-10 and 2010-11 have been submitted. Provisional Utilization Certificates for 2011-12 has also been submitted. Final Utilization Certificate for 2011-12 shall be submitted along with the Audit Report received from the Statutory Auditors.

There are no such longstanding advances in AMG, Untied fund and HMC. From 2008-09, further funds to the institutions are released after getting 80% of the UC for the funds released earlier. When State is disbursing these funds to districts it is treated as advances and districts also at the same time disbursing these amounts to peripherals treating this as advances. When these peripheral institutions reporting expenditures back, the districts are writing off these advances and same is reporting to the state.

6. Capacity building of finance personnel

- During 2012-13 District Accounts Officers/Accountants had given three training programmes under Tally/FMR preparation. Besides, monthly review meetings are conducted at the state and district level for monitoring the progress.
- Updating of FMR in HMIS is not taking place due to lack data convergence at the all level tat because of lack of policy for single source of data for programme and financial reporting.

7. Fund flows:



Delays are occurring from root level. Clerks of concerned PHCs are reporting expenditure for the previous month in the 5th or 6th of next month. These reports are consolidating the district level and district level reports are consolidating in the state level. Ward Health and Sub centre fund utilizations are to be collected from field staff. They may not be much aware about the accounting practices. CHC and PHCs are not aware about annual fund allocation usually the received fund in one NRHM account as per request and activities wise fund allocated by district. There is no as such correlation between planning, Budgeting and reporting. At the all level convergence with disease control programme is not so visible although

utilization of Part D is better than Part A, B and C. facilities are not reporting in system generated FMR so that they are not aware about most of the activities under NRHM programme.

8. State share under NRHM

Status of 15% contribution for the Year 2007-08 to 2011-12 and 25% for 2012-13.

Year	Amount to be credited by State	Amount credited	Outstanding
2007-08	51.86	0	51.86
2008-09	39.33	53.25	-13.92
2009-10	41.93	9.41	32.52
2010-11	44.72	35.92	8.8
2011-12	102.8	37.16	65.64
2012-13	126.41	68.26*	58.15
Total	**407.05**	**204.00**	**203.05**

*Sanction order for the release of another Rs.6.11crores received. The fund will be credited within a week positively. Regarding 2007-08, action is being taken to obtain certified UC for family welfare component from DHS. Action have been taken for obtaining the balance amount outstanding from 2008-09 amounting to (Rs.203.05-Rs.51.86) crores in the Supplementary Demand for Grant (SDG) of the State for 2012-13.

9 . Financial indicators are not being use for programme management, at the district and below physical and financial data are not filled in the same FMR. District magistrate are reviewing the financial progress as per allocation in monthly meeting but there is no dedicated human resource at the Block level for hand holding support to GPHN for better book keeping.

Issues and observation:-

- **HR: Vacancy of SFM-:** 01,**Pending State Share** (including releases of 2012-13): Rs. 205.42 crore.,**Audit Reports (2011-12**): Not Received.**Pending UCs: RCH-** Rs. 23.72 Cr., MFP- 40.43 Cr.**High Unspent Balances:** RCH-30.64 Cr, MFP-48.24 Cr.

- **Other Significant Financial Management Issues:**

    - That state has unspent balance of Rs. 25, 68,020/ under EC-SIP while the programme has been closed.

    - State has kept the fund in ‘Deposit in 2010-11

- Double entry system of accounts is maintained in all health facilities of both the districts except in medical college Alappuzha.
- Funds received in the pool, up to district level, but district releases funds further against activities. There is only one cash-book and ledger is being maintained at the CHC and Facilities level while there are receiving funds from all Pools , resultant of this facilities are not able to use interest money for approved activities.
- Petty Cash book is maintained at District level and all the facilities visited and noticed that petty cash book is prepared in the format prescribed by GOI and dully signed by the respective authorities.
- Check issue register was not available in THQH Thirur and in remaining visited facilities it was not well maintained.

AMG and Untied Funds have not been released to all facilitieson a regular basis. AMG for SC in a government building have been released in February for the year 2011-12.

- Inadequate human resources for the management of accounts; and those who are handling accounts, orientation and training is lacking on financial manual.
- Low utilization has been seen in untied funds, Annual Maintenance Grants of HMC (RKS) at CHCs and PHCs.(Malappuram District)
- Financial Indicators not being used for improving programme management at each level.
- Separate audit through Chartered Accountants are not undertaken for HMC accounts in all health facilities
- Electronic transfer is happening everywhere, except in the case of Cooperative Banks
- TALLY ERP-9 is introduced at district level, but not at below levels.

Recommendations

- Financial Management Report should be uniform across all levels – preferably Tally generated or CPSM.
- Strengthening of financial management at block and bellow. A support system is required for JPHN for better accounting.
- Districts should make use of financial indicators for better programme management.

- Concurrent auditors to provide hand holding support at peripheral level.
- District should disburse funds in pool wise not activities wise. A Group account should be open up at Block level.
- Expenditure of Disease Control Programme (PART-D) should be reported through FMR.
- State should develop integrated system of Planning, Financial Management and HMIS as a tool of convergence.
- Advance Register should be maintained for all kind of advances.
- Bank Reconciliation should be prepared on monthly basis at PHCs and CHCs.
- The DHS should follow up to Medical Officer on reply on action taken point out of Concurrent Audit Report 2011-12.
- Budget Vs expenditure must be analyzed to know the exact variance of budget and expenditure so that proper steps can be taken to improve the utilization of funds.

- Budget utilization is low. State may speed up activities as per the PIP. For instance overall only 36% of the approved budget for the district Alappuzha is utilized
- Due to non-availability of Block Accountants, it has become difficult for the district to collect and compile the utilization of funds at all WHSNCs. 10372 WHSCs are there in the district.
- Increased work load among peripheral health functionaries regarding bookkeeping causing expenditure tracking and timelybsubmission of UCs
- A separate account was not created for untied funds in one of the SHC
- Issue of nonavailbility of computers and internet facilities at below block levels

Annexure 1

Mainstreaming of AYUSH in Kerala :

Convergence of AYUSH systems and Allopathy under the umbrella of NRHM was primarily envisaged as a strategy to provide choice of treatment to the patients; strengthen facility functioning and strengthen the implementation of the National Health Programmes in the country.

Co-location of AYUSH services with allopathic services has not yet been achieved within the public healthcare delivery system in Kerala.

State-wise Progress report under NRHM as on 30th June 2012 - Kerala

Action Point		Remarks
AYUSH components included in NRHM-PIP		Yes
Whether AYUSH person included in	Health society	Yes
	State health mission	Yes
	Rogi Kalyan Samiti	No
	ASHA trainings	No
Number where AYUSH facilities are available as on date	DH	0
	CHC	0
	Other than CHC at or above Block level but below District level	0
	PHC	0
	Other health facilities above Sub-Center but below Block level	497
	Total	497

Number of contractual appointments under AYUSH	Doctors	597
	Paramedical Staff	238

(Source - http://www.mohfw.nic.in/NRHM/Documents/MIS/Statewise%20Progress%20under%20NRHM_Status%20as%20on%2030.06.2012.pdf)

AYUSH in Kerala

Kerala has 29945 registered AYUSH practitioners (as on 01-01-2011). It has 23 under-graduate and 6 post-graduate institutes of AYUSH systems. Each year these institutes provide 1120 AYUSH graduates and 56 AYUSH post-graduates. Only AYUSH doctors who are registered under the Travancore Cochin Medical Council (T.C Council for Ayurveda, Siddha, Unnai, Naturopathy and Yoga & T.C Council for Homeopathy) are allowed to practice in their concerned systems.

2qRecord of post sanctioned, filled & vacant for AYUSH in Kerala

Department	Post Sanctioned	Post Filled	Post Vacant
Ayurveda	250	187	63
Siddha	30	17	13
Unani	20	2	18
Homeopathy	450	318	132

(Source - Office of State Programme Manager (AYUSH), Kerala - as on 14-11-2012)

State-wise Contractual Appointments under AYUSH as on 31.03.2011 – Kerala (http://indianmedicine.nic.in/writereaddata/linkimages/4519713788-6%205%20NRHM.pdf)

Number of contractual appointments under AYUSH		Percentage distribution of contractual appointments under AYUSH	
Doctors	Paramedical staff	Doctors	Paramedical staff
499	20	4.3%	0.4%

(Source : National Rural Health Mision (NRHM), MIS- State Data Sheets upto March, 2011)

The fund for salaries /medicines & activities for ISM & H under NRHM is met from the fund provided in the approved PIP's .The salary for HR (Medical Officers) is transferred to the District Programme Manager (DPM) Health Services .The DPM's after verifying the attendance disburses the salary . In the current approved PIP no

fund is provided for Medicines .The fund for mobility support to District Officers (ISM & H) is also through the DPM's .

AYUSH Paramedical staff

Directorate Ayurveda Medical Education conducts Paramedical Courses of one year duration for Ayurveda Nurse, Ayurveda Pharmacist and Ayurveda Therapist. The course is conducted only when scarcity of nursing staff is felt in the state. Council registration is not mandatory for the nurses.

A one-year course in Nurse and Pharmacist Training in Homeopathy is conducted by the government of Kerala.

Documentation of Local Health Traditions

The Patent Cell under the Directorate of Ayurveda Medical Education (DAME) is working on the digitalization of Traditional Medical Knowledge of Kerala since 2003. This knowledge is mostly gathered from manuscripts and texts often in crude languages.

There is however no initiative for documentation of the oral knowledge traditions of the local healers/bone-setters of Kerala under NRHM.

Initiatives under the AYUSH department:

The Department of Homoeopathy is conducting School Health Programme (Jyothirgamaya) for improving the mental , intellectual and physical capacities of High School Children. The Dept is conducting different programmes like Mother and child clinic, Seethalayam (for the treatment of lady victims of domestic and social violence), AYUSH Holistic centre for the prevention and management of life style diseases (AYUSHMAN BHAVA). RAECH (Rapid Action Epidemic control Cell in Homeopathy).Geriatric care programme, Adolecent Health care and behavioral management programme, Thyroid clinic, Mobile Health Service in endosulfan affected area. De-addiction programme and Infertility Clinic.

Comments and Recommendations based on the visits made as part of 6th Common Review Mission

Facility based services –

- At the district AYUSH facility visited (Malappuram) it was noticed that there were no IEC material available regarding the various National Health Programmes and any AYUSH health initiatives.
- There seems to be no cross-referral of patients between AYUSH and allopathic systems.
- At the private facility visited, a lot of IEC material was available on the programmes/clinics run by the facility.

- The private AYUSH facility visited had applied for NABH accreditation.

Recommendations

- ➢ IEC material on Health Programmes and AYUSH health initiatives should be made available at AYUSH facilities at the earliest.
- ➢ Quality assurance standards for service delivery at government AYUSH facilities need to be included in the Kerala State Accreditation Standards and implemented.

Human resource –

- At facility, the doctor and nurses had very poor awareness about disposal of biomedical waste and sanitation standards. They were not aware of the IMEP guidelines prescribed by the government of India.
- At district level, district medical officers for ISM and Homeopathy were present. However it seemed they played a passive role in the designing of the District PIP.
- Trained Ayurvedic and Homeopathic nurses present at the AYUSH facilities have no clear career progression mapped out. The CME programmes are limited to system specific knowledge and do not provide updates on the National Health Programmes.
- Due to a scarcity (due to unfilled posts) of supporting staff the nursing personnel face problems in getting leave and often have to perform the duties of clerical staff in addition to their own.
- No staff/nurse scarcity was observed at the private facility.

Recommendations

- ➢ Doctors and staff at AYUSH facilities should be sensitized about the government guidelines on waste management IMEP and IPHS standards.
- ➢ A career progression policy for AYUSH nurses can be developed (if not already done) and their CME programmes should include updates on state and national health initiatives.
- ➢ Vacant posts of supportive staff/clerical staff need attention and should be filled at the earliest.
- ➢ Nurse assistants at AYUSH facilities can trained to substitute for the nurse when on leave.

Availability of AYUSH medicines

- There was inadequate availability of Homeopathic medicine at the district AYUSH facility visited.

Reporting structure

- There is no mechanism existing for the collection/ reporting of data from private AYUSH hospitals to the Government.
- The private Ayurveda hospital visited had their own non-digitalized record keeping system.

Recommendations –

- ➢ A functional convergence between AYUSH and allopathic systems and between the private and public health facilities can be attained by developing a common reporting mechanism. This would also help in developing a structured mechanism of cross-referrals between either system/sector.
- ➢ The mothers seeking ante-natal care advice at AYUSH facilities (public and private) should be linked with a non-AYUSH public health facility for ANC follow-up. This could be done by holding ANC counseling/immunization days at AYUSH facilities.

Involvement in National Health Programmes

- AYUSH doctors at state, district and facility levels are not actively involved in implementation of the National Health Programmes. Their general awareness about these programmes needs to be strengthened.
- The Radio Health Quiz Show, an initiative under the School Health Programme had no AYUSH component.
- AYUSH doctors are not involved in training of ASHAs.

Recommendations –

- ➢ AYUSH doctors/facilities should be involved in ASHA training and can be utilized for implementation of Pulse Polio Immunization campaigns and in Palliative Care programme in supervisory roles.
- ➢ AYUSH doctors at district level and in dispensaries should be sensitized about National Health Programmes and informed about notifiable diseases.
- ➢ AYUSH doctors from the public and private sectors can be involved in the Radio Health Quiz Show in schools. A component on AYUSH systems can be added in the content of the quiz show.

Programme Management

- AYUSH doctors at district and state level need to strengthen their skills in public health management and require training in designing PIP.

Recommendations –

- ➢ Training should be provided to AYUSH doctors in public health management and in designing state/district level PIPs. Training could be provided by the state or an external agency.

- District level AYUSH programme manager may be appointed under NRHM if required.

Infrastructure-II

Achievements in Infrastructure Development -

Health Facility	Year	No. Sanctioned	Progress of New Constructions		
			No. Completed and handed over to health department	No. Under Construction	No. Sanctioned but Yet to start
District Hospitals	2010-11				
	2011-12	5			5
SDH and other hospitals above CHC (THQH)	2010-11				
	2011-12	2			2
CHCs	2010-11				
	2011-12	1			1
PHCs	2010-11				
	2011-12				
APHC/ Others	2010-11				
	2011-12				
Sub-Centers	2010-11	1	1		
	2011-12				

Achievements in Infrastructure Development

Health Facility	Year	No. Sanctioned	Progress of Renovations or upgradations		
			No. Completed	No. under renovation	No. Sanctioned but Yet to start
District Hospitals	2010-11	4	4		
	2011-12	5	2	2	1
SDH and other hospitals above CHC (THQH)	2010-11	5	5		
	2011-12	45	33	9	3
CHCs	2010-11	3	2	1	
	2011-12	15	8	1	5
24 * 7 PHCs	2010-11				
	2011-12				
Other PHCs	2010-11	3	3		
	2011-12	6	6		
Sub-Centers	2010-11				
	2011-12				