Summer Training at
National Urban Health Mission, Karnataka
(April 3 to June 2, 2017)

• Gap Analysis of Select National Health Programs in Brihath Bengaluru Mahanagara Paalike Area under NUHM
• Untied Fund Utilization among the Urban Primary Health Centres in Brihath Bengaluru Mahanagara Paalike Area under NUHM

By
Santosh S Gad

Under the guidance of
Dr. Tanjul Saxena

MBA Hospital & Health Management
2016-2018

Institute of Health Management Research
The IIHMR University, Jaipur
2017

INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that Dr. Santosh S Gad has undergone summer training in National Urban Health Mission- Karnataka, Bengaluru, from 3rd April to 2nd June 2017.

The candidate completed the project assigned to him during summer training. His approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health Management.

We wish him success in all his future endeavors.

Col. (Dr.) Ashok Kaushik
Dean (Academic & Student Affairs)
The IIHMR University, Jaipur
Date: 16 June 2017

Dr.Tanjul Saxena, PhD
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The IIHMR University, Jaipur
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Dr. Rathan Kelkar I.A.S
Mission Director
National Health Mission

Directorate of Health & Family Welfare Services

To the Concerned

Dr. Santosh. S. Gad, a student of MBA- Hospital & Health management at the IIHMR University- Jaipur, has been pursuing his Summer Training Program at the National Urban Health Mission (NUHM)- Karnataka, Bengaluru with effect from 3rd April 2017 to 2nd June 2017.

During the period, he was entrusted to study the utilization of Untied Funds under the NUHM program along with a gap analysis of select National Health Programs in the BBMP-Bengaluru City.

During his internship, he has attended the following Summit/Workshop:

- Health Care Summit – Karnataka organized by the ELETS, India on 11th April 2017.
- NUHM Program Implementation Workshop for Urban Local Bodies organized by the NUHM-Karnataka on 21st April 2017.

His performance during the program has been found to be highly satisfactory, with a few of his recommendations worth a consideration.

This serves to certify the completion of his Summer Training Program at our organization. I trust his learnings have been immense and shall benefit from it.

We wish him all the best.

Dr. Rathan Kelkar, I.A.S.
Mission Director
National Health Mission- Karnataka
Bengaluru.

Date: 07.06.2017

Place: Bengaluru

New Building, First Floor, Ananda Rao Circle, Bangalore - 560 009, Tel : 080 2237 3587, Fax : 080 2234 0164, E-mail : mdnrhmkar@gmail.com

About the Organization

Name: National Urban Health Mission- Karnataka, Bengaluru

Address: National Health Mission Directorate, Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bengaluru-560009

Goal/ Mission: The National Urban Health Mission-Karnataka would aim to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies.

Key Focus Area:

- Revamping urban public health system
- Develop and nurture a community based mechanism to drive urban health programs
- Encourage active involvement of the urban local bodies
- Explore partnerships in driving urban health for poor and vulnerable.

Key Geographical and socio demographic profile of field covered by the organization

- BBMP & Bengaluru Urban District
- 29 District Head Quarters
- 2.35 Crores Urban population (38.57%) of the State's Total population of 6.1 Crores (2011 Census).

Work assigned to the student by the organization

- A study on utilization of Untied Funds in BBMP UPHCs
- A Gap analysis of implementation of NVBDCP, RMNCH+A, NIP, NPCDCS, NPHCE programs in BBMP Area.

Performance Remarks by Organization

(1) Has been clear and deligent in the training.
(2) Has brought out the findings without bias.
(3) Has been very satisfactory.

6/6/17

Signature of Local Mentor
Dr S.M.Sridhar
State Nodal Officer
National Urban Health Mission-Karnataka
&
Deputy Director (Medical-2)
Directorate of Health & Family Welfare Services
Bengaluru

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Acknowledgements

I offer my sincere acknowledgements to:

Shri Ramesh Kumar, Hon'ble Minister of Health & Family Welfare, Government of Karnataka,

Dr Shalini Rajneesh, Principal Secretary- DoHFW, Government of Karnataka,

Shri Subodh Yadav, Commissioner- DoHFW, Government of Karnataka,Dr

Rathan Kelkar, Mission Director- National Health Mission (Karnataka),

Dr Sridhar S M, State Nodal Officer & DD(Medical-2), NUHM-Karnataka,

for their kind consent and approval of my proposal to undergo training at the NUHM-Karnataka, and to:

Dr Srinivas K P, Senior Advisor, NUHM-Karnataka,

Dr M N Lokesh Chief Health Officer, BBMP-Bengaluru,

Dr Raghavendra, State Program Manager-NUHM (Karnataka),

Dr Suresh G K, CPMO, BNUHM-BBMP, Bengaluru

Dr Latha, DD- Immunization, DoHFW, Government of Karnataka

Dr Kalavathi, RCH Officer, BBMP-Bengaluru

Dr Diwakar, CPM, NUHM-BBMP, Bengaluru

Dr Pavan, Consultant, NUHM-Karnataka

for their active support and guidance through my training and the conduct of the study,

and to,

Dr Ashok Kaushik, Dean-Academic Affairs, IIHMR University-Jaipur

Dr Tanjul Saxena, Associate Professor, IIHMR University-Jaipur

for facilitating my summer training at the NUHM-Karnataka.

List of Abbreviations

AGHC	Anjanappa Garden Health Centre
ANC	Ante Natal care
BBMO	Brihat Bengaluru Mahanagara Paalike
CDPO	Child Development Project Officer
DPT	Diphtheria, Pertussis, Tetanus
DT	Diphtheria, Tetanus
ENBC	Early New Born Care
FP	Family Planning
FY	Financial Year
IIHMR	IIHMR University-Jaipur
IPHS	Indian Public Health Standards
JSSY	Janani Shishu Suraksha Yojana
JSY	Janani Suraksha Yojana
KGHUPHC	Kadugondana Halli Urban Primary Health Centre
KPUPHC/ KPUFWC	Kamakshi Palya Urban Primary Health Centre/ Urban Family Welfare Centre
Med Eqpt	Medical Equipment
MR	Measles Rubella Vaccine
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NACP	National Aids Control Program
NGO	Non-Governmental Organization
NHM	National Health Mission
NIDDCP	National Iodine Deficiency Disease Control Program
NIP	National Immunization Program
NMHP	National Mental Health Program
NPCB	National Program for Control of Blindness
NPCDCS	National Program for Control of Diabetes, Cardiovascular Disease and Stroke
NPHCE	National Program for Health Care of Elderly
NPPCD	National Program for Prevention & Control of Deafness
NSPUPHC	N S Palya Urban Primary Health Centre
NTCP	National Tobacco Control Program
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Program
PHE	Public Health Engineering
PIP	Program Implementation Plan
PNC	Post Natal Care
Qtr	Quarter
RMNCH+A	Reproductive, Maternal, Neonatal, Child Health + Adolescent Health Program
RNTCP	Revised National Tuberculosis Control Program

ROL	Re-Order Level
ROQ	Re-Order Quantity
RTI	Reproductive Tract Infection
SB A/c	Savings Bank Account
SBI	State bank of India
SNUPHC	Shanti Nagar Urban Primary Health Centre
STI	Sexually Transmitted Infection
UFWC	Urban family Welfare Centre
UPHC	Urban Primary Health Centre
Vit A	Vitamin A
WGUFWC	Wilson Garden Urban Family Welfare Centre
WMF	Wastage Multiplying Factor

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MBA HEALTH AND HOSPITAL MANAGEMENT (HM-21)

SUMMER TRAINING PROGRAM
AT
NATONAL URBAN HEALTH MISSION-KARNATAKA
BENGALURU

1. Objectives of the Summer Training Program at the National Urban Health Mission-Karnataka:

   To gain a deep insight into the following:

   a. Healthcare delivery system in Urban- Karnataka
   b. Organization and functioning of the Mission Directorate, NUHM-Karnataka
   c. National Urban Health Mission- Karnataka and implementation in the city of Bengaluru.
   d. National Disease Control Programs- implementation and monitoring in Karnataka
   e. Bottlenecks and impediments encountered in program implementation and monitoring.

2. Organization of the Mission Directorate, NUHM-Karnataka

Fig-1: Organogram of the National Urban Health Mission- Karnataka

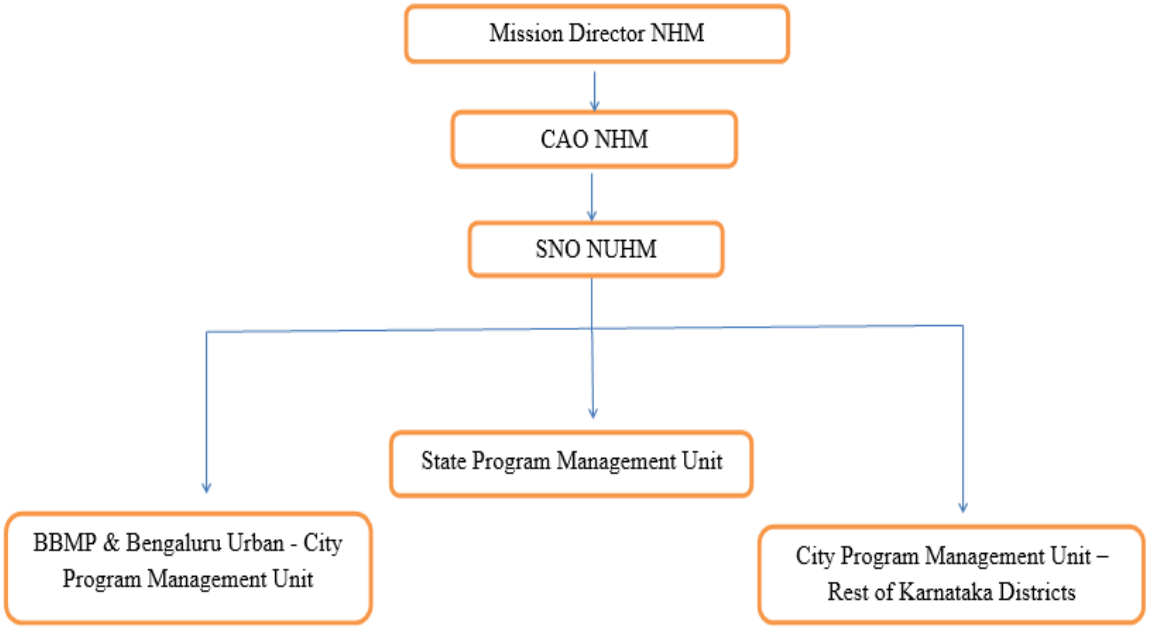


Fig-2: Organization of the State Program Management Unit, NUHM-Karnataka.

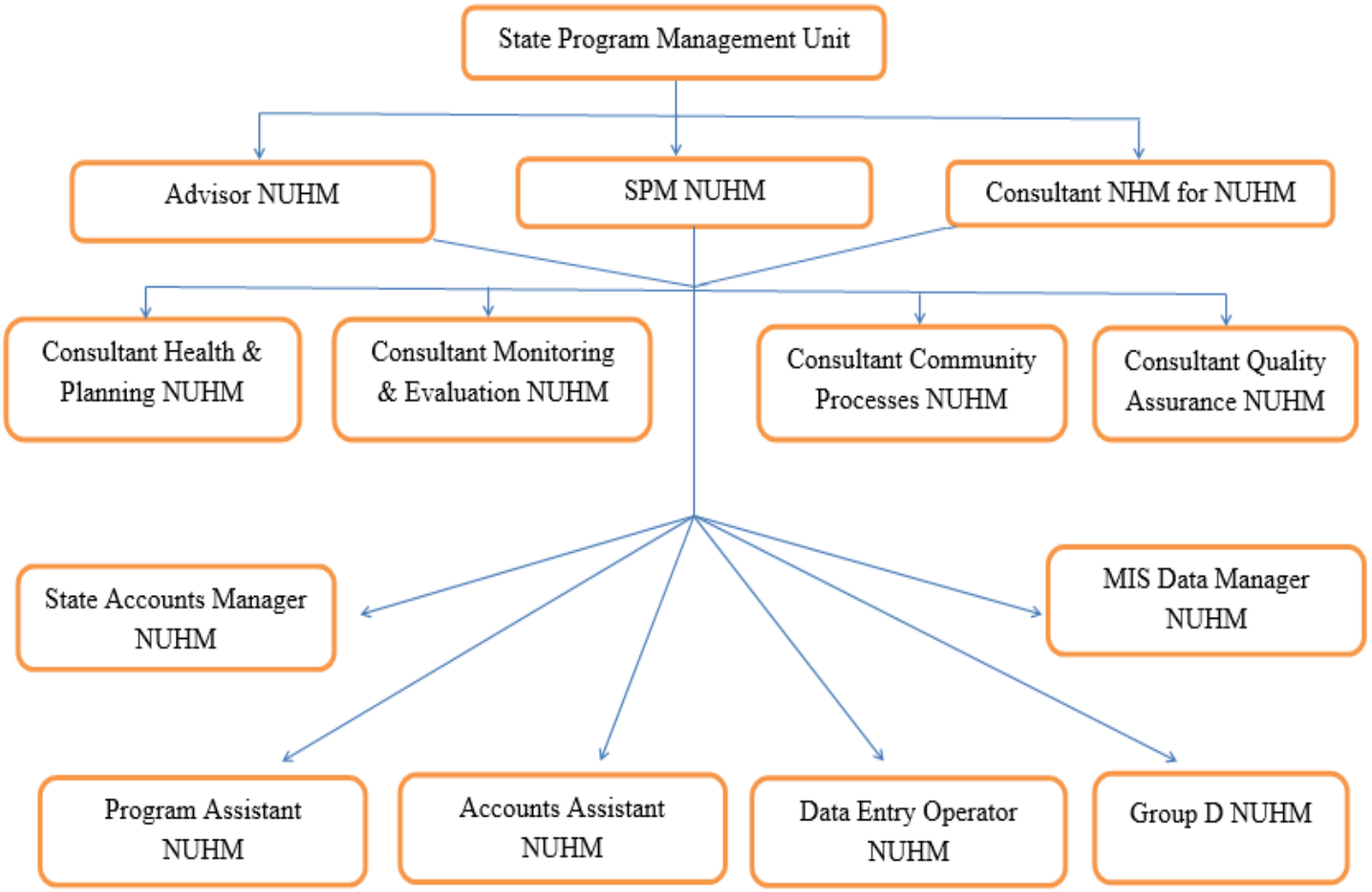
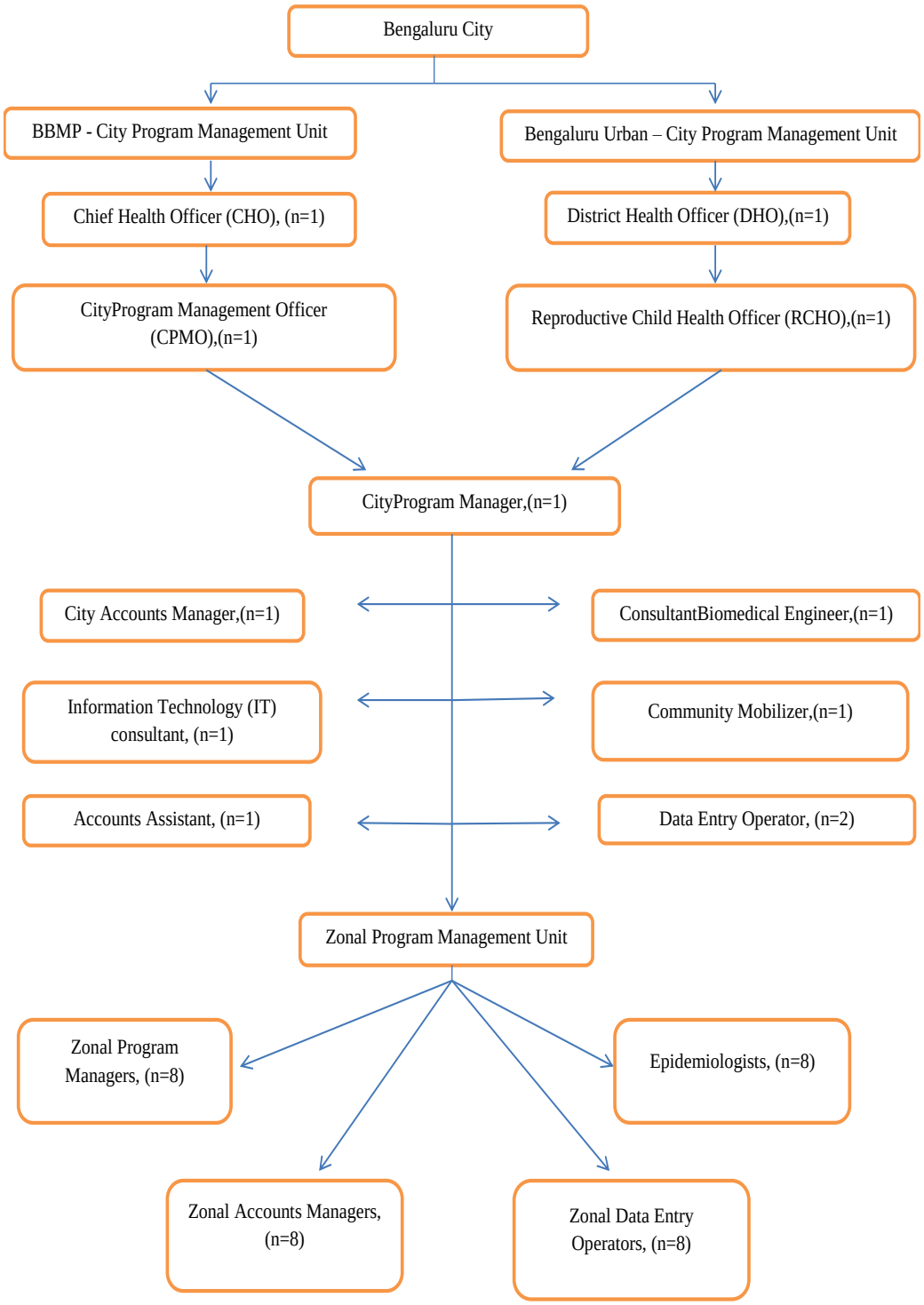
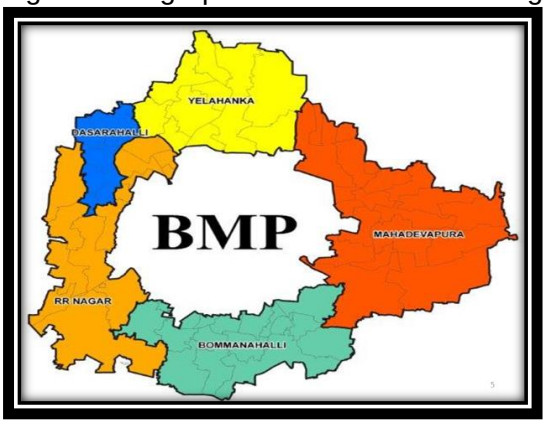


Fig-3: Organogram of the NUHM-Bengaluru City



3. Demographic profile of Bengaluru City

Fig-4: Demographic Profile of BBMP-Bengaluru City.

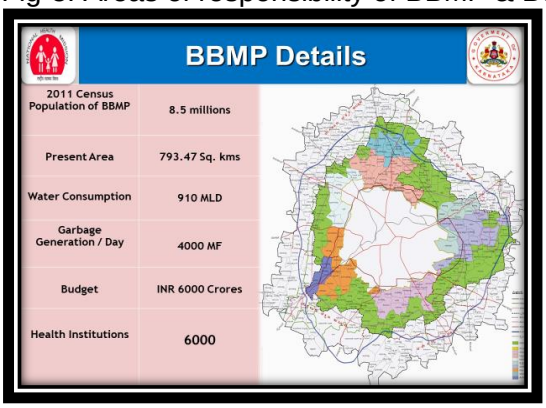


Basic Information in BBMP

Sl. No	Particulars	BBMP	Bangalore Urban District
1	No of Wards	135	63
2	Total Population #	55,52,296	33,79,815
3	No.of households	14,18,478	8,17,562
4	Total no of slums *	329	545
5	Total Slum population *	13,53,286	7,13,190
6	Birth rate**	17.6	
7	Death rate**	5.3	
8	IMR**	31	
9	MMR**	117 Per lakh deliveries	
10	Children Less then 5 years	6.8 Lakh	5.8 lakh

4. Distribution of responsibility among BBMP & Bengaluru Urban District:

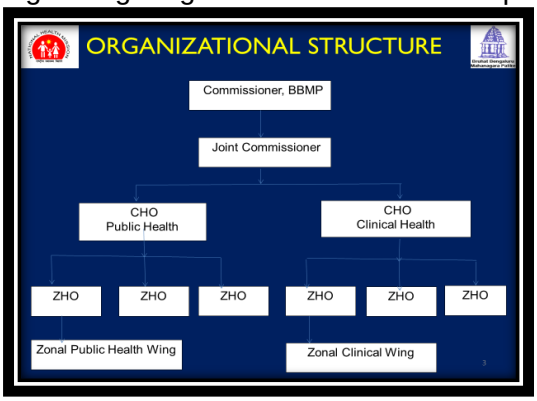
Fig-5: Areas of responsibility of BBMP & Bengaluru-Urban District



Distribution of Responsibilities
Bruhath Bangalore Mahanagar Palike (BBMP) and Bangalore Urban District (BU)

Sl.No	BBMP	Bangalore Urban
1	Implementation of NUHM programme under 135 wards in BBMP	Implementation of NUHM programme under 38 wards in BU
2	03 Zones namely a) East, b) West and c) South	05 Zones namely a) Mahadevapura, b) Dasarahalli, c) Yelahanka, d) RRNagar, e) Bommanahalli
3	75 UPHC , 26 Maternity Homes, 06 Referral Hospitals working under NUHM	38 PHC working under Bengaluru Urban District

Fig-6: Organogram of BBMP Health Dept



a. NUHM is being implemented in all 198 wards of BBMP through BCH&FW Society®.
b. Under NUHM 146 existing health facilities are selected for implementation
c. BBMP-Health dept. is responsible for 108 functional health facilities that comeunder 135 wards.
d. For the remaining 63 wards, though under BBMP jurisdiction, Urban Primary Health Centers are Under DHO (Bengaluru Urban District).

5. BBMP Health Department: Mission

BBMP- Health Department strives to ensure improved health status and quality of life of urban population with unequivocal and explicit emphasis on sustainable development measure.

6. BBMP-NUHM Goals:

- Need based city-specific urban healthcare system to meet the diverse healthcare needs of the urban poor and other vulnerable sections
- Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population
- Partnership with community and local bodies for a more proactive involvement in planning, implementation and monitoring of health activities
- Availability of resources for providing essential primary health care to urban poor
- Partnerships with NGOs, for profit and not for profit health service providers and other stake-holders.

7. BBMP-NUHM Objectives:

- To reduce IMR & MMR
- To ensure population stabilization
- To prevent and control communicable and Non-communicable diseases
- To upgrade AYUSH services for promotion of healthy life style

8. Scope of the study: To study the Implementation of the NUHM Program in the UPHCs of BBMP-Bengaluru City under the following:
    a. NUHM Framework for Implementation
    b. IPHS Standards
    c. RMNCH+A Program
    d. NIP
    e. NVBDCP
    f. NPCDCS
    g. NPHCE
9. Methodology:
    a. The study was conducted in UPHCs in BBMP's area of responsibility
    b. 6 Urban PHCs were allotted, following a convenience sampling, for the study, two from each core zone of BBMP
        1. KGH UPHC - East Zone
        2. SNUPHC - East Zone
        3. KP UFWC - West Zone
        4. AGHC - West Zone
        5. SNP UPHC - South Zone
        6. WG UFWC - South Zone
    c. A check list based on the operational guidelines on various programs, covered under the scope of the study, issued from the MoHFW, GoI was developed and used for the study. The check list is tabulated along with the findings from para 10 onwards.
    d. Data collection was done by
        a. Observation
        b. Personal Interview
        c. Perusal of records
    e. Data is tabulated and analyzed using MS-Excel.

NUHM Implementation in Bengaluru City : Findings of the Study

10. Salient Achievements of NUHM Program Implementation in BBMP Area include the following:

    a. Infrastructure- contemporary, tiled, dadoed, well located
    b. AoR (Area of Responsibility) clearly defined
    c. Full time Medical Officers cover the UPHCs
    d. Splendid movements on MCH programs
    e. Excellent coverage of immunization
    f. Communitization:
        a. ASHA recruitment has picked up pace
        b. MAS being organized
    g. System well poised to take on more programs

Table-A: NUHM Program Indicators: BBMP Area

NUHM Measurables	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Institutional Deliveries	100%	99% (one home delivery)	100%	99%	100%	100%
UHNDs	once a month, 3rd satday	once a month, 3rd satday	once a month, 3rd satday	once a month, 3rd satday	once a month, 3rd satday	once a month, 3rd satday
MAS	9	0	8	8	21	5
MAS desirable @ 1 per 100 house holds	280	266	314	154	143	194
MAS frequency	monthly	monthly	monthly	monthly	monthly	monthly
MAS Supportive supervision	no	no	no	yes	no	yes
Program Manager	0	0	0	0	0	0
ASHAs	13	7	8	6	7	7
ASHA Trg	2 modules	2 modules	2 modules	2 modules	2 modules	2 modules
Complete Immunization	96%	100%	95%	96%	97%	92%
Malarial Programme	Yes	Yes	Yes	Yes	yes	yes
TB programme	Yes	Yes	Yes	Yes	yes	yes
ANC registration	100%	100%	100%	100%	100%	100%
Birth regtn	Child births do not happen; hence intimation is not applicable					
IMR	0.00	7.14	2.85	1.43	0.00	0.00
MMR	0.00	357.14	95.06	0.00	0.00	0.00
Universal Immunization	97%	98%	96%	95%	95%	92%
Out-reach program made Operational	Yes	Yes	Yes	Yes	Yes	Yes

Thrust areas, going forward, would be

    h. ASHA head count improvement, training and retention.

i. MAS formation and involvement
j. Refining outreach activity.
k. Programmatic training of all concerned stake holders on the gaps identified, discussed in greater detail in the following paragraphs of this report.
l. Strengthen implementation, record-keeping, reporting, and monitoring.
m. Introduce program evaluation.

11. Coverage:

a. Coverage is well defined for each UPHC/ UFWC.
b. Vulnerable population is identified.

Table-1: Coverage of UPHC/ UFWCs

	SNUPHC	AGHC	WGUFWC	MRUFWC	NSP UPHC	KGHUPHC
Population	90564	26614	76801	85200	84629	78739
Vulnerable population	28000	26614	31430	15420	14294	19378
% Vulnerable Population	31%	100%	41%	18%	17%	25%
% Elite Population	69%	0%	59%	82%	83%	75%
Ward Nos	116,117	138	144,145	101,102	176,177	23,30

12. User Fees:

a. 4 of the 6 centres charge a user fee. Outpatient registrations are charged Rs.5/-, and ARV injections are charged Rs.100/-.
b. The other two centres do not charge any fees.
c. Drugs, laboratory services, immunization (other than ARV) and all other facilities are available free of charges.
d. It is recommended that a uniform policy for user fee collection may be explored.

Table-2: User Fees

User Fees Details	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
User fees collected	No	Yes	No	Yes	Yes	Yes
OPD registration	0	Rs. 5/-	0	Rs. 5/-	Rs. 5/-	Rs. 5/-
Laboratory charges	0	0	0	0	0	0
ARV(Anti Rabies Virus) Injection	0	Rs.100/-	0	Rs.100/-	Rs.100/-	Rs.100/-

13. Access and Scope of Services at the UPHCs:

a. All centres are accessible by a well-constructed, motorable road.

b. While local transport is available to all facilities, bus-facility is available only to a select few.

c. AGHC has very narrow and congested road access. Ambulance(LMV)movement is restricted and heavy vehicle movement (like fire engines) is heavily restricted. However, AGHC is the only UPHC which is located amidst the vulnerable population and is easily accessible by walk. Entire dependent population is vulnerable, with no elite dependency.

d. All UPHCs offer accessible services, with a full-time Medical Officer and nursing team. Free laboratory services and medicines are available across units.

Table-3: Access Details of the UPHC/ UFWCs

Access (as per IPHS-2012 Revised)	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Barrier free access	Yes	Yes	Yes	Yes	Yes	Yes
Well connected	Yes	Yes	Yes	Yes	Yes	Yes
Local transport available	Yes	No	Yes	Yes	Yes	Yes
Roads	good, busy	good, narrow	Very Good	very good	Good, narrow	Good, Very busy
Bus facility	No	No	Very Good	Yes	No	Very Good
Open 24 x 7	No	No	No	No	No	No
Staffed 24 x 7	No	No	No	No	No	No
AYUSH services	No	No	No	No	No	No
4-6 beds	No	No	No	No	No	No
Each bed 5.5 x 3.5 sq mtr	No	No	No	No	No	No

Fig-7 Citizens' Charter Displayed

Fig-8: Kamakshi Palya UPHC, BBMP-Bengaluru City

e. 108 Ambulance facility is available in all areas studied.
f. However, the facility is poorly lit in the evenings, with bare-minimum signage. Guiding signage on the roads leading to the centres are needed. The main gate signage needs immediate reinforcement and renovation.
g. All centres operate between 9AM and 4PM routinely, offering out-patient facility. A few of them offer evening consultations on certain days of the week and the service includes a few specialties like ENT, Medicine, Surgery, OBG, Orthopedics, Pediatrics and Diabetology.
h. None of them offer In-patient services.
i. Two of the centres are co-located with a Maternity Hospital, and therefore have the access of the specialist (OBG) next door.
j. None of them provide child birth services, and therefore do not have a labor room or a new born corner.
k. While the ANC enumeration and care is near complete, post-natal care requires attention and focus. The compliance to the recommended 7th day/ 42nd day visits post-natally by the LHV/ ANM is inconsistent.
l. 5% of the births are low birth weights on an average, and recommended additional post-natal visits by the LHV needs to be reinforced.

Table-4: Scope of Services (as per IPHS Guidelines 2012- Revised)

	SNUPHC	AGHC	WGUFWC	MRUFWC	NSP UPHC	KGHUPHC
PHC Type	Type - A	Type - A	Type - A	Type - A	Type - A	Type - A
6 hrs of OPD	9AM-4PM, 4PM-8PM(1,3,5)*	9AM-4PM, 4PM-7PM(2,3,4,5,6)	9AM - 4 PM	9-30AM - 1PM, 5PM-8PM(1-ortho, 2-Med, 3-Psy+Med, 4-Med, 5-Ortho+ Med, 6-Ortho+OBG)	9AM-4PM, 4-30PM-7-30PM, (2-Diabetologist, 5,6-OBG)	9AM-4PM, 5PM-7PM (1,3,5-ENT, 2,4-GS)
Operational six days a week	Yes	Yes	Yes	Yes	Yes	Yes
Out Patient Load /doctor/day	15	35	20	30	25	40
Coverage	Covers 90,000 population with a vulnerable population of 28,000	Covers a vulnerable population of 26,614	Covers 76,801 population with a vulnerable population of 31,430	Covers 85,200 population with a vulnerable population of 15,420	Covers 84,629 population with a vulnerable population of 14,294	Covers 78,739 population with a vulnerable population of 19,378
2hrs/day x 2 days /week field visit by MO	No	No	No	No	No	No
24 x 7 emergency services by nrsg staff	Yes	No	No	No	No	No
Medical officer on call available	Yes	No	No	No	No	No
Referral services	Yes	Yes	Yes	Yes	Yes	Yes
IP services- 6 beds	No	No	No	No	No	No
ANC	Yes	Yes	Yes	Yes	Yes	Yes
Lab services	Yes	Yes	Yes	Yes	Yes	Yes

Table continued....

- 1- Monday, 2-Tuesday, 3-Wednesday, 4-Thursday, 5-Friday, 6-Saturday, 7-Sunday.

Table-4 Scope of Services (as per IPHS Guidelines 2012- Revised) (continued)

	SNUPHC	AGHC	WGUFWC	MRUFWC	NSP UPHC	KGHUPHC
Nutrition & Health Counseling-Pregnancy	Yes	Yes	Yes	Yes	Yes	Yes
IFA/TT availability	Yes	Yes	Yes	Yes	Yes	Yes
Tracking of missed or left out ANCs	Yes	Yes	Yes	Yes	Yes	Yes
Chemoprophylaxis for malaria for Pregnant	No	No	No	No	No	No
Tobacco cessation counseling	Yes	Yes	Yes	No	Yes	Yes
24 x 7 delivery care (Normal & Assisted)	No	No	No	No	No	No
No of deliveries	0	0	0	0	0	0
Average length of stay after delivery	Na	Na	Na	Na	Na	Na
Lengthiest stay	Na	Na	Na	Na	Na	Na
Shortest stay (min 48 hrs)	Na	Na	Na	Na	Na	Na
Partograph	Na	Na	Na	Na	Na	Na
Post Natal care for 0 & 3rd day	Na	Na	Na	Na	Na	Na
7th & 42nd day visits by ANM	Yes	Yes	Yes	Yes	No	No
3 addl visits by LHV for LBW baby (<2500 gms) on 14th, 21st, 28th day	No	No	No	No	No	No
Initiation of early breast feeding	Na	Na	Na	Na	Na	Na
JSY benefits	Yes	Yes	Yes	Yes	Yes	Yes
Tracking of missed and left out PNC	Yes	Yes	Yes	No	Yes	Yes
ENBC	Na	Na	Na	Na	Na	Na
FP Services	Yes	Yes	Yes	Yes	Yes	Yes
MTP -MVA(desirable)	Yes	Yes	Yes	Yes	Yes	Yes
RTI/STI treatment	Yes	Yes	Yes	Yes	Yes	Yes
nutrition advise	Yes	Yes	Yes	Yes	Yes	Yes
Anemia/ vit-A deficiency treatment	Yes	Yes	Yes	Yes	Yes	Yes

14. Manpower availability:

a. 50% of the centres have adequate (qualified and trained) manpower, with no critical deficiency.

b. Two of the three units with deficiency, have critical deficiency in the form of a laboratory technician and lady health visitor.

c. One of the centres does not have an accountant/clerk, which is not a critical deficiency.

d. Three of the centres has deficient number of ASHAs.

e. There is a felt need for a Program Management resource at the UPHC to augment the supervision of the Medical Officer.

f. Two of the centres are being run by a Medical Officer on contract or by an out-sourced organization. These centres have a Medical Officer (on permanent rolls of BBMP) of another UPHC as the Administrative Medical Officer of the UPHC, who visits the UPHC only for the purposes of ARS meetings and untied fund utilization. The context and spirit behind such an arrangement is well appreciated and a good practice to be emulated.

Table-5: Manpower in UPHCs/ UFWCs

	Ideal (as per IPHS-2012 Revised)		SNUPHC		AGHC		WGUFWC		KPUFWC		NSP UPHC		KGHUPHC	
	Essential	Desirable	Actual	Sur/ Defi (-)	Actual	Sur/ Defi (-)	Actual	Sur/ Defi (-)	Actual	Sur/ Defi (-)	Actual	Sur/ Defi (-)	Actual	Sur/ Defi (-)
Medical Officer- MBBS	1		1	0	1	0	1	0	1	0	1	0	1	0
MO –AYUSH		1	0	0	0	0	0	0	0	0	0	0	0	0
Accountant/Clerk cum Data Entry Operator	1		1 PT	0	0	-1	0	-1	0	-1	0	-1	1 PT	0
Pharmacist	1		1	0	0	-1	1	0	1	0	1	0	1	0
Pharmacist AYUSH		1	0	0	0	0	0	0	0	0	0	0	0	0
Nurse-midwife (Staff-Nurse)	3	+1	2+1	0	3	0	3	0	7	4	6	3	6	3
Health workers (F) (for Sub-Centres)	1 (NA for UPHC)		NA	0	NA	0	NA	0	NA	0	NA	0	NA	0
Health Asstt. (Male) (for Sub-Centres)	1 (NA for UPHC)		NA	0	NA	0	NA	0	NA	0	NA	0	NA	0
Health Asstt. (Female)/LHV	1		0	-1	0	-1	1	0	0	-1	0	-1	0	-1
Health Educator		1	0	0	0	0	0	0	0	0	0	0	0	0
Laboratory Technician	1		0	-1	1	0	1	0	1	0	1	0	1	0
Cold Chain & Vaccine Logistic Assistant		1	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	10	15	6	-2	5	-3	7	-1	10	2	9	1	9	2
Multi-skilled Group D worker	2		#		0	-2	#	-2	2	0	2	0	1	-1
Sanitary worker cum watchman	1		#		2	1	#	-1	0	-1	1	0	0	-1
Grand Total	13	18	6	-2	7	-4	7	-4	12	1	12	1	10	0

: Outsourced to the Co-located Maternity Home
NA : Not Applicable

ASHAs	11.2		13	2	7	-4	8	-5	6	0	7	1	5	-3
Each ASHA covers	2500		2154	-346	3802	1302	3929	1429	2570	70	2042	-458	3876	1376
Vulnerable population Covered	30000		28000	-2000	26614	-3386	31430	1430	15420	-14580	14294	-15706	19378	-10622

15. Training Activity at the UPHCs:

a. Medical Officers are trained on the programmatic matters like guidelines, implementation and monitoring. However, unit-level documentation of such trainings is not evidenced.
b. Other staff trainings are hardly any, to be listed, even at the unit level.
c. It is recommended that a program for unit-level training by the Medical officer be developed and implemented.
d. Each UPHC may be given certain man-hours of training targets, to be achieved by the Medical Officer.
e. It may be made mandatory for the team-members to attend and earn their man hours trained' score.
f. This will help the technical team to remain abreast with the subject and more importantly, with the latest in public health scenario of their jurisdiction.

Table-6: Training Details (As per IPHS Guidelines 2012 -Revised)

Training Details (as per IPHS-2012 Revised)	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Tradition birth attendants	No	No	No	No	No	No
Health Worker (Female)	No	No	No	No	No	No
Health Worker (Male)	No	No	No	No	No	No
Medical Officer	Trainings on program implementation are conducted. Not documented at the unit level.					
Initial and periodic training of paramadics in treatment of miNor ailments	No	No	No	No	No	No
Training of ASHAs	2 modules	2 modules	2 modules	2 modules	2 modules	2 modules
Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care,	No	No	No	No	No	No
Training in FP services.-IUCD, Minilap and NSV, LSAS	No	No	No	No	No	No
Training of Health Workers in antenatal care and skilled birth attendance	No	No	No	No	No	No

16. Laboratory Services at the UPHCs:

a. All the UPHCs, except SNUPHC, have a functional laboratory.

Table-7: Laboratory Services (As per IPHS Guidelines 2012 -Revised)

Laboratory Services (as per IPHS-2012 Revised)	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Routine urine, stool and blood tests	Yes	Yes	Yes	Yes	Yes	Yes
Blood grouping	Yes	No	Yes	Yes	Yes	Yes
Bleeding time, clotting time	Yes	Yes	Yes	Yes	Yes	Yes
DiagNosis of RTI/STDs with wet mounting, grams stain etc.	Yes	Yes	Yes	Yes	Yes	Yes
Sputum testing for TB	Yes	Yes	Yes	Yes	Yes	Yes
Blood smear examination for malaria parasite	No	Yes	Yes	Yes	Yes	Yes
Rapid tests for pregnancy	Yes	Yes	Yes	Yes	Yes	Yes
RPR test for Syphills/YAWS surveillance (in high endemic area only)	No	No	No	No	No	No
Rapid tests for HIV	Yes	Yes	Yes	Yes	Yes	Yes

b. The laboratories are equipped to handle the recommended profile of tests under the IPHS-2012 (Revised).

c. In addition, most of them have been equipped to conduct the following as well..

Table-7: Additional tests conducted at the laboratories as per NPCDCS.

NPCDCS (Laboratory)	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Blood sugar,	Yes	Yes	Yes	Yes	Yes	Yes
Total Cholesterol ,	Yes	No	Yes	Yes	Yes	Yes
Lipid Profile,	No	Yes	No	Yes	No	No
Blood Urea,	No	Yes	Yes	Yes	No	No

d. However, SNUPHC has been supplied with all the lab equipment and reagents, but without a lab technician. The supplied reagents are book-transferred to an identified sister unit, and therefore the lab is not functional at SNUPHC.

17. Other Diagnostic facilities at the UPHCs:

a. Other diagnostics like X Ray, Ultrasound are not available at the UPHCs. They are referred to higher centres like Victoria/ Vani Vilas/ Bowring Hospitals.

18. Infrastructure Details of the UPHCs:

a. All centres are housed in the own building of the BBMP, with no rental expenses.

b. The centres, except WGUFWC, have a very good ambience and are 'welcoming' in their layout. They are well-lit, well-ventilated, floor tiled and walls dado-ed. The facilities have plumbed water supply, with filtered water for drinking at all UPHCs except at the AGHC.

c. All UPHCs (except WGUFWC) have a similar layout, built to contemporary standards and have huge central Atrium- cum- Waiting area, leading to utilities like MO's Examination area, Injection room, Staff Area, Minor Procedure Room, Toilets, Store, Pharmacy, and an office area at its periphery. There is an Emergency exit towards the rear aspect of the building. Basic fire-extinguishers are deployed.

d. Most UPHCs are well secured except AGHC.

Fig-9: Atrium-cum-Waiting area of the UPHC

Table-8: Infrastructure Details of the UPHCs.

Infrastructure (as per IPHS-2012 Revised)	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Own Building (BBMP's)	Yes	Yes	Yes	Yes	Yes	Yes
Plinth 350-450 sqmtrs	Yes	Yes	Yes	Yes	Yes	Yes
Prominent signages outside and within PHC	Needs Improvement	Needs Improvement	Needs Improvement	Needs Improvement	Needs Improvement	Needs Improvement
Guiding signages on leading roads	No	No	No	No	No	No
Labor room 3.8m x 4.2 m	Minor Procedure room exists	Minor Procedure room exists	No	Minor Procedure room exists	Minor Procedure room exists	Minor Procedure room exists
New born corner 20-30 sft	No	No	No	No	No	No
New born Resuscitation kit	No	No	No	No	No	No
Attached toilet in labor room	No	No	No	No	No	No
Facility well lit	Yes	Yes	Yes	Yes	Yes	Yes
Facility well ventilated	Yes	Yes	Yes	Yes	Yes	Yes
Sterilization arrangement	Autoclave available	Autoclave available; Not functional	No	Autoclave available	Autoclave available	Autoclave available
Dirty linen area	Yes	Yes	Yes	Yes	Yes	Yes
Baby wash area	No	No	No	No	No	No
Delivery kits ready	No	No	No	No	No	No
Facility facilitates patient privacy	Yes	Yes	Yes	Yes	Yes	Yes
Drinking water facility	Filtered water available	Corporation tap water manually collected, stored. Aquaguard not functional	Filtered water available	Filtered water available	Filtered water available	Filtered water available
Separate toilets for men & women	Yes	Yes; Men's toilet not functional; No plumbed water supply in toilets; In both toilets, water needs to be fetched using bucket & mug; unhygienic	Yes	Yes	Yes	Yes
Toilets hygenically maintained	Needs Improvement	Needs Improvement	Needs Improvement	Needs Improvement	Needs Improvement	Needs Improvement
Premises Secured	Yes	No; Reported repeated thefts and insecurity	Yes	Yes	Yes	Yes

e. AGHC has a perpetual problem of thefts and insecurity. A prominent manifestation of the problem is evidenced by the lack of plumbed water supply within the facility. The team including the MO used a bucket and a mug, and the water is fetched manually. Repeated thefts of the overhead reservoir (OHR) of potable water has prompted the unit to construct a cage around the tank to secure it. However, the underground sump is not as well secured as it should be to complement the OHR, with resultant contamination of the water reservoir by the community. The gate and compound wall is not secured either. Thus, the facility is frequented by unsocial elements and children (use it as their playground). The matter has been conveyed to the ARS and funds are reserved to take up the desirable works in the near future. It is recommended that the CPMU take cognizance of the matter and a lasting solution be offered through inter-sectoral (police, engineering) co-ordination.

f. WGUFWC is housed in the extension of the WG Maternity Hospital on its first floor and needs renovation.

Table-9: Implementation of National Health Programs at UPHCs

Abbreviation	Indicator	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
NPCB	The early detection of visual impairment and their referral	No	No	No	No	No	No
	Detection of cataract cases and referral for cataract surgery	Yes	Yes	Yes	Yes	Yes	Yes
	Provision of Basic treatment of common eye diseases	Yes	Yes	Yes	Yes	Yes	Yes
NACP	Condom Promotion & distribution of condoms to the high risk groups	Yes	Yes	Yes	Yes	Yes	Yes
	High risk group identification	No	Yes	No	No	No	No
	Rapid test for HIVfor igh risk froup	Yes	Yes	Yes	Yes	Yes	Yes
	Risk screening of antenatal mothers	Yes	Yes	Yes	Yes	Yes	Yes
NPPCD	Early detection of cases of hearing impairment and deafness and referral.	No	No	No	No	Yes	No
	Basic DiagNosis and treatment services for common ear diseases	Yes	Yes	Yes	Yes	Yes	Yes
NMHP	Basic Services: DiagNosis and treatment of common mental disorders	Yes	Yes	Yes	Yes	Yes	Yes
NPCDCS	Early detection of cancer with warning signals like change in Bladder/Bow	No	No	No	No	No	No
	PAP smear	No	No	No	No	No	No
	Early detection, management and referral of Diabetes Mellitus, Hypertension an	Yes	Yes	Yes	Yes	Yes	Yes
	Survey of population to identify risk/ vulnerability	No	No	No	No	No	No
	ECG	No	No	No	Yes	No	No
NIDDCP	Monitoring of Iodated salt through salt testing kits.	No	No	No	No	No	No
NTCP	Promoting quitting of tobacco in the community	Yes	Yes	Yes	Yes	Yes	Yes
	Making PHC tobacco free	Yes	Yes	Yes	Yes	Yes	Yes
NPHCE	Weekly geriatric clinic at PHC' for providing complete health assessment (	No	No	No	No	No	No
Vital Regt	report all births & deaths	Yes	Yes	Yes	Yes	Yes	Yes

19. Implementation details of the National Health Programs

a. The subject findings, based on the recommendations in the IPHS Guidelines-2012 (revised) is tabulated in Table-9.

b. The inconsistency is evident from the findings. It is recommended that the program specific trainings be organized to bring all the units on the same platform regarding implementation of the national programs.

20. NVBDCP Implementation Details at the UPHCs:

a. It is welcome to note that the occurrence of the vector borne disease in the centres' areas of responsibility is exceptionally low, reportedly.

b. However, the teams across the centres were grossly ignorant of the NVBDCP guidelines. The details are tabulated in table-10.

c. It is recommended that the training sessions be organized on priority to sensitize the team of the expectation.

d. Also, the field team including the ASHAs need to be trained on program guidelines, active case detection, conduct of rapid diagnostic tests, focus identification and reporting, etc..

e. Indoor Residual Spraying in the house-holds around the identified case/ focus area in the vulnerable areas needs attention.

f. About 77% of the malaria patients approach private healthcare establishments for treatment. The IDSP information collated from all sources may be shared appropriately with the concerned UPHC, such cases investigated, treatment followed up, ACF around the identified case be done.

Table-10: NVBDCP Implementation Details at the UPHCs

	NVBDCP Details	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Program Implementation	API	NA	NA	NA	NA	NA	NA
	Cagtegory (0, <1,1-2,2-5,>5)	NA	NA	NA	NA	NA	NA
	RDTs available	No	No	No	No	No	No
	Anti Pf drugs (ACT-SP)	No	No	No	No	No	No
	Anti Pv drugs (CQ +PQ)	No	No	No	No	No	No
	Screening with B-RDT	No	No	No	No	No	No
	Any high risk groups in the area	No	No	No	No	No	No
	Any focus identified?	No	No	No	No	No	No
	Confirmation of cases	No	No	No	No	No	No
	reference lab identfied	No	No	No	No	No	No
	all positive slides sent to ref lab	No	No	No	No	No	No
	Fortnightly house visits for screening-ACD	No	No	No	No	No	No
	LQAS conducted quarterly	No	No	No	No	No	No
	IRS coverage	No	No	No	No	No	No
	DDT/malathion/Synthetic pyrethroids	Spraying team is not part of the UPHC; Hence chemicals are not stored					
	IRS supervision	No	No	No	No	No	No
	LLIN coverage	No	No	No	No	No	No
	Last mass LLIN campaign	No	No	No	No	No	No
	Epidemic threshold established	No	No	No	No	No	No
	Training Qtrly	No	No	No	No	No	No
	Trg evaluation	No	No	No	No	No	No
	What intersectoral help is expected	Drainage cleaning/ covering, Focus elimination through PHE.					

Table continues...

Table-10: NVBDCP Implementation Details at the UPHCs (continued.)

	NVBDCP Details	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Program Documentation	M1 Report of surveillance of fever cases by ASHA / MPHW 1st fortnight- by 21st; 2nd Fortnight- by7th of the following month	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
	M2 Slide examination request to laboratory	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
	M3 Laboratory register of slide examination in laboratory	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
	M4 Fortnightly report of malaria surveillance from subcentre/PHC PHC-1st FN/28th; 2nd FN/13th of the following month	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
	VC-1 Primary record of IRS	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
	VC-2-IRS Output PHC Within 15 days of spray completion	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
	VC-3 Primary record of bed net delivery and impregnation	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
	VC-4 Bed net delivery and impregnation form	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
Monitoring	MO CHC's visit details	No	No	No	No	No	No
	MPHS visit details	No	No	No	No	No	No
	VBD consultnat visit details	No	No	No	No	No	No
	DVBDCO visit details	No	No	No	No	No	No

Table continues....

Table-10: NVBDCP Implementation Details at the UPHCs (continued.)

	NVBDCP Details	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
NVBDCP Measurables	Fever Cases (As Reported by the team)	25	15	0	0	0	0
	malaria Cases	0	0	0	0	0	0
	Pf Cases	0	0	0	0	0	0
	Pv Cases	0	0	0	0	0	0
	Malaria Dewaths	0	0	0	0	0	0
	API	0	0	0	0	0	0
	AfI	0	0	0	0	0	0
	SPR(TPR)	0	0	0	0	0	0
	TfR	0	0	0	0	0	0
	Pf percentage	0	0	0	0	0	0
	MBER	NA	NA	NA	NA	NA	NA
	ABER	NA	NA	NA	NA	NA	NA
	No treated Pf cases	0	0	0	0	0	0
	No referred for severe malaria management	0	0	0	0	0	0
	% ASHAs equipped with RDKs	0	0	0	0	0	0
	% ASHAs trained win RDTs	0	0	0	0	0	0
	% spray eqpt working	Not Applicable					
	No f suspected chikungunya fever cases	3	0	0	0	0	0
	No of samples sent	0	0	0	0	0	0
	No confirmed from lab	0	0	0	0	0	0
	No of referrals (servere cases)	0	0	0	0	0	0
	No f suspected dengue fever cases	6	0	0	3	3	0
	No of samples sent	0	0	0	25	25	0
	No confirmed from lab	0	0	0	3	3	0
	No of referrals (servere cases)	0	0	0	0	0	0

Table ends.

Table-11 NPCDCS Implementation Details of the UPHCs

NPCDCS	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Prevention and health promotion including counseling	Yes	Yes	Yes	Yes	Yes	Yes
Early diagNosis through clinical and laboratory investigations	Yes	Yes	Yes	Yes	Yes	Yes
Management of common CVDs, diabetes and stroke cases	Yes	Yes	Yes	Yes	Yes	Yes
Laboratory investigations and Diagnostics:						
Blood sugar,	Yes	Yes	Yes	Yes	Yes	Yes
Total Cholesterol ,	Yes	No	Yes	Yes	Yes	Yes
Lipid Profile,	No	Yes	No	Yes	No	No
Blood Urea,	No	Yes	Yes	Yes	No	No
XR	No	No	No	No	No	No
ECG,	No	No	No	Yes	No	No
USG (To be outsourced, if Not available)	No	No	No	No	No	No
'Opportunistic' Screening of common cancers (Oral, Breast and Cervix)	Yes	Yes	Yes	Yes	Yes	Yes
Referral of complicated cases to District Hospital/higher health care facility	Yes	Yes	Yes	Yes	Yes	Yes
Availability of Anti Hypertensive drugs	Yes	Yes	Yes	Yes	Yes	Yes
Availability of Anti diabetic drugs	Yes	Yes	Yes	Yes	Yes	Yes
Availability of Injectable insulin	Yes	Yes	Yes	Yes	Yes	Yes

21. Implementation of NPCDCS at the UPHCs:

a. UPHCs are well poised to take on the challenge of the non-communicable diseases. All that is needed is programmatic training, and good supportive supervision. Given the above, ASHAs and MAS's will be able to aid in active and early case detection, facilitating appropriate and timely intervention.

b. It is recommended that the programmatic training sessions be conducted to all involved in the program.

c. However, it is recommended that the anti-diabetic drug combinations which are frequently used by the private doctors be considered on a case basis to be included in the Essential Drug list of the UPHCs, and such ones be made available to ensure compliance of the patients to treatment.
d. Similarly, the injectable insulin available is 'Actrapid' and is sparingly used on a domiciliary basis. The desirable mixtard preparation be considered to be introduced at the UPHCs, to be useful for the doctors and the patients.
e. Also, long acting anti-hypertensives, which is a gold-standard today for all diabetic therapy, be provisioned at the UPHCs.

22. Implementation details of the RMNCH+A Program at the UPHCs:

a. The Health System deserves the best complements for the vigor with which the program is implemented, despite resource constraints that prevailed until the recent influx of resources through NUHM.
b. The program sets very high standards for other programs to follow
c. Salient achievements include a near perfect active pregnancy detection, ANC registrations, seamless availability of care, a near perfect institutionalization of deliveries with exemplary outcomes on maternal and new-born morbidity/ mortality.

Table-12 Implementation Details of the RMNCH +A Program at UPHCs

	Reproductive & Maternal Health Program	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Program Implementation	Iron + program- IFA treatment	Yes	Yes	Yes	Yes	Yes	Yes
	Pregnancy Testing Kits -Nishchay to ASHAs	Yes	Yes	Yes	Yes	Yes	Yes
	Line listing of severely anaemic women	No	No	Yes	Yes	Yes	Yes
	Tracking pregnant women with severe anaemia	Yes	Yes	Yes	No	Yes	Yes
	PPTCT-single dose Nevirapine (Sd NVP)	No	No	No	No	No	No
	24 x 7 delivery care (Normal & Assisted)	No	No	No	No	No	No
	Ambulance services for pickup/ drop	Yes	Yes	Yes	Yes	Yes	Yes
	24 x 7 emergency services by nrsg staff	No	No	No	No	No	No
	Medical officer on call available	No	No	No	No	No	No
	ANC	Yes	Yes	Yes	Yes	Yes	Yes
	Lab services	Yes	Yes	Yes	Yes	Yes	Yes
	Nutrition & Health counseling-Pregnancy	Yes	Yes	Yes	Yes	Yes	Yes
	Chemoprophylaxis for malaria for Pregnant	No	No	No	No	No	No
	Tobacco cessation counseling	Yes	Yes	Yes	Yes	Yes	Yes
	Tracking of missed and left out PNC	Yes	Yes	Yes	Yes	Yes	Yes
	ENBC	No	No	No	No	No	No
	FP Services	Yes	Yes	Yes	Yes	Yes	Yes
	MTP -MVA(desirable)	No	No	No	No	No	No
	RTI/STI treatment	Yes	Yes	Yes	Yes	Yes	Yes
	Anemia/ vitA defi	Yes	Yes	Yes	Yes	Yes	Yes

Table continues…

Table-12 Implementation Details of the RMNCH +A Program at UPHCs

	Reproductive & Maternal Health Program	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Program Measurables	No of deliveries	0	0	0	0	0	0
	% growth in deliveried YoY	0	0	0	0	0	0
	Average length of stay after delivery	0	0	0	0	0	0
	Lenghthiest staay	0	0	0	0	0	0
	Shortest stay (min 48 hrs)	0	0	0	0	0	0
	Partograph	No	No	No	No	No	No
	Post Natal care for 0 & 3rd day	No	No	No	No	No	No
	7th & 42nd day visits by ANM	No	No	No	No	No	No
	3 addl visits by LHV for LBW baby(<2500 gms) on 14th, 21st, 28th day	No	No	No	No	No	No
	Initiation of ealy breast feeding	Yes	No	Yes	Yes	Yes	Yes
	JSY benefits	Yes	Yes	Yes	Yes	Yes	Yes
	No of JSY beneficiaries	Not being tracked; benefits rendered at maternity hospital					
	% gr in JSY beneficiaries YoY	Not being tracked; benefits rendered at maternity hospital					
	AADHAR used for JSY	Yes	Yes	Yes	Yes	Yes	Yes
	Prasuti aarike-ANC(2016-17)	0	0	0	0	42	0
	Prasuti aarike-PNC(2016-17)	0	0	0	0	17	0
	Prasuti aarike-ANC(2015-16)	0	0	0	0	28	0
	Prasuti aarike-PNC(2015-16)	0	0	0	0	20	0
	Prasuti aarike-ANC(2014-15)	0	0	0	0	38	0
	Prasuti aarike-PNC(2014-15)	0	0	0	0	27	0

Table ends

d. However, the Adolescents'-Health component of the program needs attention. The menstrual hygiene program requires the desirable thrust. While the UPHC team seems confused about the program, ASHAs are unaware of the supply of the menstrual (sanitary) pads, there is no clarity of who is distributing them. It is reported that the WCD does it through the Anganwadi Centres. The Anganwadi teams also disown such a program. Faint prompts are that the education department does the activity through the office of the BEO and schools. Nevertheless, clarity on the matter and necessary education of the concerned teams-HFW/ WCD/ DYA/ DoE be conducted.

e. Adolescent clinics in the name of 'Sneha Clinic' is being conducted by a few centres. It is recommended that such a clinic be standardized across facilities and popularized. It may be appropriate to take such a clinic to the premises of the schools where suitable.

23. National Immunization Program:

a. This is another program of pride for the centres, the mega city, the state and the country.

Table-13: Implementation Details of the National Immunization Program in the UPHCs

	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Frequency of head count	Annual	Annual	Annual	Annual	Annual	Annual
head count last done	Apr-17	Mar-17	Dec-16	Apr-16	May-17	Mar-17
actual head count PW	174	206	95	710	800	612
Head count CU5Y	174	206	95	710	800	612
Beneficiary PW	348	411	95	1420	1600	1223
Beeficiary CU5Y	348	411	95	2840	3200	2446
Mothly target PW	29	34	8	118	133	102
Mothly Target CU5Y	29	34	8	237	267	204
Mothly target TT PW	58	69	16	237	267	204
Mothly target BCG	29	34	8	237	267	204
Mthly Target DPT	116	137	32	947	1067	815
Mthly Target OPV	116	137	32	947	1067	815
Mthly Target HepB	87	103	24	710	800	612
Mthly Target Measles	29	34	8	237	267	204
Mthly Target DT	29	34	8	237	267	204
Mthly Target VitA	261	308	71	2130	2400	1835
WMF for TT/BCG/DPT/HepB/DT/OPV/Measles-1.33						
WMF fro Vit A-1.11	WMF concept is well understood by the team; however, wastage is not being monitored					
No of outreach sites	4	5		8	7	8
Frequency of outreach sessions	monthly for a site; weekly for the UPHC	monthly for a site; weekly for the UPHC	monthly for a site; weekly for the UPHC	monthly for a site; weekly for the UPHC	monthly for a site; weekly for the UPHC	monthly for a site; weekly for the UPHC
No of fixed sites	4	5	5	8	7	8
Frequency of fixed sites	monthly	monthly	monthly	monthly	monthly	monthly

Table continues…

Table-13: Implementation Details of the National Immunization Program in the UPHCs (continued)

	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Map of dependant area is prepared/ clear demarcation	yes	yes	yes	yes	yes	yes
Unserved/ under served areas identified	yes	yes	yes	yes	yes	yes
Supervision plan is prepared/ updated	yes	yes	yes	yes	yes	yes
Strengthening of Monitoring & Supervision	yes	yes	yes	yes	yes	yes
Alternate vacine delivery plan	yes	yes	yes	yes	yes	yes
Mobilization of children by ASHAs	yes	yes	yes	yes	yes	yes
Alternate vaccinators for slums/ under-served areas/vacant SCs	no	no	no	no	no	no
Computer assts	no	no	no	no	no	no
Unit Review meetings	yes	yes	yes	yes	yes	yes
Cold chain maintenance	yes	yes	yes	yes	yes	yes
Printing RO cards & monitoring tools	yes	yes	yes	yes	yes	yes
Construction of waste pits/ BMW expenses	no	no	no	no	no	no
Training of ANMs/HWs	yes	yes	yes	yes	yes	yes
Training of ILR mechanincs	yes	yes	yes	yes	yes	yes
Purchase of BMW polythene bags	yes	yes	yes	yes	yes	yes
Cold chain handlers training	yes	yes	yes	yes	yes	yes
Training of DIO & Mos	Yes	yes	yes	yes	yes	yes
Vaccine delivery plan updated	yes	yes	yes	yes	yes	yes
ILR points identified/ Number of	yes	yes	yes	yes	yes	yes
Farthest session site	6km	0.75 km	2kms	1km	2.5km	2.5km
Nearest session site	0.5km	0.3 km	0.5 km	0.2 km	0.2 km	0.2 km

Table continues…

Table-13: Implementation Details of the National Immunization Program in the UPHCs (continued)

	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Coverage Rate - BCG	69%	98%	90%	93%	97%	92%
Coverage Rate - DPT	50%	98%	94%	110%	99.50%	98%
Coverage Rate - OPV	65%	98%	97%	110%	99%	82%
Coverage Rate - Measles	46%	98%	97%	120%	94%	77%
Coverage Rate - HepB	0%	98%	0%	0%	0%	0%
Coverage Rate - TT (PW)	65%	98%	92%	68%	86%	88%
Coverage Rate - VitA	47%	80%	90%	100%	94%	82%
Drop out Rate - BCG	31%	2%	10%	7%	3%	8%
Drop out Rate - DPT	50%	2%	6%	-10%	1%	2%
Drop out Rate - OPV	35%	2%	3%	-10%	1%	18%
Drop out Rate - Measles	54%	2%	3%	-20%	6%	23%
Drop out Rate - HepB	100%	2%	100%	100%	100%	100%
Drop out Rate - TT (PW)	35%	2%	8%	32%	14%	12%
Drop out Rate - VitA	53%	20%	10%	0%	6%	18%

Table continues…

Table-13: Implementation Details of the National Immunization Program in the UPHCs (continued)

	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
ILR Temperature monitoring being done	yes	yes	yes	yes	yes	yes
Temperature of the ILR	5 deg	5 deg	5 deg	5 deg	5 deg	5 deg
Diluents in contact with the ice packs	no	no	no	no	no	no
Any expired vial	no	no	no	no	no	no
Any frozen vial/ diluent	no	no	no	no	no	no
Any VVM beyong discard point	no	no	no	no	no	no
CCE kept 10 cms away from the walls	yes	yes	yes	yes	yes	yes
CCE away from sunlight	yes	yes	yes	yes	yes	yes
Fixed to power socket with "DO NOYT UNPLUG' instr	no	no	no	no	no	no
One Voltage Stabilixzer per eqpt	yes	yes	yes	yes	yes	yes
Locked/ keys tracable '24 x 7'	no	no	no	no	no	no
Any vaccines in the Deep freezer	no	no	no	no	no	no
DF temperature is monitored twice daily	yes	yes	yes	yes	yes	yes
FEFO followed in aranging	yes	yes	yes	yes	yes	yes
ILR temperature is monitored twice daily	yes	yes	yes	yes	yes	yes
Retunred unused vaccines are separaately stored	yes	yes	yes	yes	yes	yes
Record of unsed returned vaccine vial discards?	no	no	no	no	no	no
Any used vials in the cold chain?	yes	yes	yes	yes	yes	yes
Daily check list is prepared/ followed	no	no	no	no	no	no
Weekly defrost schedule is followed	no	no	no	no	no	no
Eqpt history card is available	no	no	no	no	no	no
Down time is tracked	no	no	no	no	no	no
Cold Chian sickness rate	lack of records constraints the computation					
Breakdown communication register?	no	no	no	no	no	no
Average time to respond tracked?	no	no	no	no	no	no
Alternate arrangements for vaccine storage is made in case of power failure/ eqpt failure	no	no	no	no	no	no
Emergency plan for vaccine storage exists	yes	yes	yes	yes	yes	yes
Emergecny plan last rehearsed	no	no	no	no	no	no
Concerned people aware of the emergency plan?	yes	yes	yes	yes	yes	yes
Any time float assembly facility is used?	no	no	no	no	no	no
Turn around time for float facility	Not Used; hence not tracked					

table continues…

Table-13: Implementation Details of the National Immunization Program in the UPHCs (continued)

	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Bundling is practiced	no	yes	yes	yes	yes	yes
Frequency of physical inventory check	weekly	fortnightly	no	fortnightly	fortnightly	fortnightly
Vaccine wastage rate	not tracking	not tracking	not tracking	not tracking	not tracking	not tracking
Knowledge of freeze test	no	yes	yes	yes	no	yes
Adjustment entry in the last htree months	no followed	Not followed	no followed	not followed	not followed	not followed
Any AEFI in the past 24 months	8	0	1	0	0	0
measures to deal with Anaphylaxis	yes	yes	yes	yes	yes	yes
Community engagement plan is available	no	no	no	no	no	no
knowledge of 4 key messages for immunization	yes	yes	yes	yes	yes	yes
training records available	no	yes	no	no	no	no
microplan has supervision elements	no	yes	yes	yes	yes	yes
Immunizatin card counterfoils	no	no	no	no	no	no
MCH/Immunization register	yes	yes	yes	yes	yes	yes
List of due beneficiaries	yes	yes	yes	yes	yes	yes
Tally sheet	yes	yes	yes	yes	yes	yes
Temperature log book	yes	yes	yes	yes	yes	yes
Stock/ Issue register	yes	yes	yes	yes	yes	yes
microplan	yes	yes	yes	yes	yes	yes
Date of reporting	26/monthy	26/ monthly	26/ monthly	26/ mothly	26/ mothly	26/ mothly
coverage monitoring chart	yes	yes	no	no	no	no
Surveillance data reported regularly	yes	yes	yes	yes	yes	yes
Thresholds are established for VPDs	no	no	no	no	no	no

Table ends.

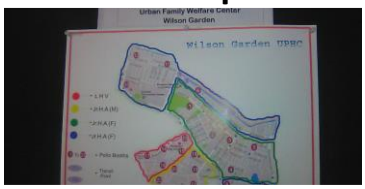
b. The program is a big success in being able to take the health systems to the door steps of citizens. This serves as a perfect example of equity, access and cost effectiveness, while assuring the desirable quality and outcome.

c. The time of conducting the head count needs to be standardized across units (say, January and July every year), and held every half-yearly.

d. The method of head count also need to be standardized among units. The team seems to be confused about the inclusion of the elite population in target setting/ computation of rates. This is evident from the fact that the coverage rate achieved is grossly inconsistent despite a good coverage of the vulnerable on ground, and on a successful conduct of ‘Mission Indradhanush’.

e. Mapping and enumeration(listing) seems to be moving towards near perfection. However, Mapping is limited to the topography of roads. It is recommended that mapping include structures. Listing of households be done subsequently, mapping them to structures.

Fig-10: Mapping of the Area of Responsibility in an UPHC



f. Line listing is near complete, though only in vulnerable areas. The head count is near complete in vulnerable areas.
g. Almost all centres have achieved immunization close to their targets, which is 100%. All centres have immunized a good proportion of children outside their dependent areas.
h. Out-reach sessions are conducted promptly, regularly, and is well accepted by the community.
i. 'Communitization' has picked up the desirable pace.
j. 'ASHA' recruitment challenge has been overcome to an extent.
k. MAS (Mahila Arogya Samithi) have been formed at the community level.
l. Microplans are updated
m. Vaccine logistics system is working well, with no shortage/ stock-outs.
n. Cold chain system is found effective, with all equipment functioning well and being monitored well.
o. Training & Documentation
    a. The team needs training regarding the target estimation based on head count. Such estimations are essential to corroborate the field activity.
    b. Achieving 120% immunization (surpassing the targets) should not always mean 100% coverage of the dependent area. The team needs sensitization on the issue.
    c. Team needs to drive its 'Full' and 'Complete' Immunization targets to conclusion.
    d. AEFI (emergency) management skills are found lacking. A training on the subject is critical.
    e. Immunization status is not updated in the RCH register. This forces the team to duplicate activities.

f. Data retrieval is time-consuming due to improper up-keep of records, wasting the man-hours significantly.
g. There is over stocking of vaccines in almost all units. The team needs to be trained on scientific inventory management.

p. Stocks: Indenting, stocking, documentation:
    a. Objective forecasting, ROL-based indenting, establishing minimum & maximum stock levels must be done.
    b. Stock books maintenance is inconsistent.
    c. Used vaccines and fresh vaccines are to be labeled accordingly
q. Vaccine Wastage Monitoring:
    a. WMF awareness is welcome finding. However, wastage is not being monitored.
    b. None of the units are aware of the stock-adjustment entries.
    c. Stock taking is not documented, though the units claim to have been following regular stock checks.
r. MAS forum can be used in a better manner to track and drive full/ complete immunization targets.
s. Cold chain System:
    a. Equipment history cards are not available at the units.
    b. Equipment preventive maintenance schedule is not available at the units.
    c. 'DO NOT UNPLUG' signage was not available
    d. Defrost schedule adherence was found to be poor.
    e. ILR, though lockable, are not kept under lock & key.
t. Unit review meetings could not be evidenced.
u. Coverage rate monitoring is not standardized across units. Needs training. This is evident from some units ticking a 67% and others 98%.
v. The Immunization counterfoils are not retained. A separate register is maintained for tracking register. RCH register is not updated. This suggests duplication and multiplicity of documents, and precipitates needless clutter.

24. Other Recommendations:
    a. Aadhar based tracking and integration of HMIS:

a. It is beneficial to capture Aadhar Id, along with Jandhan account and mobile number of the member of the household. Members of the household may then be profiled to identify their healthcare needs.
b. As of now, the HMIS and MCTS seem to capture data in a manner that facilitates healthcare team's short-term needs. Aadhar-based healthcare data would help shift towards a system that is client-centric with long term benefits and utility.
c. Such a system would help integrate health systems across geographies, help handle in- / out-migration of clients, ensuring continuum of care and reduction in dropout rate. This probably will reinforce the client-confidence in the system and will drastically improve compliance, access of services, and accountability of the healthcare systems.
d. This is even more prudent when the state is taking the lead in the implementation of 'Universal Health Care'.
e. Though national immunization program is seamless, ANC registration is jurisdictional. This imposes certain undesirable access restrictions, which can be overcome by moving towards integrated Aadhar based MIS and tracking system.

b. Elite Area Coverage:
    a. The elite areas, which are now less focused due to the following challenges:
        1. Shortage of human resources
        2. ASHAs are not accepted due to socio-economic, language and other unforeseeable barriers
        3. Repeated visits are discouraged as it may be pursued as needless disturbance
        4. Felt priority of the health-systems (to deliver healthcare) list the elite colonies at the end
    b. Once a thorough mapping and listing exercise is done, linked with the Aadhar-Id and Mobile number, it will be very easy to track the elite colony's healthcare needs. Also, the in- / out-migration among the elite house-holds is substantially less than those

among the vulnerable ones. Hence repeated visits may not be required. This automatically will make the perceived barriers ‘irrelevant’.

c. This is important from the program management perspective as the burden estimation, coverage, access evaluation, impact assessment all require a more inclusive focus than the one at present.
d. UHC can be nearer reality with improved acceptance of the system with improved access.

c. Field supervision by the Unit MOs seems to be difficult to comply with, for the following reasons:
    a. Recommended field visits 2hours/ 2days/week
    b. Two days in a week are ANC days and One day is Immunization day in the UPHC, mandating the doctor to be present all through at the UPHC.
    c. On these three days, patients with other ailments do not get adequate attention, and the wait is inordinately long!
    d. There are at least two-three meetings each doctor should attend for his routine monthly reviews, forcing him to be away.
    e. OPD, on the other three days left, will be poorly covered if the doctor moves out of the UPHC
    f. Many dependent areas are to be reached on foot, which consumes more time than stipulated.
    g. Most out-reach activities are conducted during the first half (Fore-noon) of the day, which demands the attention of the doctor both at the field and at the UPHC, a hard dilemma to crack.
    h. Many MOs are given additional charge of ‘Administrative Medical Officer’. Such a responsibility of other UPHCs require the MOs to visit other UPHCs.`
    i. All these have prompted the program planners to factor a ‘Public Health Manager’ at the UPHC. The ASHAs, ANMs, MPHWs, link workers, etc.. constitute a huge work force for any UPHC, and requires adequate field supervision, which if expected out of a

lone-Medical Officer of the UPHC, may compromise the deliverables at both the field and the clinic.

j. It is therefore recommended to augment the managerial cadre in the public health system.

d. ASHA recruitment, training & retention:
    a. 50% of the units studied have ASHA deficiency, for the vulnerable population served by the UPHC.
    b. Each ASHA in such a unit handles, on an average, 35% additional vulnerable population than recommended.
    c. The training of ASHAs needs attention. This can be a good motivating tool to retain the ASHAs. It also serves to boost the individual's self-confidence, and will directly impact her connect with the community. A well-taught ASHA is more approachable by the community, which even in the short-run, will bring in social recognition to the ASHA, which again is a strong retention tool for the health system.
    d. Presently ASHAs are trained only on two modules. It is recommended that they maybe trained on the remaining modules.
    e. Almost all programs demand ASHA intervention. Therefore, program-specific training inputs are critical for the system to achieve the deliverables.
    f. Frequent training sessions, at the UPHC, coupled with small rewards like a snack/tea/ coffee during such sessions immensely boost the belongingness of the ASHAs with the system.
    g. Small rewards, already factored for in the untied funds, if utilized properly and objectively, will turn to be good motivators.
    h. All the above help the system to deviate from the honorarium/ compensation based retention/ motivation, which is more a hygiene factor than a true motivator.
    i. Having said the above, in a metropolitan city like Bengaluru, with high cost of living, it is essential to cover for the basic needs of the ASHA's family, to allay the concerns pertaining to 'Hygiene factors' (as per Mc Gregor's Motivational Theory). This is because of the following:

1. It is presumed that 2-3 hours of work is what is required to do ASHA's job. This is practically impossible, with increasing number of programs requiring ASHAs' inputs.
2. The job is laborious and a pains-taking one as it involves full-time field work.
3. More and more clerical & record-keeping work is being expected out the ASHAs at the PHC level, by the day.
4. ASHAs' inputs in routine HMIS & MCTS requires no special mention.
5. More importantly, market today offers a lady the potential to earn twice-thrice the amount earned as ASHA's honorarium.

e. The estate maintenance needs attention. Many UPHCs have unclean estates. The storm water drains are choked turning them into vector-breeding foci with water retention.

Fig-11: SNUPHC- garbage in the estate and surrounding households disposing their effluents into the UPHC premises

Fig-12: Dr Kalavathi, RCH Officer-BBMP, monitoring the Mission Indradhanush in the AGHC Area.

f. Program Monitoring & Evaluation:

Monitoring and evaluation mechanism needs to be strengthened. Good monitoring strategies have yielded rich dividends in RCH program. The other program needs to be given equal monitoring importance. It is recommended that a central team may be constituted at the Mission Directorate for program monitoring and evaluation. This makes it possible to get an unbiased pulse of the operations.

g. Quality Assurance: It is recommended that the program for Quality Assurance at the Public Health Facilities be drawn and implemented.

h. Public Perception about the Public Health Facilities: It is but natural to expect the public perception about the public health facilities to improve with all positive interventions. However, a base-line study needs to be undertaken to be able to evaluate the program mid-course/ frequently thereafter.

i. Attendance machine has been purchased in all units, pending operationalization since past three months.

j. Asset/ Stock audit system may need further strengthening, with decentralized procurement. Such audits be conducted by a third party/ a central CPMU/Directorate team to ensure unbiased assessment.

k. Fans have been mounted in staff areas, but not in patient-waiting areas in SNUPHC

l. Television along with a DVD player exists (for IEC activities) in many UPHCs, but is being poorly utilized.

m. OPD register maintained is inconsistent and does not capture the disease and treatment details. Such data is pivotal is assessing the care burden in the area.

n. 'Prasuti Aaraike Yojane' is being implemented in a few and not implemented in a few. This deserves the CPMU's attention.

o. It may be worth displaying citizen's charter, user charges details, grievance redressal mechanism in all UPHCs.

p. It is recommended to display the ration entitlements, from PDS and Anganwadi centres, to the beneficiaries like ANC, PNC, Children. This will help building awareness and promote utilization of the schemes, and in turn improve the nutritional status of the vulnerables.

q. It may be thoughtful to consider cross-training of the nurses in laboratory processes, to cover for the absence of the lab-technician.

r. Drugs indenting, supply and procurement at the UPHCs need to be reviewed for the following reasons:

    a. Drugs are procured from the Untied Funds. It is absolutely justified to procure short-supply items like ARVs (Anti-Rabies Vaccine). However other routine items getting stocked-out and their resultant procurement through Untied funds deserve an attention.

    b. Drugs are procured valuing up to Rs. 3,500/- per out-reach camp under the SORC (Special Out-reach Camp grant of Rs. 10,000/- per camp) and 12 such out-reach camps are conducted by the UPHC each year. It is to be seen as to what unforeseen drug-requirements pop-up during routine out-reach camps, and/or no super-specialty camps are conducted.

    c. Forecasting the volumes (patient flow) could not be evidenced

    d. Scientific inventory management procedures could not be evidenced. The units seemed ignorant of the minimum/ maximum/reorder quantity/ reorder level/ lead time/buffer stock calculations, with resultant ignorance about their importance in the effective inventory management.

    e. The indenting is not objective, based rather on subjective assessment, predisposing to a undesirable inventory-related outcomes.

    f. It is found that the units are overstocked with antibiotics and stocked with those ones which the team finds they may seldom be able to use and with those which they have not indented at all.

    g. While most commonly required anti-fungal gel/ vaginal suppositories were out of stock in two of the six UPHCs studied.

    h. Anti-hypertensives, essential supplements like calcium preparations were found to be short-supplied in one of the centres.

    i. Drug stock books were not adequately maintained

    j. Antidiabetic combinations and long-acting hypertensives may need to be introduced, in line with the recent developments in diabetes mellitus management, to be able to effectively handle the diabetic

load under the NPHCE / in control of the NCDs, failing which the community may resist approaching the PHCs for their diabetic care.

Untied Fund Utilization in the UPHCs of BBMP Area under NUHM

25. Untied Fund: Context

The urban areas, due to presence of multiple health service providers, presence and access to technology and relatively higher awareness and demand of health services in the community, provide with opportunities to develop innovative strategies. Hence NUHM provides for some untied funds at all levels for developing need based innovative strategies for improved service delivery and public health action. Such untied funds are to be planned and utilized at the dependent unit level. A detailed set of guidelines are issued towards such utilization by the respective Mission Directorates.

26. Untied Fund: Amount Sanctioned

Every year, under the NUH Mission, a sum of Rs. 1,75,000/- is given to each UPHC/ UFWC as Untied Fund.

27. Untied Fund: Scope (Objectives) of the Study

The present study of six UPHC/ UFWCs proposed to review the utilization of the granted Untied Funds. The following were included in the scope of the study:

a. The amount granted and utilization
b. General procedure followed
c. Adherence to the guidelines for utilization of untied funds issued vide NHM-Karnataka letter No NHM/Suggestion/01/2015-16 dated 20th March 2017 (Appendix-1)
d. Problems faced, if any
e. Reasons for partial utilization, if any

The following were **not** part of the study:

f. Appropriateness, technical and/ or financial, of procurement procedure.

g. Appropriateness of the need of the UPHC/ UFWC

h. Stock taking (check)/ ascertainment of stock-book updating.

28. <u>Untied Fund: Methodology for the study of utilization</u>

a. Six UPHC/ UFWCs (in the BBMP Area) allotted were included in the study.

(i) AGHC

(II) KGHUPHC

(iii) KPUPHC

(iv) NSPUPHC

(v) Shanti Nagar UPHC

(vi) WGUFWC

b. NUHM-Karnataka PIP (2016-17) was the basis for the determining the amount granted.

c. Funds granted and Expenses for the period FY- 2017 (April-16 to March-17) were considered for the study

d. UPHC documents (ARS A/c Passbook, ARS meeting minutes Register, Untied funds bills, UPHC/ UFWC Cash books) were perused to ascertain utilization.

e. Purpose (of the expense) was ascertained in consultation with the Assistant Surgeon/ Medical Officer In-charge.

f. The guidelines issued by the NHM Directorate, vide para 27(c) above formed the basis to classify the purpose of the expense.

29. <u>Untied Funds: General Procedure Followed for Utilization</u>

The untied funds are available for consumption the day they are credited to the User-Unit's SB A/c. As detailed in para 1.1, this fund is to be planned & utilized by the dependent unit directly. There is a detailed set of guidelines issued by the Mission Directorate for

utilization of the grant, within the limits of which the need to obtain sanctions from the City/ District/ region/ State level approvals are dispensed with.

The proposals are consolidated and put up to a locally composed committee, which serves as the apex committee for over-seeing the financial approvals (for untied fund utilization) and the quality assurance monitoring of the UPHCs. Such a committee is called '**Arogya Raksha Samithi** (ARS)'.

Fig-13: Constitution of ARS (Arogya Raksha Samithi) at the UPHCs

The ARS is composed of the following members:

Chairman: Corporator of the Ward

Member Secretary:	Medical Office In-charge
Member:	Jr/ Sr Health Assistant
Member:	Anganwadi Supervisor
Member:	CDPO
Member:	Head Master/ Mistress of the School
Member:	Representative of the local NGO
Member:	Local Community Leader
Member:	Representative of the Women Self-Help-Group
Member:	Representative of the local SC/ ST community
Member:	Representative of the Community-based Organization

The needs are assessed, tender procedure followed, comparative statement is prepared. The ARS meets once a month routinely, and on need basis additionally. Minimum quorum of 50% is required for financial approvals. The proposals and quotations are placed before the committee and the L1 vendor is awarded the contract after due approvals from the ARS. The proceedings of the ARS meetings are minuted and support the purchase documentation.

30. Untied Funds: Findings of the study

Table-14: Untied Funds: Grant and Utilization among 6 UPHCs in BBMP Area

	AGHC	KGHUPHC	MG(KP)UFWC	NSPUPHC	Shantinagar UPHC	WGUFWC	Grand Total
Total Funds Received (Rs) (2016-17)	175000	175000	175000	175000	175000	175000	1342893
Date NUHM Untied Funds Received	3-Nov-16	3-Nov-16	3-Nov-16	3-Nov-16	3-Nov-16	3-Nov-16	
Total Utilized	57054	95513	207315	180076	190589	201027	931574
% Utilization	33%	55%	118%	103%	109%	115%	69%
Balance as on 31 March 2017 (Rs)	180297	97798	52732	4632	60497	76853	

a. Each of the six UPHCs were allotted Rs.1,75,000/- (One lac seventy-five thousand) as planned in the PIP 2016-17.
b. By March 2017 (completion of the financial year), the utilization ranged from 33% to 118%, averaging at 69% of the total allocated funds.
c. The funds, for the period Apr-16 to Mar-17, were received in Nov 2016, suggesting a delay in the funds reaching the dependent units. The resultant rush

in utilizing the funds allotted is evident in table 1.2, with 93% of the funds being utilized in the fourth (final) quarter of the year.

Table-15: Quarter-wise spread of Untied Fund Utilization

Quarter-wise Utilization Spread	AGHC	KGHUPHC	MG(KP)UFWC	NSPUPHC	Shantinagar	WGUFWC	Grand Total	%
2016								
Qtr2								
16-Apr						5708	5708	0.6%
16-May						2332	2332	0.3%
16-Jun						1268	1268	0.1%
Qtr3								
16-Jul						1295	1295	0.1%
16-Aug					847	1408	2255	0.2%
16-Sep						1421	1421	0.2%
Qtr4								
16-Nov	4874					4333	9207	1.0%
16-Dec	3587	5631	250		5972	11427	26867	2.9%
2017								
Qtr1								
17-Jan	4983	23284	70061	107877	77416.935	10607	294229	31.6%
17-Feb		3269	7953	12691	106353	145942	276208	29.6%
17-Mar	43610	63329	129051	59508		15286	310784	33.4%
Grand Total	57054	95513	207315	180076	190589	201027	931574	

d. Majority (56%) of the grants were used to ensure compliance to the IPHS Standards. The other major expense group finds a faint or no mention in the utilization guidelines, and hence classified as “Others” (purpose).

e. Also, the classification followed is for the bill and the bills have unique combination of items and therefore, such bills have been classified as Medical Equipment and grouped under the class “IPHS Compliance”. The table therefore reflects that no hemoglobinometer has been purchased by any unit. This is because the bill has other items and therefore is better classified as Medical Equipments.

f. Those purchases/ bills which do not have a faint / no mention in the guidelines have been classified as “Others”.

Table-16: Purpose of Untied Fund Expense Classified

Utilization - Purpose	AGHC	KGHUPHC	MG(KP)UFWC	NSPUPHC	Shantinagar UPHC	WGUFWC	Grand Total	%
IPHS Compliance	41475	56379	99553	139806	41627	141415	520255	55.8%
Others	13568	33503	101434	39720	140805	40988	370018	39.7%
Internet facility- running expenses	0	5631	6078	0	847	16034	28590	3.1%
Dressing equipments	0	0	0	0	4112	0	4112	0.4%
Drinking / potable water facility- reapir/ wastage elimination	0	0	250	0	3198	0	3448	0.4%
Electric supply/ electric eqpt/fans repair & maintt	0	0	0	0	0	2590	2590	0.3%
BP Apparatus	1530	0	0	0	0	0	1530	0.2%
Stationary expenses	0	0	0	550	0	0	550	0.1%
Macintosh	481	0	0	0	0	0	481	0.1%
Attendants seating/ drinking water facility	0	0	0	0	0	0	0	0.0%
Baby tray	0	0	0	0	0	0	0	0.0%
Baby weighing machine	0	0	0	0	0	0	0	0.0%
Bandage	0	0	0	0	0	0	0	0.0%
Bucket	0	0	0	0	0	0	0	0.0%
Disinfectants	0	0	0	0	0	0	0	0.0%
Dusting powder	0	0	0	0	0	0	0	0.0%
Glass/ Fabric screen- to promote patient privacy	0	0	0	0	0	0	0	0.0%
Hemoglobinometer	0	0	0	0	0	0	0	0.0%
IPHS/ implementation guidelines HR expenses-to acompany DHS approval	0	0	0	0	0	0	0	0.0%
Kelley's pad	0	0	0	0	0	0	0	0.0%
Labor table	0	0	0	0	0	0	0	0.0%
Mother weighing machine	0	0	0	0	0	0	0	0.0%
Mug	0	0	0	0	0	0	0	0.0%
Patient Examination Table	0	0	0	0	0	0	0	0.0%
Plastic/ rubber sheet	0	0	0	0	0	0	0	0.0%
Post-partum clean area- sundry payments	0	0	0	0	0	0	0	0.0%
Soakage pits repair and maintt	0	0	0	0	0	0	0	0.0%
Staff rewards- To accompany DHS aapprovals	0	0	0	0	0	0	0	0.0%
Stethoscope	0	0	0	0	0	0	0	0.0%
Stock-out medicines	0	0	0	0	0	0	0	0.0%
Stool	0	0	0	0	0	0	0	0.0%
Transport-Drugs/ vaccines trasnport & storage	0	0	0	0	0	0	0	0.0%
Transport-emergency free referral exp	0	0	0	0	0	0	0	0.0%
Transport-emergent trasport of lab ssamples	0	0	0	0	0	0	0	0.0%
Total Utilized	57054	95513	207315	180076	190589	201027	931574	

All these line items are clubbed under the head 'IPHS Compliance' above, due to inseparability of the bills.

Table-17: Purpose of Untied fund expense under "IPHS Compliance" explained (refer to Table-16 above)

IPHS Compliance Details	AGHC	KGHUPHC	MG(KP)UFWC	NSPUPHC	Shantinagar UPHC	WGUFWC	Grand Total	%
Medical Equipment, Instruments	41475	36503	64434	100170	41627	25710	309919	60%
Lab reagents/ eqpt, BMW necessities	0	14891	0	1899	0	39580	56370	11%
Drugs & Consumables	0	4985	13580	32039	0	0	50604	10%
R & M -Plumbing/ Water supply	0	0	21539	0	0	6740	28279	5%
R & M Carpentry	0	0	0	0	0	19600	19600	4%
R & M- Electric Supply	0	0	0	0	0	19600	19600	4%
Phenol for HK	0	0	0	5698	0	0	5698	1%
Medical Furniture	0	0	0	0	0	27924	27924	5%
Fire Extinguishers	0	0	0	0	0	2261	2261	0%
Total	41475	56379	99553	139806	41627	141415	520255	
%	8%	11%	19%	27%	8%	27%		

Table-18: Purpose of Untied Fund expense under "Others" explained (refer to Table-16 above)

"Others" - Details	AGHC	KGHUPHC	MG(KP)UFWC	NSPUPHC	Shantinagar UPHC	WGUFWC	Grand Total	%
Lab cabinets			70301				70301	19%
Attendance Machine	13568	13511	13511			13568	54158	15%
CCTV eqpt installation					49500		49500	13%
Refrigerator				28800			28800	8%
Essential office eqpt-staff locker,metal racks, computer table					27090.7		27091	7%
Others					25059.26		25059	7%
UPS+ Battery+ Stabilizer					21594.7		21595	6%
Table		19992					19992	5%
Window Vetical Blinds			17622				17622	5%
Eqpt for siddapura UPHC						15597	15597	4%
Kitchen cook ware, stove						10105	10105	3%
Foldable chairs/table for outereach camp					7917		7917	2%
Megaphone for IEC					3509.425		3509	1%
Thermos+ Wrench+ Cookware				3213			3213	1%
Teacups+ Garden hose-pipe+ Disposable platic bags				3057			3057	1%
Essential IT eqpt-mobile handset in lieu of landline connection, pendrive, table bell, rubber stamp					2774		2774	1%
Deepa+ Puja set				2550			2550	1%
DVD player for IEC					2524		2524	1%
refreshments				2100			2100	1%
Flex board						1718	1718	0%
Table fan for outreach camps					835.85		836	0%
Total	13568	33503	101434	39720	140804.935	40988	370018	
%	4%	9%	27%	11%	38%	11%	100%	

31. <u>Untied Funds: Discussion & Recommendations</u>:

a. The provisioning of Untied Fund, appropriate decentralization of planning/ need-based UPHC-led procurement has served to bring in a perceptible change in the ambience of the UPHCs studied. Also, it is observed that such a change is more effective among the units who could utilize their grants to the fullest.

b. The change in ambience seems to bear a positive influence on the morale of the team of the beneficiary UPHC. The team feels better empowered than before. The confidence of being resourceful is evident during interactions. This again is more evident among the units who could use their grants to the fullest. However, this seems to have been achieved by the PMU after a hard pursuit at allaying the apprehensions and by supportive guidance & supervision. More needs to be done furthering such pursuit to reinforce the confidence of the unit leaders in the system, discussed/ recommended more elaborately in the paragraphs that follow.
c. All the units studied operate a dedicated SB A/c at the nearest SBI branch. The Asst Surgeon or the Medical Officer In-charge is the designated signatory along with the senior most Staff Nurse/ ANM of the Unit as the second signatory. Almost all payments are made by cheque, and seldom by cash.
d. The book of accounts is termed 'cash-book' while no cash transaction occurs! The register may therefore be termed as 'Accounts register', which may record both bank and cash transactions (if one were to happen).
e. There is no dedicated resource for book-keeping/ accounting in four of the six UPHCs studied. In the two centres where there was a clerical resource, s/he was available on a part-time basis for two days in a week. The unit-team finds such a resource/ deployment serving the purpose any hardly, and thereby is forced to do the job by itself. Therefore, while a full-time resource is not justified for the volume of accounting work, a part-time resource is found ineffective. It becomes therefore prudent to train the MO and the ANM in book-keeping/ accounting.
f. Given the above (7.d) the UPHC team (MO & ANM) are not trained in book-keeping. It is recommended that a training program be conducted for the purposes of book-keeping. This is important even from the point of view of effective supervision, despite availability of the trained/ qualified resource.
g. There is a substantial delay in the Untied Fund reaching the beneficiary-unit. The delay imposes an undesirable haste in utilizing the funds within a very short period. Given that the component of 'Untied Funds' is now almost a standard and fixed line-item of the annual PIP, a mechanism may be drawn up to ensure that the funds reach the user-units by the first quarter of the financial year. This ensures a constant flow/ availability of funds to the units. The matter deserves the importance as the issue of equity-access-quality in an operational public health service organization, though is a routine matter, is at many times an emergent issue, and

it affects the perception of the community about the quality assurance of the facility provider. Even a small lapse serves detrimental to the community's trust and confidence in the health-systems hard-earned through constant endeavor and hard-work.

h. The guidelines for utilization is quite broad and accommodative in providing for an expense to 'ensure compliance to the IPHS'. Also, one can appreciate the spirit behind restricting an expense the revolves around 'personal comforts' of the team. It is evident that the given liberty is very 'patient/ client centric'.

i. However, the second most expensive class – "Others" cannot be justified as per the extent guidelines on the subject. It is recommended that the guidelines be reviewed in the light of the findings and suitable inclusions be considered in the guidelines.

j. The ARS (Aarogya Raksha Samithi) is constituted in all the units studied and is very 'widely' representative of the community the UPHC serves. The composition innately drives transparency in the system, drives a truly democratic functioning, establishes collective responsibility, absolves the Medical Officer of getting targeted, and imposes responsibility on the chair-person to be socially accountable. However, there are instances when political considerations take an upper hand. It is therefore important to hold the ARS accountable to the unspent funds. Escalation matrix to handle such issues needs to be established.

k. Four of the six units have spent more than the granted funds for the year due to the pending balances from the previous financial period. Timely disbursals can help to drive the desirable financial discipline among the user-units.

l. Two of the six units could not spend the allotted fund, reportedly due to delayed decisioning. AGHC has 67%, and KGHUPHC has 45% of the untied funds unutilized.

    a. AGHC has a perineal problem of thefts and insecurity. A prominent manifestation of the problem is evidenced by the lack of plumbed water supply within the facility. The team including the MO used a bucket and a mug, and the water is fetched manually. Repeated thefts of the overhead reservoir (OHR) of potable water has prompted the unit to construct a cage around the tank to secure it. However, the underground sump is not as well secured as it should be to complement the OHR, with resultant contamination of the water reservoir by the community. The gate and

compound wall is not secured either. Thus, the facility is frequented by unsocial elements and children (use it as their playground). The matter has been conveyed to the ARS and funds are reserved to take up the desirable works soon. It is recommended that the CPMU take cognizance of the matter and a lasting solution be offered through inter-sectoral ((police, engineering) co-ordination.

b. KGHUPHC has a need to furnish its laboratory with the requisite cabinets and storage facility. Hence the team is ready with all the requisite ground work and waiting for a ARS deliberation/ sanction for the proposal.

c. However, whether the untied funds are to be used for a 'such' capital expenses is a matter that deserves the attention of the CPMU/ Directorate.

m. One can foresee a thrust building in the system for assuring quality and seeking accreditation. Expenses like calibration of equipment, quality improvement initiatives may be considered for inclusion in the utilization guidelines.

n. Having bought capital items in the previous years, the need for such procurement may cease in the units. A system may therefore be necessary to consider case-based sanction at the CPMU level.

o. Attendance machine has been purchased in all units, pending operationalization since past three months.

p. Asset/ Stock audit system may need further strengthening, with decentralized procurement. Such audits be conducted by a third party/ a central CPMU/Directorate team to ensure unbiased assessment.

q. Drugs indenting, supply and procurement at the UPHCs need to be reviewed for reasons deliberated in para 24 (r) above.

ರಾಷ್ಟ್ರೀಯಆರೋಗ್ಯಅಭಿಯಾನ

ಆರೋಗ್ಯ ಮತ್ತುಕುಟುಂಬ ಕಲ್ಯಾಣ ನಿರ್ದೇಶನಾಲಯ,
ಮೊದಲನೆ ಮಹಡಿ, ಅನಂದರಾವ್ ವೃತ್ತ, ಬೆಂಗಳೂರು–09

ಕ್ರ.ಸಂ.: ರಾ.ನಿ.ಆ/ಸಲಹೆ/01/2015–16 ದಿನಾಂಕ:20.03.2017

ಮುಕ್ತನಿಧಿ ಬಳಕೆ ಮಾರ್ಗಸೂಚಿಗಳು (ಆವೃತ್ತಿ–2) – ನಗರ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು

ಗಮನಿಸಿ:
- ಕೆಳಗಡೆ ನೀಡಿರುವ ಮಾರ್ಗಸೂಚಿಗಳು ಸಾಮಾನ್ಯ ಮತ್ತು ದೈನಂದಿನ ಕಾರ್ಯ ಚಟುವಟಿಕೆಗಳಿಗೆ ಕಟ್ಟುನಿಟ್ಟಾಗಿಅನ್ವಯಿಸುತ್ತವೆ.
- ತುರ್ತು ಮತ್ತು ಪ್ರಾಣಾಂತಿಕ ಸಂದರ್ಭದಲ್ಲಿಕಾಯಿ ಮಗುವಿನ ಮತ್ತು ರೋಗಿಗಳ ಪ್ರಾಣ ಉಳಿಸಲು ಅಗತ್ಯವಿರುವಎಲ್ಲಾ ವೈದ್ಯಕೀಯ ಖರ್ಚುಗಳನ್ನ ಮಾಡಲುಅವಕಾಶವಿದೆ.
- ಅಂತಹ ಸಂದರ್ಭದಲ್ಲಿಆರೋಗ್ಯರಕ್ಷಾ ಸಮಿತಿ, ಜಿಲ್ಲಾಆರೋಗ್ಯ ಸಂಘದಿಂದತ್ವರಿತನೋತ್ತರ ಮಂಜೂರಾತಿಯನ್ನು ಪಡೆಯತಕ್ಕದ್ದು.
- ಪ್ರ/ಆರ್ಥಿಕ ವರ್ಷದಕ್ರಿಯಾಯೋಜನೆಯನ್ನ ಹಿಂದಿನ ವರ್ಷದ ಮಾರ್ಚ್ ತಿಂಗಳಲ್ಲೇ ಸಿದ್ಧಪಡಿಸಿ, ಆರೋಗ್ಯರಕ್ಷಾ ಸಮಿತಿಯಅನುಮೋದನೆ ಪಡೆದು, ಆದಂತೆಯೇ ವೆಚ್ಚ ಭರಿಸತಕ್ಕದ್ದು.
- ರೂ. 100.00 ಮೇಲ್ಪಟ್ಟ ಪಾವತಿಗಳನ್ನ ಚೆಕ್ ಮೂಲಕವೇ ಮಾಡಬೇಕು.
- ಪ್ರತಿ ತಿಂಗಳು ನಗದು ಕಿರ್ದಿ ಪುಸ್ತಕ ಹಾಗೂ ಬ್ಯಾಂಕ್ ಪಾಸ್ ಬುಕ್‌ನ ಶಮೂದನೆಗಳನ್ನು ತಾಳೆ ಮಾಡಿರಬೇಕು.
- ಸಾಧ್ಯವಾದ ಮಟ್ಟಿಗೆ ಫೋಟೋ ದಾಖಲೆಗಳನ್ನ ಇಟ್ಟಿರಬೇಕು.
- ಮಾರ್ಗಸೂಚಿಗಳಿಗೆ ಲಗತ್ತಾಗಿರುವಅನುಬಂಧ (I) ಮತ್ತು (2) ರಂತೆಅಸ್ಥಯಿಕ ಅಧಿಕಾರಿಗಳು ವರದಿಗಳನ್ನ ಸಲ್ಲಿಸತಕ್ಕದ್ದು.

1. **ಪರಿಚಯ:**2013–14 ರಲ್ಲಿ ಪ್ರಾರಂಭಗೊಂಡರಾಷ್ಟ್ರೀಯ ನಗರಆರೋಗ್ಯಅಭಿಯಾನವು, ಒಟ್ಟಾರೆಆರೋಗ್ಯಅಭಿಯಾನದಒಂದು ಪ್ರಮುಖ ಮತ್ತು ಬಹುಮುಖ್ಯವಾದ ಭಾಗವಾಗಿರುತ್ತದೆ. 2005–06 ರಲ್ಲಿ ಪ್ರಾರಂಭವಾದರಾಷ್ಟ್ರೀಯಗ್ರಾಮೀಣಆರೋಗ್ಯಅಭಿಯಾನದಅನುಭವದ ಮೂಸೆಯಲ್ಲಿ ಮತ್ತು ನಗರಆರೋಗ್ಯದಕೊರತೆಯನ್ನ ಮನಗಂಡು, ನಗರದಲ್ಲಿ ವಾಸಿಸುವ ದುರ್ಬಲ ವರ್ಗದವರ ಮತ್ತುತಾಯಿ ಮಕ್ಕಳ ಆರೋಗ್ಯ ಮತ್ತುಅಭಿವೃದ್ಧಿಯದೃಷ್ಟಿಯಿಂದ ರೂಪಿಸಿದ ಸಮಗ್ರಆರೋಗ್ಯಯೋಜನೆಯಾಗಿರುತ್ತದೆ.

2. **ಉದ್ದೇಶ:** ಮೂಲತಃಆರೋಗ್ಯಕ್ಷೇತ್ರದ ಸುಧಾರಣೆ, ನಿರ್ವಹಣೆಯಲ್ಲಿಕಾರ್ಯಕ್ಷಮತೆ, ಸ್ಥಳೀಯ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಿಗೆ ತಾಂತ್ರಿಕ ನಿರ್ವಹಣಾ ಸ್ವಾಯತ್ತತೆ ಹಾಗೂ ಪ್ರಮುಖವಾಗಿಆರೋಗ್ಯ ಸೇವೆಗಳಿಂದ ವಂಚಿತರಾದವರಿಗೆಗುಣಮಟ್ಟದ, ನಿಲುಕುವ ಸೇವೆಗಳನ್ನ ಸಮುದಾಯ ಮಟ್ಟದಲ್ಲಿ ನೀಡುವಉದ್ದೇಶವನ್ನ ಹೊಂದಲಾಗಿರುತ್ತದೆ. ತತ್ಪಲಿತವಾಗಿದುರ್ಬಲ ವರ್ಗದವರು ಸಾಮಾಜಿಕ ಮತ್ತುಆರ್ಥಿಕಅಭಿವೃದ್ಧಿಯನ್ನ ಹೊಂದಲುಅಗತ್ಯ ಭೂಮಿಕೆ ಸಿದ್ಧಪಡಿಸಿದಂತಾಗುವುದೆಂದು ಆಶಿಸಲಾಗಿದೆ.

3. **ಒಳಗೊಂಡ ಅಂಶಗಳು:** ಈ ಹಿಂದೆಗ್ರಾಮೀಣಆರೋಗ್ಯಅಭಿಯಾನದಲ್ಲಿ ನೀಡಲಾಗಿದ್ದಆರೋಗ್ಯರಕ್ಷಾ ಸಮಿತಿಯಬೀಜಾನುದಾನ, ವಾರ್ಷಿಕಕಟ್ಟಡ ನಿರ್ವಹಣಾಅನುದಾನ ಹಾಗೂ ಮುಕ್ತ ನಿಧಿಯನ್ನ ಒಟ್ಟುಗೂಡಿಸಿ ನಗರಆರೋಗ್ಯಅಭಿಯಾನದ ಮುಕ್ತ ನಿಧಿಯನ್ನಾಗಿ ನೀಡಲಾಗಿದೆ.

4. **ಅನುದಾನದ ಮೊತ್ತ:**ವಾರ್ಷಿಕರೂ. 1,75,000(ಒಂದು ಲಕ್ಷದಎಪ್ಪತ್ತೈದು ಸಾವಿರ). ಪ್ರಾರಂಭದ ವರ್ಷದಲ್ಲಿ ಈ ಮೊತ್ತದಅನುದಾನವನ್ನು ನೀಡಿದರೂ ಸಹ, ನಂತರದ ವಾರ್ಷಿಕಅನುದಾನ ಬಿಡುಗಡೆ ಮಾಡುವಾಗ ಭಾರತ ಸರ್ಕಾರ ಪತ್ರದಕ್ರ.ಸಂ. F.No. 7(80)/2014-NRHM-I ದಿನಾಂಕ: 05-02-2014 ರಮಾರ್ಗಸೂಚಿಗಳಂತೆ ವಾಸ್ತವಿಕ ಬಳಕೆಯ ಆಧಾರದ ಮೇಲೆ ಲೆಕ್ಕ ಹಾಕಿ ನೀಡಲಾಗುವುದು/ಭರಿಸಲಾಗುವುದು. ಆದುದರಿಂದ ಪ್ರತಿ ನಗರ ಪ್ರಾಥಮಿಕಆರೋಗ್ಯಕೇಂದ್ರದಅಧಿಕಾರಿ ಮತ್ತುಆರೋಗ್ಯರಕ್ಷಾ ಸಮಿತಿಯಿತಮಗೆ ನೀಡಲಾಗಿರುವ ವಾರ್ಷಿಕಅನುದಾನವನ್ನುಅದೇಆರ್ಥಿಕ ವರ್ಷದಲ್ಲಿ ಪೂರ್ಣವಾಗಿ ನಿರ್ದಿಷ್ಟಪಡಿಸಿದ ವಿಷಯಗಳಿಗೆ ಮಾತ್ರ, ಚಾಲ್ತಿಯಲ್ಲಿರುವ

PKS

ಸರ್ಕಾರದ ಸಂಗ್ರಹಣಾಕಾರ್ಯ/ಕಾಲ ಕಾಲಕ್ಕೆ ಅಧಿಯಾಸದಿಂದ ನೀಡಲಾದ ನಿರ್ದೇಶನಗಳನ್ವಯ ಪೂರ್ಣವಾಗಿ ಬಳಸಲು ಸೂಚಿಸಿದೆ.

5. ಅನುದಾನ ಬಳಕೆ ಮಾಡಬೇಕಾದ ವಿಷಯಗಳು:
   - ಆರೋಗ್ಯಕೇಂದ್ರದ ಮೂಲ ಸೌಕರ್ಯಗಳ ಮಾರ್ಪಾಡು:
     - ರೋಗಿಗಳವಿಶ್ರಾಂತಿಕೊಠಡಿಯಲ್ಲಿಗಾಜಿನ/ಬಟ್ಟೆಯ ಪರದೆ.
     - ಕುಡಿಯುವ ಮತ್ತು ಬಳಕೆ ನೀರಿನ ಸೌಲಭ್ಯ, ದುರಸ್ತಿ ಹಾಗೂ ನೀರು ಪೋಲಾಗುವುದನ್ನುತಪ್ಪಿಸುವ ವ್ಯವಸ್ಥೆ.
     - ವಿದ್ಯುಚ್ಛಕ್ತಿ ದುರಸ್ತಿ, ವಿದ್ಯುತ್ ಉಪಕರಣಗಳ ಮತ್ತು ಪಂಕಗಳ ವ್ಯವಸ್ಥೆಯ ದುರಸ್ತಿ (ಬಾಕಿ ಇರುವ ವಿದ್ಯುತ್ ಶುಲ್ಕ ಭರಿಸಲು ಬಳಸಬಾರದು. ಅದನ್ನುಇಲಾಖೆಯಿಂದಲೇ ಭರಿಸಬೇಕು).
     - ಇಂಗುಗುಂಡಿಗಳ ದುರಸ್ತಿ ಮತ್ತುಕಾರ್ಯ ನಿರ್ವಹಣೆ.
     - ರೋಗಿಗಳ ಸಂಗಡ ಬರುವ ಮಕ್ಕಳು, ಸಹಾಯಕರು ಹಾಗೂ ಸಮುದಾಯದ ಸದಸ್ಯರಿಗೆ ಆಸನ ಮತ್ತುಕುಡಿಯುವ ನೀರಿನ ವ್ಯವಸ್ಥೆ.
     - ಹೆರಿಗೆ ನಂತರದಕೊಠಡಿ ಶುದ್ಧೀಕರಣದತಾತ್ಕಾಲಿಕ ಪಾವತಿಗಳು.
     - ಇಂಟರ್‌ನೆಟ್ ಸೌಲಭ್ಯಕ್ಕೆತಗಲುವ ಚಾಲ್ತಿ ವೆಚ್ಚಗಳು.
     - ವರದಿ ಸಲ್ಲಿಸಲು ಲೇಖನ ಸಾಮಾಗ್ರಿಗಳ ವೆಚ್ಚ.
   - ಸಾಗಣೆ ವೆಚ್ಚಗಳು:
     - ತುರ್ತು ಸಂದರ್ಭದ ಶುಲ್ಕ ರಹಿತReferalಗಾಗಿಆದ ಖರ್ಚುಗಳು.
     - ಸಂಗ್ರಹಿಸಿದ ಪ್ರಯೋಗಶಾಲಾ ಮಾದರಿಗಳನ್ನು ತುರ್ತುರವಾನೆ.
     - ಔಷಧಿ/ಲಸಿಕೆಗಳ ಸಾಗಣೆ/ಸಂಗ್ರಹಣೆ.
   - ಸಂಗ್ರಹಣೆ (ಅಗತ್ಯಕ್ಕನುಗುಣವಾಗಿ ಮಾತ್ರ):
     - ರೋಗಿ ಪರೀಕ್ಷಾ ಮೇಜು, ಹೆರಿಗೆ ಮೇಜು, ಬಿ.ಪಿ. ಉಪಕರಣ, ಹಿಮೊಗ್ಲೋಬಿನ್ ಮೀಟರ್, ಬೇಬಿ ಟ್ರೆ, ತಾಯಿ ಮತ್ತು ನವಜಾತ ಶಿಶುಗಳ ತೂಕದಯಂತ್ರ, ಪ್ಲಾಸ್ಟಿಕ್/ರಬ್ಬರ್ ಶೀಟ್‌ಗಳು, ಮೆಕಿಂಟಾಷ್, ಕಿಡ್ನಿಸ್ ಪ್ಯಾಡ್, ಸ್ಟೂಲ್, ಡ್ರಿಪ್ಸಿಂಗ್ ಉಪಕರಣಗಳು, ಸ್ಟೆತ್, ಬಕೆಟ್, ಮಗ್ ಹಾಗೂ ಧಾರತೀಯಜನಾರೋಗ್ಯ ಪ್ರಮಾಣಿತ ಮಾನದಂಡಗಳನ್ವಯ ವ್ಯವಸ್ಥಿತ ಗುಣಾತ್ಮಕ ನಿರ್ವಹಣೆಗೆಅಗತ್ಯವಿರುವ ಉಪಕರಣಗಳು.
     - ಬ್ಯಾಂಡೇಜ್, ಕೊರತೆಯಿರುವ ಔಷಧಿಗಳು, ಚಲುಮೆ ಪುಡಿ, ಸೋಂಕು ನಿವಾರಕಗಳು ಮತ್ತಿತರೆ ಖರೀದಿಗಳು ನೇರವಾಗಿ ಫಲಾನುಭವಿಗಳಿಗೆ/ರೋಗಿಗಳಿಗೆ/ಸೇವೆಯನ್ನರಸಿ ಬರುವವರಕೇಂದ್ರೀಕೃತ ಖರೀದಿಗಳಾಗಿರಬೇಕು.

6. ನಿಷೇಧಿತ ಬಳಕೆ/ವೆಚ್ಚಗಳು:
   - ವಾಹನ ಖರೀದಿ.
   - ವೈಯಕ್ತಿಕ ಸೌಲಭ್ಯಕ್ಕೆ ಬಳಸಲಾಗುವ ಸಾರಿಗೆ/ಸಾಗಣಿಕೆ ವೆಚ್ಚಗಳು.
   - ಕಛೇರಿಯಲ್ಲಿ ಸ್ವಂತ ಬಳಕೆಗಾಗಿ ಆರಮದಾಯಕ ಸೋಫಾ ಮತ್ತು ಖುರ್ಚಿಗಳು.
   - ವೃತ್ತ ಪತ್ರಿಕೆಗಳು/ನಿಯತಕಾಲಿಕಗಳು/ವಾರ್ಷಿಕ ಸಂಚಿಕೆಗಳಿಗೆ ನೀಡಲಾಗುವಜಾಹೀರಾತು.
   - ಮಾಹಿತಿ ಶಿಕ್ಷಣ ಮತ್ತು ಸಂವಹನ ಆಧಾರಿತ ಖರ್ಚುಗಳು.
   - ಆರೋಗ್ಯ ಮೇಳಗಳಲ್ಲಿ ವಸ್ತು ಪ್ರದರ್ಶನದ ಕೊಠಡಿಗಳ ವಾಡಿಗೆ.

7. ನಿಷೇಧಿತಆದರೆ ವಿಶೇಷ ಸಂದರ್ಭದಲ್ಲಿಜಿಲ್ಲಾ/ನಗರಆರೋಗ್ಯ ಸಂಘದಒಪ್ಪಿಗೆಯ ಮೇರೆಗೆವೆಚ್ಚಗಳು:
   - ಉತ್ತಮಕಾರ್ಯನಿರ್ವಹಣೆಸಿಬ್ಬಂದಿಗಳಿಗೆ ನೀಡಲಾಗುವ ಪ್ರೋತ್ಸಾಹಕ ಬಹುಮಾನಗಳು ಮತ್ತು ಪಾರಿತೋಷಕಗಳು.
   - ಅನುಷ್ಠಾನ ಚೌಕಟ್ಟಿನಡಿ ಮತ್ತು ಧಾರತೀಯಜನಾರೋಗ್ಯ ಮಾನದಂಡಗಳಿಗೆ ಅನುಗುಣವಾಗಿ ಸುರಿತ ಸೇವೆಗಳನ್ನು ಖಾತ್ರಿ ಪಡಿಸಲುತತ್ಕಾಲಕ್ಕೆ ಮತ್ತುಅಲ್ಪಾವಧಿಗೆತಜ್ಞ ವೈದ್ಯರುಅಥವಾ ಸಿಬ್ಬಂದಿಗಳನ್ನು ಪಡೆಯಲು ಮತ್ತುಅವರಿಗೆಗೌರವಧನ.

8. ಸಂಗ್ರಹಣಾ ವಿಧಾನ:
   - ಈಗಾಗಲೇ ತಿಳಿಸಿದ ಹಾಗೆ ಪಾರದರ್ಶಕ ಸಂಗ್ರಹಣಾ ವಿಧಾನವನ್ನುಕಟ್ಟುನಿಟ್ಟಾಗಿ ಪಾಲಿಸಬೇಕು.
   - ಸಹಕಾರಿ ಸಂಸ್ಥೆ, ಸರ್ಕಾರಿ ಮಳಿಗೆಗಳು/ಔಷಧ ಗೋದಾಮುಗಳಲ್ಲಿ ನೇರವಾಗಿಖರೀದಿಸಬಹುದು.

9. ನಿಷೇಧಿತ ಸಂಗ್ರಹಣಾ ವಿಧಾನ:
   - ನೇರವಾಗಿ ಮತ್ತು ನಿಯಮ ಬಾಹಿರವಾಗಿ ಮುಕ್ತ ಮಾರುಕಟ್ಟೆಯಿಂದಖರೀದಿ.
   - ಕೇಂದ್ರೀಕೃತ ವ್ಯವಸ್ಥೆಯಲ್ಲಿಎಲ್ಲಾ ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಿಗೆ ಸಗಟುಆದೇಶದಲ್ಲಿಜಿಲ್ಲಾ ಮಟ್ಟದಿಂದ/ನಗರಕೇಂದ್ರದಿಂದಖರೀದಿ.

10. ನಿಧಿ ನಿರ್ವಹಣೆ ಮತ್ತು ದಾಖಲೆಗಳು:
    - ಬಿಡುಗಡೆಯಾದ ಮುಕ್ತ ನಿಧಿಯನ್ನು ನಗರ ಪ್ರಾಥಮಿಕಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಲ್ಲಿ ರಚಿಸಿ ಅಸ್ತಿತ್ವದಲ್ಲಿರುವ ಆರೋಗ್ಯರಕ್ಷಾ ಸಮಿತಿಯ ಬ್ಯಾಂಕ್‌ಖಾತೆಯಲ್ಲಿಡಬೇಕು ಮತ್ತುಅಧಿಕೃತ ವ್ಯಕ್ತಿಗಳಿಂದ ಜಂಟಿಖಾತೆ ನಿರ್ವಹಣೆ ಆಗಬೇಕು.

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- ಸ್ಟೇಟ್ ಬ್ಯಾಂಕ್‌ಆಫ್ ಮೈಸೂರ್ ನಲ್ಲಿ ಮಾತ್ರಪಾತೆಗೆದಿರಬೇಕು ಮತ್ತು ಉಳಿಕಾಯ ಖಾತೆ (ಎಸ್.ಬಿ.) ಖಾತ್ರೆಯಾಗಿರಬೇಕು.
- ವಾರ್ಷಿಕಕ್ರಿಯಾಯೋಜನೆ, ಆಗತ್ಯ ನಡಾವಳಿಗಳ ಪ್ರತಿಕ, ಕರ್ಚಿ ನಗದು ಪುಸ್ತಕ, ಬ್ಯಾಂಕ್ ಪಾಸ್ ಬುಕ್ ಮತ್ತು ರಶೀದಿಗಳನ್ನು ಧೃಢೀಕರಿಸಿ ನಿರ್ವಹಿಸಬೇಕು.
- ಮಾಸಿಕ, ಭೌತಿಕ ಹಾಗೂ ಆರ್ಥಿಕ ಪ್ರಗತಿಗಳನ್ನು ಆಧಿಯಾನನಿರ್ದೇಶಕರಾಗಲಿ/ಆಡಳಿತಾಧಿಕಾರಿಗಳಾಗಲಿ/ ಆರ್ಥಿಕಾಧಿಕಾರಿಗಳಾಗಲಿ ಆಧವಾಆವರಿಂದಅಧಿಕೃತಗೊಂಡ ವ್ಯಕ್ತಿಗಳಾಗಲಿ ಹೇಳಿದ ಮಾದರಿಯಲ್ಲಿ ಸಿದ್ಧಪಡಿಸಿ ಕಾಲ ಕಾಲಕ್ಕೆ ನಗರಆಧಿಯಾನಕ್ಕೆ ಸಲ್ಲಿಸಬೇಕು.

11. **ಪೂರ್ವಾನುಮತಿ:** ಮುಕ್ತ ನಿಧಿಯಿಂದ ಅನುಷ್ಠಾನಗೊಳಿಸುವ ಮಾರ್ಗಸೂಚಿಯಲ್ಲಿರುವಯಾವುದೇ ಕಾರ್ಯಕ್ರಮಗಳಿಗೆ ಕ್ರಮಸಂಖ್ಯೆ 7 ರ ವಿಷಯಗಳನ್ನು ಹೊರತುಪಡಿಸಿ ರಾಜ್ಯ/ಜಿಲ್ಲಾ/ನಗರ ಮಟ್ಟದಿಂದ ಪೂರ್ವಾನುಮತಿ ಆಗತ್ಯವಿರುವುದಿಲ್ಲ.

12. **ಸಂಕಯ ನಿವಾರಣೆ ಮತ್ತು ಹೆಚ್ಚಿನ ವಿವರಗಳಿಗೆ:** ತಮ್ಮಜಿಲ್ಲಾಯೋಜನಾ ನಿರ್ವಹಣಾಧಿಕಾರಿಗಳು, ಬೆಂಗಳೂರು ನಗರಯೋಜನಾ ನಿರ್ವಹಣಾಧಿಕಾರಿಗಳು, ಜಿಲ್ಲಾಆರೋಗ್ಯ ಮತ್ತುಕುಟುಂಬ ಕಲ್ಯಾಣಾಧಿಕಾರಿಗಳು, ಮುಖ್ಯ ಆರೋಗ್ಯಾಧಿಕಾರಿಗಳು ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪಾಲಿಕೆ, ಉಪ ನಿರ್ದೇಶಕರು, (ಸಮುದಾಯ ನಿರ್ವಹಣೆ) ರಾಷ್ಟ್ರೀಯ ನಗರಆರೋಗ್ಯಆಧಿಯಾನಆಥವಾ ಸಲಹೆಗಾರರನ್ನು ಸಂಪರ್ಕಿಸಲುಕೋರಿದೆ.

13. **ಕೇಂದ್ರ ಸಂಸ್ಥೆಗಳಿಗೆ ವಾರ್ಷಿಕಅನುದಾನ ಬಿಡುಗಡೆ ಬಗ್ಗೆ ಸ್ಥೂಲ ವಿವರಣೆ:** ವಾರ್ಷಿಕಅನುದಾನ ಬಿಡುಗಡೆ ಮಾಡುವಾಗ ಭಾರತ ಸರ್ಕಾರ ಪತ್ರಸಂಖ್ಯೆ ಸಂ. F.No. 7(80)/2014-NRHM-I ದಿನಾಂಕ: 05-02-2014 ರಮಾರ್ಗಸೂಚಿಗಳಂತೆ ವಾಸ್ತವಿಕ ಬಳಕೆಯ ಆಧಾರದ ಮೇಲೆ ಲೆಕ್ಕ ಹಾಕಿ ಜಿಲ್ಲಾ/ನಗರಆರೋಗ್ಯ ಸಂಘಗಳು ಅನುದಾನವನ್ನು ಪ್ರಾಥಮಿಕಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಿಗೆ ಬಿಡುಗಡೆ ಮಾಡಬೇಕಾಗಿರುತ್ತದೆ. ಕಮ್ಮಗ್ರಹಿಕೆಗೆಆವಕಾಶವಾಗದಂತೆ ಭಾರತ ಸರ್ಕಾರದ ನಿರ್ದೇಶನಗಳನ್ನು ಕೆಳಕಂಡಂತೆ ಅನ್ವಯಿಸಲಾಗಿದೆ.

- Each facility is to receive an assured fixed top up of to 50% of the facilities entitlement and remaining 50% would be pooled and allocated amongst similar level facilities by the DHS (CHS)
- The DHS are expected to make responsive allocation to facilities based on case loads, fund utilization etc.
- For further details and illustrative live example of Karnataka may be obtained in the GoI Health Website.

ಆಧಿಯಾನನಿರ್ದೇಶಕರು
ರಾಷ್ಟ್ರೀಯ ಆರೋಗ್ಯ ಆಧಿಯಾನ

To:

1. DH &FWOs of all the 30 districts.
2. DRCHOs of all the 30 districts.
3. The DPMs of all the 30 districts.
4. The DAMs of all the 30 districts.
5. CPM of 11 districts & DDM of 11 districts

Copies to:

1. Private Secretary to the Principal Secretary, Health & Family Welfare Department with a request to place it before the Principal Secretary.
2. Commissioner, Health & Family Welfare and AYUSH Services.
3. Director, Health & Family Welfare Services.
4. Chief Financial Officer, NHM.
5. Chief Administrative Officer, NHM.
6. State Nodal Officer, NUHM
7. Consultants, NUHM.

PKS

STUDY OF IMPLEMENTATION OF SELECT NATIONAL HEALTH PROGRAMS UNDER NUHM IN THE UPHC's OF BRIHATH BENGALURU MAHANAGARA PAALIKE AREA

A Gap Analysis of BBMP UPHCs

Date: 3rd June 2017

Submitted to:

BBMP Health Department
&
Mission Directorate
National Health Mission
Karnataka
Bengaluru

A Gap Analysis of BBMP UPHCs
Methodology

- Six allotted UPHC/UFWCs studied
- Two UPHC from each of the 3 core zones in the BBMP area
- Primary data collected with a check list
- Check list developed based on the program guidelines in force
- Methods of data collection:
  - Interview
  - Observation
  - Record perusal
- Programs studied:
  - NUHM
  - RMNCH+A
  - NVBDCP
  - NPCDCS
  - NIP
  - NPHCE

NUHM in BBMP Area: Snap Shot

NUHM Measurables	SNUPHC	AGHC	WGUFWC	KPUFWC	NSP UPHC	KGHUPHC
Institutional Deliveries	100%	99% (one home delivery)	100%	99%	100%	100%
UHNDs	once a month, 3rd satday	once a month, 3rd satday	once a month, 3rd satday	once a month, 3rd satday	once a month, 3rd satday	once a month, 3rd satday
MAS	9	0	8	8	21	5
MAS desirable @ 1 per 100 house holds	280	266	314	154	143	194
MAS frequency	monthly	monthly	monthly	monthly	monthly	monthly
MAS Supportive supervision	no	no	no	yes	no	yes
Program Manager	0	0	0	0	0	0
ASHAs	13	7	8	6	7	7
ASHA Trg	2 modules	2 modules	2 modules	2 modules	2 modules	2 modules
Complete Immunization	96%	100%	95%	96%	97%	92%
Malarial Programme	Yes	Yes	Yes	Yes	yes	yes
TB programme	Yes	Yes	Yes	Yes	yes	yes
ANC registration	100%	100%	100%	100%	100%	100%
Birth regtn	Child births do not happen; hence intimation is not applicable					
IMR	0.00	7.14	2.85	1.43	0.00	0.00
MMR	0.00	357.14	95.06	0.00	0.00	0.00
Universal Immunization	97%	98%	96%	95%	95%	92%
Out-reach program made Operational	Yes	Yes	Yes	Yes	Yes	Yes

NUHM in BBMP Area: Snap Shot

Salient Achievements:

- Infrastructure- contemporary, tiled, dadoed, well located
- AoR clearly defined
- Full time Medical Officers cover the UPHCs
- Splendid movements on MCH programs
- Excellent coverage of immunization
- Communitization:
  - ASHA recruitment has picked up pace
  - MAS being organized
- System well poised to take on more programs

Mapping Activity

Gap	Suggestions
Mapping is restricted to topography of roads	• Structures to be mapped • House-holds per structure to be mapped • Individuals to be mapped to the house-holds • Individuals profiled for their healthcare needs. Ex: adolescent, newly wed, ANC, PNC, Neonate, Infant, child, diabetes, tobacco/alcohol exposures, occupational exposure factors, hypertension, mental abnormalities, Life-style factors, sexual practices, dietary factors, etc..
House-holds profiling is made with specific reference to RCH program. Comprehensive healthcare need assessment is to be done.	• Such profiling has to be directed by program-specific guidelines. • A detailed check list may therefore be developed to be used by the ASHAs and the ANMs to be used while such profiling.

Human Resources

Gap	Suggestions
Human Resource gaps, critical (ANM/LHV/ Lab tech/ Pharmacist/ etc) exist. ASHA resource gaps in many UPHC force them to take on an additional burden to about 35%.	• Needs to be plugged at the earliest. • Lab tech at eh SNUPHC. • ASHA recruitment gaps to be plugged.

Human Resources

Gap	Suggestions
MO at the UPHC is unable to give time for field supervision • Recommended field visits 2hours/ 2days/week • Two days in a week are ANC days • One day is Immunization day • At least two-three meetings- routine monthly reviews, forcing him to be away. • Additional charge of 'Administrative Medical Officer'. • Many dependent areas are to be reached on foot, which consumes more time than stipulated. • OPD, on the other three days left, will be poorly covered if the doctor moves out of the UPHC • Out-reach activities are conducted during the first half (Fore-noon) of the day, which demands the attention of the doctor both at the field and at the UPHC, a hard dilemma to crack.	• A Public Health Cadre be raised, with appropriate resource at the UPHC, to augment the existing managerial & supervision activity. • More programs demand active field inputs (ASHA, ANMs, LHV, TBV, etc..) making supervision inevitable.

Human Resources

Gap	Suggestions
MO at the UPHC requires a sensitization on issues pertaining to organizational behavior.	• A sensitization program on OB be organized to the MO and the team.
Attitude of the team to the clients Develop a culture of mutual respect.	• To stop addressing people in singular. • Render and assure dignity • Conduct a study to assess public perception about the behavior of the HC team; intervene suitably to eliminate access barrier.

Training

Gap	Suggestions
Program specific knowledge lacking among the team	• Training on program guidelines, implementation, monitoring of various National Health programs like NVBDCP, NPCDCS, NPIDD, NTCP, NACP, RNTCP, NIP, etc.. to be undertaken on priority. • System is well focused on RCH program. There is a need to move beyond the RCH program, while further strengthening the RCH activities. • ANMs & ASHAs need to be trained on what to look for during their field visit/ household profiling/ need assessment. • A check list to be developed from this perspective for ANMS/ ASHAs.

National Health Program Implementation

Gap	Suggestions
NPCB	• Out-reach eye clinics with refraction study facility
NACP	• High risk population mapping, follow up.
NAPPCD	• Outreach clinic for detection of preventable deafness
NPCDCS	• Early cancer detection measures like BSE, out-reach specialty clinics, etc.. • Survey: Active Detection of hyperglycemia/ treatment • Survey: Active detection of hypertension and treatment • ECG facility at the UPHCs
NIDDCP	• Iodine monitoring: Random audit of iodine content of the salt used in the community
NPHCE	• Weekly geriatric clinic at the UPHCs

NVBDCP Implementation

Gap	Suggestions
NVBDCP: Nil incidence of Malaria is a welcome measure; however under-reporting may be a concern UPHCs information system about the vector-borne disease incidence requires relook ACD not happening RDKs not available with the ASHA/ ANMs ASHAs not trained on RDTs Anti malarial drugs not available at the UPHCs	• Nearly 77% of the reported cases approach the private set-up(1). • The IDSP information obtained from the private HCEs need to be fed to the concerned UPHCs. • UPHCs need to investigate such cases • Identify foci • Liaise with the concerned agencies (PHE, etc) for focus elimination • Consider ACF exercise once in 15 days around the incident case &/or identified Foci (until elimination) • Active treatment follow-up

RMNCH+A Program Implementation

Gap	Suggestions
RMNCH+A: Listing is only from the vulnerable area	• Elite areas to be covered as well • Each UPHC to develop a list of probable private establishment approached by the elite population. • A regular info-sharing mechanism on the ANC, deliveries, still births, MTPs, Abortions, neonatal/ infant/ child deaths, etc..be established
Drop out follow up difficult	• Though care is portable, transfer b/n UPHCs, of the ANC/ PNC is not practiced. • Hence drop out is difficult to trace.
Adolescent Health component is not stressed	• Sanitary hygiene program (health/ WCD/Education ???) • ASHAs / ANMs confused about distribution • Adolescent Boys • Sneha Clinic

RMNCH+A Program Implementation

Gap	Suggestions
RMNCH+A: Coverage: certain ANCs are forced to approach a different UPHC (far off) for registration, while they prefer a near-by UPHC for care	• Area of Responsibility may need a review for a few UPHCs.
Drop out follow up difficult	• Though care is portable, transfer b/n UPHCs, of the ANC/ PNC is not practiced. • Hence drop out is difficult to trace.
Post-natal care follow up is inconsistent	• Compliance to the recommended 7th day/ 42nd day visits post-natally by the LHV/ ANM is inconsistent. • 5% of the births are low birth weights on an average, and recommended additional post-natal visits by the LHV needs to be reinforced.
RCH Register is not well-maintained	• Drive compliance to upkeep of register • Avoids duplicacy/ wastage of time.

National Immunization Program Implementation

Gap	Suggestions
NIP: Target estimation is inconsistent • Only vulnerable • Vulnerable + Elite • Targets are given by the BBMP…..	• Standard head count of PW • Done twice a year • Estimation of immunization load • Team needs to drive its 'Full' and 'Complete' Immunization targets to conclusion. • Coverage rate monitoring to be standardized across units
Drop out follow up difficult	• Though care is portable, transfer b/n UPHCs, of the ANC/ PNC is not practiced. • Hence drop out is difficult to trace.
AEFI management skills require reinforcement	• Training on AEFI emergency management to ANMs is to be done on priority.
RCH Register: Immunization status is not updated	• Drive compliance to upkeep of register • Avoids duplicity/ wastage of time.
Vaccines are over-stocked in units	• ROL-ROQ based indenting • Adherence to stock & consumption audits • Wastage monitoring & accounting

National Immunization Program Implementation

Gap	Suggestions
NIP: Cold Chain Equipment	• Equipment history cards to be maintained. • Equipment preventive maintenance schedule is to be available at the units. • 'DO NOT UNPLUG' signage for ILR plug point • Ensure weekly Defrost schedule adherence. • ILR and vaccine stocks to be secured under lock & key
Immunization counterfoils are not retained	• Counterfoils to be retained; RCH register should be the only register. • This avoids duplicity.

ASHA Recruitment, Retention

Gap	Suggestions
• 50% of the units studied have ASHA deficiency, for the vulnerable population served by the UPHC. • Each ASHA in such a unit handles, on an average, 35% additional vulnerable population than recommended.	• ASHAs to be recruited as per recommended scales
The training of ASHAs needs attention. A good motivating tool to retain the ASHAs	• serves to boost the individual's self-confidence, and will directly impact her connect with the community • good motivating tool to retain the ASHAs • To be trained on all seven modules
Boost belongingness to the organization	• Frequent training sessions, at the UPHC, coupled with small rewards like a snack/tea/ coffee during such sessions • Priority to patients brought by the ASHAs • Small rewards, already factored for in the untied funds, if utilized properly and objectively, will turn to be good motivators.

MAS

Gap	Suggestions
MAS formation, logistics, activity inconsistent	• Needs priority • MAS accounts teeting problems to be addresses • Activity to be standardized across UPHCs.

User Charges

Gap	Suggestions
User Charges policy is inconsistent	• Needs standardization across UPHCs.

Estate maintenance

Fig-1: Shantinagar UPHC Estate: Unclean estate and surrounding house-holds draining their effluents/ sewage into the UPHC estate.

Program Monitoring

Fig-2: Dr Kalavathi, RCH Officer, BBMP on a monitoring 'Mission Indradhanush' in the AGHC area

- A central team be formed to monitor implementation of the programs at the PH Facilities within the BBMP area
- This will standardize assessment
- Shall provide first hand information/ feedback to the CPMU.
- Scheduled and surprise visits by the assessors be carried out to ensure constant surveillance

Untied Fund Utilization

Gap	Suggestions
Book of account is termed 'cash-hbook'	• It may be termed as 'Book of account- Untied Fund' • May capture both cash and bank transactions.
There is no dedicated resource for book-keeping MO/ ANMs are not trained in book keeping	• MO & ANMs are to be trained in book keeping and accounting.
There is a substantial delay in the Untied Fund reaching the beneficiary-unit	• Timely disbursals, preferably in the first quarter will help the UPHCs to assure equity-access-quality.
Guidelines do not contain provisions, to justify expense, that are a priority at the UPHCs	• Review guidelines and consider suitable inclusions for fund utilization.
About 35% of the untied funds for theFY-17 have not utilized	• ARS to be accountable for such unspent amounts • Escalation matrix for such issues to be established. • Funds to be timely disbursed to encourage financial discipline.

Untied Fund Utilization

Gap	Suggestions
	• Asset/ stock audits to be strengthened
	• Quality assurance, calibration of appropriate equipment to be included in the utilization guidelines. • (after due training on Quality Assurance Guidelines for the Public Health Facilities issued by the GoI)
There are frequent drug stock outs, frequent local purchase, inadequate stock keeping.	• Drug indenting, supply, stock-keeping, stock-checking, documentation processes needs a thorough audit.

References:

Operational Guidelines for Quality Assurance in Public Health Facilities-2013, MoHFW, Government of India

A Strategic Approach to Reproductive, maternal, New-born, Child and Adolescent Health in India- Jan 2013, MoHFW, Government of India

National Urban Health Mission- Framework for Implementation: No.L.19017/1/2008-UH Government of India; Ministry of Health & Family Welfare; Department of Health & Family Welfare.

Indian Public Health Standards- guidelines for Primary health Centres-2012 (Revised)

NUHM-Karnataka Program Implementation Plan 2016-17.

National Immunization Program- Operational guidelines, MoHFW, GoI

NPCDCS Operational Guidelines – revised (2013-17, MoHFW, GoI

Guidelines for utilization of untied funds issued vide NHM-Karnataka letter No NHM/Suggestion/01/2015-16 dated 20th March 2017

(1) Anirudh R Acharya et al, Trend of Malaria Incidence in the state of Karnataka, India for 2001-2011; Archive of Applied Science Research. 2013, 5 (3) : 104:111