Annexure-II

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली-110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi-110011

सौरभ जैन, भा.प्र.से.
संयुक्त सचिव
SAURABH JAIN, IAS
JOINT SECRETARY

D.O. NHSRC/EDSectt/22-23/VisitReport/0017
Dated 20th May 2025

Dear Sir,

As you are aware, the Ministry of Health and Family Welfare (MoHFW) team recently visited the State of Karnataka to conduct a thorough review and provide orientation regarding the interventions under the National Health Mission (NHM) within the domain of Health Systems Strengthening. This team was led by the Executive Director of NHSRC, Maj Gen (Prof) Dr. Atul Kotwal, and included advisors from the various divisions, along with lead consultants.

The discussions between the NHSRC team and the State NHM team were both insightful and productive, leading to a comprehensive understanding of the current program implementation and key focus areas. Several critical action points emerged during these discussions that require immediate attention from both the State NHM and MoHFW. These are as follows:

- Revisit Human Resource Plans: The State needs to reassess its plan for reallocating human resources, specifically addressing the removal of the CHO positions at Ayushman Arogya Mandir (AAM) and establishing ANM-led AAM.
- HRH Audit: NHSRC should undertake a Human Resources for Health audit for the State.
- Support for SHA, SHSRC, and Research Activities: NHSRC to provide support for State Health Accounts, State Health Systems Resource Centre, and research-related activities.
- Routine Review and Technical Support: NHSRC divisions to offer routine reviews and technical support for concerned national programs as needed by the State.
- Infrastructure Strengthening: The State should expedite the infrastructure strengthening of primary care facilities and focus on transitioning urban facilities to government-owned buildings.
- Prioritize Key Activities: The State must prioritize and expedite activities related to AAM operationalization, implementation of free medicines and diagnostics across PHF, MMU, PHMC, IPHS compliance, NQAS, and Kayakalp implementation.

The reallocation of CHOs across Ayushman Arogya Mandir and the establishment of ANM-led AAM were highlighted as areas of critical concern and require immediate action. With the launch of Ayushman Arogya Mandir, it is imperative to provide an expanded package of services, including Non Communicable Diseases (NCD),mental health care etc, compared to the earlier RCH-based services. CHOs are integral to the Comprehensive Primary Health Care approach under Ayushman Bharat and are trained across various packages to deliver all types of basic healthcare services to citizens at their doorsteps. Therefore, ensuring the full functionality of AAM across the state with a complete staff led by CHOs should be a priority action area for the State.

Cont....

We kindly request the State to revisit the current AAM operationalization plan and provide the status of actions taken to ensure the positioning of CHOs across the AAM facilities in the State.

Please find attached a brief summary of the discussions with the NHSRC team during their visit, for your reference and further action. For any further clarification and details, please reach out to the Executive Director of NHSRC, Maj Gen (Prof) Dr. Atul Kotwal, at (atul.kotwal@nhsrcindia.org)

With Regards,

Yours sincerely,

Enclosure as above

20/5

(Saurabh Jain)

Sh. Harsh Gupta
Principle Secretary (Health),
Govt. Karnataka, Bengaluru

Copy to:

- **Mission Director, Karnataka**
- **PPS to AS & MD, NHM**

Summary of Discussions

Karnataka Visit

April 15th, 2025

A team from NHSRC led by Executive Director, Maj Gen (Prof) Dr Atul Kotwal visited the State of Karnataka on 15th April 2025 for a meeting with Shri Harsh Gupta, Principal Secretary Health, Dr Naveen Bhat Y, Mission Director NHM, and other State Officials. The NHSRC team comprised of Advisors and Division I/C; and the State officials included State Nodal officers, Programme officers and SHSRC team. The meeting started with brief overview of the NHSRC presented by the Executive Director, which was followed by a division wise presentation by respective Advisors and Lead Consultants, which covered overview of each division's domain areas, as well as current status in the context of Karnataka. The discussions took place during each presentation.

Summary of discussions is as follows:

i. The State shared their concern with Ayushman Arogya Mandir, where state Finance department had raised a query regarding positioning of two people at one centre i.e. AAM. Highlighting the concerns pertaining to HRH availability, the state quoted a recent BCG study and shared that state is planning to issue an order regarding repositioning of CHOs as a temporary arrangement across the AAM and only ANMs at several AAM. It was shared that State is planning to reallocate HR across AAM, in view of ongoing directions form the Finance Department.

ii. The PS-Health, Karnataka pointed out that since ANM was not initially mandated to do the expanded packages, given the responsibility, she should be able to provide services in expanded packages as well. He also added that the State Finance Department had got a study conducted to know the efficacy of health system with CHO and ANM or with availability of one of them at the AAM-SHC and deduced that both were not required for adequate functioning of AAM-SHC, and the same amount of work could be accomplished by either of them.

iii. Executive Director, NHSRC, clarified that it was incorrect to suggest that the ANM could have performed the activities assigned to CHO. Had that been the case, there would not have been any change in the footfalls, referrals and overall patient turnout at the AAM-SHC. It was also pointed out that the gains achieved in various RCH indicators were largely due to the community connect of the ANM and ASHA

as well as outreach services provided by them. However, ANMs were not doing any work other than that.

It was also pointed out that there was difference in the qualification of ANM and CHO, while the former had undergone 18 months ANM training course after 12th class, the latter was mostly B.Sc. (Nursing) after 12th class and had to undergo a further training of 6 months to be eligible for posting as CHO.

iv. Executive Director NHSRC shared that the BCG study findings were not relevant to reflect on the current role of CHOs and overall functioning of AAM, as the study focussed only on the role of ANM before the expanded packages were introduced, i.e. only RMNCH and thus totally neglecting the role of CHOs in NCD and other expanded packages under CPHC. It was suggested that state may relook into the decision and should not plan to relocate CHOs. It was suggested that State should prioritize the recruitment of CHOs for vacant positions for an effective delivery of CPHC through AAM.

v. Findings from CRM and AAM assessment were also discussed to provide evidence of increased footfalls across the AAM with CHO added as a new cadre of health care provider. It was further clarified that there was evidence from global examples that addition of Mid-Level Healthcare Provider (MLHP – CHO) at the AAM-SHC level improved the health outcomes for the community while also helping reduce overcrowding at the secondary and tertiary level facilities and reduce out of pocket expenditures.

vi. The differences between the functioning of AAM-SHC and non-AAM-SHC were also discussed, and it was shown how the availability of CHOs at AAM-SHC had reduced the travel distance of patients to the primary and secondary health care facilities. The role of tele-consultation, bi-directional referral and continuum of care was also discussed, and it was clarified that all this had been made possible only with the addition of CHOs.

vii. State also shared that approximately 500 CHOs have left, and this can be attributed to lack of career progression pathways for CHOs, to which NHSRC responded by sharing the ongoing discussions for CHOs career progression pathways.

viii. Adding to the discussions, the findings from the Time and Motion Study undertaken by NHSRC were also shared with the state which reflected that a complete team of AAM i.e. CHO, ANM and ASHAs are required to achieve the vision of CPHC.

ix. It was discussed that the findings from the BCG's assessment of CHO and PHO show that while calculating the time utilization of ANM, the field visit time has not been added. Also, the study had been done for the older situation and did not take into

account what is envisioned and what this Primary Health care team needs to do futuristically. The 12 packages are yet to be taken up fully and in future we may like to add more services. Thus, it was advised not to consider the findings, given its irrelevance to the current context of AAM. It was reiterated that the AAM-SC team is required for promotive, preventive, curative, rehabilitative and palliative care. With increasing NCD and geriatric population more of these services would be required closer to home than at hospitals. So while CHO or ANM in the short term could be a strategy to overcome HRH shortages, Karnataka should consider the above evidence before taking a decision.

x. In the end, PSHFW, Karnataka mentioned that the State would have a re-look at the proposal of doing away with CHOs and decide rationally.

xi. Karnataka has about 20,000 additional human resources from NHM. The HRH in place is 87% whereas the expenditure is in the range of 60%. MD Karnataka mentioned that there would not be any big reason for this, and it could be accounting error. But he would want the team to come for HRH Audit and also help in performance management and HRH reorganization.

xii. Secretary Health Karnataka had previously mentioned about Staff nurses, LT or Pharmacist not being fully utilised in some of the facilities. The root cause is double the number of PHCs. As per IPHS there is one PHC for 30,000 population whereas in many places in state there are PHCs at 10,000 population. And so, there isn't enough caseload to keep the HRH productive throughout the day. Secretary health asked for suggestion and example of Bihar (15 years ago) was given. A more practical suggestion would be withdrawal /not filling up the vacancies in the facilities below a particular threshold of caseload. State agreed to see if they can apply this caseload criteria to 'Critical Vacancy'. The numbers could be slowly reduced over a period of time. Also having assured services as per timings of the facilities is more appreciated by the community than a greater number of facilities where availability of HRH is not sure.

xiii. HRH requirement for the State has been calculated using IPHS 2022 and in some of the HRH categories more posts need to be created. Secretary health wanted the basis and calculation details. In the case of specialists, essential and desirable both requirements as per IPHS 2022 have been added in the table as they would be required to run the district hospitals and CHCs as FRUs 24x7. It was suggested to go beyond numbers and ensure that the skill mix required in a team is met. Accessibility, primarily the distribution of HRH is crucial in a State like Karnataka where some districts have lesser number of human resources. Acceptability to community in terms of gender, culture, language, stream of medicine, etc., should

be looked into. Service utilization: placing people as per service utilization and not only as per norm. Quality: not only in terms of skills, but how the community perceives the quality to be and especially the soft skills /behaviour of HRH.

xiv. While discussing NHM HRH, it was shared that earlier there was no capping which resulted in some States budgeting more than 50% of RE in HRH hence now AS&MD has asked the States to keep it below 50% to start with. The basic principle is that state must provide for HRH and all the regular posts as per IPHS 2022 and the state's requirements should be created. In the short to medium term, NHM would supplement and do the 'Gap-Filling". In program management, there is a capping by the Mission Steering Group (MSG) of 9%. PHMC was discussed and the state was advised to take steps towards these cadres as approved by the MoHFW as per the mandate by CCHFW.

xv. On PIPs, it was shared that comparison of state PIP under NRHM with other states is not possible as the context differs vastly. As a matter of financial prudence, it is good to keep the approvals up to 125% of the resource envelope. When approvals are more than that many of the essential services could be compromised and funds could be spent on other items which are non-essential. It was proposed that Karnataka PIP can be reviewed and try differentiating essential and non-essential proposals (if any).

xvi. NHSRC Team suggested State to align the State IT work on Health Portals with Ministry initiative to avoid duplicity of efforts and maintain single source. State was also briefed on the Integration efforts being done at Ministry towards Integration of Health Portals. On NCD Application the State emphasized on additional features, which NHSRC agreed as acknowledged and has taken into Product development pipeline.

xvii. Another aspect discussed was that availability of diagnostic tests under the Free Diagnostics Service Initiative is very low and the diagnostic gap is in the range of 40–80%, which needs to be addressed by the state.

xviii. Appreciating the State's in-house model of FDSI programme, it was shared that this has strengthened its diagnostic capacities and infrastructure across the state. However, the availability of tests at the facility level depends on the supply chain and its effective monitoring. It was suggested to establish the sample transportation where samples move instead of patients, as this would improve the diagnostic availability and reduce the out-of-pocket expenditure for the patients. The State was informed regarding the DVDMS (Diagnostic Module) developed by MoHFW which has been piloted in few states and will help in addressing the visibility of availability of tests and supply chain related issues. The State was also

encouraged to engage with OEMs for rate contracts on reagents and consumables, especially for closed-end systems.

xix. Given low AERB compliance in the state at present, it was recommended that the State may implement the program through an in-house mode. Also, the AERB compliance program focuses on facility licensing for centres with X-ray-related equipment, and a PASS KEY is required for equipment procured before 2017. The State was advised to assess the condition of existing equipment and recommend Beyond Economic Repair (BER) action for obsolete equipment.

xx. NHSRC team shared that it has developed a list of 25 critical life-saving equipment under the BMMP program which need to be monitored for their uptime and availability at the facilities at the state level for improved health outcome. The State was advised to conduct an annual equipment census, carry out equipment audit and condemn BER items. State was informed that there is a provision of having one Biomedical engineer per district as per IPHS-2022 and his role would be to monitor the performance of the PPP service provider.

xxi. Appreciating the implementation of Pradhan Mantri National Dialysis Program in PPP mode through the QCBS framework of selection of service provider methodology, the team stressed upon the need for effective monitoring of the key clinical quality parameters and the water testing parameters. NHSRC team also raised their concern over the single use dialyser and its effective bio-medical waste disposal and requested the state to develop some mechanism for monitoring and recording of the biomedical waste generated to ensure proposer disposal.

xxii. Under NQAS, it was shared that out of 133 sanctioned quality-related positions in the State, 12 remain vacant. The State was advised to expedite recruitment to fill the vacant position under Quality Assurance. Also, it was requested to ensure availability of External Assessors in each district. Out of the 57 available External Assessors, 37 are concentrated in a single district.

xxiii. NHSRC team requested State to ensure nominations for NQAS External Assessors Training, out of total 17 seats offered in previous batches of External Assessors Training, no nominations have been received from the State. Nominations for Ayushman Assessor Trainings were discussed with the State team, and it was recommended to prioritize candidates from underrepresented districts.

xxiv. State was also suggested to ensure coordination among State Pollution Control Board, Mother PHC & AAM-SHC for effective Bio Medical Waste Management at AAM-SHC, as per BMW rules; and also, to prioritize availability of medicines as per EML at AAM-SHC.

xxv. While discussing Infrastructure Gaps and Utilisation, an issue was raised pertaining to high proportion of SCs (26%), PHCs (19%), and U-PHCs (54%) continuing to function from rented premises and its inadequate urban infrastructure was highlighted. The state was advised to fast-track infrastructure completion by Dec 2025, prioritise NUHM and 15th FC-supported urban health infra projects, and transition of all U-PHCs to government-owned buildings; ensure land availability support.

xxvi. Also, for weak outreach in urban slums, state was suggested to carry out vulnerability assessment and mapping exercise.

xxvii. Regarding Public Health Management Cadre (PHMC), the issues discussed were related to delay in implementation, delays in taskforce formation, mapping, and cadre rule finalisation. It was suggested that NHSRC team to get in touch with Dr Desai and support for developing the plan. Also, it was suggested if the information on IPHS Compliance can be shared with the State Nodal.

xxviii. For Referral transport and service delivery systems, it was shared that state has 50 MMUs sanctioned but non-functional; and it was decided that the state nodal would work with NHSRC for planning MMU deployment.

xxix. The strengthening of command-and-control centres was also discussed. It was suggested that upgradation is to be done for 30% of fleet to ALS in high-priority districts. And Integration to be done for 108 (Arogya Kavacha) with 112 helpline and conduct periodic mock drills.

xxx. While discussing the State Health Accounts, it was discussed that SHSRC-K would work with NHSRC to undertake the SHA as routine activity.

xxxi. Supporting the State Health Systems, the strengthening of SHSRC was also discussed, where it was suggested to engage a full-time director for SHSRC and also establishing State Innovation Hub for its effective functioning.

xxxii. State was also briefed on State Review Mission, and it was suggested that SHSRC can plan this activity within the state and support the monitoring and review of programmes for its effective implementation.

xxxiii. Regarding State's query on rapid assessments, it was proposed that NHSRC can support such assessments based on State's requirement.

xxxiv. The Principal Secretary, Health, Karnataka also suggested if routine interactions can be ensured where reviews on programmes are done and action points are shared with the State Principal Secretary and Mission Director for effective programme implementation.

Summing up the discussions, the key actions planned as next steps were –

- State to revisit its plan for reallocating HR, including removing the positions of CHOs at AAM and establishing ANM led AAM.
- NHSRC to undertake HRH audit for the State.
- NHSRC to support for State Health Accounts, SHSRC and research related activities.
- Routine review and technical support for concerned national programme to be provided to State as per need by NHSRC divisions.
- State to expedite infrastructure strengthening of primary care facilities and also focussing on transition of urban facilities to government owned buildings.
- State to prioritize and expedite the activities pertaining to AAM operationalization, implementation of Free medicines and diagnostics across PHF, MMUs, PHMC, IPHS Compliance, NQAS and Kayakalp implementation.