3. Strategic Analysis of Health and Nutrition in Karnataka

In this section, we focus on what are the strengths, opportunities, gaps and strategic interventions in the health and nutrition sector. Based on the current health and nutritional status trend, the strengths, opportunities, gaps and strategic interventions have been presented in the table below.

Sl No.	Topic	Strengths	Gaps	Opportunities and Enablers	Strategy
1	**Equity**	-	- **There is huge gap with respect to North and South Karnatka, districtwise and backward Talukas as per Nanjundappa Commitee** - Unequal distribution of health facilities between North and South Karnataka districts is seen in terms of regional, pattern of utilisation of health services (public and private), provision of government primary health care facilities etc. - No data is available on the actual inequities, based on gender, age, region and disabilities. - Taluk level disparities have also been identified in all divisions of the State	There are lot of people in the backward districts and Taluks, who are **demanding** for equity. Vairous committees have been formed to bring in equity	**Specific planning and budget of the backward districts and taluks.**
2	**Quality**	- The department has initiated the process of accreditation across the public health facilities	- The major gap seen is that very few government institutions have received accreditation for quality. - Of the about 4,000 hospitals across Karnataka, only 119 have National Accreditation Board for Hospitals and Healthcare	-To ensure quality assessment and accreditation of all government facilities	- Full implementation and follow up of quality accreditation of all public health facilities which wil improve the utilisation and perception about public health facilities among people - Need for quality assessment

			Providers (NABH) recognition. And Only 4 of the 119 NABH-recognized hospitals are government institutions - **The quality of care is poor and needs to be looked into, which in turn has an effect on the utilisation of public health facitlites** which is poor as well		of all government facilities against IPHS standards - -**Effective implementation of NQAC and NABH**
3	**Primary Health Care**	- Number of PHCs are more than the Govt of India norms -Introduction of Urban Primary Health Centres	- **Vacancies** is a big concern that needs to be addressed - Current **infrastructure is poor** and needs to be improved both in Urban and rural settings - Rural PHC: Referral system has been poorly implemented and managed	- Enhancing existing services by working towards filling in vacancies and provision of better infrastructure	- **Reorganisation of PHCs and their population across the district and the state** - Filling up all exisiting vacancies - Strengthening the referral system
4	**Secondary & Tertiary Health Care**	---	-Major factor affecting the efficiency and quality of care provided by the secondary and tertiary care hospitals in the government sector is the **mismatch** between requirements and the provision of buildings, number of beds, equipments, laboratory and other facilities on the one hand and the actual human and material resources. - Emergency Services: The ambulance service serves a population of 85,000. This needs to be reconsidered.	- Enhancing existing services by working towards filling in vacancies and provision of better infrastructure	- **Make the secondary and tertiary health care institution fully functional, with the required staff (avoiding mismatch) and equipment in good working condition.** - The **equipments** must be maintained in good working condition; the downtime must be reduced to the absolute minimum - All **diagnostic service** laboratories must be strengthened or restructured as shown above and all vacancies should be filled up and equipment and reagents provided in a time bound

					fashion so that the entire system is fully functional - The specific specialty hospitals should be spread across the district and a multi-specialty hospital should be present in all the districts.
5	**Public Health**	-Many national programmes and state level schemes have been introduced under NHM -Various departments and supervisory staff have been implemented -Targets under certain programmes have been achieved such as being Polio free state etc - **Introduction of health programmes to address health needs of specific age groups (elderly and adolescents)**	**-Absence of public health cadre** -Implementation of programmes continue to have a vertical approach - Typhoid continues to be a major concern, yet the typhoid vaccine has been withdrawn have withdrawn the typhoid vaccine -Cholera is still a problem that needs to be addressed - **Lack of assessment, supervision, monitoring and evaluation of the programmes** - **Absence of addressing oral health needs of community and integrating it in services**	- Create a system that can assess, monitor and evaluate the programmes	- **To implement the Public Health Cadre to improve the public health** - Relook at the implementation of programmes with an integrated approach - Create a system that can assess, monitor and evaluate the programmes - Oversee and conduct regular intermittent trainings for staff on a regular basis - Recording, reporting and communication systems will need to function with accuracy and speed and lead to decision-making and response at the district level - The private and voluntary sector to be included in the coverage by the surveillance system - Introduce oral health promotion as an integral part of health promotion at every level of health care and as part of the school health programme.
6	**Mental Health & Neurosciences**	-Mental care resources in the state consist of NIMHANS, Bangalore, Institute of Mental Health in Dharwad, departments of	- **Only few districts** are covered and the topic has been addressed - Absence of a Mental Health Officer at district level	- Proper implementation of current mental health programme at district and PHC level	- **Overall mental health programme needs to be strengthened and implemented in all districts and health centres.**

		psychiatry in the medical colleges, private psychiatric hospitals/nursing homes in major cities like Bangalore, Mysore, Hubli, Davanagere and services provided by voluntary organisations. - District Mental Health Programme has been implemented and first of it's kind based on the National Mental Health Policy has been passed - Introduction of psychiatrists at district level	- Deaddiction centres are few in number		- **Deaddiction centres for alcohol, drugs and tobacco** - to enhance the mental health skills of all doctors - to develop a wide variety of community based rehabilitation facilities - ensure availabilitiy of essential drugs for management of mental health disorders
7	**Women and Child Health**	- Maternal Mortality Rate has decreased over the years - Infant Mortality Rate has seen a significant decline	- The health needs of women are addressed by the RCH programmes, which are restricted to the reproductive phase. - Health seeking behaviour of women has been affected by gender insensitiveness in society - Neonatal Mortality Rate has not seen any decline - **Rural setting, IMR continues to be higher in comparison to urban setting**	- Strengthen the existing facilities with workforce and infrastructure	- **Ensure Functional FRUs in all Talukas and CHCs** - **Streghthen district level SNCU's and add Taluka level SNCU's** - Ensure availability of trained staff especially ANMs - To ensure child and maternal care, the Government to create an awareness on pre-pregnancy, during pregnancy and post-pregnancy related topics. *Refer Public Health
8	**Population Stabilisation**	- State has achieved the expected goal of 1.9 Total Fertility Rate	-**Backward districts need more focus** - Poor implementation of Family planning methods is observed -Sterlisation approach is gender biased with main focus on women - **Number IUD users is poor** - unmet needs have not	-To focus on backward districts where TFR is yet to be achieved	-Focus on backward districts where TFR is yet to be achieved **-The approach to this should be through Community Needs Assessment (CNA) not via expected levels of achievment or a target type of approach**

			been fulfilled		- Scope to further reduce the TFR and reach the unmet needs for family planning services
9	**Special groups (Tribal Health; Elderly health)**	- **Healthcare in tribal areas by NGOs** -Introduction of national health programme on elderly health	- Number of PHCs in tribal areas are very few in number - Need for filling in the vacancies in the PHCs in tribal areas - **No disaggregated data available for special groups** - Referral services in tribal areas are neglected.	-To have specific planning for Tribals, Elderly and Differently abled.	- Tribal Health: - **Establish Health Wellness centres in Tribal areas** **- Region specific and tribe specific health plans should be made** - Traditional healing systems must be encouraged and documented in tribal areas and there should be integration of Allopathic medicine with the Traditional systems - There should be increased collaboration between the government and the NGOs in tribal areas. The voluntary agencies must be involved in all health and development activities undertaken by the government - Differently abled: Shift from institutional approach to a community based rehabilitaion approach; single to multi-disability approach - **Geriatric care facilities should be provided at secondary and tertiary levels.** - Sensitization on special needs of the elderly both public and private institutions
10	**Health Promotion and Advocacy**	-	- **Neglected domain** - Very less is spent towards the same	- To provide more expenditure towards this area (Other	- Need to provide more expenditure towards this area (Other countries spend 6%)

				countries spend 6%)	- Ensure it is headed by Additional Director with communication expertise - Soft skill training of staff - **Reinforce importance in VHSNCs and ARS** - The Non Governmental organisations must be encouraged in their activities for health promotion including innovative programmes
11	**Human Resource Development**	- Introduction of renewal process of license via attendance of Continued Medical Education sessions by respective state councils - Medical - Establishment of State level Institute of Health and Family Welfare (training institute) - **Initiation of Compulsory Rural Se-rvice**	- **Public health cadre** highly recommended in the Task Force Report of Health and Family Welfare, 2001 has not been implemented -The **issue of absenteeism of doctors in the health facilities needs to be addressed** - **Vacancies of existing posts** what is required according to the norms; PHU (1600) converted to PHCs with less staff Medical education is not producing the HR needed for the health system (Specialists) - delay in compulsory rural service - AYUSH has not come under	- NHM initiated programmes	- The issue of **Maldistribution** needs to be addressed where local recruitment is done (Selection of the health staff needs to be more local) - **Continuous capacity building:** Training of workforce that is continuous with the goal of providing best knowledge and practice - Medical education system should provide the specialists needed for the secondary and tertiary care - **Certificate courses -> Diploma courses -> Master's courses** - Medical education should provide all the specialists needed for the secondary and tertiary care (Specialist cadre) under the rural service act. - Primary Health Care will be managed by the health department while strengthening the secondary and tertiary care by the medical colleges - Provision of more

					Postgraduate seats for doctors inservice - Ensuring one year of rural service after internship period to add on for the public health cadre -Coordination between departments not integration (secretaries, one medical education secretary in health department) - AYUSH, Pharmacy, Nursing could be be integrated under the umbrella of Medical Education
12	**Health System Management/ Governance and Leadership**	- Introduction of Transfer policy - Establishment of KPME Act - The implementation of decentralisation across district level - Establishment of Human Resource Management System - Establishment of State Health System Resource Centre(SHSRC)	**- Corruption in procurement of drugs and equipment,** **- Corruption in hospitals for services** - Conversion of PHUs to PHC's but vacancies have not been filled in - Absence of a grievance redressal system - Goverment has not been able to procure drugs from good companies - No disaggregated data on tribals and gender based - HMIS data is not used at each level and it goes to a top level where it is not utilised or analysed - Lack of coordination between the medical education and health department	- To strengthen existing governance and management	- **Transparency and accountability mechanisms** **- Ombudsman for good governance** **-Strengthening the coordination between Medical Education department and Health and Family Welfare Department to address vacancies** - Biometric presence at the facilities with access to data by all - Set up performance targets where citizen engagement is seen (VHSNC and ARS) -Improving quality of infrastructure, basic services and security for the staff and not just filling in vacancies - **Accommodation at** facilities should be provided for all staff
13	**Health Financing**	- State initiated health	- **Overall expenditure**	- New National Health	**- Increase the health**

		schemes have been implemented	**towards health is extremely low** -Adequacy of funding in relation to the present and future needs and to the functions and responsibilities of the Department; - The adequacy of financial delegations; - Operational issues relating to reduction of accounting workload at field levels and simplification of procedures - Expenditure on health is very low: Optimum utilisation of existing budget is not being done OOP is increasing due to poor governance (mostly spent on drugs and diagnostic invest on making them freely available) - Due to less budget, state initiated schemes also see a fallback in providing for beneficiaries.	Policy, 2017 states that state expenditure on health should be 8%.	**expenditure towards health to 8% for essential drugs, increasing the salaries of doctors and specialists and non practising allowance to stop private practice** - A comprehensive review of the financial reporting system is necessary so that it becomes part of the HMIS - It should be ensured that release of funds and sanction orders are issued well in time and that the quantum of funds released should be adequate since such releases, in combination with sufficient financial delegations, would ensure maintaining and improving health services - CSR funds could 2% to be used towards (govt regulation)
14	**Drug and Food Control/ Management**	- Establishment of Standard Treatment Guidelines; Essential Drug List	- To revise EDL and STG as well as budget allocation towards drugs		- Essential Drug List & Standard Treatment Guidelines needs to be revised - Budget allocation towards drugs is INR 340 Cr- in Task Force Report, it was suggested that 10% of budget be used towards drugs which in turn will reduce OOP - Drugs and therapeuatic committee needs to be implemented
15	**Indian Systems**	- Mainstreaming AYUSH	**- Poor implementation and**	- To establish or	- **Establish or relocate units**

	of Medicine (AYUSH)	into PHC level - Payscale in sync with MBBS graduate	**administration** - Cross practice - Absenteeism of AYUSH doctors - Inadequate funding	relocate units of ISM&H with necessary infrastructure at CHCs, Taluka and District hospitals	**of ISM&H with necessary infrastructure at CHCs, Taluka and District hospitals** - Doctors qualified in a particular system of medicine should practice only that system;
16	**Panchayat Raj and empowerment of people**	- Introduction of VHSNC's and ARS - Decentalisation has helped in reducing absenteesim	- **Poor implementation, monitoring and supervision of VHSNCs and ARS** - Decentalisation has not had its impact, no trust. - **Untied fund utlisation is poor** - Monitoring component needs to improve as it is not effective, currently	- NHM gives importance to communitisation processes	**- Strengthen the implementation of VHSNCs, ARS and community processes** - the strengthening of the community partnership in the ownership and management of the programme should be undertaken orienting and **involving Panchayatraj institutions actively in the process** - The functions, functionaries and resources for such services at PHC, CHS and Taluka hospitals should be placed with the PRI's with full operational control -The involvement of the Panchayat institutions and of the community in providing health services should be encouraged for improvement and enhancement of these services based on real need - Improve community participation and monitoring mechanism
17	**Strengthening Partnerships**	- Introduction of Arogya Bandhu scheme and SAST - Tradtional partnerships initiated under blindness control, TB etc	- **Delay in reimbursement** - **Abrupty withdrawing the Arogya Bandhu scheme** - Most of these General Practitioners are in the	- NHM gives importance for streghtening partnerships and this needs to be	- We need to focus our attention as to how the services of the General Practitioners can be utilized to the health care needs of our

		- Integration on service delievery for specific government schemes	private sector; some of them may be employed in certain non-governmental health organizations. - 70% of the population utilise private services; need for more stronger integration of services	strengthened	population particularly in rural areas. - The “Not for Profit” can play a significant role, through appropriate operational and financial partnerships with the government, in delivery of primary and public health services. -To clearly distinguish between NGOs and for profits. More opportunities to be provided to NGOs tand to strengthen the same. **- The Arogya Bandhu scheme for NGOs must be strengthened** **- SAST for partnering with private sector** -A state level regulator covering private and public hospitals both may be considered to improve accountability in the entire health sector. The role of such regulator may encompass the following aspects. a.Objective, transparent and unobtrusive regulations and regulatory mechanism for the private hospitals; b. Common minimum standards and protocol for infrastructure, manpower and treatments for private and public hospitals; and

					c. Performance and productivity oversight on public hospitals.
18	**Multisectorality and Intersectoral Collaboration**	- A lot of intersectoral programmes have been initiated, such as swachh bharat abhiyan, school health programmes (RBSK) etc	- Need for better implementation and monitoring of the intersectoral collaborations	- **There are other determinants that impact health:** To work with other deparments to integrate health in their programmes, with a cross sectoral approach (police department, water, nutrition etc)	- **Work with other deparments to integrate health in their programmes,** so cross sectoral approach (police department, water, nutrition etc) - All developmental programmes must have inputs from the health sector to make use of the opportunity to improve health and prevent problems.
19	**State Health Policy**	- Task Force on Health and Family Welfare, 2000 - Integrated State level policy was introduced; which underwent revision in 2017. - Introduction of Palliative Care Policy	- The revised Integrated state health policy was released before the National Health Policy: Would have been useful if it was parallel to the NHP - **Many interventions suggested in SHP 2004 yet to be implemented**		- **Need to relook at the state health policy and revise it in line with the national health policy**
20	**Health Assurance (SAST)**	- Formation of SAST -To avoid duplicity and scope for misappropriation, GoK took a conscious decision to bring all Health Schemes under one umbrella of SAST	- **Limited to only secondary and tertiary care services** -**Limited budget allocation** (500 cr)	- Integrating RBSY, Yeshaswini and Rajiv Arogyashree schemes	- **To build on this successful model and replicate/ upscale it to Primary Health Care as well- Universal Health Coverage** **- increase in budget allocation**
21	**Health Technology & Innovations**	**- Initiation of use of technology in health such as HMIS, Tele-medicine**	- **Limited use of technology** **- Poor use, implementation and monitoring** - The use of technology is not geared towards management of the service	- Bengaluru is the slicon valley and many entrepreneurs and start ups available	- To grow and utilise health technology towards better service delivery such as telemedicine, EMR and HMR, drug logistics, e-partograph etc. - The technology should be

			delivery from the perspective of the personnel delivering the services or the patients receiving those services.		used with bottom-up management approach
22	Health Industry	- Growth of number of hospitals, pharma industry and equipment is seen	**- Not utilised for public healthcare**	- Further growth of hospitals of pharma, hospitals and equipment	**- To increase or improve collaborations with the health industry for appropriate drugs and equipment**
23	Nutrition	-There are programs to provide food grains per month to each member of priority households. -Free meals for pregnant women and new mothers (up to six months after delivery) through the AWCs. -Free meals through local AWCs for children between the ages of six to sixty months. -One mid-day meal, free of charge, on all school working days, for children in the age group of six to fourteen years. -Food security allowance from the state government for persons who do not receive supply of the entitled quantity of food grains or meals. - There are established nutritional rehabilitation centres	- Ineffective implementation of the ongoing programmes: - Inadequate screening and referral for nutritional support at primary health care level. - In spite of effective identification of severely malnourished children at a younger age, only a fraction of them received treatment at NRCs. (October 2012) - Nearly 50% severe stunting was observed by nutritional surveys in the backward districts of Karnataka, in children aged up to three years and 11 months. - Poor implementation of the food supplementation - The quantity and quality of food supplied to AWCs is below par, contrary to the supplementation objective of the programme. - Poor infrastructure and maintenance at the AWCs. - Bal Vikas Samitis do not have a major say in the functioning of the AWCs. - Rightful beneficiaries are	- To stregthen existing programmes and introduce a policy on nutrition - National Nutrition Mission has just been launched	- State and district nutrition missions can be strengthened with good intersectoral coordination and budget allocation so that sufficient pulses and food products are available for provision - Adopting the intergenerational, life cycle approach by addressing the nutritional needs of infants, children, adolescent girls and pregnant and nursing mothers - Increase program coverage by demand creation by involvement of thecommunity - Integrate and monitor multisectoral ongoing programmes - The efficacy of iron tablets and folic acid tablets being given to school children in addressing the problem of malnutrition, the State may be take up food fortification (rice, oil and salt) in Mid-Day Meal Programme in schools and in ICDS in Anganwadies. The fortified oil and salt are available in the market. For

			not completely covered under the ICDS programme - Poor implementation of the MDM Programme - Inadequate monitoring by Vigilance Committees and Food Security Committees, which are inactive.		rice fortification, fortified rice kernels are available from several suppliers. The Government will have to set up blending units in each district. Such initiative for the Mid-Day Meal Programme in four districts is being taken up already by the Education Department.