INTRODUCTION

To facilitate and orient district planning team towards need based planning process and to encourage focused attention for the high priority districts, vulnerable population, disease specific hot spot areas in their respective District Health Action Plans Central teams were constituted by MOHFW for facilitation process in 235 districts across India.

In Karnataka 7 Districts was selected as high priority districts by MOHFW based on composite index, literacy rates, health indicators performance and SC/ST population etc. while State has also identified additional 6 C grade district out of those districts 2 are overlapping and in total in Karnataka there are 11 district (Bellary, Bidar, Kolar, Davangiri, Chittardurga, Gulbarga, Chamrajanagar, Bagalkot, Kopaal, Raichur, Bijapur) of high focus.

Composition of Team:

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Communication made by central team to all districts and state teams:

- Guidelines by MOHFW communicated to all districts
- Pre-appraisal sub-committee of MOHFW dates were communicated which is to be held at Bangalore
- It was communicated that DHAP from these high priority districts has to be presented during Pre-appraisal at Bangalore along with SPIP presentation.
Methodology for Planning Facilitation:

First phase: 21st December to 24th December 2009
During the first phase, one of the team members called all the 7 districts identified by the MOH as priority districts and briefed them what a district planning needs to incorporate this time as per Government of India priority areas. they are:

- Neo Natal Mortality – Facility and Home based care for newborn.
- Population Stabilization
- Vulnerable groups and underserved areas
- Malaria.
- MDR – TB.
- Making facilities family friendly – water, electricity, clean toilets, lights, security.
- Vibrant VHSCs and RKSs.
- NABH/ISO certification of government facilities

On 4th Jan, 10, the team visited to Taulka Hospital, 24x7 PHC of Kolar district (one of the identified high focus district) and interactions with the providers has been made to understand the field situation of the district. Then we made field visits to above districts which included FRUs, CHC, 24x7 facilities, PHCs, subcenters, DHO office and District hospital. We interacted with ASHAs and a few villagers on the service deliveries.

Taluka Hospital - Mullubagal

Observations

- Taluka Hospital is functioning as FRU.
- Earlier the Taluka Hospital was 50 bedded but now it has been upgraded to 100 bedded hospital
- The Sanctioned position of MO is 12 that includes 2 dentist, General Physician, Ophthalmologist, Pediatric -1, Aneasthetist-1 and General Surgeon is 1,
Obstetric and Gynecologist -1, Orthopaedician 1, Skin specialist -1, GDMO-1 and ENT specialist post is vacant

- Amongst Staff Nurse there are 14 filled positions against 20 sanctioned positions
- Number of Deliveries performed during the month of December 09 is -166, 26 LSAS, 8 MTP and No NSV
- Blood Storage unit has all the equipments available but it is still not operationalised
- There is one baby warmer and one phototherapy functional in the facility.
- Availability of 2 ambulances at the FRU
- Prusti Arkya as per State norm for 100 bedded is available at the facility.
- Orthopedic services available only for minor surgeries.
- Bio-Medical Waste Management is weak.
- Untied fund not received for the current year as last year funds were not utilised.
- 35 cases transferred to other facility- due to reasons of complications and 26 conducted at the facility
- BHO office is situated in the same facility, he is in charge of 17 facilities, earlier one PHC was under this facility and now it is shifted to Kurudumalai
- Taluka Officer shared about 3 PHC which are covering SC/ST population of remote and inaccessible areas in 12 villages.

**PHC Thailo**

- It is 24x7 PHC and staffed with only one Medical officer
- Total OPD is 100
- New adult OPD is 30
- MO is not trained in SBA or any other programme but very enthusiastic.
- 2 SC are located near the PHC which are non functional and ANMs of those SCs are rendering the services in this PHC

**District Health Office**

- During the discussions the DHO shared that earlier (before NRHM) there were PHU that have been upgraded to PHC.
• Although state took the step of upgradation but not planned the requisite manpower regarding the norms of the PHC.
• It was shared that Resource envelope is not communicated to the District by the State.
• National Disease Control Programmes do not have clarity on the budget.

We reviewed Kolar District DHAP at Kolar DHO office where all their program officers were present. Went in detail on planning, data support, strategies, activities and budgets. The district has identified under servicing areas and vulnerable groups and made special plans for them as priority. We discussed these issues and activities at length which will be provided later as common findings of these districts.

Overall observations of the field visits: The key features of the health system are:

• Infrastructure is good in most of the districts.
• PHCs, subcenters are more than the prescribed norms of population
• In many places duplication of health facilities
• In some of C category districts, health facilities are less in numbers
• HR deficiencies and Specialists gaps are observed some facilities but overall a better situation.
• Disease control program have no clear budget approvals making this difficult for district program officers to plan well, particularly RNTCP, NVBDCP and IDSP
• Issues in timely release of budgets to disease control program particularly RNTCP

5th January 2010

Followed by this, we have called 2nd phase 11 districts - all the 7 districts and another 4 districts of C category (6 C category districts which identified as most backward districts by Karnataka state, of which 2 are included with MOH 7 backward districts). The districts DHOs, DPMs and state program officers participated in the state level review of DHAPs.

After the formal introduction, Importance of good monitoring and supervisory mechanisms, micro-planning exercises, need based gradation of training of the staff, rational deployment, non-monetary incentives; had been discussed with the district teams.
We have gone through the DHAP first draft of few districts before we called for 2nd meeting and identified the gaps in the DHAPs. All the districts have made power point presentations on their first draft DHAPs and we reviewed district by district. All the districts have wonderfully identified the vulnerable areas, underserved areas and SC/ST population and made special strategies and activities to improve health care service delivery to them.

The State has submitted the first draft on 31st Dec, 2009 to MOHFW and accordingly districts were already prepared and submitted their DAPs to State. The observations and suggestions made on the PIP are as follows:

- There was good description of HR but there was scope to include the sanctioned positions to give more clarity and to identify the HR gap.
- NDCP programme was not addressed in detail even the plan for 24x7 and FRU operationalisation plan was missing in the PIP.
- The DAPs did not clearly spelt out the Sick children and malnutrition strategy. There was more focus on Grade –III and Grade IV strategy rather than controlling/minimizing them at I and II.
- The DHAPs were not addressing the linkages with NGO/CBOs/ Charitable trust ect. For the unserved and underserved areas including the vulnerable areas. The team advocated for NGO participation for vulnerable pockets.

- **Vulnerable area mapping**: The Districts have clearly identified the vulnerable areas like under serving areas, flood affected areas, SC/ST populations (Tandas) remote and inaccessible areas with separate plans, which is appreciable.

The District Teams have mapped information related to vulnerable areas each in their area maps and visualize the strength/ problems/ concerns so that further activity can be planned accordingly. Many districts have done the exercises successfully for even thematic areas also. There was micro operationalisation of activities for some strategies have been also shared by few Districts which were strengthened through discussions. **The central team shared, timeline for execution, monitoring and supervision mechanisms the team suggested for Intersectoral convergence also for overall effectiveness in these areas.** Few examples were: VHND, sanitation, roads, water supply, education to girls etc.
- There was planning for Teen clinics in all the DHAP at PHC level. The Districts do not have clear strategy for the clinics at PHC level, there was a suggestion by the team that first district should plan them for the higher level facility. Instead to focus more on strengthening of ARSH through VHNDs
- There are vulnerable identified flood areas with temporary shelters which are providing MMU services which are acceptable but for underserved and vulnerable areas the MMU are not acceptable rather Districts should plan for static facilities along with the MMU.
- The District not utilized the data to plan the PIPs. Suggestion was improving DHIS data for analysis and support to strengthen the document.
- MMR Projections need to be validated and denominators need to checked
- State authorities advised to negotiate with Medical Colleges to use interns under supervision of Taluka health officers to serve the Vulnerable population and underserved PHC where HR is a problem,
- There was request from Bagalkot for the support from NHSRC to reduce the prevalence rate of HIV in the specified area.
- In Nittoor CHC of Bidsar district Dr, Rajendr was member of the and later elected as Chairman Zila Parishad and joined the CHC as contractual MO afterwards absorbed on the payroll and before his joining the deliveries were 20 /months which increased to 70/month after his joining. He provides free meals to all the PNC for 3 days without support from state resources.( against the norm of the State which does not allow free meal for less than 100 bedded facility)

To create new subcenters in under serving areas with provision of full staff with extra incentives in addition to the services planned to provide by Mobile medical units.

- Training and retraining of ANMs of these areas
- Focus on disease control programs at par with RCH
- Orientation training to all block level health officers on disease control programs with provision of supervisory check lists and periodic monitoring of programs and health facilities
- Operationalisation FRUs with provision of blood storage units. Only NIMHANS is identified as training center for this and the this along waiting list
of candidates. Advised the state to identify more such institutes with support from KSAPS.

- The state has requested for simple format for collating the all the districts plans, hence we have given the simplified structure format to them which was given in UP

- The Maternal Death audits have shown in the state that the major causes of maternal deaths are anemia and PPH. Accordingly the team has advised state to categories the ANC/anemic women based on the HB%. One anemic group below 7gm% as moderately anemic and below 4gm% as severely anemic which need parenteral administration of Iron sucrose or blood transfusion or packed cell volumes. This categorisation will help to strategies the intervention for different level of treatment (IFA supplement/ sucrose supplementation)

- Infant death audit has shown the major causes of Infant deaths are due to low birth weight, asphyxia: This emphasizes the need for delivery protocols to be followed to reduce birth asphyxia mortality and improve nutritional status of women and to reduce infant deaths due to low birth weight.

- It was also suggested to provide complete meals to pregnant women in undeserving areas and vulnerable groups either through ICDS system or the program similar to Velugu in AP state.

- During the discussion with State authorities it was advised to the state MD, NRHM to involve district chairmen of the health societies in convergence activity which is very important for undeserving areas. The MD share that the state is planning for a meeting with CEOs who are chairmen of most of the societies and departments.

There was a presentation by the State MIS team. They have online information till block level and also maps available upto block level. The central team shared that State has lot of rich data that could be utilised for the PIP planning and monitoring. The team emphasized on strengthening situation analysis of the State/districts/blocks by triangulation of HMIS data (from DHIS portal as well as web-portal), DLHS 2 and 3, facility survey reports, CRM feedback.
As model example: Chitrdurga district has highest number of home deliveries in the state with high MMR. When this was analysed there were 3 PHC which have almost 40 to 60% of home deliveries. If these PHC areas are taken care in provision of institutional deliveries with proper support systems like 3 ANCs and referral transport, the percentage of home deliveries and also MMR of the state will come down considerably. Qualitative inputs from the providers and program officers have been incorporated to strengthen the situational analysis of these PIPs. Validation of data while tabulating for situational analysis also been shared with them. Gap identification and prioritization based on situational analysis, field realities and financial matters has been shared with the team with the assistance of central team.

Finance Report:

04.01.2010

FMG member of our team visited State head quarter and met Mr. Narayan Programme Assistant (Accounts) as CFO was not available at office. Some of the points i discussed with him are as follows.

1) Concurrent Audit: It was explained by staff that total 27 districts out of 29 districts in which concurrent audit appointed and district covered .for Bellary and Ramnagar auditor not appointed .State office have one person who compiled concurrent audit report recd .from districts but same was not Sent to fmg. Out of total 27 districts in which concurrent auditor appointed only 14 districts have satisfactory performance.

As explained by person handling concurrent audit at state level major concern of poor performance of concurrent audit is lesser amount of fees which is between Rs2100- 4000.it was endorsed by CFO on 05.01.2010 when i met him. State is proposing Rs.10000 per month in their PIP.

2) Tally –ERP 9.0: It was explained it is implemented in all 29 districts of state as well as state head quarter .All District Accounts Manager is trained in Tally .State is planning ti implement Tally on block in 2010-11.for this state is proposing for
these expenses in their pip, state have total 29 license of Tally at district level and on multiuser at state level.

The CFO has expressed his concern, lack of computer in DHS. As SHS have only on computer which is used by DAM as well DPM hence they are facing problem in using Tally. CFO has one more concern about manpower in implementation of Tally in block level. It was advised them for proposing in their pip for additional computer and manpower as well.

3) **Manpower**: Status have manpower are as under
   
   A) **SPMU** - 5 Persons (State have neither SFM nor SAM one person from state service who is looking after other project is working as CFO)
   
   B) **DPMU** - Out of Total 29 DAMs 27 is filled for balance 2 post is already advertised
   
   C) **BPMU** – Out of total 176 block accountant 171 is filled 5 post is vac ants.

   More ever Block account is from outsource agency M/S OBJECT TECHNOLOGY

4) **E-banking**: State have already implemented e-banking. State is transferring fund to district online further district also transferring und to block electronically. State Bank of Mysore and State Bank of India is two major banks in state. CFO has one concern that state is receiving fund from GOI through ICICI Bank. State is planning open Account of ASHA so that their incentive can be transferred to their respective Account directly.

**05.01.2010**

**Financial Power**: It was pointed out by one of the DHO that they are facing problem in signing cheque from chairman of Arogya Samiti due to which they face problem in making payment. Mission Director of state NRHM advised there is need of orientation of these people.

1) During presentation of HMIS it was observed that in case of JSY there is no bifurcation of Institutional deliveries. It is advised to take action for bifurcation of institutional deliveriws into rural and urban deliveries.

2) It was observed that state has not incurred any expense in following head till 30.09.2009

   a) **CHILD HEALTH** - Rs.300 Cr.
b) ARSH - Rs.40 Cr.  RCH Flexible Pool

c) TRIBAL RCH - Rs.280 Cr.

d) NEW CONSTRUCTION - Rs.3900 Cr.

e) AMG - Rs.50 Cr.

f) PANCHAYATI RAJ - Rs.200 Cr.  Mission Flexible Pool

g) HEALTH INSURANCE SCHEME - Rs.200 Cr.

h) SHRSC - Rs.100 Cr.

i) SUPPORT SERVICES - Rs.1072 Cr.

j) OTHER EXPENSES - Rs.373 Cr.

It was advisable to consider this non utilization in consideration while making PIP.

There is difference in physical data and financial data in case of JSY for the period April to Nov '09.