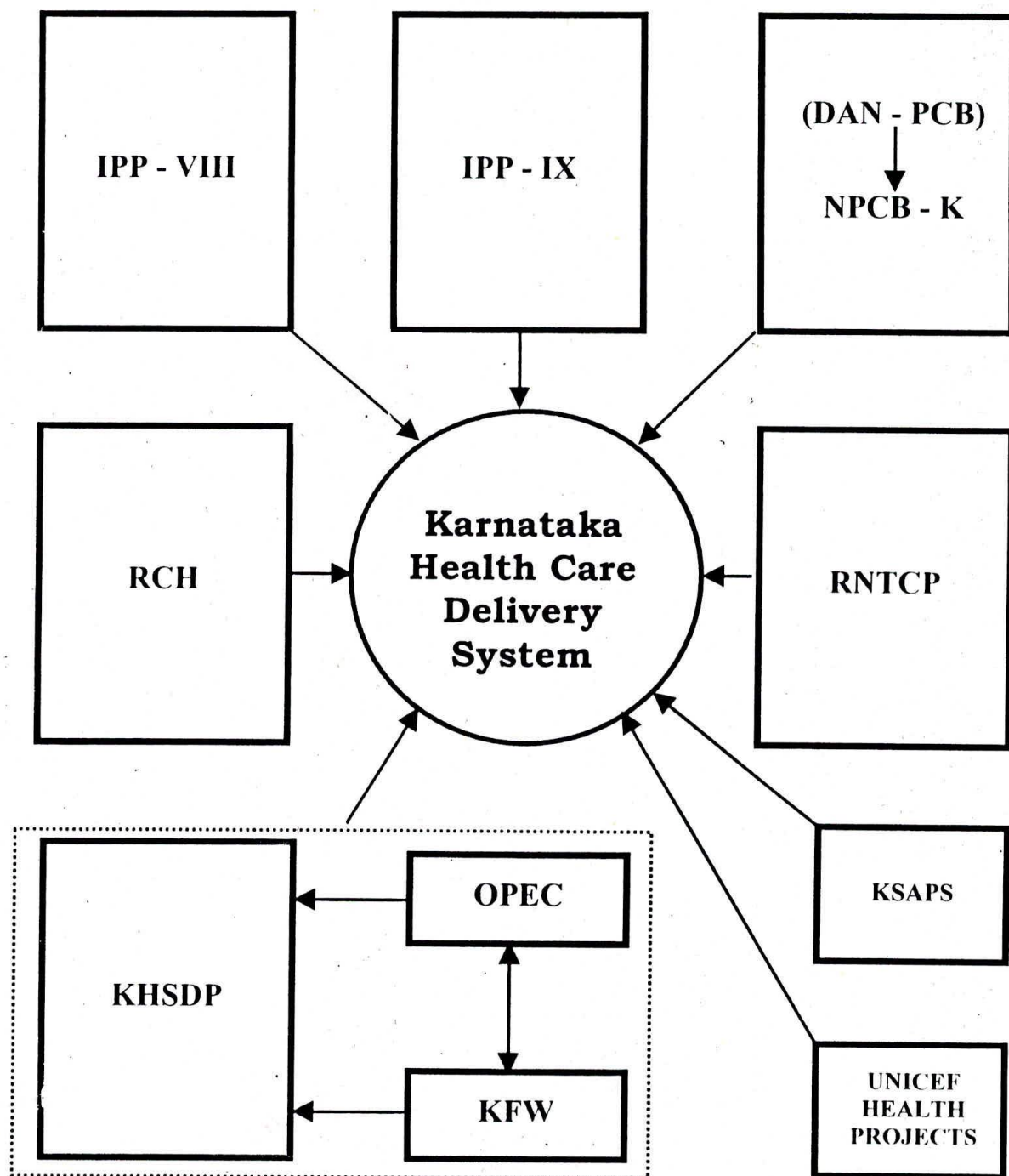


**Review of  
Externally-Aided-Projects  
in the context of their integration into  
Health Service Delivery in Karnataka**



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**Community Health Cell,**  
Society for Community Health Awareness, Research and Action,  
Bangalore, Karnataka.

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**PROJECT REPORT: Review of Externally – Aided – Projects (EAPs) in the context of their integration into Health Service Delivery in Karnataka.**

**A: Introduction**

Since the early 1970's the Karnataka Government has negotiated and received various grants and loans from international funding agencies, including the World Bank, for health related projects that supported the growth and strengthening of primary and secondary health care services in the state. These externally aided projects have had their own particular focus; objectives; framework; operational strategies; and management information systems geared to support and or enhance both quantitatively and qualitatively, different aspects of Health Sector Development in the state. Each of them has their own cycles of mid-term reviews and concurrent reviews. The Human Development in Karnataka Report 1999 described five of these (see box).

Currently there are however atleast ten major externally aided health projects in the state- IPP VIII, IPP IX, KHS DP, OPEC, KfW, RCH, RNTCP, NACO, NLEP, DAN-PCB being implemented through the Government and Directorate of Health and Family Welfare Services. In addition UNICEF has provided project support to different health related sectors including Child Development and Nutrition; Water and Environmental Sanitation; Education; Child Protection; Communications and Strategic Monitoring. For the purpose of this Review all UNICEF Projects have been taken together as one and NLEP has been left out for unavoidable reasons. Health related externally aided projects, e.g. for nutrition, water supply and sanitation, implemented through other departments are not included under the scope of this review.

The Karnataka Task Force in Health, while reviewing these projects in their interactive and informal discussions and deliberations have raised some important questions for review and enquiry:

- i) What are the learning points from each of these projects?
- ii) How can they be integrated into the health system incorporating beneficial points and avoiding distortions.
- iii) What has been their experience concerning issues of sustainability, accountability and transparency.

In the late 1990's, policy researchers, academicians and decision-makers have also begun to seriously review the "piecemeal pursuit of separately financed projects" as against 'the evolving options of more appropriate sector wide approaches'. This is linked to the growing recognition of some of the problems associated with single

### Important externally assisted health projects

Karnataka Health Systems Development Project (KHSDP)	The Karnataka Health System Development Project is proposed to be implemented over five years (1996-2001) with assistance from the World Bank. Its main objectives are improvement in the performance and quality of health care services at the subdistrict and district levels, narrowing current coverage gaps and improving efficiency. Major components include improvement of the institutional policy framework, strengthening implementation capacity, development of a surveillance system, extension and renovation of all secondary level hospitals, improvement of their clinical effectiveness and establishment of a properly functioning referral system. The project outlay is Rs. 546 crores.
Kreditanstalt fur Wiederaufbau (KfW)	The KfW of Germany is financially assisting a project in the four districts of Gulbarga division with objectives similar to those of the KHSDP. The project outlay is Rs.59 crores of which 90% is being provided by KfW as a grant. The project was launched in 1998.
India Population project (IPP) VIII	IPP VIII is being implemented in the slums of Bangalore since 1993-94 with World Bank assistance. Major objectives are improvement in maternal and child health and reduction of fertility among the urban poor. Strategies adopted include involving the community, improving the quality of services provided by the City Corporation, strengthening existing delivery services, establishing new facilities and providing services at the doorsteps of the urban poor. The project cost is Rs.39 crores.
India Population project (IPP) IX	This is the fourth in the series of India Population projects following IPP I and IPP III. The project is under implementation since 1994 in 13 districts. The main objectives are reduction in the crude birth and death rates as well as the infant and maternal mortality rates and increase in the couple protection rate. Strategies adopted include the promotion, strengthening and delivery of services through the involvement of the community and improvement in the quality of services by providing training and strengthening the monitoring and evaluation systems. The project outlay is Rs. 122 crores.
Reproductive and Child Health Services (RCH) Project	<p>The Reproductive and child Health Services Project marks a change in the existing culture of achieving targets by shifting to a policy of provision of quality services. The project helps clients meet their own health and family planning needs through the full range of family planning services. It is a natural expansion of the earlier child survival and safe motherhood programme which was under implementation till 1996. It also includes the treatment of reproductive tract infections, sexually transmitted infections and the prevention of AIDS. All the districts of the state are proposed to be covered under the project.</p> <p>The budget for RCH project for five years (1997-98 to 2002-03) is Rs. 190 crores.</p>

Source : Human Development in Karnataka – 1999



focus sector project assistance, which include:

- Fragmentation;
- Conflict and or duplication;
- Donor driven agendas;
- Recurrent operational costs;
- Undermining of national capacities,
- Lack of flexibility,
- Varying standards of provisions, and
- Issues of ownership.

This short-term interactive review has been undertaken to explore some of these issues and address these concerns in the context of the Task Force recommendations for the Health Sector development policy for the state.

Within the time constraints, the researchers have tried to achieve the following:

- a) Review all the externally aided projects not just individually but in their collective context reviewing available documentation as well as interacting with programme managers.
- b) Using a SWOT approach, trying to identify the key strengths, weaknesses as well as opportunities and threats (distortions) from all these projects.
- c) Trying to do this review in such a way so that the stakes of programme managers and hopefully the Health Directorate to learn from project experience and address seriously the concerns and issues of sustainability and integration are enhanced especially by improving in-house capacity and system development.

(See Appendix "A" for Project protocol and issues and questions to be addressed.)

2. Programmes/Projects  
While some are state components of GOI programmes (RCH, RNTCP, NPCB, <sup>KHSDP, UNICEF</sup>); others are state level projects (e.g. KHSDP, IPP-VII, IPP IX, KfW, OPEC,)

### **B: General Description of EAP's**

**Table I** shows the 10 EAPs included in the review. From the table the following key general observations on EAP's in Karnataka can be made.

#### **1. Number**

- There are ten EAP's which contribute to the Health Service Delivery in the state. (NLEP has not been included in the review fully).

#### **2. World Bank : Main player**

- While UNICEF and DANIDA have been long standing partners since 1970's the World Bank has become the key partner now supporting six out of the ten projects (this is particularly so since the 1990's) and there is reason to believe that since the World Bank takes over as the key player the other funding partners are getting somewhat sidelined or ignored.

#### **3. Grant to Loans in the 1990's**

- While the earlier bilateral donors were providing grants like UNICEF and DANIDA, the trend in the 1990's has increasingly moved towards mainly loans rather than grants with varied interest rates and associated conditionalities. The World Bank support being mainly in this category it is therefore even more important today to ensure that these loans are utilized efficiently with greater accountability and transparency since if they were misutilised then we would have the double problem of ineffective utilization coupled with a debt burden.
- The German government (KfW) and the Organisation for Petroleum Exporting Countries through the OPEC fund have joined World Bank in supporting primarily infrastructure development. The former is a grant and the latter is a soft loan to be paid over a twelve year period after a five year initial gap.

#### **4. Stand alone**

- Each of these projects are relatively distinct entities with clear cut objectives, framework, programmes and though they have to be complementary or supplementary to each other due to overlap at the field level (similar districts, health centres, health teams) this is not at all emphasized in the project reports or built into their outlines. There is a fair degree of compartmentalization and hence they mostly stand alone with little dialogue between projects and seldom visualized as smaller components of a larger strategic plan.

Even though presently the KfW project utilizes the engineering division and other resources from KHSDP, this linkage was not originally planned and took place only because the ZP engineering divisions envisaged to make decentralised decisions could not maintain requisite standards.



TABLE - I

**Externally Aided Projects in Health Service Delivery in Karnataka  
GENERAL DESCRIPTION**

S.No / Name	Year of Starting	Short Description <i>Main Source of Funds *</i>	Total Amount of Grant/Loans in Rs. <i>Project size</i>	Period
1. India Population Project IPP VIII (Family welfare - urban slums project)	1993-94	<u>World Bank</u> Improvement in MCH & Fertility Reduction in Bangalore's urban slums <i>Extended to 11 cities and towns due to savings and differences in Foreign exchange conversion rates.</i>	39 Crores (387.2million) Loan <i>Part Loan / Part Grant</i>	1993-2001 (in phases)
2. India Population Project IPP IX (Strengthening of Family welfare and MCH services)	1994	<u>World Bank</u> Reduction in CDR/ CBR & IMR in Rural areas through PHC Strategy. (13 Districts)	122 Crores (1220.9million) Loan <i>Part Loan / Part Grant</i>	Launched in 1994
3. Karnataka Health Systems Development Project (KHSDP)	1996	<u>World Bank</u> Improvement of Quality and Performances of Health care at District and subdistrict level	546 Crores (109 per year) Loan <i>Part loan / Part grant</i>	1996 -2001 5yrs
4. Kreditanstalt fur Wiederaufbau(KfW)	1998	<u>KfW of Germany</u> Improvement of Quality and Performance of Health care at District and subdistrict level (Gulbarga Division 5 backward districts)	59 Crores ( 0.38 million DM) Grant	Launched in 1998
5. Organisation of Petroleum Exporting Countries Fund for International Development (OPEC)	1991	<u>OPEC Fund</u> 350 Bed Multi specialty hospital in Raichur.	29.25 Crores (OPEC - 90% 25.7 crores) Soft loan	Agreement in 1991
6. Reproductive and Child Health Services (RCH) Project	1997	<u>World Bank</u> Improving Quality of Family Welfare Services	190 crores 38 crores/year. <i>Part Loan / Part Grant</i>	1997 - 98 - 2003
7. Karnataka States AIDS Control (Karnataka State AIDS Prevention society)	1999	<u>World Bank</u> Reducing the rate of growth of HIV infection in the state and in strengthening the states capacity to respond to HIV/ AIDS	7 Crores (2000-01) Loan <i>Part Loan / Part Grant</i>	1999- 2004

S.No / Name	Year of Starting	Short Description <i>Main Source of Funds</i>	Amount of Grant/ loans in Rs.	Period
8. Revised National TB control programme (RNTCP)	1994	<b>World Bank</b> Supporting new approaches to effective TB control in state using SCC/ DOTS and other components.	Phase III 18.3 Crores Loan <i>Part Loan / Part Grant</i>	1994- Neelasandra 1998 Entire Bangalore corporation 1996 - Chitradurga Bellary Raichur Bijapur 1999 - Davangere Koppal Bagalkote
9. National Programme for control of blindness (DANPCB) now NPCB - K	1990	<b>DANIDA</b> To reduce prevention of blindness from 1.4% to 0.3% by 2000 AD	3 Crores 30 million Loan <i>Grant</i>	<i>Till 2001</i>
10. UNICEF-GOK Programme of Cooperation in 2001.	1970's	<b>UNICEF</b> To promote comprehensive and holistic survival, growth and development of children in the state	6.3383 Crores (2001) Grant	<i>UNICEF has been supporting continuously since 70's</i>

*\*\* See Table Ia and Ib for further details.*

*\* All these projects have a contribution from state or central government respectively.*



### **C: Project Goals, Focus and Distribution of EAP's**

A perusal of **Table II** on the project goals, focus and distribution helps to identify certain significant trends.

#### **1. Primary Vs Secondary**

- <sup>7</sup> 8 out of 10 projects support Primary Health care <sup>level</sup> while 3 out of 10 projects support secondary care <sup>level</sup> (one of three also support Tertiary care).
- If the project costs / budgets are taken into account as a sign of priority or emphasis then only thirty three percent <sup>(33% cron. u.)</sup> is on primary care and sixty six percent <sup>(66% cron. u.)</sup> focussed on secondary and tertiary care. (Using project <sup>size</sup> outlays as a general indicator)

#### **2. Comprehensive Vs Selective**

- Within the Primary Health Care group <sup>two</sup> three of the projects IPP-VIII, IPP IX and UNICEF are more comprehensive in their design focussed on 'Urban and Rural' primary health care and child health (and social development) respectively, but the remaining five are more selective primary health care strategies with RCH being a slightly more composite package and the remaining three being focussed vertically on single disease problem of AIDS, TB, and Cataract Blindness.

#### **3. Population agenda**

- Even IPP VIII and IPP IX which are more comprehensive than the others are strongly driven by the Family planning or population agenda with health needs other than fertility related, getting much less focus.

#### **4. Diversity and overlap**

- When the objectives and goals of these EAP's are reviewed collectively then the following observations can be made (refer **Table II**)
  - Each project is relatively multidimensional with different components and strategies. At the implementation level some components get more emphasized than others.
  - The objectives vary from very general ones to very specific outcome oriented ones as seen in AIDS, TB, and Blindness control.

TABLE - II

**Externally Aided Projects in Health Service Delivery Karnataka  
OBJECTIVES/ FOCUS / REGIONAL DISTRIBUTION**

S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
1. IPP VIII	<ul style="list-style-type: none"> <li>• Delivery of FW &amp; MCH to urban poor and promote CS &amp; SM.</li> <li>• Reduce Fertility rate and promote late marriages.</li> <li>• Promote male participation in FP.</li> <li>• Awareness and action for personal hygiene, better environment and prevention of diseases</li> <li>• Non Formal Education (NFE) and vocational training for women</li> <li>• Promote Female Education</li> </ul>	<ul style="list-style-type: none"> <li>• Urban Poor / Primary Health Care <i>Selected focused on</i> (FW+MCH+CSSM+ )</li> </ul>	<ul style="list-style-type: none"> <li>• Bangalore urban slums.</li> <li>• 0.851 million population of urban poor in about 500 slums in an area of 225 sq. kms.</li> </ul>
2. IPP IX	<ul style="list-style-type: none"> <li>• Implement a program sustainable at village level to reduce CBR, IMR and MMR and increase CPR (Couple protection rate) through</li> <li>• Involve community in promoting delivery of family welfare services.</li> <li>• Strengthen delivery of services by support to drugs, kits, supplies to TBA's SC and PHC, mobility of ANM's; buildings of center and residential accommodation.</li> <li>• Training to Personnel and TBA's, Community leaders and voluntary workers.</li> <li>• Strengthen Monitoring and evaluation by MIES (from district to state level )</li> </ul>	<ul style="list-style-type: none"> <li>• Rural (Family welfare and MCH)</li> <li>• Primary Health care Focus</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Civil works Focus</u> Bellary, Chickmagalur, Dakshina kannada, Hassan, Kodagu, Mandya, Mysore, Uttar kannada, Shimoga, Chitradurga, Belgaum, Bijapur, Gulbarga</li> <li>• <u>IEC / MIES Focus</u> In all districts</li> </ul>



S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
3. KHSDP	<ul style="list-style-type: none"> <li>Improvement in performance and Quality of Health Care services at District and Subdistrict level</li> <li>Narrowing the current coverage gaps by facilitating access to health care delivery.</li> <li>Achievement of better efficiency in the allocation and use of health resources.</li> </ul> <p>By</p> <ul style="list-style-type: none"> <li>-Strengthening implementation capacity.</li> <li>- Strengthening delivery of service.</li> <li>- Improving functioning of referral.</li> <li>- Establishing effective surveillance system.</li> <li>- Improvement of cost recovery mechanisms.</li> <li>- Improving access to disadvantaged sections SC/ST/women</li> </ul>	<ul style="list-style-type: none"> <li>Secondary level health care</li> <li>- To provide critical support to PHC Networks</li> <li>- Establish essential linkages with tertiary level.</li> </ul>	<ul style="list-style-type: none"> <li>31, District General Hospitals</li> <li>15, Hospitals for specific disease and special problems.</li> <li>165 Taluk hospitals, (24, hospital upgrading casualty wards)</li> </ul> <p>Totally - 211 hospitals</p> <p><u>Renovating = 70</u></p> <p>CHC - 14</p> <p>Taluk Hosp. 34</p> <p>Sub Dist HQ Hosp - 9</p> <p>District Hosp - 6</p> <p>Women &amp; Children Hosp - 5</p> <p>Epidemic Disease Hosp - 2</p> <p><u>Extending = 131</u></p> <p>CHC - 28</p> <p>Taluk Hosp. - 71</p> <p>Sub Dist HQ Hosp - 16</p> <p>District Hosp - 9</p> <p>Women &amp; Children Hosp - 6</p> <p>Epidemic Disease Hosp - 1</p> <p><u>Grand Total = 201</u></p>

S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
4. KfW	<ul style="list-style-type: none"> <li>• Significant Improvement in the Health status of socio-economic backward region / state.</li> <li>• Setting up a Comprehensive referral system in the division through strengthening and revamping secondary hospital network.</li> <li>• Sustainability of Infrastructure and Equipment.</li> <li>• Increase Sustainability of Health care.</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Secondary level</u> Gulbarga district. (Northern disadvantaged districts)</li> <li>• Renovation and upgradation of facility.</li> <li>• Improvement of Maintenance</li> <li>• Improving Sustainability through fee collection.</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Gulbarga Division</u> Bidar - 6 hospitals Bellary - 10 Gulbarga - 18 Raichur - 13 47 hospitals</li> <li>26 in Phase One 21 in Phase Two</li> </ul>
5. OPEC	<ul style="list-style-type: none"> <li>• To build a 350 bed multi speciality hospital which will cater to Raichur District and four districts around. (Med/Surg/ENT/ ortho Physiotherapy, Cardiology / Cardiothoracic, Ophthal, Dental, Nephrology, Urology, Burns wards, Gastroenterology, Biochem, Path, Microbiology Radiology and CSSD).</li> </ul>	<ul style="list-style-type: none"> <li>• Secondary and Tertiary health care</li> <li>• Old District hospital will remain as a women and children hospital with skin, psychiatry, Leprosy and TB (250 beds)</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Raichur</u> - / Gulbarga, Bidar, Gadag, Bijapur (and some neighbouring districts of AP will be benefited.</li> </ul>
6. RCH	<ul style="list-style-type: none"> <li>• To meet individual client health and family planning needs and to provide high quality services through a gender sensitive and responsive client based approach.</li> <li>• Aim to reduce the burden of unplanned and unwanted child bearing and related mortality and morbidity</li> <li>• Reducing 'unmet need' increasing 'service coverage' ensuring quality of care.</li> </ul>	<ul style="list-style-type: none"> <li>• Selective Primary Health Care with focus on Reproductive and child health.</li> <li>• Prevention and Management of unwanted pregnancies.</li> <li>• Maternal care <ul style="list-style-type: none"> <li>- Antenatal</li> <li>- Natal</li> <li>- Post natal</li> <li>- Child survival</li> <li>- Treatment of Reproductive tract infections and STDs.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• All districts in 3 years.</li> <li>• Districts categorized into A, B, C category A = better off B = average C = weaker</li> <li>• 1<sup>st</sup> year = 9 District A2, B1, C3 2<sup>nd</sup> year = 8 Districts A1, B4, C3 3<sup>rd</sup> year = 3 Districts B3</li> <li>(Rationale of selecting districts not clear).</li> </ul>



S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
7. KSAPS	<ul style="list-style-type: none"> <li>To assist state in reducing the rate of growth of HIV infection and strengthen capacity to respond to HIV / AIDS on a long term basis.</li> <li>This includes: <ul style="list-style-type: none"> <li>- Delivering cost effective prevention against HIV / AIDS</li> <li>- Promotive intervention for general community.</li> <li>- Low cost AIDS care.</li> <li>- Institutional strengthening.</li> <li>- Intersectoral coordination.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Selective Primary Health Care /AIDS / HIV Control <ul style="list-style-type: none"> <li>- Surveillance and clinical Management.</li> <li>- Sentinel Surveillance</li> <li>- Blood safety programme.</li> <li>- STD control</li> <li>- IEC</li> <li>- NGO coordination</li> <li>- Training programmes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>14 sentinel sites in 10 districts</li> <li>25 NGO's in 9 districts (15/25 in Bangalore)</li> <li>30 STD clinics in 21 districts.</li> </ul>
8. RNTCP	<ul style="list-style-type: none"> <li>Detect atleast 70% of estimated incidence of smear – positive cases through quality sputum microscopy.</li> <li>Administer standardized SCC under DOT during intensive phase and quality supervision during continuation phase.</li> <li>Achieve 85% cure rate among all newly detected sputum positive cases.</li> </ul>	<p>Selective Primary Health Care including</p> <ul style="list-style-type: none"> <li>Strengthening and reorganizing state TB control unit.</li> <li>Rigorous method for detection treatment and monitoring.</li> <li>Strengthening training research capacity</li> <li>Targeting smear Positive cases.</li> <li>SCC with DOT</li> <li>Decentralizing service delivery to Periphery</li> <li>Rigorous system of patient recording and Monitoring.</li> </ul>	<ul style="list-style-type: none"> <li>Initially Bangalore Urban only Now 7 districts of Chitradurga, Bellary, Raichur, Bijapur, Mandya, Bangalore urban (excluding BCC area)</li> </ul>

S.No/ Name	Objectives/ Goals	Focus	Regional Distribution
9. DANPCB Now NPCB-K	Reduction in the prevalence of cataract blindness from 1.4% to 0.3% by 2000 AD	<ul style="list-style-type: none"> <li>- Selective Primary Health Care and Secondary care.</li> <li>- State Ophthalmic Cell</li> <li>- Upgradation of Medical colleges, District hospitals, Taluk hospitals, mobile units and PHC's</li> <li>- Eye Bank</li> <li>- Training of surgeons and ophth assistants.</li> <li>- District Blindness control societies.</li> <li>- Cataract surgeries</li> <li>- Microplanning</li> <li>- IEC, MIS, SES</li> <li>-</li> </ul>	<p>Focus on all districts in all divisions.</p> <p>(Performance very good in Bangalore urban Udipi, Bagalkot, Dharwar, Gulbarga.</p> <p>Very poor in Chitradurga, Chamrajnagar, Kodagu, Gadag, Haveri, Belgaum, Bijapur, Davangere).</p>
10. UNICEF - GOK	<ul style="list-style-type: none"> <li>• To promote comprehensive and holistic survival, growth and development of children in state through</li> <li>- Improved new born care.</li> <li>- Development protection and early stimulation of vulnerable 0-3 years.</li> <li>- Enjoyable and quality education for pre school and primary level.</li> <li>- Access to clean water and sanitary environment.</li> <li>- Protection from child labour.</li> <li>- Improved Nutritional status.</li> <li>- Better child care practices.</li> </ul>	<ul style="list-style-type: none"> <li>- Multidimensional child health care and social development. (Primary Health care)</li> <li>• Community, convergent action (CCA)</li> <li>• Health Action</li> <li>• Child Development and Nutrition.</li> <li>• Water and Environmental Sanitation.</li> <li>• Education</li> <li>• Child Protection (Sericulture and Bonded labour)</li> <li>• Communication and strategic planning.</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Different Districts</u></li> <li>• <u>CCA</u> - Mysore, Chitradurga, Gulbarga and Raichur.</li> <li>• <u>Health</u> - Bidar, Raichur, Gulbarga and Bijapur.</li> <li>• <u>School sanitation</u> Mysore, Tumkur, Chitradurga. and Raichur</li> <li>• <u>Other Activities</u> In all districts</li> </ul>



- There is overlap between projects in different areas e.g.
  - IPP IX and RCH have fair degree of overlap
  - Training overlaps in many of them. (see also case study)
  - Also IEC and MIS
  - Surveillance and Health Management Systems especially since they often focus on same districts, same categories and same health centres and teams. (This will be considered again later).

## **5. Equity Focus**

- The focus on disadvantaged or marginal groups in the community varies from explicit to ambiguous. In IPP VIII (Urban poor) and KHSDP (disadvantaged sections /ST/SC/women) it is more explicit while in all the others it is ambiguous, mostly with a sort of 'reaching all' focus. In RCH there is specific reference to 'Gender sensitivity' and in UNICEF's programmes focus on 'child labour' is emphasized, which are significant.
- In terms of addressing Regional disparities in health structures and systems in the state, EAP's have a very varied contribution
  - KfW and OPEC are specifically focussed on the disadvantaged Northern Karnataka (Gulbarga Division), though the donor decided this focus in the latter loan, not the state.
  - IPP VIII is focussed on urban poor in Bangalore being the largest urban conglomeration in the state though in the next phase other cities and towns are being covered.
  - KHSDP, KSAPS, NPCB-K focus more widely.
  - Others like IPP IX, RCH, RNTCP and UNICEF do focus selectively on some districts more than others for different components, but while the disadvantaged Northern Districts of Karnataka do get included quite often, the focus is not based on data for regional disparities or need, but seem more adhoc, responding to more extraneous pulls and pushes for selection including districts patronized by politicians or other 'lobbies' or other such non-technical reasons.

## **6. Local and National Agendas**

- Finally except OPEC and KfW which are only Karnataka determined and focussed; and KHSDP which is Karnataka focussed but has counter parts in Punjab, West Bengal and now Orissa; all the other projects are similar to those promoted by the funding agencies in other states as well. Many like RNTCP,

AIDS, NPCB-K, perhaps even RCH and IPP IX are evolved as framework / packages at National level and then offered to the state as a 'fixed package deal'. Sometimes the state directorate and experts have tried to modify or review these national level prescriptions and tried to adapt them to state level realities but by and large this process of adaptation is rather weak and adhoc.

- However while the sense of ownership by the state was very strong in KHSDP / OPEC / IPP VIII it was relatively much less in the others and very little perhaps in RCH which showed absence of stakes in planning and formulation.
- Incidentally in IPP VIII especially in the sector of innovative schemes there are different approaches and schemes being tried out in Bangalore, Hyderabad, Delhi and Calcutta – a diversity which was both welcome and significantly different from the usual 'central top down' prescribed packages.
- Regional disparities between states and within states are so stark that greater emphasis on District level planning in the context of local socio-epidemiological evidence and situation analysis is an important policy imperative. EAP's could well be an instrument to experiment with such diversity of approaches.

**Status of Bank Group Operations in India (March 31, 1999)**  
**Original Amount with US\$ (Millions)**

Sl. No	Project	Fiscal year	IBRD	IDA	Cancel	Un disbursed	Develop Obj	Implemental Projects
1	Population VIII (IN-PE-9963) *	1992	-	79.00	-	55.86	S	S
2	National Leprosy Elimination (INPE-10424) *	1993	-	85.00	9.07	24.71	S	HS
3	Karnataka Water Supply and Environment Sanitation (IN-PE-10418) *	1993	-	92.00	-	31.64	S	S
4	Population (IN-PE-10457) *	1994		88.60		50.16	S	S
5	Blindness Control (IN-PE-10455) *	1994		117.80		81.38	S	S
6	State Health System II (INPE-35825) *	1996		350.00		263.11	S	S
7	Reproductive Health (IN-PE-10531) *	1997		248.30		233.16	S	S
8	Malaria Control (IN-PE-10511) *	1997		164.80		152.45	S	U
9	Tuberculosis Control (IN-PE-10473) *	1997		142.40		128.63	S	U

S – Satisfactory, U – Unsatisfactory and HS – Highly Unsatisfactory

Note: This table is not specific to Karnataka but is an overview of the All India situation. Projects which are relevant to Karnataka are shown by an asterisk.

Source: Report No. 18918-1 N Project Appraisal Document May 13 1999.



## **D: Overview of Programmes and Activities**

- **Table III** provides an overview of the overall focus of the programmes and activities using budget headings including special programmes and allotments. About 34 components were identified of which 13 were the commonest in all the 9 projects (UNICEF was excluded in this table). These were

### **6 and more than 6 out of 9**

- Construction;
- Furniture;
- Equipments;
- Drugs and supplies;
- Local training;
- Local Consultancies;
- Maintenance of Vehicles and Equipment;
- Contingencies.

### **4 and less than 6 out of 9**

- Staff salaries
- Vehicles
- Management Information System (MIS)
- Information - Education - Communication (IEC)
- Project management
- NGO support.

- **Hardware over Software**

The main focus of most of these have been hardcore infrastructure development (Buildings, Equipment, Vehicles etc) and though software- like training, IEC, MIS and NGO support were included and envisaged, at the operational level, hardware always got greater focus than software. Also hardware was seen as absolute necessity so often as in IPP IX and KHSDP, constructions were focussed upon rather than initiating some of the software using locally available facilities and resources concurrently. Also hardware investment was substantial and needed greater supervision and control distracting from software development which however is probably more important if long term sustainability is to be thought off.

- **Inadequate quality improvement focus**

Another feature of the overview findings are that some elements which contribute to improving quality especially at operational or performance level were not always included in the project design and cost allotments.

These included

- Provision for books and training materials;

**TABLE III**  
**Externally Aided Projects in Health Service Delivery in Karnataka**  
**COMPONENTS OF PROJECT PROGRAMMES AND ACTIVITIES FOCUS**  
**(Review of Budget Headings)**

Sl No	Component	IPP-8	IPP-9	KHSDP	KfW	OPEC	RCH	KSAPS	RNTCP	NPCB-K	Score
1	Land Purchase / prepn	+				+					2
2	Construction	+	+	+	+	+	+		+		7
3	Furniture / Equipment	+	+	+	+	+	+	+	+	+	9
4	Drugs and supplies	+		+	+		+	+	+		6
5	Vehicles	+	+		+		+		+		5
6	Training (Local)	+		+	+		+	+	+	+	7
7	Consultancy (Local)	+	+		+	+	+		+		6
8	Training (Foreign)	+	+								2
9	Consultancy (Foreign)	+									1
10	Books / Training Mtrls	+	+								2
11	Innovative schemes	+	+								2
12	Additional staff-salaries	+					+	+	+		4
13	IEC Materials prodn		+				+	+	+	+	5
14	Revolving Fund		+								1
15	Maint Vehicles & Eqpt	+	+	+	+				+		5
16	Training Material		+							+	2
17	Evaluation studies		+						+		2
18	Kits		+			+					2
19	Video / Media		+								1
20	Waste Handling			+							1
21	Surveillance			+				+			2
22	Safety Net for Disadvan			+							1
23	Improving women health	+		+							2
24	MIS		+	+			+		+		4
25	Design and Engineering				+						1
26	Project Management	+	+	+	+						4
27	Sustainability				+						1
28	Contingencies	+	+	+	+	+				+	6
29	NGO support	+					+	+	+	+	5
30	Blood safety							+			1
31	Voluntary testing							+			1
32	Adolescent Health						+				1
33	Remunerations									+	1
34	School Health									+	1



- Training material development;
- Innovative schemes;
- Revolving funds;
- Evaluation studies;
- Documentation.

Very few projects had them as special allotments. No doubt some may have spent on these items under other budget heads but allotment of a budget need for any programme activity is definitely a sign of priority or significance.

- **Equity focus**

Finally special focus on poor, disadvantaged and on women was mentioned in many projects but only in IPP VIII and KHSDP were their specific programmatic allotments for women orientation and involvement (IPP VIII and KHSDP) and for safety net for the disadvantaged (KHSDP). Only a special allotment can ensure that the thrust is part of operational policy.

- **Additional items**

However since there were variations in the focus of the health problems addressed by different projects specific allotments for specific additional themes were observed. These included waste handling (KHSDP); Blood safety and voluntary testing and counseling (KSAPS); Adolescent Health (RCH); School Health (NPCB-K) all very important and significant. Some elements like school as a focus of health activity should be a compulsory component of all health projects because preparing / orienting future citizens is a policy imperative.

- **Learning from previous experience and each other**

While UNICEF schemes were not included in the table their allotment to a range of themes around child health exemplified a much more holistic; practical and operational approach. The programme highlights included convergent community action; border cluster strategy for MCH and ICMI (Integrated Management of Childhood Illness); Child development and nutrition; Water and environmental sanitation; *Janashala*, programme child labour protection; HIV / AIDS prevention activities, etc.

**NB:** It is unfortunate that UNICEF's longer experience of moving from 'biomedically defined technological approaches' to more 'holistic initiatives responding to broader socio-economic cultural realities' has been totally ignored and World Bank's 'selective prescriptions and initiatives' allowed to distort health planning and in many cases leading to a reinventing of the wheel. Dialogue between project funders and building on past experiences is crucial otherwise EAP's could be a wasteful distortion and also being 'loans' rather than 'grants' could be wastefully counter productive.

## **E : Overall Strengths and Weaknesses of EAP's**

**Table IV** lists out the key strengths and weaknesses of different programmes as identified by literature review and endorsed by interactive discussions. They vary from programme to programme and cover wide range of sectors and issues.

### **Strengths**

Taken as a composite group the key strengths of these projects are:

#### **1. Infrastructure development**

They have focussed primarily on infrastructure development, which includes buildings for hospitals and health centres, operation theatres, staff quarters etc. While these were necessary since the directorate had not invested in adequate maintenance of existing infrastructure nor invested in adequate construction to fill up the lacunae in the past, the demands of infrastructure often have tended to overshadow all aspects of the project.

#### **2. Support field action**

In the situation when programme action budgets are shrinking with salaries taking over greater and greater percentage these projects help to promote specific action components and field activities.

#### **3. Framework of strategy : planning capacity enhanced**

Conceptually whether primary or secondary, comprehensive or selective, many of these projects have led to generation of some framework of strategy and action and have been supported by a degree of background homework. Though the data base is often patchy it is better than some of the adhoc decisions in the past which were often repetitive without adequate evidence or data. Project formulation including setting objectives; outlining strategies; identifying action plans; identifying outcome and impact indicators and benchmarks all have helped build planning capacity even though the compartmentalization causes overlap and some distortions.

#### **4. Innovations**

Project autonomy, which is relative has allowed many innovations to be experimented with, which is a change from the routine generalized top down prescriptions thrust on the whole system in different districts uniformly and at all levels in the past. All the innovations cannot be listed out here but from the table some of them need to be highlighted. These are

- a. Link workers (IPPVIII)
- b. Women's clubs (SHE clubs) – IPP VIII
- c. Gender sensitivity and women's orientation – IPP VIII



- d. Herbal gardens – IPP VIII
- e. Help desks and Boards of visitors – IPP VIII
- f. Tribal ANM training – IPP IX
- g. Partnership with NGOs to run centres, (IPP VIII, IPP IX, RCH and KSAPs)
- h. Special interventions for disadvantaged – yellow card, KHSDP
- i. Comprehensive MIS being evolved – KHSDP
- j. Improvement of referral links - KHSDP
- k. Good mechanisms for construction and supervision – KHSDP
- l. Efforts at quality improvement (IPP VIII, KHSDP)
- m. Focus on women specific and budget heading (KHSDP)
- n. Decentralization of accounts (KfW)
- o. Focus on Northern disadvantaged districts (KfW, OPEC, RCH, UNICEF)
- p. Links with Literacy campaign (RCH)
- q. Focus on adolescent age group (RCH)
- r. Partnership with private sector – some contract services (KHSDP)
- s. Involvement of Medical colleges (RCH, UNICEF)
- t. Newsletters (KHSDP)

Many more may be there but these are a representative sample. However there seemed little effort at documenting these 'innovations' and even less on monitoring or evaluating them in any sort of methodical or rigorous way. It is important to ensure that they add value in quality and efficiency to the existing PHC option programme before they get adopted by the whole system as an added innovation.. This element of operational research was significantly absent.

### Weaknesses

The key overall weaknesses of EAPs were

#### 1. Overemphasis on infrastructure

While focus on infrastructural development was a strength as pointed out earlier, it also tended to overshadow all the so called 'software' or action / programmatic components.

#### 2. Inadequate operational management capacity

Overall there were inordinate delays between launch of the projects and getting operational strategies of the ground. These seemed to be lack of capacity at all levels to convert 'good project objectives' into ground level strategies. While these improved over time at the state level as seen in KHSDP, IPP IX, at the ground level i.e., the District level; the PHC level and Panchayati Raj Institutions (PRI) level these remained a weak chain in the link.

#### 2. Inhouse Planning capacity not enhanced

Many of the projects used external consultants who helped to improve project planning capacity but this did not necessarily get internalised into the existing health system.



TABLE - IV

## Externally Aided Projects in Health Service Delivery in Karnataka

## SOME STRENGTHS AND WEAKNESSES

S.No/EAP	Strengths	Weaknesses
1. IPP VIII	<ul style="list-style-type: none"> <li>• <u>Comprehensive Conceptual Framework</u> (Family Welfare, MCH, CSSM Water supply and sanitation Education, Community Development).</li> <li>• Link Workers</li> <li>• Women's clubs (SHE clubs) (Social Health and Environment)</li> <li>• Establishing crèches, NFE and Vocational training.</li> <li>• Involvement of NGOs</li> <li>• <u>Involvement of Community</u></li> <li>• Gender sensitivity and women orientation</li> <li>• Flexibility e.g. different innovative schemes in Bangalore, Calcutta, Delhi and Hyderabad.</li> <li>• Social paradigm awareness stronger at all levels.</li> <li>• Operational guidelines for most aspects of project quite good.</li> <li>• Some good practices: <ul style="list-style-type: none"> <li>- Help desks in centres.</li> <li>- Herbal gardens in all</li> <li>- Overall morale and discipline of staff good.</li> <li>- Contract for cleaning / security efficient</li> <li>- Board of visitors.</li> <li>- NGO participation.</li> </ul> </li> <li>• Citizens charter</li> <li>• Slum based centre (more accessible)</li> <li>• Human Resource Development.</li> </ul>	<ul style="list-style-type: none"> <li>• Focus on Family Welfare predominant other programmes present but adhoc and not adequately integrated perhaps even inconsistent. (Need to actively convert from FWC to urban Primary Health care centre).</li> <li>• Long term sustainability especially regularization of centre staff not adequately addressed.</li> <li>• Partnership and Liaison of project team with Corporation Health Centres problematic (ownership by corporation inadequate)</li> <li>• IEC more material preparation than field use.</li> <li>• Orientation and motivation of Doctors not maintained after initial training (need for more problem solving sessions)</li> <li>• Many innovative schemes built upon but not in a sustained way.</li> <li>• Involvement of NGO's and community and G Ps patchy. Not adequately evaluated or monitored.</li> <li>• Lab facilities and services to be improved.</li> </ul>

S.No/EAP	Strengths	Weaknesses
2. IPP IX	<ul style="list-style-type: none"> <li>• Focus on rural Primary Health care - Filling gaps.</li> <li>• Flexibility in project formulation and utilization across financial years without lapsing of funds.</li> <li>• Software inputs like IEC, Training included in project components</li> <li>• Innovations like <ul style="list-style-type: none"> <li>- Tribal ANMs for tribal area (relaxed requirements strengthened training)</li> <li>- NGO take over of PHCs (two experiments)</li> <li>- In some activities like IEC focus on Northern Karnataka based on regional disparities has been project emphasis (at proposal level only)</li> <li>- Short listing of NGO's done through a planned / realistic procedure though time consuming.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Hardware(civil works) Moved better than software.</li> <li>• Overall implementation delays with complacency in the initial stages and some lack of clarity/ capacity.</li> <li>• Ownership by District Health officers Inadequate.</li> <li>• Centralized implementation except for building aspects.</li> <li>• Operational guidelines for many aspects were not initially catered for e.g. Fund flow mechanism to ZPs.</li> <li>• Monitoring mechanism not adequate to support effective implementation.</li> <li>• Community involvement of village committees - not adequately implemented. Involvement of NGO equivocal.</li> <li>• Lack of continuity of key personnel in the project – handicapped the project.</li> <li>• IEC virtually a non-starter</li> <li>• Training process direction given to NIHFW (National) rather than SIFHW (State) which led to delays.</li> <li>• Government level decision making bureaucratic - 3 standing committees delay decision</li> </ul>
3. KHSDP	<ul style="list-style-type: none"> <li>• More than just secondary Care. Conceptually also focuses on: <ul style="list-style-type: none"> <li>- Special interventions for Disadvantaged (Yellow card scheme).</li> <li>- Comprehensive Surveillance system</li> <li>- Trauma centre</li> <li>- Hospital Waste Management.</li> <li>- Blood Bank modernization.</li> <li>- Improvement of Referral links.</li> </ul> </li> <li>• KHSDP, OPEC, KfW share capacity building initiatives.</li> <li>• Good mechanisms for Construction and infrastructure development has been organised that can be used by other projects as well.</li> <li>• Some areas of focus relevant for Quality development – Equipment maintenance, Quality, Women and disadvantaged, Drug procurement policy, Medical waste management.</li> </ul>	<ul style="list-style-type: none"> <li>• Delay in construction and civil works continue and 'local problem solving' to get over constraints not yet adequately decentralised.</li> <li>• <del>huge</del> Cost over runs affecting planning and process.</li> <li>• Contracting out and partnerships with NGO's and others not being adequately monitored (Are the effects really better?)</li> <li>• Strategic planning cell has not been developed adequately at capacity level and from the point of sustainability of planning process it is adhoc, marginal.</li> <li>• Ownership problems especially for long term sustainability not adequately addressed. DHS or ZP who will maintain?</li> </ul>



S.No/EAP	Strengths	Weaknesses
4. KfW	<ul style="list-style-type: none"> <li>• Focus on a disadvantaged Region.</li> <li>• Linked to KHSDP for most of software development.</li> <li>• Account in Gulbarga (helped decentralised utilisation by Additional director for project stationed there.</li> <li>• Improve Administrative facilities at hospital level as well as for District Health officers and Taluk Medical officers.</li> <li>• Strengthen referral.</li> <li>• Additional staff.</li> <li>• Project conceptually includes focus on disadvantaged and women.</li> <li>• Epidemic preparedness.</li> </ul>	<ul style="list-style-type: none"> <li>• Only lip service for Software components (Training, referral, MIS, support services not adequately addressed inspite of availability of KHSDP support system).</li> <li>• Slow fund release / Utilization.</li> <li>• Seems mostly brick and mortar project.</li> <li>• Decentralised utilisation of funds without close monitoring led to problems of leakage, poor quality control, 'thoughtless payments' (Dilemma of centralization Vs decentralization)</li> <li>• Foreign consultants (SANI Plan) from Germany were not very effective in their coordination with local consultants. hence inordinate delays. Affected by Indo - German relations. Scaled down after the nuclear bomb!</li> </ul>
5. OPEC	<ul style="list-style-type: none"> <li>• Focus on a disadvantaged region of the state (but the choice seems to have been by the donor).</li> </ul>	<ul style="list-style-type: none"> <li>• Not a comprehensive plan. Very focussed on just a hospital and not need based.</li> <li>• Inadequate local planning and ownership.</li> <li>• Delays and adhoc action.</li> <li>• In the planning no clarity on how to implement or actually go about running the institution.</li> <li>• No clarity on how government will raise minimum Rs. 10 crores per annum to run the hospital (Now approaching Private sector for partnership!)</li> <li>• No clarity on how tertiary, secondary input would link or support PHC through referral system.</li> </ul>

• Presently the hospital has been inaugurated and providing minimal OPD services. Plans have been initiated to find a private sector partner!!



S.No/EAP	Strengths	Weaknesses
6. RCH	<ul style="list-style-type: none"> <li>• Attempt to adopt Community Needs Assessment approach (in principle).</li> <li>• Adolescent Health priority.</li> <li>• Links with literacy campaign</li> <li>• <u>Financial envelope idea:</u> <ul style="list-style-type: none"> <li>- Focus on disadvantaged.</li> <li>- States free to choose intervention.</li> <li>- Flexibility etc.</li> </ul> </li> <li>• Focus on Northern districts <ul style="list-style-type: none"> <li>- Gulbarga, Bidar, Raichur, Koppal, Bijapur, Bagalkote.</li> </ul> </li> <li>• Bellary sub project which involved NGOs.</li> <li>• Partnerships with NGOs, Professional bodies and medical colleges initiated.</li> </ul>	<ul style="list-style-type: none"> <li>• The work of UNICEF support in the earlier phase of RCH not acknowledged. Programme not learning from earlier experience and strategies.</li> <li>• Civil works preoccupation like</li> <li>• Other WB projects with delays and cost over runs.</li> <li>• Software components like IEC, Training, moving very slowly or not at all.</li> <li>• Too much Family planning oriented not integrated with health adequately (Population agenda strong).</li> <li>• Delays in basic training / delivery kits etc.</li> <li>• Focus on Secondary care more than primary care - institutional services more than field services.</li> <li>• Top down Package deals oriented rather than 'process' and local planning and empowerment oriented.</li> <li>• Overall progress of RCH project which is high priority is very slow and financial utilization seems quite sluggish.</li> <li>• Nutrition neglected in programme.</li> <li>• Consultants not clear about actual roles.</li> <li>• Not adequately integrated at project planning level (left to adhoc decisions).</li> <li>• Too women oriented need to retain balance and involve men as well.</li> <li>• Personal Hygiene kits pushed by ST manufacturers and other lobbies without adequate planning.</li> <li>• Sustainability not addressed</li> <li>Community Needs Assessment on paper.</li> </ul>

Delete

S.No/EAP	Strengths	Weaknesses
7. UNICEF	<ul style="list-style-type: none"> <li>• Complementarity of initiatives like CSSM, RCH, and immunization.</li> <li>• Using fixed day session and campaign approaches.</li> <li>• Pilot schemes tried out in some districts or towns and then expanded / replicated in other areas.</li> <li>• Generation of training materials and training programmes more local and relevant.</li> <li>• Involvement of Medical colleges, research centres in MICES survey and other projects.</li> <li>• Learning from experience and responding to local needs and demands good.</li> <li>• Policies, guidelines manuals evolved with local expertise.</li> <li>• Policy to focus on Northern Karnataka and districts with weakest child development indicators.</li> </ul>	<ul style="list-style-type: none"> <li>• High vacancy rates of ANMs in disadvantaged Northern districts.</li> <li>• Logistics of cold chain Drugs, kits not adequately tackled delays etc.</li> <li>• Orientation / training of Programme managers to deal with many departments network, sustain partnership is still not adequately developed.</li> <li>• Complementary of UNICEF and RCH (WB) programmes not adequately tackled due to project compartmentalization.</li> </ul> <p>Inspite of attempts to promote inter sectorality UNICEF support programmes still get listed to one department or the other.</p>
8. RNTCP	<p>Very important priority problem. Hence selective strategy still required and emphasized.</p>	<ul style="list-style-type: none"> <li>• Many DTC's do not still have District TB officers (9)</li> <li>• Laboratory technicians posts vacant.</li> <li>• Abrupt transfer of trained personnel.</li> <li>• Some DTC's have no building (9).</li> <li>• Complex procurement procedures.</li> <li>• Lack of cooperation from medical colleges / major hospitals.</li> <li>• Inadequate budgetary support at state / district level.</li> <li>• RNTCP districts Vs short course chemotherapy districts of SCC – continuing ambiguity.</li> <li>• Overall TB still low priority.</li> </ul>



S.No/EAP	Strengths	Weaknesses
9. KSAPS Phase I	<ul style="list-style-type: none"> <li>• Zonal blood testing centres established.</li> <li>• Modernisation of Blood banks.</li> <li>• Surveillance centres set up (8 + 5 new)</li> <li>• NGO involvement good leading to development of AIDS Forum Karnataka – mostly Bangalore (includes work with sex workers, truckers and care and support for PLWHA's)</li> <li>• Strengthening of STD clinics.</li> <li>• IEC activities at many levels.</li> <li>• Training activities on a regular basis.</li> <li>• State AIDS prevention society set up.</li> </ul>	<ul style="list-style-type: none"> <li>• Supply of drugs delayed and continuity of care and treatment (due to complicated procurement procedures)</li> <li>• Lab diagnostic facilities for voluntary testing in all districts still inadequate.</li> <li>• Lack of full or sustained partnership with NGO's in other parts of Karnataka.</li> <li>• Lack of counseling facilities in District and major Hospitals.</li> <li>• Inadequate policy guidelines on HIV testing.</li> </ul>

4 Maintenance of infrastructure not built in  
In spite of lot of infrastructure development, no planning or provision has been made for future maintenance of developed infrastructure. The state or ZPs capacity to maintain them adequately has also not been addressed

### 3. IEC non starter

IEC was an overall weakness – with preparation of materials often overshadowing actual efficient use in the field. Often materials did get printed / produced but logistics of distribution were not adequately planned and operational use by health workers and others at the field level were most inadequate with a few exceptions.

### 4. HMIS, Monitoring and Evaluation weak

The monitoring and evaluation of the projects seemed weak in spite of efforts at building up M and E strategies and lots of effort in some projects to evolve HMIS systems. Most of the HMIS seemed to be used only by higher levels to help the central planning process or monitor the programme. At the field level or base the quality of HMIS data was often poor since the 'collector of data' did not see himself or herself as a user of the data for their own planning purposes and was collecting it disinterestedly for someone else at a higher level.

### 5. Sustaining innovative ideas was inadequate

Many innovative ideas were being tried out but their long term integration or sustainability was not properly planned for. Many schemes started but were discontinued without proper evaluation; while many others were continued just for the sake of continuity without monitoring evidence of value addition, if any. Some other issues are included in the next chapter as policy imperatives.

To begin with even the complete documentation has been inadequate

#### **An Innovative Scheme**

"Under an innovative scheme the IPP IX project has provided funds to the Vivekananda Trust to train girls from the tribal hamlets and post them as ANMs in those hamlets. This training is a one-year course following the government-approved ANM curriculum with an added component of tribal medicine. The training has not been recognized by the Nursing Council, and the trained tribal ANMs are working through the NGOs working in these areas. Following discussions with the MOHFW, the trained ANMs have been accepted as trainees in the ANM training centers at the completion of which they will also be eligible for employment in the non-tribal areas. An evaluation of the first batch of 40 tribal girls trained as ANMs indicated a satisfactory knowledge of MCH, herbal medicine, nutrition, and personal hygiene. However, their knowledge of the reproductive system and human anatomy needed strengthening, and this will be rectified through training in the government ANM training schools. This scheme ensures access to MCH services in the remote and underserved tribal areas, and the presence of a female service provider at the SCs. Another important benefit is the opening up of job opportunities to tribal women within and outside of the tribal areas".

Source : IPP IX World Bank Review Mission Aide Memoire



## **F. Lessons from Case studies**

In spite of the time constraint the researchers felt that it would be a good idea to add a few case studies of the situation on the ground vis a vis some operational aspects of these EAP's. Using two strategic opportunities – a quick assessment of 'training' opportunities experienced by a group of medical officers in a Northern district was included as case study A and a surprise visit to an urban health centre covered by an EAP was included as case study B. Both case studies focus on some learning experiences from ground level realities and are not meant to be taken as any sort of rigorous evaluation.

### **1. Lessons from case study – A**

An interview of 6 doctors in a surprise visit to a Northern district showed the quantity and quality of training inputs from a wide variety of EAP's (around five EAP's) These are described in case study A. They show the following important trends:

- i. Five out of the 6 doctors had undergone some training or the other with three of them having attended 5-6 training programmes. *Most of these have been in the past 5 years (1995 onwards)*
- ii. The EAP's supporting these training programme included IPP IX, RCH, NACO, DAN-PCB AND CSSM (UNICEF)
- iii. The programmes ranged from 4 days to 18 days.
- iv. Most of them were in the Rural Health and Family welfare training centre though one was at Hubli and other at Bangalore Medical college.
- v. Most of them wanted CME's atleast once or twice a year.
- vi. They suggested better skill orientation in training programmes and more comprehensive induction training when they first join as PHC medical officers.
- vii. Have suggested better resource persons and better centres than at present.

*This has not been a uniform process with some getting more opportunities than others*

On the whole the case study shows that the EAP's have managed to support training of project managers at field level even in the disadvantaged Northern districts which is very creditable. However since these are done by different project administrations there is overlap in themes and focus and the selection of courses do not fit in to any available training schedule or CME of a local PHC. The selection and deputation seems adhoc and opportunistic. Very often the MO gets transferred after a special training programme so he is not able to add value after training to his ongoing work.

### CASE STUDY – A : Training Experience in Northern district

A few Doctors with Government service varying from 6 months to 20 years were interviewed regarding their training under various projects / programmes. Some details about the training of these doctors are given below:

1. Dr. A with about 7 1/2 years of government service had undergone the following training

a.	MCH Training	CSSM	1 week	1995	RHFWTC
b.	FP & MCH Training	RCH	1 week	1997	"
c.	FP Training	CSSM	2 weeks	1998	"
d.	Management Training	IPP IX	2 weeks	1999	"
e.	Administrator Training	MO Training	1 week	1999	Nauzad Ahmed, Rural Development Training Centre

In spite of all the regular training feels necessity for skill based training in MTP, tubectomy (learnt tubectomy himself) and CME's (atleast twice a year). Also felt that quality of training at RFWTC could be improved by getting trained resource persons from private / professional institutions.

2. Dr. (Mrs.) B with about 5 1/2 years service underwent the following:

a.	CSSM Training	CSSM	-	RHFWTC
b.	Combined Medical Education	IPP IX	18 days	"
c.	Blindness Training	DANPCB	-	"
d.	Leprosy Training	-	4 days	"
e.	AIDS / STD Training	NACO	4 days	At Hubli
f.	RCH Management Training	RCH	5 days	RHFWTC

Had not been given any training in MTP or tubectomy. Felt that such skill based training would enable to cater to the female population. Felt the need for CME's (1-2 per year).

3. Dr. C with 1 year service (excluding 4 years contract service). Very capable, efficient young MO, underwent the following training:-

a.	Reorientation Training	IPP IX	2 weeks	1996	RHFWTC
b.	MCH Training	RCH	2 weeks	1997	"
c.	Leprosy Training	-	1 week	1998	"
d.	Management Training	-	1 week	2000	"
e.	STD / AIDS Training	NACO	1 week	2000	"
f.	Medico-legal Training	-	2 weeks	2000	Bangalore Medical College.

Is able to assist in tubectomy only. Feels the requirement of better training courses and skill based training in MTP and tubectomy. Also feels that he could benefit from CME's.

4. Dr. D having 6 1/2 years service has underwent only Orientation training and Management training under IPP IX. Has assisted in tubectomies. Feels the necessity for more comprehensive induction training and training in Administration and Medico-legal aspects.

5. Dr. (Mrs) E also serving in the District with 5 months service has had no training whatsoever (regular KHSDP appointment). Feels the requirement of rigorous training in all aspects to effectively perform the job responsibilities of a PHC doctor.

6. Dr. F serving in the District with 5 years Government service underwent only 3 weeks continued Medical Education Training under IPP IX on induction (1995 October) and no other training. Assists in practical training of ANM's at the co-located ANM Training Centre. Feels the requirement of regular training especially skill based and activity based training. Training needs identified include MTP, tubectomy (including laparoscopic), anesthesia and Medico-legal training (including post-mortem is a must), as he has performed 30-35 autopsies in his short service.



## **2. Lessons from Case Study – B:**

A visit to an urban Family Welfare (Health centre) supported by an EAP showed some interesting features described in the observations listed out in case study B.

The case study emphasizes that inspite of quite a good level of conceptual framework generation and the evolution of a large number of guidelines the gaps between concept and practice can be wide.

Various local adhoc, modifications of programmes: temporary or permanent short cuts: lack of continuing education: supportive supervision and motivation of field staff: poor logistical support to supplies: and lack of sustained efforts to maintain an innovation can lead to discontinuation of innovations; closure of certain functions; modifications of strategies which can be wasteful or counterproductive; or result in glaring mismatches and distortions as exemplified by the observations.

While some functions go on fairly well and as per the objectives, some get distorted or modified. The case study exemplifies the need for continuous monitoring and evaluation; efficient supplies and logistic support; constant problem solving supportive supervision; and good team work and continuing education to ensure the quality of the implemented programme and to reduce what is often called in policy circles 'the implementation gap'.

## CASE STUDY B- An Urban Health Centre

SECTOR OF WORK	OBSERVATIONS
1. <u>Family Planning Oriented</u>	No male patients seen; No well baby clinic; No well women clinic; No screening for Breast Cancer or Cancer of the Cervix; Only IUD insertion carried out, CCs and OPs distributed
2. <u>Referral Oriented</u>	No normal deliveries conducted even in day time. All deliveries referred to Maternity Centres (MCs) Referral card not well designed and common to all categories. ANC card not given to the patient. Laparoscopic Tubectomy or Tubectomy at MCs only.
3. <u>Laboratory services not available</u>	Only Haemoglobinometer available cases usually referred to MCs, long queue; Tests sometimes done at UHC by visiting Lab technician's; Lab tests - VDRL Hb, Blood group, Urine Albumin.
4. <u>Family Planning services</u>	Only where LMO trained, only Menstrual Regulation Conditional i.e., only if patient willing for tubectomy / IUD.
5. <u>Drugs Inadequate</u>	Inadequate quantity to routinely treat OPD patients. Very limited antibiotics. No pediatric preparations/ syrups, no eye/ ear drops (except chloroapplicaps) or skin ointments. Definitely not Rs.50,000/- p.a. worth of drugs. LMOs give prescriptions for purchase from outside.
6. <u>SHE clubs defunct</u>	Earlier vocational training - now discontinued. Only serve as community feedback group.
7. <u>Link workers a strong asset</u>	From community, dedicated. Low honorarium so frequent turnover. Bring ANC cases early as well as children immunization.
8. <u>LHV / ANMs from corporation</u>	Experienced, competent (could be corrupt)?
9. <u>Immunization</u>	Cold chain maintained. Vaccines available. Outreach immunization also. Twice a week, so load less.
10. <u>Health Education IEC activities discontinued.</u>	Do not put posters in slums as destroyed by children. A-V van discontinued due to corruption. Mainly printing - less lecture demos.
11. <u>ISO 9002 Certification</u>	Purely technical assessment. Based on parameters like cleanliness, record keeping, waste disposal, sterilization of OT and equipment etc. Would not significantly improve quality of care. False sense of perfection.
12. <u>Fall in activities / performance</u>	Since start of centre all activities have reduced significantly. Assessment required of reasons for this.
<div style="display: flex; justify-content: space-between;"> <div> <p>Glossary IUD – Intrauterine devices</p> <p>MC - Maternity Centres</p> <p>OPD - Outpatients department</p> <p>CC - Conventional contraceptive (Condom)</p> </div> <div> <p>LMO – Lady Medical officer</p> <p>ANC - Antenatal card</p> <p>UHC – Urban Health centre</p> <p>OP - Oral Pills</p> </div> </div>	



## **G : Some Policy Imperatives Including Integration and Sustainability**

The previous chapters provide an overall framework of the 10 EAP's in Karnataka and some of the quantifiable or qualitatively describable indicators and features of these projects to help the project overview. As indicated in the project protocol this exercise was primarily a critical policy review and not an evaluation exercise of each of the EAP's per se. Some of the finding in the previous chapters and tables have addressed some of the questions that were included in our original list. In this chapter we try to address those which have not been adequately covered by the earlier one as well as provide some additional critical comments even on those that have been covered, drawing primarily from the very candid and frank interactive discussions we had with a wide variety of project directors. These policy issues and imperatives are as follows:

### **1. Scope of Projects**

All the projects focus on Health System Development with varying degrees of emphasis on Primary Health care. While some focus on secondary level (e.g. KHSDP) there is a built in assumption that the secondary care support is with a view to support through efficient referral systems – the primary health care network. While in practice the links may not be so well established the conceptual framework is well directed to this issue. It is at the 'Public Health' context level however that the projects show a general weakness inspite of the fact that unlike other states in the country 'public health expertise' is available even among the senior leadership of the state. One can only surmise that in the changing financial situation perhaps financial management contingencies and bio-medically defined management framework are inadvertently distorting public health concepts and priorities. The focus on basic determinants of health is weak (nutrition, water supply, sanitation, environment) both at content level, emphasis and linkages; key public health components like surveillance and health promotion are inadequate; and the 'new public health' emphasis on empowerment of the community and public at large in health decision making is totally overshadowed by top down provision of specific packages euphemistically called social marketing. This lacunae / weakness needs to be seriously addressed.

### **2. Project Planning**

In the absence of a strong Strategic Planning Cell in the Directorate (inspite of a provision in KHSDP for this) problems of project flexibility, design, long lead times and delays, in preparation, complications in procedures and various ongoing management and operational problems, all of which have been experienced in one EAP or another – are a symptom of lack of adequate attention to building in-house capacity for more realistic project planning and management. This has led to compartmentalized planning, inadequate collection of field based data or evidence, and adhocism in decision making further compounding the problem. Lessons are not learnt from positive and negative experiences of a particular EAP or its success

at some form of system development so the 'wheel is reinvented' each time by each project and the system is not enriched by the collective experience. E.g. Different EAP's have had different experiences of dealing with the 'NGO sector' or the private sector – some positive; some not so positive; some even disastrous in terms of unreliable partners or even 'fly by night' operators but the whole system does not learn from this to evolve a Directorates policy for NGO or Private sector partnership. This situation may change with the Task Force recommendation on state policy directives but for the present this is a lacunae to be urgently addressed.

### 3. Who drives the projects?

This was a very difficult policy issue to address. On the face of it, the State Government / State Health Directorate drives the project not the funding partners or their external consultants and all sorts of mutual consultations / reviews are organised. However two factors do affect the 'driving' of the project.

- Absence of local homework

In the absence of rigorous 'policy' and evidence based homework on the governments / directorate side due to a lack of strategic planning capacity as mentioned earlier, external consultants of funding partners are often able to drive the decision by just providing more options, more evidence based on data marshalled from experience elsewhere and the state policy makers are then more easily influenced or ready to accept them. e.g. During the study period an external funding agency resource person provided more data and perspective on private sector in Karnataka, than could be marshalled by local expertise thus inadvertently pushing the private sector agenda. The reliability of this data or whether it was extrapolated from quite different sources could not be commented upon, adequately without local homework.

- Conditionalities of funding partners

World Bank loans more than other agencies are also usually supported by some conditionalities that are clearly stated in their documents.

- i. The need for economic reforms.
- ii. The need to engage the private sector.
- iii. The need to promote user fees as a means of cost recovery.
- iv. The need to follow certain forms of 'tender' or 'consultancy 'laid down by bank' etc.

There does not seem to be adequate home work in-house on these and their implications especially long term options, before loan agreements are signed.



### Some World Bank conditions

"The Country Approach Strategy (CAS) recommends focussing Bank-group financed investments on states that are undertaking economic restructuring programmes and supporting sectoral policy reforms. Karnataka is one of the state that has initiated important fiscal, sectoral and governance reforms. Further more it supports the CAS objectives by strengthening institutional capacity ....., engaging the private sector .....,

"Each project state ..... shall levy user charges in district and subdivisional hospitals in accordance with a program and time schedule acceptable to the Association(IDA)".

"Goods and works shall be procured in accordance with provisions of section I of the guidelines for procurement under IBRD loans and IDA credits" (International competitive bidding, bid packages etc).

"Consultants services shall be procured under contracts awarded in accordance with the provision of the Guidelines for the use of consultants by World Bank borrowers and by the World Bank as executing agency – published by the Bank in August 1981".

*Source : Various reports of the Bank and Project Agreements*

Both these factors lead to the continuing perception and the fact that indeed the 'external agent' does drive the project intentionally through general conditionalities or 'inadvertently through inadequate borrowers homework'. This needs to be addressed urgently.

*Even where conditionalities are inevitable, there should be closely monitored and either reviewed if they have negative consequences or internalized into the system if they have positive implications*

#### 4. Are there areas of overlap / duplication ?

- Compartmentalized projects by the very fact of being developed independently as 'stand alone' projects and not as components of a larger wholistic integrated project are bound to produce overlap and duplication.
- Not surprisingly the chairperson of the Task Force during one of his recent inspection visits found 'three operation theatres in a PHC compound' built by different EAP's with no evidence from the MIS of local needs that warranted such investment. In HMIS, IEC, and Training there are many overlaps and duplications .
  - So different projects produce manuals and teaching aids or audio visual aids for Health Education which are quite similar in content;
  - Health functionaries are expected to maintain a wide variety of registers that cater to the needs of different HMIS of different EAP's ; and

- Doctors go for different training programmes organised by a wide variety of EAP's that add to variety but not to a coordinated training plan at district or PHC level (see case study A)

- An <sup>over all</sup> integrating <sup>and training</sup> planning exercise is therefore urgently required. At the directorate / state level there are efforts to prevent this duplication of input and efforts but systematic change to streamline this process and prevent even accidental or inadvertent duplication is required since the health sector functions under a constant financial resource constraint and any effort to ensure more efficient deployment of available resources is welcome.

*A good example of adhoc integration is the utilization of KHSDP Resources for Kfw project needs.*

## 5. Ownership and Leadership

- In most projects the state level ownership is strong except perhaps in those projects which are 'package deals' decided at the centre.
- Because some of the EAP's have established independent structural identities e.g. KHSDP, IPP VIII, IPP IX, the links and feeling of shared ownership by the parent directorate (in the case of KHSDP and IPP IX) and the parent Municipal Corporation (in the case of IPP VIII) is weak. E.g. no serious consideration regarding sustainability issues and integration challenges relevant to KHSDP or IPP IX projects have been addressed at the directorate or Health secretariat. Nor is the Municipal Corporation adequately concerned about the very same issues vis a vis IPP VIII project.
- Another significant lacunae seen in the EAP's as they are presently structured, is that ownership at District level – at the point of implementation is quite weak vis a vis District Health Officers and PHC MOs; and perhaps non-existent vis a vis PRI institutions. All these three groups are crucial to ensure the integration and long term sustainability of all these projects. *Ownership can be enhanced by involving all of them from the very inception and conceptual planning of such projects.*
- Leadership of the project directors has been good as long as there have not been frequent changes of leadership or the burdening of project directors by multiple and additional responsibilities.
- However the leadership and ownership are particularly crucial if EAP's have to become more complementary or supplementary to each other and the whole health care delivery system. Leadership that coordinates, networks and promotes linkages is crucial.
- Public Health orientation and socio-epidemiological orientation of the leadership - whether generalist administrator or medical / technical leadership is an important necessity to prevent inadvertent distortions due to extraneous lobbies or market forces. This will also enhance capacity to negotiate with external consultants and others as well.



## 6. Intersectorality

While in many EAP's the importance of this factor is mentioned, the intersectoral coordination between departments and programme managers and decision makers of different concerned ministries is still not given adequate priority. At the heart of good 'public health strategies' is the emphasis on intersectoral coordination and while EAP's may have not seized the opportunity in this aspect so far, the evolving Integrated Health, Nutrition and Population project (HNP) must focus on this aspect urgently and significantly. Even at the grassroots level a better coordination between PHC, ICDS centre, local schools, women credit cooperatives and development workers would strongly strengthen programme performance and outreach.

## 7. Integration

There is urgent need to integrate Health with Family welfare; public health, primary health care and the population agenda with each other to avoid not only duplication by compartmentalization but also to reach the community and tackle the health problems of people especially the poor in a more integrated way. Much lip service has been paid to the issue of integration but the stand alone EAP's have not tackled this issue adequately. In fact different EAP's focussed on different problems even further disintegrate the work of the directorate.

DHO's and MO's are constantly preoccupied or distracted at ground level by frequent visits of consultants, review teams, project teams asking for this and that data or feed back; the more EAP's the more such distraction from the normal planning and management routine.

At the directorate level different EAP's require different protocols to be filled, (different MIS mechanisms) so quite a bit of directorate staff time is spent in filling up questionnaires, schedules enhancing paper work but not necessarily enhancing efficiency of planning and management.

Consultants for each EAP provide their own framework of ideas and decision making. These do not allow for any inter-EAP consultant communication. One EAP may appoint a consultant that suggests one type of ideas, another EAP another type and all these have to function at the same PHC level or the same district level or have to be operationalised by the same health functionary. This situation necessarily leads to adhocism and anarchy especially in the absence of state policy guidelines. Integration and coordinated communication is urgently required.

Another urgent area for integration to avoid wasteful duplication of time and procedure is the need for integrating all the single project related district level and state level societies into one Health society at both levels to receive and disburse the funds. Serious policy reflection also needs to be done to ensure that the District society's work under the purview of the Zilla Parishad and PRI.

## 8. Equity

While overall the EAP's do not have a well planned Equity focus some emphasis on Northern disadvantaged districts and on women and SC/ST have been identified and noted. HMIS of all EAP's as well as the Directorate must begin to focus on Equity in a more concerted way in the years to come. This 'equity imperative' must include

- i. Geographical – Within districts and between districts.
- ii. Gender – between male and female sections of the population and especially focus on girl child.
- iii. Class / Caste – Between rich, middle class and poor or the so called haves and have – nots or 'landed' and 'landless' etc.
- iv. Marginalisation – SC / ST or special groups such as child labour or rural migrants to urban areas, street child, elderly, people with disabilities etc.

Unless the HMIS focusses on disaggregated data the equity principle cannot be furthered by active policy or programmatic intervention. EAP's could build this in to their framework more concretely so that they go beyond policy rhetoric.

## 9. Partnerships

All EAP's have built some form of partnerships with the voluntary sector, NGO's, private sector, academic institutions or research institutions. But these do not build on a larger policy framework of the state since guidelines on such partnerships are not available. They tend to be some what adhoc. The directorate should actively move towards some form of Resource Directory; Accreditation system; or reviewing and registering system for such partners so that EAP's and different health departments can draw from pooled experience and pooled resource lists. A partnership cell in the Directorate like the erstwhile Society for Coordination of Voluntary Agencies (SCOVA) idea could build such directories, framework of guidelines and linkages, of use to all departments and projects.

## 10. Community Partnership and Empowerment

The resistance of the Health department to work with Panchayati Raj Institutions is well known and though some of the reservations of the health leadership may be very genuine and based on difficult or awkward situations of 'interference' or extraneous push / pull factors in decision making – there is urgent need to review this and get over the problem rather than ignore it. With increasing political decentralization, PRIs will play an important part in local planning and administration in the future and EAPs should promote this process and not distort it.

The district level societies which leave decision making in the hands of the bureaucracy may be good for efficient disbursement of EAP funds but they definitely mitigate against active community participation. EAP's in particular must



begin to focus on human development more than infrastructure; and in this human development component strengthening of community based organizations like PRI institutions to contribute to local planning and ensure accountability and transparency through capacity building will become as crucial as building health teams to deliver the programmes efficiently and effectively.

#### 11. Accountability / Transparency

EAP's may develop their own monitoring system and evaluation systems, even audit systems but they are not accountable to the people, the political system, the legal system in the same way as the directorate and its regular programmes. While bureaucrats and technocrats may be closely involved with the development of these projects and the evolution of their frameworks of action there is still the danger of creation of a parallel system of decision making and programme management which may be seen as relevant in the short term but could become problematic in the long term.

However it was noted that overall some of the guidelines and procedures of the projects were able to immunize the project from the corruption and political interference which affect the larger system all the time since it does prevent the influence of extraneous 'push' and 'pull' factors due to clear cut guidelines that are not easy to circumvent.

In the short term review we were not able to make clear cut judgement whether extraneous interference's were making any sort of affect on programme formulation or implementation. The use of retired government personnel as consultants was common (a sort of 'old boy' network) which affected the dynamics of the programme and subsequently its performance in some cases but not necessarily to integrity. On the whole it may be surmised that EAP's are as subject to outside interference as the rest of the system not necessarily more.

However in the matter of construction costs and delays and whether some contractors were favoured rather than others – These areas were difficult to explore in the time constraint. There was hearsay evidence of this type all the time including architects inflating designs / and enhancing profit margins in other ways, etc.

#### 12. Sustainability

This was one area on which there was very little real focus or policy discussion or planning in the projects at any level – project plans, project dialogue, project implementation mechanisms and so on.

*It is important to emphasize that sustainability is often seen as being financial only. It is actually more than this and includes staff and other policies as well.*

The overall assumptions which ignored this imperative and the trends seen were as follows:

- i. The projects were seen as filling lacunae in the existing system and not creating additional structures or functions.
- ii. The parent unit or department like the BMP in the case of IPP VIII and Health Directorate in the case of IPP IX, KHSDP etc were expected to take over the project when the period of the project was over. There seemed to be no contingency plans being evolved for this inevitable reality.
- iii. In some project documents there was mention of cost recovery usually through user fees mechanism; or sustainability was to be made possible by NGO – or private sector partnership or take over but this was not followed up by serious operational guidelines or planning with the concerned parties.
- iv. Sustainability as an issue seemed to be considered in the last year of the project as a knee-jerk reaction rather than as a serious plan evolved from the very beginning.
- v. Unless the directorate estimates recurrent costs, running costs, maintenance costs and other such definable entities seriously as the time for phasing out of the project nears and unless these costs are budgeted for or recovery planned in some sort of methodical way – Sustainability like cost recovery will remain rhetorical and ultimately ignored or considered as someone else's problem at a later date.
- vi. In some cases there seemed to be a confidence that some project donor would always step in to fill the lacunae if one donor phased out – so again this complacency led to a fatalistic non-planning situation which was not at all uncommon.

Sustainability of these relatively large EAP's is a very serious policy issue that needs urgent attention at the highest level and the active involvement of the finance ministry as well.



## **H. Some Reflections on the Financial / Economic implications of EAP's**

Understanding the financial / economic implications of the increasing reliance on EAP's to support the health care delivery system in the state and the gradual shift from grant giving funding partners to becoming 'borrowers' of loans, was not an easy policy issue to review due to atleast two constraints.

- The financial management of the EAP's are separate systems not easily listed to the states own health budgeting / accounting system.
- The loan implications and the debt burden and debt servicing implications are not easy to explore in a short time constraint under which the project functioned.

The reviewers studied some earlier analysis particularly the review document (Analysis of Expenditure Medical and Public Health, Family welfare by S.Subramanya) and the more recent study of Dr.Vinod Vyasulu and group and also studied the credit agreements of various projects and the budget and account statements as well as status of project tables from World Bank and other sources. From a review of all these secondary sources of data the following conclusions and policy concerns are listed out: (See also box items which are extracts from authentic source and support our conclusions)

1. While the overall expenditure on health and family welfare is gradually decreasing and hovering between 1.1 and 1.4 of net state domestic product which is itself an overall low investment (ICSSR / ICMR recommend 8%), the reliance on EAP's is increasing which means Non-plan expenditure is coming down and Plan allocations are increasing. This is not a very healthy trend.
2. Most of the expenditure in non-plan is now directed to salaries with less and less available for programme / action components. EAP's are tending to take over more and more of this programme component – again not a healthy trend.
3. Considering that EAP's are now more and more loans rather than grants or long term soft loans this is a worrisome development. If these loans are not utilized with efficiency then we have the double burden of continuing ill health and a 'debt burden'.
4. Though all the projects talk about sustainability and cost recovery and user fees mechanism is often mentioned as a long – term option there is no indication that this mechanism is effective in reality. While some recovery has been demonstrated; and some efforts to identify those who cannot pay etc is being experimented; and the decision to let the amount / revenue collected be kept at the institutional level for local use rather than transferred to the general account or treasury – none of the mid-term reviews show that this could be a major option for sustainability even though in the short term they may help to improve quality by enhancing consumer participation. Researchers and programme evaluators are not unjustified in their concern that 'user fees' may ultimately



## Health Financing – An Analysis

1. "State Finances, Health Finances and Efficiency: Three key issues, with regard to public sector finances at the state level need to be addressed. First the overall fiscal situation in many states has deteriorated sharply since the early 1990s, with a rise in the fiscal deficit, an increase in interest payments as a share of total revenues, and an increase in debt outstanding as a share of state domestic product. The deterioration in the overall financial situation faced by the states has had a deleterious effect on the health sector. The share of health and family welfare in the total state revenue budget has declined since the early 1990s suggesting that past declining trends of health sector's share in the budget has been exacerbated, rather than reversed. The decline in the health sector's share occurred despite a rise in real per capita expenditures in all states up to 1991, indicating that total government expenditures rose faster than health expenditures. Total government spending is about US\$ 2-3 per capita for health services and is inadequate to meet the government's stated objectives. To achieve the government's objective of funding a basic package of health services, substantially more resources for health care are required, but the overall state finances noted above pose a serious problem. Second, within the health sector in most states, resource allocation in the public sector is skewed in favour of tertiary care services relative to needs at the primary and secondary levels, particularly rural and community hospitals. Third, much of the resources are absorbed by salary costs. The recurrent budget for operations and maintenance is chronically under-funded and the programs are not fully effective".
2. "Alternative Methods of Health Care Financing : The resource constraints faced in the health sector will required alternative methods of health care financing to supplement budgetary allocations. Alternative methods of financing health care, such as cost recovery, social and private insurance, and participatory schemes, are limited. Reported revenue data indicate that cost recovery in the health sector is about 3% on an average in India, although there are problems in estimating the level. Some of the problems faced with cost recovery include:
  - a. Lack of an appropriate mechanism within the government to review user charges;
  - b. Weak administrative mechanism for collecting user fees;
  - c. Difficulty in targeting the poor for exemption from user fees; and
  - d. Constraints to greater retention of funds generated through user charges at the point of collection.

Based on international experience it should be noted, however, that a cost recovery rate of 15-20% in the health sector is about the most that can be expected in the public sector. In the long run, issues such as private insurance and managed health care will need to be addressed, as the industrial and urban sectors in India expand, and cost containment becomes increasingly important".

*Source : Analysis of Expenditure on Medical & Public Health, Family Welfare*



### State Health Finances

“Non Plan expenditure, which is met from resources raised internally by the state, accounted for 63-69 percent of the total expenditure on health and family welfare between 1990-91 and 1994-95; this came down to 57 percent in 1995-96. Reduction in the proportion of non-Plan expenditure in 1995-96 is because of increase in Plan allocations and capital outlays. One reason for this increase could be the availability of funds from externally assisted population and health projects and Central government aided projects such as the AIDS control programme”.

“With expenditure on health and family welfare accounting for only 1.21 percent of the net State Domestic Product down to 1.14 percent in 1991-92, but up to 1.24 percent in 1992-93, decreasing again to 1.22 percent in 1993-94 before increasing to 1.37 percent in 1994-95. It is clear that fluctuations of this nature are undesirable for the growth of the health sector as also that expenditure on health and family welfare is, by any reckoning, inadequate. A study group on Health for All, set up jointly by the Indian Council of Social Science Research and Indian Council of Medical Research, recommended ‘a substantial increase in public expenditure on health at about 8 or 9 percent per year (at constant prices) over the next 20 years”.

*Source : Human Development in Karnataka – 1999*

de-emphasize the need to focus on the marginalised. Other problems with this mechanism are highlighted in the box items as well.

5. There is a danger that increasing reliance on EAP's will ensure that programme costs in the regular non-plan health budgets will be ignored with a long – term distortion in budgeting creeping in. (This will perpetuate long standing budgetary imbalances with long term implications for health budgets).
6. There seems also a tendency to be more extravagant with issues like constructions, consultancies, equipment, vehicles, etc because EAP's promote unwittingly a more 'private sector' ethos so thrift, careful planning, basic simplicity and other such values that would ensure 'quality' at low cost or a more judicious use of resources so that more is available for grassroot needs is being affected.
7. Finally it may be important to caution that reliance on EAP's should only be a short term plan. Ultimately health budgets like the investment on education and welfare (social sector) should be increased as a long term investment in quality human development. Enough economic analysis and theory – including the more recent endorsement by the work of economists like Amartya Sen and others show this direction as the way ahead. This needs political will and commitment and some courageous state development policy planning. Let short term solutions like EAP's not come in the way of concerted, action for sustained development and higher investment in health.

## **J. General Policy Concerns : Are we reinventing the wheel?**

The key researcher for this study and some of his colleagues had reviewed the World Bank activities in the Health Sector in India based on a case study on "The World Bank's role in the Health system in India" facilitated by the Sector and Thematics Evaluation Group of the Operations Evaluation Department of World Bank in August 1999.

That review had raised seven sets of questions / findings for a policy meeting organised by the Bank with Planning Commission, Ministry of Health and Family Welfare and others. The review of EAP's in Karnataka was a good opportunity to look at these propositions in a wider variety of project initiatives and with partnerships beyond the one with the bank. Our findings suggest that many of these concerns are very real ones even in the context of the current EAP's in the state and need to be given serious consideration by policy makers and project directors within the state before these distortions and concerns become too systemic. They are equally important for the funding partners. These concerns are enumerated as a set of policy questions that project directors and partners should reflect upon as they review their projects for long-term sustainability and integration within the larger system.

### **1. Is Public Health not being adequately emphasised in problem analysis project planning and formulation?**

- Is there a confusion in understanding public health?
- Is economic or techno-managerial context taking precedence over socio-epidemiological analysis?
- Are the wider determinants of health like nutrition, water supply, sanitation, and pollution not adequately addressed?
- Is the focus on poor, indigent, marginalised not central?
- Are regional diversities and differentials not central to decisions on focus of programme?

### **2. Is Primary Health Care being given adequate emphasis and priority ?**

- Is there focus on selective 'cost effective treatment strategies' rather than enabling / empowering processes?
- Is there focus on first referral units rather than primary health centres, subcentres and home based care?
- Is community involvement in planning and organisation mostly rhetorical with community capacity building made subservient to exigencies of top down management systems.
- Are Panchayati Raj institutions generally ignored and registered societies promoted as an instrument of decentralization but under bureaucratic control?



### **3. Are these partnerships adequately transparent and accountable ?**

- Are the partners willing to share the costs of failure and distortions due to poor programme design or planning which ultimately affects the poor?
- Is long term sustainability or integration into existing health care system being adequately addressed or followed up as an end of project after thought?
- Is there unhealthy competition between projects rather than collaboration and sharing of expertise and experience?
- Are accountability and transparency systems not clearly defined and hence not actively monitored?

### **4. Some ethical issues and dilemmas ?**

- What is the ethics of promoting NGO-private sector partnership in the absence of solid evidence that these are more efficient operational options?
- What is the ethics of taking credit when an initiative is successful and yield positive results while pointing a finger to the directorate or ministry when the initiative is problematic?
- What is the ethics of expanding quality at the cost of or absence of adequate and operational quality control?
- What is the ethics of promoting infrastructure and 'hardware' at the cost of 'software' that can more easily focus and reach the poor?

### **5. Some management issues and dilemmas?**

In spite of marshalling lots of expertise both local and foreign is there a tendency to:

- Develop 'hardware' rather than 'software'?
- Expect 'training' to get over needs for serious management reforms?
- Little thought to social accountability and transparency?
- Inadequate attention to building ownership among different stake holders particularly district level players?
- Focussing on 'user fees' as the only primary fund enhancing option rather than looking at diverse options?
- Overall neglect of health human power issues like continuity, skill development and promoting team concept?

### **6 Is the political economy adequately addressed?**

- Are the health projects adequately located in a broader, political, social, institutional analysis and adequately based on evidence of how projects run or do not run?

- Are issues such as political will; corruption and influence of lobbies political interference; market economy; being given adequate emphasis in the strategic planning exercises?
- Without developing a strong 'public health policy resource group' within the directorate is the free lancing, free floating, adhoc Consultancies and commissioned studies not allowing the means of change to become systemic?

#### **7. Is cultural context being disregarded?**

- In spite of a rich and diverse tradition of Indian and alternative systems of medicine, including promotion and investment in health manpower development in these systems by government and private initiative; are the EAP's ignoring the local cultural context and these alternatives in their formulation?

All these issues are relevant today and it was surprising to find that most of them were applicable to all the EAPs in the state and not only for those supported by World Bank. However it must be noted that the current health leadership both bureaucratic and technocratic seemed much more alive to these policy issues. That was a positive finding, symbolizing future potential. However as was brought out again and again in the interactive discussions **local holistic problem analysis and policy homework was inadequate in all these aspects. Strengthening of strategic policy analysis and development was an urgent action imperative. Policy makers and project managers need urgent orientation to Public Health aspects of decision making and socio-economic politico - cultural aspects of health situation analysis.** Any strategic planning exercise in the future for the continuation of the existing projects or the evolution of newer one must take these crucial questions into account so that the projects can be implemented more effectively and in a more realistic context with reduction in the implementation gaps.



## **J. Final Conclusion and Recommendations from a future Policy point of view.**

The previous sections highlight the key findings and trends that emerged from the review process. However taken as a whole set of project experiences the key issues and conclusions that have emerged as significant for a concerted policy response are the following :-

1. While the EAP's do focus on a large number of health problems and health sector development issues, addressing various lacunae in the existing Health care delivery system in the state at both primary and secondary level, **they do evolve, exist and function in relatively compartmentalized ways without fitting cogently into a comprehensive, integrated strategic larger state health policy / plan evidenced by -**
  - The absence of any state health policy document that includes serious reviews or details of all of them.
  - Any coordinating mechanism at directorate level that addresses them in a collective context.
  - Any consistent and rigorous strategic planning exercise / document that was used by programme designers when these EAPs were evolved. Some congruence / complementarity between / across projects has evolved since the members of the project committees overlap with senior policy makers common to all, but this is 'ad hoc' and not always intentional.

[Probably the HDR Report, Karnataka Task Force in Health and the recently evolving HNP project are fore-runners for this much needed paradigm shift from selective compartmentalized programme planning to more comprehensive integrated Health sector planning processes].

2. On the other hand while **compartmentalized evolution** may have lead to some problems of duplication and integration, especially in IEC and training, but also sometimes in infrastructure development, the very feature of compartmentalization has also lead to a certain degree of project autonomy that has lead to many interesting initiatives and innovations in structure, framework, operational mechanisms, evaluation and monitoring, some of which have been identified by this short-term review. These need to be rigorously documented, objectively evaluated further and adopted / adapted by the whole system as the projects phase out and get taken over and integrated by the ongoing larger systems.

3. Overall the **Directorate / EAP's have shown**

- An ability to evolve laudable objectives for each EAP.
  - General lack of competence in the evidence based homework required to translate objectives into implementable strategies leading to delays in starting up times.
  - Diffidence in guidelines and systems development leading to operational and execution delays.
  - While ability to handle the hardware (infrastructure construction - civil works, equipment and transport) has been established, effective software development (training, IEC and Quality Assurance) has remained a weak skill / capacity. Also cost over runs have been many compounded with poor utilisation in other areas showing in-different financial management capacity as well.
4. Like the general health care services development, the projects have not shown any **evidence-based focus on equity, gender, regional disparity or other policy imperatives like impact assessment, community partnership and ownership, partnership building and decentralization** and hence though there are some successes and some failures as well, in none of these areas can EAP's be shown to have used their own programme / project autonomy to enhance the **health sector** experience in these areas. This is partly a reflection also that at the Ministry level there are no clearly circulated policies or programme guidelines on these policy imperatives and hence project managers have had to explore these dimensions if at all with diffidence rather than confidence and clarity. Similarly the issues of corruption, political interference, transparency and accountability seem to effect them just as much as they affect the larger public health system- no less, no more though perhaps in the tendering / purchase policies sometimes as conditionalities of the funding agencies, there seems to be an overall feeling among programme managers that outside or local interference is less!
5. **Lack of continuity of key personnel** has been an important handicap and lack of systems to monitor quality of care and responsiveness to local needs had handicapped the establishing or the enhancement of effectiveness. In addition selection of consultants and senior project consultant need to be critically reviewed and made more competence based and transparent. Apart from an old-boy network phenomena selection is not always focussed on skills for the job.



6. While the general impression of the programme managers seemed to be that these EAPs were not consciously **donor driven** and there was space and opportunity for local technical opinion to evolve project formulation, the impression of donor driven agenda was often attributed to lack of local homework and evidence generation and hence a tendency to accept the suggestions / frame work / ideas of working external consultants as an easy option. This aspect again underlines the urgent need to develop and enhance the strategic planning capacities of the Ministry / Directorate and making it multi-disciplinary as well [The KfW and OPEC experiences have however been good examples of the need 'to look at gift horses in the mouth' seriously which could have avoided all the problems that have followed. They have also shown the absence of long term planning capacities especially in **human resource development** for the hospitals being upgraded].
7. **Integration** as an issue does not seem to have been seriously considered by any of the projects since many projects were seen as stand alone or focusing on infrastructure not process. [The absence of clarity in development of a **referral system** complex between primary and secondary care (for example: IPP VIII, IPP IX and KHSDP) is a case in point. Similarly IPP VIII, IPP IX and RCH could have been more complementary, etc.] This leads to wasteful duplication at the ground - level.
8. **Sustainability** is another policy imperative that does not seem to have been taken seriously by the whole system since in many ways this should be a long term concern of the Directorate and not just of the EAPs. KfW project had some serious options outlined in the project part which were not adequately experimented with. [Efforts to evolve systems of user fees; efforts to identify and hand-over (contract) out services to NGO's and or private sector etc. are being experimented with in KHSDP, IPP VIII, RCH but these experiments seem adhoc and not within a clear-cut policy framework. Nor are they being evaluated objectively to establish relevance or effectivity]. Overall the human power development experience that is crucial for sustainability has often been ignored or inadequately addressed.
9. Overall EAPs do not seem to be adequately drawing upon the **Public Health / Community Medicine capacities** of the state in any concerted or formal way nor for that matter on the phenomenal inter-disciplinary capacities of institutions such as IIM, ISEC, NLSUI and other resource centers of health, social development or strategic planning expertise- many of which are also available in other districts and regions. In fact there seems to be an **overall lack of public health / sociological orientation in problem identification, situation analysis or programme planning** in the EAPs evidenced by a sense the researchers got of the dominance of :
  - Infrastructure over human resource development.
  - Bio medicine over socio-epidemiology.

- Secondary care over primary health care (especially preventive public health).
- Centralization over decentralization.
- Provision of services over enabling / empowerment strategies.

10. Finally a **review of EAPs** undertaken by us, inspite of the time and methodological constraints, lead us to suggest that there is urgent need to:-

- a) *Develop strategic planning capacities in the Health sector of the State to handle the complexities of Health sector development as well as the challenges of negotiating sustainable projects with external agencies and funding partners that develop not distort / enhance capacities all round / and integrate not disintegrate.*

This capacity should be multi-disciplinary, directorate-based and as an immediate starting point should also become the integrated evidence based monitoring unit for all the health programmes of the state including EAPs.

- b) *Develop mechanisms of integrated planning that would start as a first step of all programme managers and programme implementers being networked into a coordinated planning mechanism that from time to time focuses on integration and sustainability issues beyond the dynamics of compartmentalized projects / program. [The project preparatory committee of the current HNP project could well become the starting point of such a mechanism].*
- c) *Both these mechanisms should draw on multidisciplinary professional expertise in the state especially public health and the behavioral sciences from all the resource centres both public, NGO, private and the professional colleges. (The HNP project is trying to do this by involving a multi disciplinary group like Community Health Cell (an NGO) but this needs to be done with greater clarity and flexibility.*
- c) *A more detailed internal review and analysis of current EAPs should be undertaken as an in-house exercise by both (a) and (b) supported by (c) so that the positive lessons from EAP experience is integrated into health sector development in the state and distortions / problems handled by a more decentralized programme implementation mechanism or countered through more effective evidence based long term strategic programme planning.*



### **K. Limitations of the Review Exercise**

- The task of reviewing ten Externally aided projects in Health in the state in a short term framework of 4-5 months was a very stupendous and exhaustive task and perhaps quite unrealistic as well.
- Hundreds of pages of reports, reviews and other documents had to be perused and interactive interviews had to be arranged with a large number of very busy government officials and project managers within this short term framework by researchers who also had to work within a framework of complementary demand and deadlines.
- In two cases RNTCP and KSAPS interactive discussions with programme directors could not be completed so we used reported information monthly - both presentations at KTFH meetings and documents and one other programme due to time constraint. NLEP (Leprosy control) was not included. Since this review was trying to identify the broader policy issues relevant to Externally aided projects in general all the nitty gritty's of all the projects were not focussed upon.
- The study was also focussing on many issues that are neither easy to measure nor always easy to elicit because qualitative judgements on qualitative issues are often not easy to collect especially if the judgements are negative or critical. We must record however that most of the people interviewed showed a phenomenal degree of openness, frankness and willingness to discuss even 'sensitive' areas and this candidness is really appreciated.
- We have tried to do our best integrating the rich, response and feedback that was received in the interactive discussions supported by background notes and papers and our own reading and critical analysis of all the documents that we were able to access. The effort has been made to make this review a learning experience as a partner not as a critical external reviewer.
- We hope we have been able to collate and highlight the salient features – both strengths and weaknesses of EAP's when taken collectively. Much more needs to be done to address all the questions originally listed out, some have been answered, others only just considered. More time would definitely have helped. However the experience has shown that full justification can only be done if this review, both in-house and external becomes part of the ongoing Strategic Planning Cell of the Directorate / Ministry. If our study has helped to get this message across we would have felt fully complimented by our efforts.

### **L. Acknowledgements**

To the Karnataka Task Force in Health for the opportunity to make an overview of the externally aided Health projects of the state.

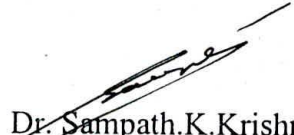
To all the project directors particularly Mr. Arvind Risbud (KHSDP, OPEC, KfW), Mr. Krishna Rao (IPP VIII and IPP IX), Dr. G.V.Nagaraj (RCH) and Dr. Jayachandra Rao (IPP VIII) Dr. Shamanna (NPCB-K) and all their consultants and supportive staff for the frankness and openness with which they participated in the review and made available reports and other documents.

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Finally to Mr. Anil Kumar (Secretarial cum Account Assistant) who typed the manuscript, Mr. M.Kumar (Administrative Officer) and the rest of the CHC office team, who particularly helped with all the operational aspects of the short term project.

*Ravi Narayan*

Dr. Ravi Narayan,  
Community Health Adviser,  
Community Health Cell,  
Bangalore.

  
Dr. Sampath.K.Krishnan,  
Policy Fellow &  
Research Associate,  
Community Health Cell,  
Bangalore.

Dated: 28<sup>th</sup> March 2001.



## **M. Bibliography**

(This is a partial bibliography which includes the main document / reports. It doesn't include all the aide Memoir's, review mission notes, newsletters, credit agreements, project partnership documents, submissions by project directors and other formal and informal documents).

### **General:**

1. Human Development in Karnataka, 1999. Planning Department, Government of Karnataka.
2. Analysis of Expenditure on Medical and Public Health, Family Welfare (Dr. S. Subramanya, KHSDP)
3. Case study of World Bank Activities in the Health Sector in India, May 1999 (Sector and Thematic Evaluations Group, Operations Evaluation Department, The World Bank).
4. Comments on 'Case study of World Bank Activities in the Health Sector in India', Ravi Narayan et al in Health and Equity – Effecting change, HIVOS Technical Report series 1.8 (2000).
5. A guide to sector – wide approaches for health development – concepts, issues and working arrangements, Andrew Cassels. (WHO, DANIDA, DFID, European Commission), WHO, 1997.
6. Towards Equity with Quality in Health (Karnataka), Interim Report of Task Force on Health and Family Welfare Karnataka.
7. Health Budget in Karnataka – Vinod Vyasulu ( a report presented to Task Force on Health and Family Welfare, Karnataka).
8. Handbook of Health and Family Welfare – Sector investment programme Department of Family Welfare, GOI and EC Health and FW programme office, March 2000.

### **IPP VIII:**

9. Family Welfare (Urban slums project) Brochure of IPP VIII, Bangalore.
10. Staff Appraisal Report, India, Family Welfare (urban slums) project, May 1992, The World Bank (India county operations department (10548-IN)

### **IPP IX:**

11. Strengthening of Family Welfare and Maternal and Child Health services India Population Project-IX Proposal, Department of Health and Family Welfare, Karnataka June, 1994.
12. IPP IX Background notes for World Bank Review Mission November 1999.
13. IPP IX Project Review and implementation status Report for World Bank Review Mission May 2000.
14. India: Family welfare project (Population IX) World Bank Review Mission Aide Memoire (May 2000).
15. IPP IX – Project implementation status, September 2000.
16. IPP IX World Bank Review Mission, Aide Memoire, September 2000.
17. Evaluation of ANM training for Tribal girls under India Population Project –IX – Innovative scheme (P.J. Bhattacharjee and R. Venugopala Raju), Population Centre, Bangalore, March 1999.

### **KHSDP:**

18. Karnataka Health Systems Development, Project proposal Department of Health and Family Welfare, GOK, May 1995.
19. KHSDP project proposal – January 1996.
20. KHSDP Referral system manual, June 1999.
21. Staff Appraisal Report, February 1996, The World Bank, (State Health Systems Development project II).
22. Procurement Workshop Manual, Second State Health Systems project (Karnataka, Punjab, and West Bengal) September 1996.

23. Status Report of Manpower position in Karnataka Hospitals, KHSDP, April 2000.
24. Overview of Training programmes under KHSDP and KfW project, KHSDP, June 1999.
25. Newsletters of the Strategic Planning Cell, KHSDP.

**KfW:**

26. Upgrading secondary level Health care facilities in the state of Karnataka, Final project proposal for KfW, Germany, Department of Health and Family Welfare, GOK, July 1995.
27. KfW project – Progress Reports numbers 8 to 12.

**OPEC:**

28. Project Proposal for OPEC Assisted Hospital at Raichur, Department of Health and Family Welfare, GOK, May 1996.

**RCH:**

29. Reproductive and Child Health services, Programme. District level Implementation Guidelines, RCH project Bureau, April 1999.
30. A brief note on Reproductive and Child Health, GOK, November 2000.
31. Reproductive and Child Health Project – status report, sub project Bellary, October 2000.

**UNICEF:**

32. Approach paper for 2000 – Karnataka, Hyderabad Field office, UNICEF.
33. Border Cluster Districts Project, A strategy paper (Sanjiv Kumar)
34. Reproductive and Child Health – UNICEF Cooperation – Achievements, Impact, Constraints – a hand out.

**RNTCP:**

35. Project Report for Revised National TB control programme, Department of Health and Family Welfare, GOK, 1997.
36. RNTCP – Project implementation plan, DOHFW / GOK April 2000.

**DANPCB / NPCB-K:**

37. National Programme for control of Blindness, Karnataka State profile, August 2000, State Ophthalmic Cell, GOK.
38. NPCB – Schemes for implementation during IX plan, 1997-2000 Ophthalmology / Blindness control section, DGHS, MOHFW, GOI.
39. NPCB – Guidelines for District Blindness control society, GOI.
40. NPCB – Course material for training in District programme GOI.
41. NPCB – Schemes for participation of voluntary organizations GOI.
42. DANPCB – Eye care through Primary Health centres.
43. DANPCB – Creating awareness and demand generation for cataract surgery.
44. DANPCB – Rapid Assessment of cataract Blindness, February 1997.

**NACO / KSAPS:**

45. The Karnataka Strategy on Management of HIV / AIDS – The way forward, KSAPS, September 2000.
46. NACO, Scheme for prevention and control of AIDS – Phase II.
47. KSAPS Project implementation plan, - Phase II – December 1998.



# APPENDIX - I

## Project Proposal

### **Review of externally Aided Projects in the context of their integration into the Health Services Delivery in Karnataka.**

#### ***Content List***

1. Introduction
2. Objectives
3. Methodology
4. Budget
5. Project Outcome
6. References
7. Appendices

#### **Submitted by**

Dr. Ravi Narayan, M.D. (AIIMS), D.T.P.H, (London), D.I.H. (U.K.)  
Community Health Adviser  
Community Health Cell  
367, 'Srinivasa Nilaya', Jakkasandra 1st Main,  
Koramangala 1st Block, Bangalore - 560 034.  
Tel / Fax: 5525372  
Email: sochara@vsnl.com

## 1. Introduction

Since mid 1990's, Karnataka Government has negotiated and received grants / loans from International Funding Agencies for an increasing number of Health related projects. These have included IPP - 8, IPP-9, KHSDP, KFW, RCH, Prevention of Blindness, RNTCP and other projects. These externally aided projects have their particular focus and framework and operational strategies to support and enhance both quantitatively and qualitatively different aspects of the Health Sector development. Each of them has had various mid term and concurrent reviews and some of them are currently reaching the end of specific phases. The Karnataka Task Force in Health while reviewing these projects informally in their discussions and deliberations have raised some important questions for review.

- i. "What are the learning points from each of these projects"
- ii. How can they be integrated into the health system incorporating beneficial points and avoiding distortions?
- iii. What are the issues for consideration of sustainability, accountability and transparency" (1)

This project proposal is a short-term initiative to explore some of these issues qualitatively as a preliminary to perhaps a larger study at a later date.

Community Health Cell is a technical Community Health and Public Health oriented policy research and training group that has reviewed external aided projects in the past. Four policy initiatives are relevant to this study.

- 1) Review of health projects in India supported by Misereor / Germany. (7)
- 2) Review of Health Partnership of Memisa in Netherlands. (6)
- 3) Review of partnership in Health (Cebemor Netherlands Government) (5)
- 4) Policy reflections on World Bank Activities in India - (see references) (3)

## 2. Objectives of Study

1. The study will review all the externally aided projects not just individually but in their collective context and relation to the Primary Health Care and Public Health system development in the state using a SWOT approach.

More specifically it will look at

- a. The **Strengths** of each project and the positive learning experiences.
- b. The **Weaknesses** or difficulties encountered in each project.
- c. The **Opportunities** that have been created or exist to enhance primary and public health care system development in the state.
- d. The **Threats** or distortions that may have been inadvertently caused by the project assistance to the health sector or that may be caused during the process of integration.

Some specific questions are in Appendix one, though a more structured approach will emerge after the literature, review.



### 3. Methodology

The time frame work of three months is too short to evolve a rigorous data based, quantitative approach to project design and therefore a more qualitative approach that will focus on a participation, interactive process is being suggested rather than an expert external review the method suggested will try to make it a collective learning experience for all concerned. Each project will be requested to allot atleast one project staff to be part of an evidence collecting, evidence sifting; and evidence collecting exercise.

The steps of the process will be

#### **A. Phase one 15<sup>th</sup> September - 15<sup>th</sup> October 2000**

- i. Literature Review of all project proposals and mid term/ concurrent reviews and aide memoirs.
- ii. Informal discussions with all project leaders and support team to clarify the nature and process of review and seek required support and participation (As a half day interactive workshop together, tentative date 10<sup>th</sup> October 2000.)

#### **B. Phase Two - 15<sup>th</sup> October - 30<sup>th</sup> November 2000**

- i. Qualitative interviews with Directors and staff of each of these projects and with a small representative sample of other stake holders including medical officers and other staff. (Some visits outside Bangalore will be required)
- ii. Interactive participation workshop with representatives of all the projects to address the issues of sustainability accountability etc. and all those issues, which are common to all projects and derive from phase one review. (atleast two, to be discussed at A. ii)
- iii. A questionnaire survey of some key aspects relevant to the study to be filled up by each project as 'evidence contribution' to the review.

#### **C. Phase Three – 15<sup>th</sup> November - 15<sup>th</sup> December 2000**

- i. Integration of all the data/evidence from phase one and phase two processes into a project analysis document.
- ii. Circulation of this document to all concerned with a weeks time framework for replies.
- iii. Incorporation of all comments / suggestions and final editing of a document to be submitted to KTFH hopefully not later than 15<sup>th</sup> October 2000.

## **4. Budget**

A budget proposal to support the study and including costs of Researchers, other assistance, office support including photocopying, computer facilities, postage, stationery, travel of research assistant and co-ordinator of study and some supportive costs for three interactive workshops is included in Appendix Two.

The study will be undertaken by Dr. Ravi Narayan of CHC supported by a full time research associate for 3 months and drawing upon short-term research assistance from some other members of CHC team on a flexi-time basis.

Some elements of the study / review are complementary to the project proposals of Mr. Vinod Vyasulu of Centre for Budget and Policy Studies, Dr. Ramesh Kanbargi of ISEC; Mr. As. Mohamed of SJMC and Dr. Pankaj Mehta of Manipal Hospital and so their involvement in some aspects of the study will be operationalised through informal interaction at no additional cost.

Finally to make the short term process more cost effective and efficient under the circumstances - close co-ordination with the project leaders will be established so that some aspects of the study including the interactive aspects can be linked to any ongoing schedule of meeting/training programmes or midterm/concurrent reviews so that opportunity costs are enhanced.

## **5. Project Outcome**

A project report highlighting a SWOT review of the External Aided Projects and Policy guidelines for integration, sustainability and future projects of this type.

## **6. References**

1. Topics for Action Research Studies identified by Task Force ( a KTFH handout)
2. Comprehensive Health, Nutrition and Population services development initiative in Karnataka (An idea draft from CHC)
3. Comments on Case Study of World Bank Activities in the Health Sector in India (A CHC policy reflection)
4. A Guide to sector-wide approaches for Health development - concepts, issues and working arrangements (Andrew Cassels) A WHO/DANIDA/DFID publication.
5. Programme Evaluation-Basic Health Services India (cebemo / icco/DGIS), October 1994. (CHC)
6. Partners in Health - Challenges for the next decade: A process review of the Indian Partnership of Memisa - 1989-1994, (October 1994. CHC)
7. Promoting Health in India: A process review of the Indian Partnership of Misereor, December 1994. (CHC)



## APPENDIX - II

### Integration of Externally Aided Projects in Health Services Delivery (Karnataka)

#### Some Issues and Questions to be addressed in the Review Project by Literature Review and Interactive discussions.

##### *A Check List*

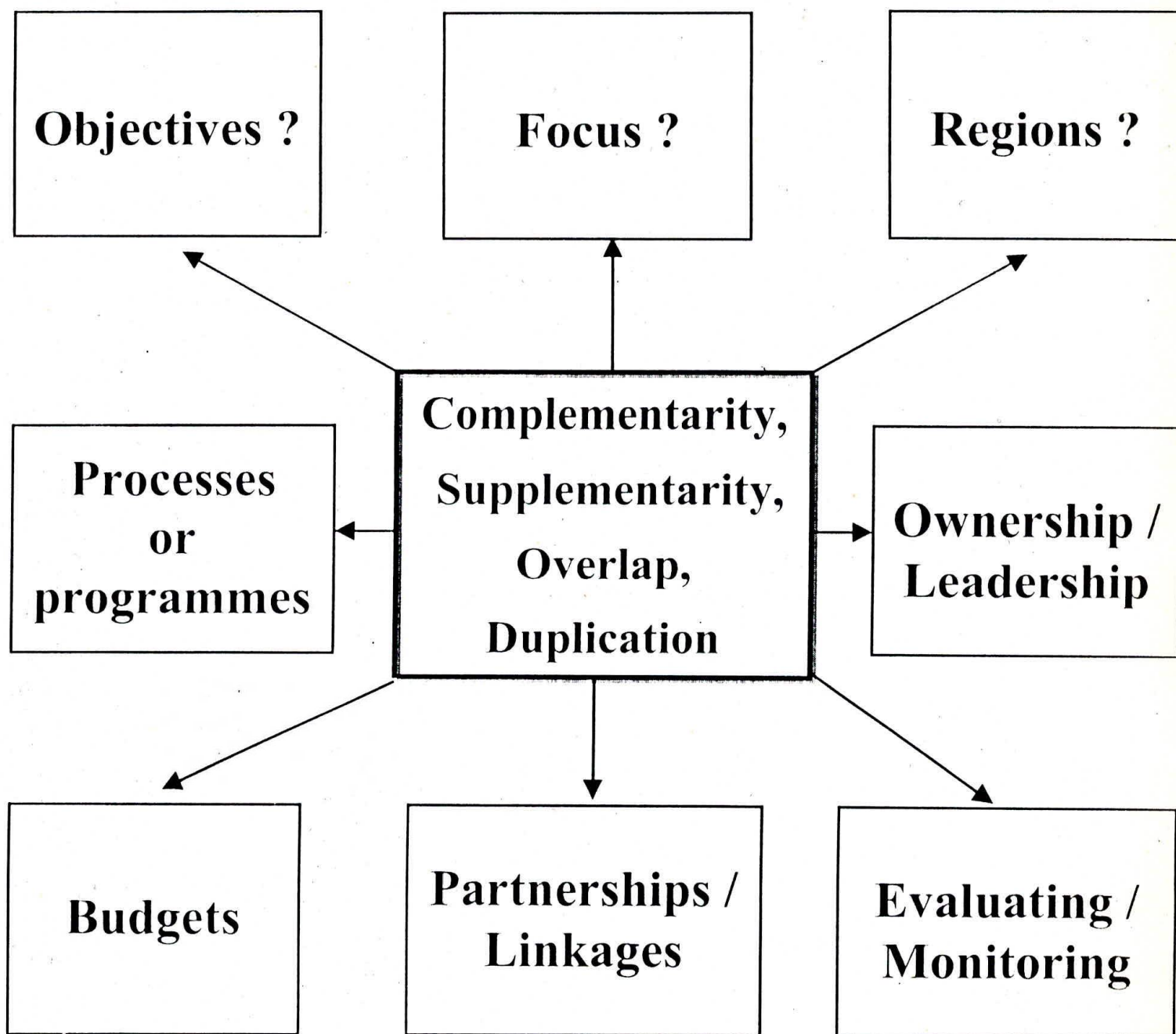
1. Descriptions of each project including year of starting, period, focus, objectives, components, programmes, budgets, reviews, etc.
2. Was the 'problem analysis' and the 'problem solution' comprehensive or selective?  
If selective then factors used for prioritization? or selection of strategies?
3. How does the project support,
  - a) Health System Development ?
  - b) Primary Health Care?
  - c) Public Health?
4. How is the project funded?
  - a) Direct or indirect
  - b) Loan agreement/conditionality
  - c) Repayment
  - d) Budget components etc.
5. What has been the experience of
  - a) financial management
  - b) disbursement
  - c) expenditure
  - d) delays
  - e) shortfalls, etc.
6. Is the project funding leading to distortions in spending priorities?
7. Are a reliance on projects perpetuating long-standing budgetary imbalances; implications on existing state health budget etc.?
8. Are there diversities in accounting/auditing procedures?
9. Strengths, Weaknesses, Opportunities, Threats of each project including those identified by mid-term reviews.
10. Are there problems of
  - a) Project flexibility
  - b) Overdesigned
  - c) unnecessary long lead time, preparation delays
  - d) Slow rates of disbursement
  - e) Complicated procedures
  - f) Any other managerial/operational problems.

11. Are there areas of overlap / duplication with other projects?
  - a) HMIS
  - b) IEC
  - c) Training
  - d) Staffing
  - e) Others
12. Are projects creating islands of excellence in an otherwise under funded sector?
13. Who drives the project?
  - a) State Health Directorate
  - b) Funding partners
  - c) External consultants
  - d) Others
14. Are there problems of :
  - i) Ownership
  - ii) Leadership
  - iii) Intersectorality
  - iv) Implementation
  - v) Monitoring and Evaluation
  - vi) Any other areas
15. How do the projects perform in the context of some policy imperatives:
  - a) Equity
  - b) Gender sensitivity
  - c) Regional disparities
  - d) Partnerships
    - i. NGOs
    - ii. Private sector
    - iii. Academics-Research
    - iv. Others
  - e) Accountability including corruption and political interference
  - f) Community involvement and partnership
  - g) Decentralization and Panchayatiraj
16. Do multiple projects make it difficult for the government to develop and implement a coherent health policy for the health sector as a whole?
17. What has the project done in the context of sustainability?
18. Any other cross cutting themes that emerge in the discussion between researchers and the project leaderships.

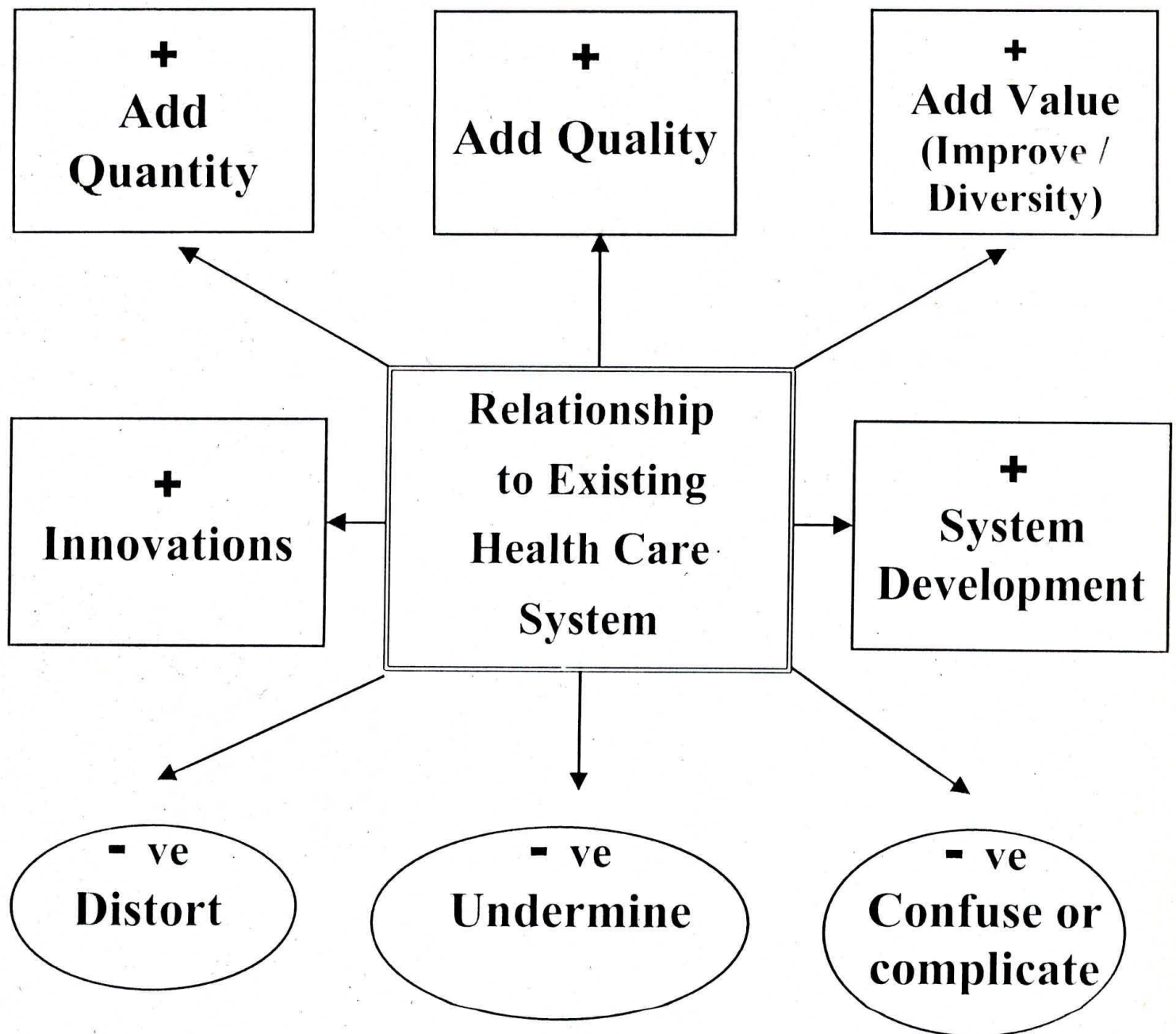


# **Integration of EAP's in Health Service Delivery Karnataka**

## **CONCEPTUAL FRAME WORK (2)**



**Integration of EAP's in Health Service Delivery  
Karnataka  
CONCEPTUAL FRAMEWORK (3)**





# **Integration of EAP's in Health Service Delivery Karnataka CONCEPTUAL FRAMEWORK (4)**

