TFHFW/5/2000.

PRESS RELEASE

The State of Karnataka has endeavored to develop itself into a welfare state. The bold initiatives taken during under the princely state of Mysore has been a precursor for many national level endeavors: The Urban Family Welfare Centres, the five-year plans, the primary health units, water and sanitation, Electrification, Local self governments. The state has experimented with and has implemented the Panchayathi Raj system for promoting decentralised governance.

The Government of Karnataka has constituted the Taskforce on Health and Family Welfare (vide Government order Health and Family Welfare 545 CGM 99, Bangalore dated 14-12-99). The terms of reference are broad. These include the following:

a. **Suggestions for delineating policy measure for improving the Public Health system in the state.** There is a need to strengthen the Primary Health Care Delivery system, making it more accessible to the poor and the poorest of the poor. We need to think, develop and implement services and systems that respond to the needs and aspirations of the larger sections of the society.

b. **Suggestions for improvement in the management and administration of the Department of Health and Family Welfare.**

c. **Recommend changes in the Health and Medical Education system** so that it fulfils the requirements of the people at the grass root level and simultaneously keeping up with the ever expanding vista of science and Technology, so that it could sincerely contribute to the Human Resources Development

In achieving its endeavor the task force intends to document the current health status of the people of Karnataka, review the situation with experts and different stakeholders and derive suitable, appropriate, pragmatic and meaningful recommendations so as to improve the quality of life of the people of Karnataka not just in the short term, but also in the long run. The terms of reference give the Task Force the mandate to monitor the implementation of its recommendations. The Task Force also plans to produce a draft health policy for the state in consonance with the National Health Policy and the new revised draft National Health Policy.

The members of the Taskforce have initiated the process of consultations. In this context we would like to request concerned individuals / organisations / institutions / Citizen groups / Professional bodies and all the people of the state to contribute towards the recommendations of the Task Force. The opinions / suggestions / comments / notes / thoughts or any related matter may be kindly be sent to the following address:

Dr. H Sudarshan,

Chairman, Task Force on Health and Family Welfare,

Ground Floor, PHI Building Annexe,

Sheshadri Road, Bangalore – 560 001

Phone : Extension 225 of (+80) 2271021 / 2277390 / 2274883 / 2245041 / 2245042

Fax : (+80) 2277389
Email : khsdp@vsnl.com
healthtaskforce@indiatimes.com

(Dr. Sudarshan) (Dr. S. Subramanya)

Chairman - Taskforce on Health Member - Convenor

Back

Search Results for ' medline '

Official Web Sites

Sites that most closely match your search term.

- PubMed - National Library of Medicine

Web Site Categories

1 - 5 of 5

Groups of reviewed web sites related to your search term.

- Medline - found in: Health > Medicine > Reference
- Patient Education - found in: Health > Education
- Professional - found in: Health > Resources
- Reference - found in: Science > Biology
- Journals - found in: Science > Biology

Reviewed Web Sites

1 - 10 of 67

Web sites reviewed and categorized by a team of editors.

- Pubmed Medline Editor's Choice
  (USA) The National Library of Medicine's MEDLINE and Pre-MEDLINE Database (WWW Access). This is the gold standard for MEDLINE searches.
  http://www.ncbi.nlm.nih.gov/PubMed/
  found in: Health > Medicine > Reference > Medline

- MEDLINEplus
  The National Library of Medicine's MEDLINEplus, the consumer version of MEDLINE, is designed to assist you in locating appropriate, authoritative sources containing information that will help you research your health questions.
  http://www.nlm.nih.gov/medlineplus
  found in: Health > Education > Patient Education

- NetMedicine
  Free database searches of the world's medical literature on MEDLINE and cutting edge medical information for healthcare professionals and consumers. Find specific medical information on the web with the revolutionary MedFinder search index. Cyber patient medical simulations.
  http://www.netmedicine.com/
  found in: Health > Resources > Professional

- Evaluated MEDLINE
  New, free MEDLINE search from BioMedNet; includes full-text links, Document Delivery Service from British Library, & personal search history allowing queries to be combined & refined.
  http://www.biomednet.com/db/medline/advanced
  found in: Science > Biology > Reference

- PubMed
  National Library of Medicine's search service that provides access to over 10 million citations in MEDLINE, PreMEDLINE, and other related databases, with links to participating online journals.
  http://www.ncbi.nlm.nih.gov/entrez/query.fcgi
  found in: Science > Biology > Journals

- HealthGate Data Corp

(USA) Medical site, includes MEDLINE, AGELINE, PsycINFO, EMBASE, Drug Information and other databases.
http://www.healthgate.com
found in: Health > Medicine > Reference > Medline

- A Guide to MEDLINE services
  Reviews various services including data range, access time, features and related services.
  http://www.omni.ac.uk/general-info/internet_medline.html
  found in: Health > Resources > Professional > Free Indexes

- A Guide to Medical Information and Support on the Internet
  Covers medical chats, newsgroups, listservs, doctors online, Medline access, research tips, and comprehensive medical and health sites.
  http://medguide.org
  found in: Health > Education > Patient Education

- MEDLINE
  Direct, public access to the NLM's MEDLINE Biomedical Literature Search Engine through the NCBI.
  http://www.ncbi.nlm.nih.gov/PubMed/medline.html
  found in: Science > Biology > Reference

- Journal Database Browser
  The PubMed Journal Browser allows you to look up journal names, MEDLINE abbreviations, or ISSN numbers for journals that are included in the PubMed system.
  http://www.ncbi.nlm.nih.gov/PubMed/jbrowser.html
  found in: Health > Education > Patient Education > Journals

Next 10 web sites for ' medline '

Search Again

medline Search

Search Categories

Arts	Health	Reference	Society
Business	Home	Regional	Sports
Computers	News	Science	World
Games	Recreation	Shopping	

Additional results for ' medline ' using Google!

 MS To open an account for Medline Pl. find out what the Subscription is. JN 22/2/2000

Overview

Help / FAQs

New/Noteworthy
NEW

Clinical Alerts

Consumer Health

Advanced Search

Clinical Queries

Journal Browser

MeSH Browser

Citation Matcher

Loansome Doc

Internet Grateful Med

NLM Home

NCBI Home

NIH Home

Credits

Restrictions on use

PubMed

Click here to enter the new PubMed System

NLM's search service to access the 9 million citations in **MEDLINE** and Pre-MEDLINE (with links to participating on-line journals), and other related databases.

Search MEDLINE for:

Number of documents to display per page: 20

Entrez Date limit: No Limit

- Enter one or more search terms.
- Author names should be entered in the form Smith JB, but initials are optional.
- Journal titles may be entered in full, as valid MEDLINE abbreviations, or as ISSN numbers (see Journal Browser for more information).

Questions or comments? Write to the Help Desk.

Department of Health & Family Welfare Services

Evolution of Health System in Karnataka

DHFW
DHS
DJD
DHO
TLH
CHC
PHC
NP
DISTRICT HOSPITAL
TERTIARY HOSPITAL
SUB CENTRE

Karnataka has developed its own Health care delivery system based on timely guidelines issued by the Government of India.The recomendations of BHORE'S committe, MUDALIAR committee and many other committees have been taken into considerations in providing comprehensive Health care at the door steps of community.During the previous five year planperiods a large network of primary health care infrastructure institutions covering the entirestae have been established.Wide range of communicable diseases namely Malaria, Filaria, Tuberculosis, Cholera and several other vaccine preventable diseases like Diptheria, Purtosis, Polio, Measles & Tetanus are given due importance. Several important non-communicable disease like Iodine deficiency disorder, Blindness, Cancer, Diabetes are also given due importance.

Major initiatives were taken to reach the goal of health for all by 2000 AD on the lines of policy directives issued by the Govenment of India keeping national health policy as a major objective.During the eighth plan period due emphasis was given to reach the entire population including the high risk venerable group i.e., Mother & Children and also to focus attention in the under previelaged segments of population in tribal areas.

The state Govt. keeping all the above factors into picture has created the Department of Health & Family Welfare under the leadership of Honourable Minister for health & Family Welfare & a seperate Minister for Medical education to fulfill the needs of the department. Next in order to reach all the activities of the Department of Health & Family Welfare, a seperate Directorate has been established to implement the programmes of the department.

KHSDP IPP

Next in order to reach all the activities of the Department of Health & Family Welfare, a seperate Directorate has been established to implement the programmes of the department.

To supplement the Health Care Delivery System the following departments are also established.

Directorate of Medical Education

Directorate of Indian System of Medicine & Homeopathy

Drugs Control Department

Evolution of KHSDP

Health services in Karnataka are being provided by the State at three levels, Primary, Secondary and Tertiary. Over the years, Primary Health Care has received considerable attention and resources through the State's own funding as also external agencies, through various India Population Projects. The main objective of these projects is to promote integrated family welfare through strengthening of the health infrastructure and planned improvement of the delivery system and the quality of health services at the primary level.

The Secondary Level of Health Care, comprising all rural hospitals of varying types and magnitude, has not, however, received attention and assistance on a similar scale. There are also marked disparities in the availability of infrastructure and the quality of services provided by these hospitals, across different regions in the State. The fact that the broad network of the secondary hospitals discharging, as they do, the essential first referral services all over the State, is only a natural and organic extension of the Primary Health Care system has now been recognised all over the world.

The Karnataka Health Systems Development Project (KHSDP) has been formulated for filling the glaring gaps within our Health Care System and also its thorough restructuring, in accordance with modern norms and the felt needs of the present day. Renovation and expansion of buildings, augmenting equipment and providing full complement of trained staff are planned to upgrade the secondary level hospitals. Several new components, such as formulation of an effective surveillance system, specific interventions for the disadvantaged sections, e.g. the scheduled castes and tribes, and, women, and measures to strengthen the institutional capability at various levels, as also an outline of the needed reforms in the Health sector.

The broad objectives of the project are to:

1. Improving the performance and quality of health care services at the district and sub-district level of the health care system,

2. Narrowing the current coverage gaps by facilitating access to health care delivery, and

3. Achieving better efficiency in the allocation and use of health resources.

The emphasis of this project will be on district and sub-district (or secondary) level health care institutions as the interventions at this level provide critical support to the entire primary health care network, enhancing its effectiveness and credibility and establishing essential linkages with the tertiary level.

The project components and sub-components are:

a). Management Development and Institutional Strengthening:

1. Improving the institutional framework for policy Development;

2. Strengthening management and implementation capacity; and

3. Developing surveillance capacity for major communicable diseases.

b). Improving Service Quality, Access and Effectiveness.

1. Extending/renovating Community, Taluka and District hospitals;

2. Upgrading their clinical effectiveness;

3. Improving referral mechanism and linkages with primary and tertiary level; and

4. Improving access and equity to disadvantaged sections.

Strengthening of Infrastructure Facilities:

Renovation of buildings and expansion of physical space will be carried out in 253 hospitals of the State with assistance from the World Bank in 201 hospitals in the Bangalore, Belgaum and Mysore Divisions, 52 hospitals in Gulbarga Division with assistance from KfW. A super speciality hospital will be constructed at Raichur with financial assistance from OPEC. During the project period over 5,600 beds will be added. All the facilities are also provided with adequate equipment and manpower. Based on the norms developed for equipment and staffing the facilities are being strengthened.

Maintenance of Facilities

Maintenance of facilities (building & equipment) being one the critical issue in providing better health care, concrete measures will be taken to address them as part of the Health Systems Project. For the first time a complete in-house maintenance set-up is provided for maintaining both building and equipment. As the management and disposal of hospital waste is a critical element in the effective functioning of a high quality health care system, it is proposed to establish a hospital waste disposal system on efficient and scientific lines.

Quality of Services

In order to improve the quality and effectiveness of hospital services in the government sector, a system of regular in-service training of all categories of staff is provided to update their clinical, managerial and maintenance skills. Training is focused on the clinical and practical skills so as to enable staff to provide good quality care in the range of services. Training also covers on the use of equipment by medical and paramedical staff and to carry out simple maintenance checks.

A systematic programme of quality assurance will be developed and implemented to cover aspects of clinical quality, user satisfaction and management of resources. This is to ensure that the interventions such as physical resources, implementation of staffing and equipment norms, training, and strengthening of management, etc., are actually translated into better quality of care. Such a system will empower managers, clinicians and technicians to monitor the quality of care provided by their own hospitals and assist in instituting rapid remedial measures wherever shortfalls in quality are noticed.

Referral Mechanism

A credible and an effective Referral System will be established in the State with new guidelines on the referral system. Such a system would provide patients access to levels of health care facilities that are appropriate for their need at minimum cost and delay. Continuity of care is ensured which includes follow up and long term therapy and rehabilitation.

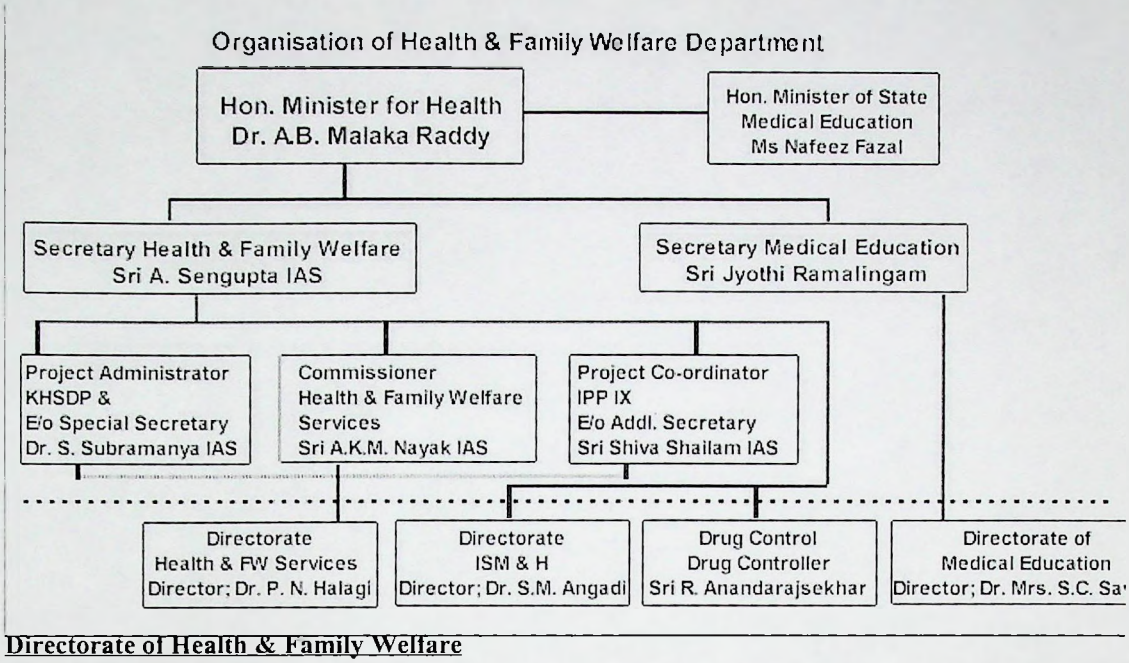
Innovative Schemes

The state has also come up with innovative ideas to provide access and health care to disadvantaged sections of the population. Large number of such innovative schemes are planned to be launched throughout the state and continued on a permanent basis

The Project Budget

CIVIL WOR
YELLOW CA
WASTE MG
PROTOCOL
EQUIPMENT
DRUGS
STAFF
TRAINING
FINANCE
GOVT. ORD
MANUALS
RELATED P

Components	Million Rs	
Policy Frame Work & Implementation Capacity		522
Policy Frame Work	49	
Implementation Capacity 43.32	473	
Improving Service Quality Access and Effectiveness		3898
Extending / renovating Community/ Taluka and District Hospitals 276.34	2982	
Upgrading their clinical effectiveness	316	
Improving referral mechanism and linkages with primary and tertiary level.	106	
Improving access and equity to disadvantaged areas	494	
Physical & Price Contingencies		1499
Physical Contingency 32.33	709	
Price Contingency 105.00	1090	
Total Project cost including contingencies		5919



Directorate of Health & Family Welfare

Directorate of Health & Family Welfare Services

The Directorate of Health & Family Welfare Services is responsible for:

- Providing Health Care Services through various types of institutions.
- Providing Family Welfare and Immunisation Services.
- Implementing National Programmes for eradication/control of diseases.
- Implementing Externally Aided Projects.

Health Care Services

Curative services under allopathic system of medicine are provided by Hospitals in large and medium urban centres and by Three Tiered Health Infrastructure in smaller urban centres and villages.

There are 176 hospitals (including those attached to medical colleges) with total bed strength of 23,223.

	Institutions	Beds
District Hospitals	16	5788
Teaching Hospitals	9	5907
Major Hospitals	8	1521
Specialised Hospitals	16	3330
General / Maternity Hospitals	127	6677
All	176	23223

Three Tiered Health Infrastructure

The Three Tired Infrastructure to provide curative, preventive and promotive health services consists of Community Health Centres, Primary Health Centres and Sub-centres have been patterned along the guidelines provided by the Government of India. In addition there are institutions known as Primary Health Units which also provide curative, preventive and promotive health services.

	Institutions	Beds
Community Health Centres	130	4,263
Primary Health Centres	1,561	11,297
Primary Health Units	569	702
Sub-centres	8,143	0

National Programmes From Central Govt.

- National Aids Control Programme
- National Leprosy Eradication Programme
- National Tuberculosis Control Programme
- National Programme for Control of Blindness
- National Malaria Eradication Programme
- National Family Welfare Programme
- National Filaria Control Programme

Home | Org.Chart

Primary Health Care Centres

Details of Primary Health Centres

1. *Members*:
   - Medical Officer
   - Paramedical Staff + Other Staff
2. *Number of Beds:4-6*
3. *Population:*
   - Plain Area:30000
   - Hilly/Tribal Area:20000
4. *Activities*
   - Curative & Preventive Services
   - Promotive Services
   - Family Welfare Services

Home | Org.Chart

Different Types of Curative & Preventive Services

Preventive Services
The various programs that come under preventive services are as follows:

- DPT Vaccination(First,Second,Third & Booster doses)
- Polio Vaccination(First,Second,Third & Booster doses)
- BCG Vaccination
- Measles Vaccination
- DT Vaccination(For children below 5 years)
- TT Vaccination(For children of 10 & 16 years of age)
- IFA to chidren(1,2,3.....Doses)
- Vitamin 'A' to children(1,2,3.....Doses)

Curative Services
The various programs that come under curative services are as follows:

- Registration,Referral & Follow-Up of TB cases
- Registration,Referral & Follow-Up of Leprosy cases
- Malaria Blood Smear collection,presumptive & radical treatment
- Providing ORS
- Recording communicable diseases & follow-up
- Registration,Referral & Follow-Up of disability cases
- Registration,Referral & Follow-Up of Acurate respiratory infection cases
- RTI/STD ases recorded

Different Types of Promotive Services

- Registration & follow-ups of Ante-Natal Care(Follow-up No: 1,2,3)
- TT doses for Mothers(1,2,booster)
- Initiation & completion of IFA for mothers
- Conducting Deliveries
- Post-Natal Care

Different Types of Family Planning Services

The various programs that come under Family Welfare services are as follows:

- Contacting Eligible Couples
- Family Welfare folloe-Up
- Referring for Vasectomy & Tubectomy
- IUD insertion & Removal
- Supply of Condoms & Oral Pills
- Registration & Follow-Up of MTP

Home | Org.Chart | PHC

Different Types of Curative & Preventive Services

Preventive Services
The various programs that come under preventive services are as follows:

- DPT Vaccination(First,Second,Third & Booster doses)
- Polio Vaccination(First,Second,Third & Booster doses)
- BCG Vaccination
- Measles Vaccination
- DT Vaccination(For children below 5 years)
- TT Vaccination(For children of 10 & 16 years of age)
- IFA to chidren(1,2,3.....Doses)
- Vitamin 'A' to children(1,2,3.....Doses)

Curative Services
The various programs that come under curative services are as follows:

- Registration,Referral & Follow-Up of TB cases
- Registration,Referral & Follow-Up of Leprosy cases
- Malaria Blood Smear collection,presumptive & radical treatment
- Providing ORS
- Recording communicable diseases & follow-up
- Registration,Referral & Follow-Up of disability cases
- Registration,Referral & Follow-Up of Acurate respiratory infection cases
- RTI/STD ases recorded

Different Types of Promotive Services

- Registration & follow-ups of Ante-Natal Care(Follow-up No: 1,2,3)
- TT doses for Mothers(1,2,booster)
- Initiation & completion of IFA for mothers
- Conducting Deliveries
- Post-Natal Care

Different Types of Family Planning Services

The various programs that come under Family Welfare services are as follows:

- Contacting Eligible Couples
- Family Welfare folloe-Up
- Referring for Vasectomy & Tubectomy
- IUD insertion & Removal
- Supply of Condoms & Oral Pills
- Registration & Follow-Up of MTP

Home | Org.Chart | PHC

Different Types of Curative & Preventive Services

Preventive Services
The various programs that come under preventive services are as follows:

- DPT Vaccination(First,Second,Third & Booster doses)
- Polio Vaccination(First,Second,Third & Booster doses)
- BCG Vaccination
- Measles Vaccination
- DT Vaccination(For children below 5 years)
- TT Vaccination(For children of 10 & 16 years of age)
- IFA to chidren(1,2,3.....Doses)
- Vitamin 'A' to children(1,2,3.....Doses)

Curative Services
The various programs that come under curative services are as follows:

- Registration,Referral & Follow-Up of TB cases
- Registration,Referral & Follow-Up of Leprosy cases
- Malaria Blood Smear collection,presumptive & radical treatment
- Providing ORS
- Recording communicable diseases & follow-up
- Registration,Referral & Follow-Up of disability cases
- Registration,Referral & Follow-Up of Acurate respiratory infection cases
- RTI/STD ases recorded

Different Types of Promotive Services

- Registration & follow-ups of Ante-Natal Care(Follow-up No: 1,2,3)
- TT doses for Mothers(1,2,booster)
- Initiation & completion of IFA for mothers
- Conducting Deliveries
- Post-Natal Care

Different Types of Family Planning Services

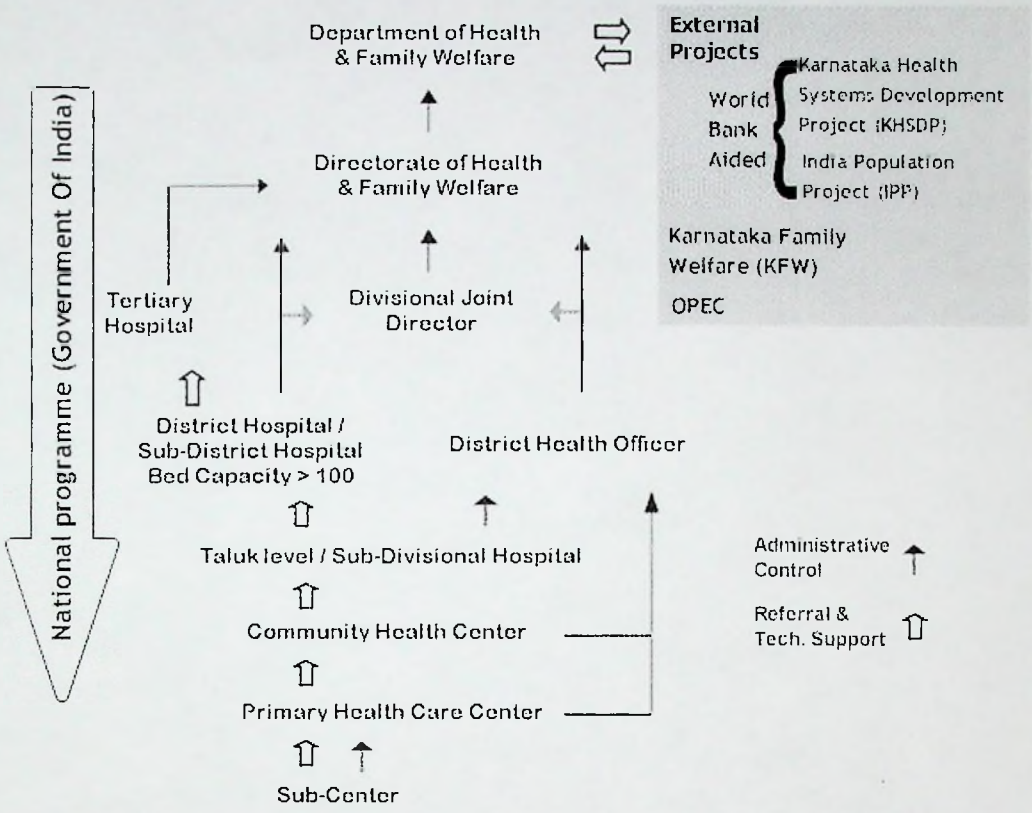
The various programs that come under Family Welfare services are as follows:

- Contacting Eligible Couples
- Family Welfare folloe-Up
- Referring for Vasectomy & Tubectomy
- IUD insertion & Removal
- Supply of Condoms & Oral Pills
- Registration & Follow-Up of MTP

Home | Org.Chart | PHC

<% newsarea = request("newsarea") %>

Organizational Structure of the Department of Health & Family Welfare Services (Govt. of Karnataka)



National Programmes From Central Govt.

- National Aids Control Programme
- National Leprosy Eradication Programme
- National Tuberculosis Control Programme
- National Programme for Control of Blindness
- National Malaria Eradication Programme
- National Family Welfare Programme
- National Filaria Control Programme

Home | Org.Chart

Divisional Joint Directors

The four divisions in Karnataka are:

1. Bangalore Division
2. Mysore Division.
3. Belgaum Division.
4. Gulbarga Division.

Home | Org.Chart

Brief Introduction About District Health Office:

The District Health Officer is the head for an District Health Office the following are the activities that are performed in a District Health Office:

- Supervise taluka medical activities
- Co-Ordinating PHC activities
- Monitoring referral systems.
- Quality Assurance.
- Surveillance of Communicable Diseases.

Organizational set-up in Districts:

Organisational set-up in the District there is one Divisional Joint Director in-charge of each of the four Revenue Divisions and report to DHS. In each district, there is a District Surgeon to manage the district hospital and a District Health Officer (DHO) to manage primary health care,all hoapitals other than those under the District Surgeon,and programmes to control diseases.The activities managed by DHO fall under the jurisdiction of the Zilla Panchayat.Consequently ,he reports to the Chief Executive Officer(CEO) of the Zilla Panchayat .who is an IAS officer.The DHOs are under the administrative control of the DHS in so far as evaluation of their performance,promotions and transfers are concerned.The organisational set-up under the DHO is almost similar to that under DHS

The Zilla Panchayats receive grants from the State Government to meet expenditure on health care.Such grants and actual express are reflected in the Health Budget of the State,under the District Sector component.

The Karanataka panchayat Raj act,1993which is now in force in the state,specifies the functions to be performed by the zilla panchayats,taluka panchayats,and the grama panchayats.The matter to be dealt with by the zilla panchayat,in respect of health and family welfare,at the district level,are:1.management of hospitals and dispensaries excluding the district hospital and other hospitals under the direct management of Government (above 50 beds).2.Implementation of maternity and child health programmes;3.Implementation of family welfare programmes;(4)Implementation of immunisation and vaccination programmes.The taluka panchayats deal with;1.Promotion of health and family welfare programmers ;2.promotion of immunisation and vaccinatoin programmes at the taluka level ,3.health and and sanitaton of fairs and festivals .At the village level the grama panchayats deal with implementation of family welfare programmes,preventive measures againest epidemics,regulation of sale of food articles.partucipation in immunisation programmers,licensing of eating establishments and regulation of offensive and dangerous trades.apart from operating the district sectorbudget,the zilla panchayats also

Implement such state sector schemes as are entrusted to them by government .

Home | Org.Chart

Brief Introduction About District Hospital:

The District hospitals are located in the district headquarters of each of the 27 districts & cater to the health needs of 2 million population on an average. The District Surgeon is the Head for a District Hospital & the following are the service facilities that are offered in a District Hospital. :

1. General & speciality outpatient care.
2. Emergency/Casuality services.
3. General & speciality in patient care.
4. General & special diagnostic & therapeutic facilities.
5. Post Mortem facilities.

The district surgeon, in addition to overall supervision of patient care in the district hospital, ia also responsible for the following areas.

- Maintenance of Equipment.
- Waste Management.
- Training of Technical Staff.
- Monitoring referral systems.
- Quality Assurance.
- Surveillance of Communicable Diseases.
- User Fees.
- Medical supervisory powers to lower level hospitals like training,equipment repairs etc.(Implemented by KHSDP)

Organizational set-up in Districts:

Organisational set-up in the District there is one Divisional Joint Director in-charge of each of the four Revenue Divisions and report to DHS. In each district, there is a District Surgeon to manage the district hospital and a District Health Officer (DHO) to manage primary health care,all hoapitals other than those under the District Surgeon,and programmes to control diseases.The activities managed by DHO fall under the jurisdiction of the Zilla Panchayat.Consequently ,he reports to the Chief Executive Officer(CEO) of the Zilla Panchayat .who is an IAS officer.The DHOs are under the administrative control of the DHS in so far as evaluation of their performance,promotions and transfers are concerned.The organisational set-up under the DHO is almost similar to that under DHS

The Zilla Panchayats receive grants from the State Government to meet expenditure on health care.Such grants and actual express are reflected in the Health Budget of the State,under the District Sector component.

The Karanataka panchayat Raj act,1993which is now in force in the state,specifies the functions to be performed by the zilla panchayats,taluka panchayats,and the grama panchayats.The matter to be dealt with by the zilla panchayat,in respect of health and family welfare,at the district level,are:1.management of hospitals and dispensaries excluding the district hospital and other hospitals under the direct management of Government (above 50 beds).2.Implementation of maternity and child health programmes;3.Implementation of family welfare programmes;(4)Implementation of immunisation and vaccination programmes.The taluka panchayats deal with;1.Promotion of health and family welfare programmers ;2.promotion of immunisation and vaccinatoin programmes at the taluka level ,3.health and and sanitaton of fairs and festivals .At the village level the grama panchayats deal with implementation of family welfare programmes,preventive measures againest epidemics,regulation of sale of food articles.partucipation in immunisation programmers,licensing of eating establishments and regulation of offensive and dangerous trades.apart from operating the district sectorbudget,the zilla panchayats also

Implement such state sector schemes as are entrusted to them by government .

Home | Org.Chart

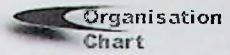
Community Health Centres

Details of Community Health Centres

1. *Members*:
   - Surgeon
   - Gynaecologist
   - Physcician
   - Paediatrician
   - 21 Paramedical Staff + Other Staff
2. *Number of Beds*:30
3. *Population:*
   - Plain Area:120000
   - Hilly/Tribal Area:80000
4. *Facilities*
   - Operation Theatre
   - Labour Room
   - Laboratory

Home | Org.Chart | Job Responsibilities Manual

<% newsarea = request("newsarea") %>
Sub-Centre's
<% if not isEmpty(newsarea) then %>



home

Details of Sub-Centres

1. *Members*:
   - Multi-Purpose Female workers
     (Females are also called Auxillary Nursing Midwives{ANMs})
   - Multi-Purpose Male workers
2. *Population:*
   - Plain Area:5000
   - Hilly/Tribal Area:3000

OPEC Project

The super speciality hospital at an estimated cost of Rs. 29.25 crores at Raichur is assisted by OPEC. This super speciality hospital will cater to the needs of the people of the districts of Gulbarga Division. There are two phases in this project.

* The improvements and repairs along with upgradation to the existing 250 beded district hospital to be developed as Women & Children Hospital. The total estimated cost of is Rs. 2.86 crores.

* Construction of 350 beded super speciality hospital at a total project cost of 26.3 crores. For this work, the tenders are already issued and expected that the construction activity will start in the month of April/May 1997.

Even though the project agreement was signed in 1991, due to various constrains, the project could not take of till 1995-96. Now the project activities have been started and it expected that the project will be completed by 1998 as agreed to.

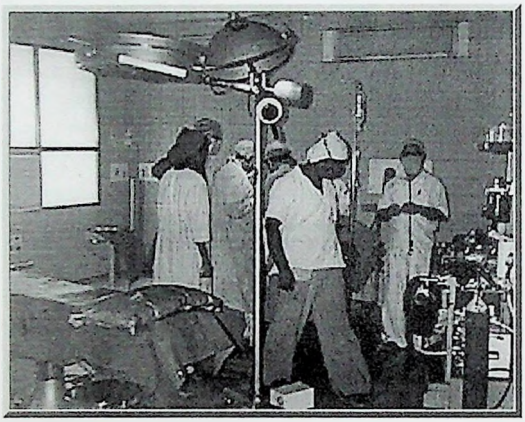
Home | Org.Chart

Photographs taken at District Hospital - Tumkur

Tumkur situated 70 Kms from Bangalore has a District Hospital with 330 beds. The hospital has bed occupancy rate of more then 85%. The civil works of the District Hospital is almost being completed. The hospital has all infrastructure viz., Major OT, Radiology Block with Ultrasound room, endoscopy room, IPP OT labour theatre, an upgraded causality department and outpatient department of various specialties The maternity section has been provided with a foetal monitor for the improvisation of the obstetric work.

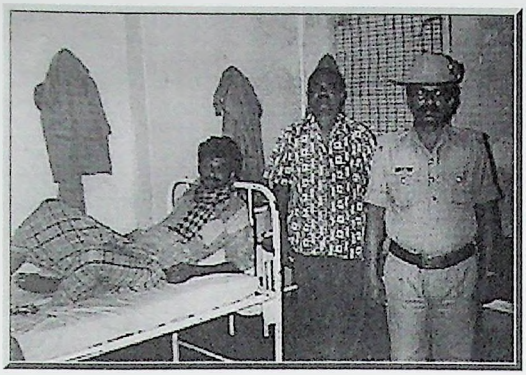
Home

The Female Ward

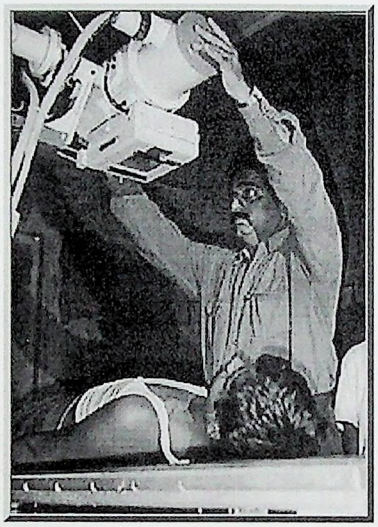


Operation Theatre

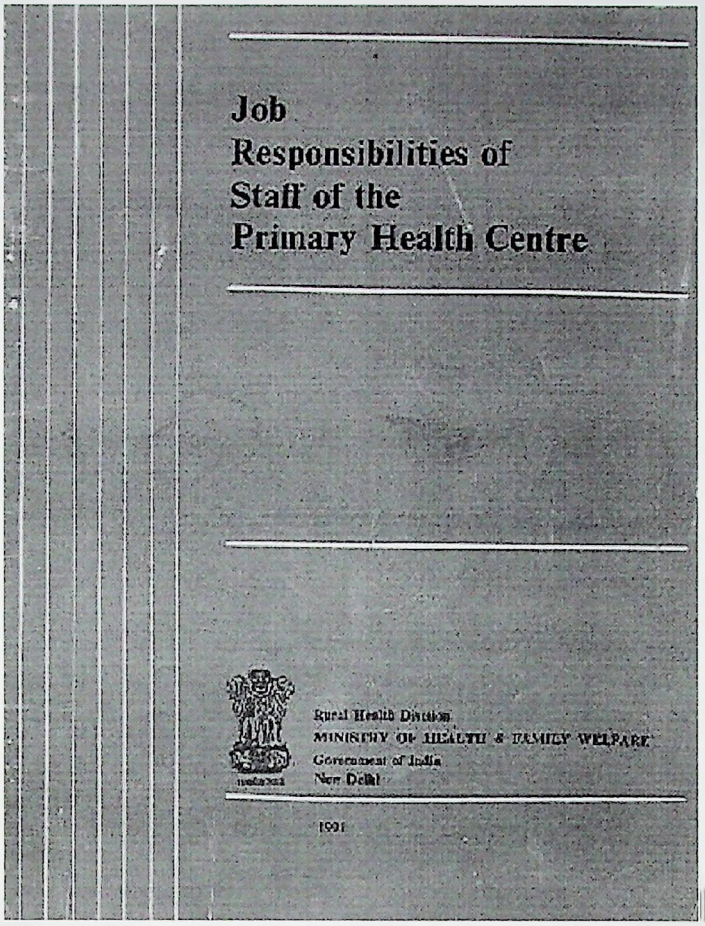
Pharmacy



Jail Ward



X-Ray Equipment


Job
Responsibilities of
Staff of the
Primary Health Centre
Rural Health Division
MINISTRY OF HEALTH & FAMILY WELFARE
Government of India
New Delhi
1991

Next

Job Responsibilities of Staff of the Primary Health Centre

Rural Health Division
MINISTRY OF HEALTH & FAMILY WELFARE
Government of India
New Delhi
1991

Next

ACKNOWLEDGEMENT

This booklet is the revised version of earlier published 'Job Responsibilities of Staff of Primary Health Centre' brought out in 1986. The revised responsibilities incorporate the policy changes which have taken place in National Health Programmes during the past 5 years. Maternal & Child Health Programmes have been brought into sharper focus because of the priority attached to these programmes by Government of India. An attempt has been made to define the duties of Health Providers in the programmes like ARI, Diarrhoeal diseases and Maternal Health Care.

I am grateful to all the National Health Programme Officers for the changes suggested for each category of Health Providers to meet the needs of their programmes which have tried to incorporate.

I am also thankful to Dr. (Mrs.) T. Bhasin, Assistant Commissioners(RHS), who has taken keen interest in the revision of this booklet. Without her efforts, it was not possible to update this document.

New Delhi
6th May, 1991

Dr. (Miss) A. Bhardwaj
Deputy Director General (RHS)

Next

Contents

Next ➔

The Daily Star
Prepared by Onirban

Features

Volume 1 Number 312 July 04, 1998

Onirban

CHITTAGONG HILL TRACTS

Seeking Options for Better Land Use

by Zulfiqar Ali

THE area of Chittagong Hill Tracts, comprising the three hill districts - Rangamati, Khagrachhari and Bandarban - is 13181 sq. kilometres. The area is composed of hills, valleys, ravines and cliffs. The land is uneven.

In the year 1961 the then government of Pakistan engaged a Canadian company - Forestal International - to survey the soil and topography of Chittagong Hill Tracts. The survey conducted by them revealed that most of the soil of the area is very poor. The Forestal report had graded only 3.2 per cent of the land as category A - suitable for cultivation. It may be mentioned here that currently, only 2,90,000 acres are under cultivation in the three hill districts.

The B grade land accounted for 2.9 per cent as suitable for terraced agriculture. They graded 15.5 per cent of land as category C which were found to be suitable mostly for horticulture and partially for afforestation. The next category C-D accounted fore only 1-4 per cent. Finally category D which was about 7 per cent of the area and might be used only for afforestation.

Many of the educated people of the country think that in CHT vast cultivable land is lying vacant and kept fallow unnecessarily. This reflects their ignorance about the area. From the above information one may conclude that the arable land is scarce. The scarcity of land, when taxed by the settlement of plainlanders during late 70s and early 80s, became more acute. Scarcity of land was thus the basic cause of conflict which continued in Chittagong Hill Tracts for more than two decades.

Jhum cultivation is an integral part of the way of life and culture of the tribal people. Because of the land pattern there is no other alternative than to adopt Jhum cultivation in most of the areas in Chittagong Hill Tracts, though there are also constrains of Jhum cultivation. Apart from soil erosion, the same land cannot be cultivated twice in succession without a normal cycle of 5 to 10 years. The increase in population has increased the pressure on land thereby reducing the Jhum cycle from 5-10 years to 2-3 years, which aggravates the situation with the decrease in fertility of soil.

By the end of last century, the then British government had started encouraging plough cultivation. To this end the government provided loans to the plough cultivators. The initiative was partially successful. A portion of the flat land came under plough cultivation, though the cultivators were the plainlanders

from the neighbouring Chittagong. But it failed to make any headway at that time in the way of life of the tribal people because of their love for a free style sort of life. The plough cultivation had aimed at settling the tribals at a particular place to facilitate collection of revenue. The hill men are not nomadic in the true sense of the term. They generally move within the mouza they use to reside in.

The survey conducted by Forestal International, among others, had recommended to undertake orchard plantation in Chittagong Hill Tracts. The government initiative to develop horticulture during late 60s was successful as far as fruit gardens were concerned, but the government efforts ultimately did not succeed due to bad communication system, lack of credit, storage and marketing facilities. Over the years the communication system in the area has developed to a satisfactory level which coupled with credit and marketing facilities may open a new horizon for the development of the people as well as the area. As the arable land available is very scarce, for the best use of the land large scale afforestation and orchard may be undertaken. But before doing that arboureal survey may be conducted in the area.

The Chittagong Hill Tracts Regulations of 1900 and the rules made under Regulation 18 were and still are the guiding principles relating to land administration and land revenue. The three circle chiefs and the mouza headmen are the main instruments in the field of land management in the Chittagong Hill Tracts.

The question of conducting cadastral survey of the area did not arise earlier because of its status as a non regulation district and the existence of a different pattern of life style of the hill people. Due to the system prevailing there the hill people, in general, were not required to take lease of land by name. According to the Chittagong Hill Tracts Regulation of 1900 and the rules framed there under it, the hill people used to enjoy a kind of customary and community right on land, although the land belongs to the state. A hillman can settle to a place of his choice within the mouza he used to reside with an intimation to the mouza headman. The mouza headman keeps record of land settled in favour of a person. So most of the hill people did not require documents relating to settlement or ownership of land. Certain amendments, relating to land management incorporated in the regulation, made during the British, Pakistan and post independence period, as the hill men feel, have infringed the customary and community right on land. The increase in population has increased the pressure on land which has since not only changed the relationship between the hillmen and the non-hillmen but also indirectly curtailed their customary right on land.

The three circle chiefs - the Chakma chief, the Bohmong chief and the Mong chief - used to collect land revenue on behalf of the government from the mouza headmen appointed by the Deputy Commissioner in consultation with the respective circle chief. The mouza headmen used to collect land revenue from within his mouza and maintain records of land, land settled and transferred. There are no Tahsildars in the three hill districts. The two traditional offices in Chittagong Hill Tracts - the circle chief and mouza headman - may be strengthened for the purpose of land administration and collection of land revenue. The headmen with the basic training on land matters, may efficiently perform the functions of Tahsildar.

[Top][Home][Onirban Online]

In Oil and Gas

The Labyrinth Must End

by Md. Shah Jahan

AT the end of the dark tunnel of our national life, since independence, we sighted a flicker of hope when we were told that our country was "floating on oil and gas." We had thought our dark nights of poverty were over. We dreamed of a bright morning which would give real meaning to our independence. But what we see and hear now all around is totally disheartening. It is alleged that deep conspiracies are underway to grab our natural resources through lobbying by the local agents, which was totally prohibited in the 70s.

In the absence of transparency in awarding Production Sharing Contracts to foreign companies and dealing with the bidding process there exists a total chaos and confusion. Baseless, motivated and contriving figures of gas reserve have been doled out by the multinational companies. Goaded by these figures our former Energy Minister remarked that Bangladesh had a gas reserve of 80 TCF to 100 TCF. But national experts say our gas reserve is 10.5 TCF. The potentiality of gas reserve in our country said Dr. Badrul Imam, Chairman of the Geology Department, Dhaka University, can be around 25 TCF.

It is alleged that the Government has no regard for the 1995 Energy Policy and also did not formulate a clear national strategy identifying national priorities to optimise the benefit from gas for present and future generations. It is pursuing an aimless policy in the energy sector. People are in the labyrinth of numerous questions: What is the extent of exact gas reserve we have in the country? Should we lease out all the blocks at a time to foreign companies? If we do so what will be the consequences?

Do we have enough expertise to supervise activities of foreign companies? How best we can use our gas reserve? What potentiality we have for alternative energy in case of exhaustion of our gas reserves?

Though Petrobangla, directly and through its subsidiaries like BAPEX, Titas, Bakhrabad Gas and others, has made significant contributions in discovery of oil and gas, in developing technological expertise in exploration, production and distribution and management of oil and gas sector, but today it has been cornered and many of its senior experts have left it, causing serious vacuum in Petrobangla.

Since 1989 BAPEX alone made five exploratory wells out of which four were discovery well and one was dry wells in addition to its having done development and appraisal work, and work-overs of many producing wells. But it is alleged that systematically this national organisation is made crippled with the pretext of lack of fund - BAPEX is not being awarded contracts and has rather been kept in the process of total elimination.

As a national petroleum organisation BAPEX should be properly equipped so that it can play important role in developing and harnessing natural resources and also can transcend national boundary and earn money for the country. Under the Production Sharing Contracts all costs in the name of development are recoverable by the contractor. It is alleged that contractors are recovering expenditure even for the "drinks consumed by their men" under cost recovery heading. BAPEX should be entrusted with the responsibilities of supervising activities of multinational companies operating under PSCs in various blocks.

To strengthen BAPEX the lucrative blocks 9,10 and 11 should be kept reserved for it instead of putting forward motivated argument of lack of fund. It can be argued that if we could provide fund while our economy was still under the rubbles of war in 1974 then why we cannot provide such funds today? BAPEX is made disable at the very labour room by assigning to it only the responsibilities of exploration which means it will only incur costs but no profit. Government should allow BAPEX to work freely and to try to arrange its own funds by floating shares in national and international markets.

[Top][Home][Onirban Online]

Cropland Agro-forestry
Potential Area for Intervention

by Arifa S Sharmin

ONE of the major challenges facing all countries of the South Asian Region is to find means of producing enough food to feed rapidly increasing population and, at the same time, combat poverty and increasing rate of deterioration of their natural resources. Forestry is one of such important sectors where the rate of deforestation has reached an alarming position.

In Bangladesh, forest lands constitute only 15 per cent of the total land area and the actual green coverage is hardly 6 per cent. On the other hand, the current annual rate of deforestation is about 3 per cent, against a much lower deforestation rate in South Asia (0.6 per cent) as a whole during 1981-1993 (FMP, 1993).

As a result of increasing population, demand for tree products like timber, fuel wood, fodder, fruit etc. is increasing, whereas supply of such products is decreasing as a result of declining supply sources.

Different studies revealed that, present demand for wood is estimated at 476.75 million cubic feet per annum. Forest Department of the Bangladesh Government could only meet 24 per cent of the demand and village forestry sources meet 70 per cent of the increasing demand for timber. Besides, 90 per cent fuel wood and bamboo supply come from village forestry.

With this in mind, in 1987, Village and Farm Forestry Programme (VFFP) of Swiss Agency for Development and Co-operation (SDC) intervened as an innovative pilot research project in the north western district of Bangladesh. Considering the scope and reality, VFFP try to introduce tree in the existing crop field and woodlot in the degraded land and intensify homestead tree plantation in a way that will restore many of the benefits of the villagers along with solving problems of land degradation and storage of fuel wood, poles and fodder.

In the primary stage, VFFP concentrated its work under some selected areas of the northern districts of Bangladesh. The main focus of the programme is to promote private planting on private land. VFFP concentrated to introduce tree in the existing crop field and woodlot, in the marginal land and intensify homestead tree plantation with view to solve problems of timber, fuel wood, fodder and fruits which will ultimately contribute towards mitigating the increasing cash problem of villagers.