HP 1

Chapter 2

Organisational Reform, Project management, monitoring and research

" God grant me the serenity
To accept the things I cannot change;
The courage to change the things I can;
And the wisdom to know the difference;"

- Reinhold Niebuhr.

2.1 Reforms in Administration

The current structure of health services has evolved over the years, with differing emphasis on the preventive and curative aspects at various points of time. There is a need for the reinstitution of a **strong public health** element in health services. This element, which was the foundation on which these services were instituted, has virtually disappeared due to changing approaches towards the content of these services, mainly from a preventive approach to a curative approach. It is evident that even in current times the absence of the public health element has resulted in skewed services, de-emphasizing fundamental issues such as sanitation and prevention. What would seem essential is to reconstitute the system to have a fair balance between both preventive and curative approaches.

The proposed re-structuring of health services has been indicated by the Task force in its Final Report. The current posts have been redistributed / redesignated. For example, the Maintenance / Engineering Division now included in the Directorate is the transfer, in effect, of the one that is now part of the Karnataka Health Systems Development Project. Also, the posts at all levels have been redistributed..

The posts indicated do not include supporting staff. It would also be necessary to take into consideration the current levels and numbers in the professional cadres while putting in place the proposed structure with the revised positions and designations. The Task Force has kept the following main principles in view while considering the changes to be made in the structure of health services:

1. The emphasis on Public Health should be revived and its essentiality recognized;
2. Separate cadres would be constituted for Public Health and Medical (clinical) responsibilities of the Department;
3. Common functions such as IEC and publicity, supplies and maintenance would be integrated to avoid duplication and lack of internal coordination;
4. The Divisions would be reorganized on the basis of integrated responsibilities and current needs;
5. The cadres should be reorganized so that all health personnel up to the district level form District Cadres, selection being the mode for filling up higher posts. The latter would constitute State Cadres;
6. The State Cadres would constitute the Karnataka Health Service.

7. The availability of services at PHC and taluk levels should be ensured through administrative means, including institution of special pay, a team at taluk level, etc;
8. All national programmes which now function in vertical fashion would be integrated into the system so that local supervision and management of these programmes is at District level;
9. The structures for implementing Externally Aided Projects (EAP) would be more directly integrated into the structure of the Directorate of Health Services;
10. Discipline and control measures would be strengthened while, at the same time building up both expertise and morale through nurturing enhancement of skills and a transparent transfer policy;
11. A Commission on Health would be constituted as a mechanism for interaction with professionals and to assist in policy formulation.

2.2 Strengthening Institutions and Capacity Building

A key element in the process of restructuring the Department is in making various units in the organisation functionally empowered and accountable. In specific terms this will imply the following:

The Directorate of Health and Family Welfare has a large number of very senior officers. However, there is hardly any delegation of powers to them. As a result they are not made accountable and responsible for their sphere of work. Additional Directors need to be given powers of minor heads of department and made fully accountable in their sphere of work. Some autonomy has been given in the functioning of the RCH project to the Project Director, but here too the unit clearly needs to take greater initiative and become more accountable. Two new positions of Additional Directors have been put in place to look after Primary Health Centres and Communicable Diseases and they have been recently given job responsibilities. However, these two vitally important offices are yet to be given clear budgets and responsibility in implementation of programmes.

The role and responsibilities of the Commissioner has now been more clearly spelt out. There is need to delegate greater financial and administrative powers to the Commissioner so that routine programme implementation goes on unimpeded. This matter is currently under examination in the Government.

Over a period of time the Secretariat and its field organisation, the Directorate has become distanced. With the creation of the position of the Commissioner some administrative restructuring is called for to ensure speedy decision-making and avoidance of duplication of work. Apart from delegation, introduction of reforms such as "single file system" and "desk officer system" are under consideration of government. The Administrative Reforms Commission has also recommended these changes.

Clarity of roles, responsibilities and specific accountability upto Joint Director level need to be worked out. Internal decentralization mechanisms for Joint Directors and District level functionaries need to be put in place with adequate powers. Freedom and accountability systems need to be developed.

- Rapid communication systems and mechanisms need to be established. Modern facilities of fax, email, and internet access need to be provided below district level at Taluka and PHC level also.

2.2 Karnataka Health Service

All posts that constitute the State level cadre could be constituted into a service called the "Karnataka Health Service". This would contribute to morale building and create a sense of common identity. The major advantage of constituting such a Service would be that young professionals would, through a process of selection, rise to occupy middle level management positions fairly early. This would ensure that officers with a reasonably long tenure would, in due course, hold senior positions so that stability in management is ensured at higher levels. Often, officers are promoted to senior positions when they have very short periods (a few months) of tenure remaining before they are due to retire. The main features of this Service would be as follows:

1. The Service would consist of all posts above the District Cadres and would include both the Public Health and Medical Cadres;
2. Posts in the Service would be filled through two methods:-
    a. Promotion from the District Cadres on the basis of merit cum seniority; and
    b. Through a process of direct induction from the District Cadres.
3. Appropriate proportions of the posts of the State Cadre, in both Public Health and Medical Cadres, would be reserved for promotion and for induction from the District Cadres. It has been recommended by the Task Force that this proportion be 50 per cent each;
4. All officers in the District Cadres who have the necessary qualifications and satisfy such other criteria as may be specified, including minimum period of experience, would be entitled to apply and compete for the posts reserved in the Health Service for recruitment through this method.
5. All officers appointed to the Karnataka Health Service will, on appointment, be trained in administration and management.
6. In public interest, if officers who satisfy the stipulations of the Cadre and Recruitment Rules are not available for appointment to posts at any level in the Service, and for such time as they are not available, such posts may be filled by induction of suitable persons, with the stipulated qualifications, laterally, on contract basis.

2.3 District Cadre and Zilla Panchayats

The cadres, both Public Health and Medical, up to the District level would be District Cadres coming under the management of the Zilla Panchayat.

With the institution of Constitutional local governments at the village, taluka and district levels, it would be necessary to consider how, in the long run, social services, including health services, appropriate mechanisms could be established to ensure community participation and management of social services, including health services at the district level.

All health services at all area levels are now departmentally organized and managed. The revised structure envisages all health services within a district being managed by the Zilla Panchayat. The health services assigned to the ZP would be those currently offered by PHCs (and Sub Centres), CHCs and Taluka Hospitals. All specialized institutions would continue to be under the Department.

In effect, the ZP, and at the lower area levels, the other panchayat organizations would be responsible for management of the health services in their local areas. The ZP would be the nodal agency and would oversee the working of these services in the talukas and at village level. Such an arrangement is already partly in existence, but what is envisaged in the revised structure is assigning full responsibility to the ZP and including all health services and programmes within the ambit of its responsibilities. It need hardly be mentioned that financial

allocations commensurate with these responsibilities would have to be allocated, to that extent reducing the allocation to the Departmental budget.

The revised structure would imply that all posts of health and medical officers from the village level up to and including the district level, excluding all district level posts such as the DHO / DMO and equivalent, would be part of the establishment of the ZP. The recruitment, control, postings within the district and related matters would be entirely within the competence of the ZP. It must be emphasized that this would not at all mean the absence of Government control, supervision and monitoring. The ZPs would function within guidelines and other stipulations specified by Government with regard to all matters relating to health services. The DHO / DMO, as at present, would continue to represent Government. In effect, a distinct cadre of health personnel would have to be constituted for each district, with common features.

It is recognized that the structure suggested here is a radical departure from the current one. However, it has the merit of ensuring that local persons find employment within their districts, which would reduce the difficulty of filling rural posts. It would also mean that the community, through their elected bodies, takes full responsibility for the adequacy, accessibility and quality of the health services in their district. The Department would then be responsible for overseeing and monitoring of the health services and not have direct administrative responsibility for these services. Its energies would then be better spent in ensuring the efficiency and effectiveness of these services and setting standards through more intensive inspections and reviews.

2.4 Commission on Health

The health services must be responsive to the expectations of the public and must meet current needs. The working of the Department should be transparent and the structure should be able to induct outside expertise as and when necessary for special studies or consultancies. It would be desirable to create a mechanism for general overseeing of the health system which would assist the Government and for providing policy inputs. The facility of lateral advice being tendered at the highest level would assist in ensuring both transparency and public confidence. For this purpose, it is recommended that a Commission on Health be established by Government consisting of both senior officers and non-official professionals.

Commission on Health

Chairperson	Principal Secretary of Health and FW
Members	Secretary (Medical Education), Project Administrator of EAP, Director of Health Services, Director of Medical Services, Director of Medical Education, Director, State Institute of Health and Family Welfare, Director, Indian Systems of Medicine and Homeopathy, Drugs Controller, Vice Chancellor, RGUHS, 8 to 10 eminent persons from professionals, NGOs and prominent persons.
Member Secretary	Commissioner of H & FW

The functions of the Commission would include:

1. Preparation of the Perspective Plan for health services;

2. Monitoring inter-sector issues and recommending corrective appropriate measures;

3. Monitoring implementation of Plan programmes, externally funded projects and Central Schemes and general management of health services;

4. Ensuring that public health is an important component of the health services;

5. Suggesting such studies or consultancies that are found to be necessary from time to time;

6. Reviewing all such aspects of health services as it may consider necessary for ensuring improvement of such services.

The Commission would not be concerned with the administration of the Department, or with disciplinary cases. The Planning and Monitoring Division could serve as the secretariat of the Commission.

2.5 Review and Amendment of Cadre and Recruitment Rules

The structure suggested would need considerable amendments to the existing Cadre and Recruitment Rules.

Recommendations have been made with regard to introducing mandatory tenures of service in rural areas and selection criteria being introduced for certain posts. Also, elsewhere in this Report, there are recommendations that have implications for the C & R Rules. It would, therefore, be necessary to review these rules to take into consideration the recommendations made herein and to bring them up to date. In particular, the rules should identify posts which for which selection criteria should apply such as Joint Directors and above, introduce stipulations regarding tenure in rural postings for entitlement to confirmation / promotion. It is recommended that a Committee for Review of the C & R Rules be set up, with the Commissioner as Chairman, and the Director of Health Services, Joint Secretary, Health Department and a representative of the Law Department as members.

It is recommended that the new structure should be in place within the next one year, with recruitment and cadre choice to new recruits being as suggested above.

2.6 Corruption and enforcement of discipline

The prevalence of corruption in the health services is a serious issue. Corruption in any official agency is deplorable and must be eliminated. However, its presence in an essential social sector such as health is particularly obnoxious because it increases the costs of the services the public is entitled to and quite often determines both availability and quality of the services provided. It is pernicious and pervasive and operates at different levels in different manner. It could range from (a) demanding payment for services which are free or even paid for and for carrying out the legitimate duties of the personnel involved, (b) direct diversion of supplies meant for patients or from hospital supplies, (c) carrying on private practice when this is prohibited, (d) deliberately treating patients outside stipulated hours and charging personal fees for such services, and (e) diverting patients to private clinics with which one is associated and charging fees or obtaining commissions. In particular, corruption in government hospitals has a serious effect on the availability of medical services to the poor.

How to eliminate corruption?

That corruption exists, the various methods adopted in its practice and points at which it is practiced are well known. The issue is the mechanisms for its detection and elimination. The detection of corruption is dependent on the cooperation of the public and the internal

mechanisms for this purpose. In this context, it is admittedly difficult for the public to complain of corruption in a situation where medical services are required because, unlike other official contacts, the need for these services cannot be postponed. However, the system should encourage complaints being received even after the event. Secondly, the consideration of complaints and completion of enquiry proceedings must be quick and thorough. The latter is particularly important to avoid enquiries being deemed as improperly conducted on procedural issues, as is quite often the case.

The current mechanisms inhibit quick enquiry. In particular, the procedures where major punishments are proposed to be imposed are complicated and invariably tend to delay enquiries beyond reasonable periods of time. It would, therefore, be vital for these procedures to be reviewed so that, without taking away constitutional rights to justice, enquiries could be completed within two to three months. It is recommended that the Commissioner of H & FW evaluate the current procedures to determine how they could be modified to ensure quick completion of enquiries.

In the majority of cases, under the current procedures, officers of a senior level are appointed as enquiry officers in individual cases. Such assignments are invariably viewed as an additional burden and given very low priority. There is rarely a sense of urgency and quite often enquiries have dragged on indefinitely. This results in a feeling of complacency in the corrupt that the system is incapable of dealing with them while, at the same time, reducing the morale of the honest and hardworking. The mechanisms for enquiry being within the Department would also seem to inhibit quick enquiry and strong action.

The enquiry into corruption cases, depending on the nature and content of the complaint, are either dealt with by the Vigilance Commissioner or within the Department by the appointment of an enquiry officer. There is, however, no institutional mechanism for detection of corruption. It is recommended that such a mechanism be set up on the lines similar to the Food Cell or Forest Cell. In the latter, a senior police officer on deputation is independently assigned the responsibility of follow up of complaints on corruption, carrying out test checks and the like. This cell should be preferably under the Principal Secretary or under the Commissioner for Health and not an adjunct of the DHS. The specific role and duties of the Cell could be defined. It should be empowered to investigate and take action against corruption and absenteeism. An appeal procedure would have to be provided but time limits must be fixed for disposal of such appeals.

The public should be aware of the services they are entitled to in the Sub Centres, the PHCs, at the Taluka and District levels and in Government Hospitals. Prominent boards should be put up indicating what services are free and the fees for services for which charges are levied. The officer who should be contacted if money is demanded should be indicated and an assurance held out that corruption charges would be investigated. The hospital Visitor system should be strengthened and one of the functions should be to enquire about harassment and demands of money, particularly from the poorer patients. Wide and constant publicity should also be made of measures taken promptly. All complaints of corruption should be acknowledged against corruption.

2.7 Centrally Funded Projects and integration of vertical programmes

A number of Centrally Sponsored Schemes have been implemented, at various points of time, as part of the successive Plans. These include programmes relating to control of blindness, malaria, AIDS, tuberculosis, leprosy and goitre, and enhancement of nutrition. The general principle of funding has been that for the Plan period these are funded either fully or partially by the Central Government, with the financing being taken over by the State at the end of the Plan period. There have, of course, been some exceptions to the latter.

The main issue is not so much the funding or the content of these schemes, since they all deal with important aspects of health services. It is the structural aspects that need consideration since separate hierarchies, with Programme Officers, were established under each such scheme for a specific purpose. This has created vertical hierarchies of a specialized nature within the Department. Also, it has complicated the reporting system by requiring different streams of reporting within the Department and to the Government of India. Such a structure does not lend itself to cost effective use of personnel or coordinated management of services. The difficulty of control and management of such separate vertical hierarchies for some activities is particularly noticeable at the district level. It is at this level that management and coordination need to be clear and effective. The relative seniorities between the DHO and the Programme Officers have added to the problems of coordination.

The vertical programmes must be reviewed to determine the mechanisms of eliminating the concept of independent vertical hierarchies, better utilization of the professionals in the Department, and establishing only one focal point of administration of personnel, management of services and reporting at the district level. It must be emphasized that this can be done without in anyway diminishing attention to these important programmes. As in most activities of the Department, designated officers would be responsible for specific activities. What is desirable is to eliminate vertical hierarchies that are under-utilized and give rise to loose administrative practices. Such integration is possible at all levels, including the senior posts at headquarters. It may, at this point be mentioned that a revised structure for the Department has been suggested later. The review of the vertical programmes would be part of this new structure.

2.8 Externally Aided Projects

There are a number of externally aided projects in operation in the State. In the health sector, the Karnataka Health Systems Development Project and the India Population Project are the major externally funded projects. These projects deal with specific health issues and are not experimental in nature. They operate independent of the DHS though they are very much concerned with health issues in terms of objectives, structure and content. The management structure of these projects is independent of the DHS and so devised as to ensure efficient performance. Special officers are placed in charge of such projects, with officers of various specializations on deputation, and the induction of outside expertise is often assured through a system of appointment of consultants. Decision-making in these projects is expeditious because the high power Project Governing Board and the Standing Committee are delegated with full powers. The conventional system of seeking sanctions, administrative and financial, with many layers of official scrutiny and many departments to be consulted, is absent. There are no financial constraints and performance is intensively monitored by both external and internal agencies. In view of the structure and management independence, these projects are successful and appear as islands of excellence in governance of health services.

These projects are successful because they have well defined objectives, with leadership not generally available in other activities of government, selected competent staff and with operational independence. They provide lessons in management of the health services and innovative structures of delegation of authority and of monitoring and internal control and review systems. However, experience would indicate that once the project is over and the maintenance phase commences, the same performance levels rapidly disappear and the work gets "routinised". While the projects definitely add to both assets and experience, there are fundamental issues that need to be considered if full and, more importantly, permanent advantages have to accrue to the health system from the implementation of such projects. These are (a) how one transplants the work culture of these projects into the larger, parent organization, namely the Health Department, (b) how the tempo and efficiency of the project implementation period could be sustained, (c) how the assets created are maintained for effective use, (d) how the human resources created could continue to be used effectively and

productively and (e) how is adequate funding to be ensured for these purposes. In short, the issue is one of sustainability over time of both the organizational and professional advantages of these projects and building them into the culture of the department itself.

2.9 Sustainability

The issue is essentially one of sustainability of the projects objectives and systems. It would be difficult to integrate the project structure in toto into the departmental structure at the end of the project period, nor would this be necessary. However, the main difficulty would be that the project leadership would no longer be available and the Director of Health Services would have been only generally associated with the project [1]. If integration of project activities in the maintenance phase has to be effective, it would be necessary to ensure that the project is built into and implemented within the departmental structure from the start. While a separate wing or division could be considered desirable because of the special needs of the project and the need to complete it within a fixed period, this wing / division should be a part of the Department; an exclusive project division within the Department should implement such a project. This would ensure that the Director is not merely involved in the project but is also responsible for its efficient implementation. It is recognized that this could limit the choice of officers for being appointed as project administrators but the Project Governing Board and the Steering Committee of the project should be able to enhance their supervision / monitoring to ensure effective implementation. Also, the Commission on Health, suggested as part of the restructuring of the Department, could also be empowered to monitor / review the implementation of the project. The present practice of establishing a separate but temporary project administration structure outside the Department should be given up and the special unit created for implementation of such projects should be placed within the department, even while maintaining its separate identity, with the appropriate structure and operational freedom, for expeditious and efficient completion of the project. The Director should be responsible for not merely fostering the work culture of the project but also for the spread of such a work culture in the other divisions of the Department.

2.10 Transparency / morale building

The Department of Health Services is one of the larger administrative organizations of the State. Its importance both in terms of size and responsibilities dictate that the morale of the officers and staff should always be high. It should be managed in such a manner that administration is not accused either of favouritism or lack of direction. **Morale building** would depend on the personnel having a conviction of fair dealing in matters such as postings, selection for postgraduate courses, promotions and quick redressal of grievances. At present, unfortunately, there would appear to be no internal guidelines or traditions for many of these aspects.

2.11 Transfer Policy

Transfers are admittedly necessary in the department for manning vacant posts, on promotion or for other reasons. However, the system of routine transfers that are made every year has virtually deteriorated into a scramble for "good" postings or for postings in Bangalore, with pressures and pulls of all sorts having free play. In particular, it is most unfortunate that political pressures predominate. This works to the disadvantage of those who adhere to the rules or who have no political backing, and encourages indiscipline and inefficiency. It would be necessary to formulate and adopt a transfer policy under which the transfers would be **transparent** and **unassailable**.

2.12 Delegation of duties and powers

Morale and functional efficiency are also dependent on the ability to exercise powers appropriate to each level in the hierarchy. Currently, there are orders delegating both administrative and financial powers various levels. In particular, the powers of the senior officers are well defined to permit them to function with adequate independence. However, in practice, these powers do not seem to be exercised fully because traditions have been built up that favour centralization of decision-making or excessive caution operates in exercising them. This is reflected in complaints of inability to carry out adequate touring, delays in processing of even simple requisitions, etc. The adequacy of the delegations and, more importantly, the processes through which they are exercised would need review.

There is need to carry out a review of the administrative and financial powers delegations in the Department to –

1. Evaluate their adequacy and determine if any further delegations are necessary;
2. Examine the procedures of exercising of the delegated powers to determine if there are any procedural factors that reduce their effective use.

2.13 Ensuring Overall Responsibility on Health Matters in Urban Areas

The administration of health services in urban areas is largely the responsibility of the local administrations such as the municipalities and Municipal Corporations. The staff in the larger cities are appointed and managed by the Corporations. While the administration of the services in these areas and the management of the staff would be the responsibility of the municipal body, it would be necessary to ensure that the Commissioner, the Director of Public Health and Director of Medical Services have overall responsibility for the technical aspects of these services so as to ensure quality and availability. The Directors should have the right of inspection and monitoring. Such general authority would be specially important in periods of outbreak of diseases and emergency situations. In particular, the public health aspects of urban areas, including water quality and the like, should be reviewed by the Director of Public Health.

2.14 Inter-sectoral Coordination

Health should not be viewed in isolation. While, for pragmatic administrative purposes, the DHS is in charge of health services, the success of the latter depends on the successful implementation of many other programmes. The latter include programmes relating to nutrition, sanitation and water supply, meeting minimum housing needs, literacy, transportation, communication, and the like. It is also dependent, in a larger sense, on social policies, as for example, raising the age of marriage of girls. More specifically, the health services are closely associated with the ICDS and school health programmes.

It is evident that health services would need to be coordinated with activities of the programmes referred to. Such coordination would be necessary both with regard to the relevant elements of these programmes and with the implementing agencies. The establishment of an effective coordination mechanism would also ensure more optimum use of the funds invested in the health services and these programmes. The establishment of a high level mechanism for coordination would develop synergy among these activities. It is recommended that a High Power Coordination Committee be set up with the Development Commissioner as Chairperson, and members being the Commissioner of Health and FW, Director of Health Services, Principal Secretary and Director of Primary / Secondary Education, Principal Secretary, Woman and Child Welfare Department and Director ICDS, Principal Secretary Rural Development and Panchayati Raj, and officers in charge of rural

water supply and sanitation programmes. Other officers could be co-opted if necessary. Representatives of prominent NGOs could also be inducted as members. Similar coordination mechanisms must be established at the district and taluka levels.

2.15 Coordination with other institutions

There are autonomous specialty institutions, which include the Kidwai Memorial Institute of Oncology, Sri Jayadeva Institute of Cardiology, Sanjay Gandhi Accident Hospital and Research Institute, and others. Government is represented on the management of these institutions and, therefore, mechanisms are present for ensuring coordination. The links permit review of performance, monitoring of activities and also provide for an active role of intervention if necessary.

2.16 Contracting out non-clinical services

The KHSDP has identified 28 non-clinical services, which could be performed by private sector agencies on contract. The advantages are obvious. Large number of staff need not be on the permanent payroll of government. Services are likely to be performed better because penalty clauses could be enforced, which would not be easy in the case of government employees. It would allow more time and effort to be invested in health and medical issues. It is recommended that this system of contracting out non-clinical services could be extended to as many hospitals as possible.

In the context, the view that general services cannot be contracted out under the laws relating to abolition of contract labour would seem to be of doubtful validity. In the arrangement contemplated, the contract would be with service firms and not individuals.

2.17 Improving Registration of Births and Deaths

The importance of improving the system of registration of births and deaths cannot be overemphasized. The data provided by the system, if complete in coverage and valid in recorded information, would provide information at regional, sub-regional and micro level on health parameters.

The placement of the system of reporting would seem to need consideration. Currently, it is monitored by the Director of the Bureau of Economic and Statistics, with a network of notifiers and registrars at the field level. The latter are revenue officials. The system merits a review for its reorganization and vitalization. It is recommended that this be examined in consultation of the Departments involved. The Government of India would also have to be consulted at the final stages.

2.18 Planning and monitoring

Health services must meet current needs and the management must have the capacity to adapt them to such needs. Any modifications or expansion of services have implications in terms of staff, training, and financial outlay. It is therefore necessary to have an in-built ability for carrying out such reviews and in the preparation of perspective plans. Tthe Department should also have a strong, unified system of reporting as part of the Health Management Information System. This would necessarily have to form part of the planning and monitoring structure of the Department. These activities would call for the establishment of a **Planning and Monitoring Division**.

Present structure

There is, at present, a Joint Director in the office of the DHS in charge of planning. The post is currently designated as Joint Director (Health and Planning). The JD (H & P) is assisted by a Deputy Director (Planning) with supporting staff. The functions of this post include preparation of the annual plans, five -year plans, and preparation of the monthly monitoring reports (MMR) which deals with financial and physical progress and the Karnataka Development Plan which deals with staff and organizational issues, that are submitted to Government. An important function is the preparation of the Annual Report of the Department. The Preparation of these reports involves obtaining information from all units in the Directorate, including the Programme Officers on a monthly basis. Coordination and constant interaction with the other Divisions and sections in the office of the DHS are essential elements of the post. The JD (H & P) is concerned with the preparation of only schemes relating to the Plan. Non-Plan elements are prepared by the Chief Accounts Officer cum Financial Adviser. This is because the latter are more concerned with staff and maintenance issues. However, information on the latter is incorporated in the reports mentioned above. The JD (H & P) is also in charge of the Bureau of Health Intelligence.

Role of the Planning and Monitoring Division

The planning process in the office of the DHS is restricted in scope and serves the immediate administrative needs of routine reporting. The process of preparation of Plan schemes is also fairly well established, as well as statistical reporting in specified formats. These are essential activities in themselves but the constant internal monitoring of performance, particularly the sensitive appraisal of available information, is near absent. The Planning Unit, which should be designated as the Planning and Monitoring Division in view of its importance, should play a more central role in the management of information systems within the Directorate. It should be responsible for all information flows, appraisal of such information and feed back of such appraisal to the functional divisions concerned. Currently, the appraisal of performance is within the functional divisions concerned, which would render it routine. Also, a total appreciation of the functioning of the Directorate would not be available to the Director.

The reporting system is envisaged as common to the Department and not in sectional components, more related to individual programmes, as at present. With this change in the structure and focus of the HMIS, it would be logical to place its management under the Planning and Monitoring Division.

Functions of the Planning and Monitoring Division

1. Coordination of all reporting activity as part of the unified system of the HMIS and providing the information that other Divisions would require on the basis of the unified HMIS;

2. Coordination of all statistical activity in the Department, at various levels, including ensuring of quality of data, and processing and analysis of such data in the prescribed manner as may be required for various purposes;

3. Production of the Annual Report, periodic reports such as the Monthly Monitoring Reports, Karnataka Development Plan, and such other prescribed reports. The reports of the projects such as IPP and KHSDP should be incorporated so that there is one report for the entire health department;

4. Monitoring progress in implementation of Plan programmes and schemes each month to enable mid-course corrections to be made;

5. Preparation of Annual Plans and Five year Plans of the Department, coordinating with the other wings such as Medical Education, State Institute of Health and Family Welfare and the like;

6. Preparation of a perspective plan for the Health Sector and its updating at appropriate intervals.

7. Organization and management of the Geographical Information System that is recommended for establishment;

8. Organization and management of the Computer System that is recommended for establishment;

Structural changes in the Statistical System

The statistical system within the Department has developed in a rather ad-hoc manner. The statistical and reporting system at headquarters could be said to consist of three distinct wings as follows:

a) The Bureau of Health Intelligence (BHI)

b) The Demography and Evaluation Cell (D & E Cell)

c) The statistical units / personnel attached to some Divisions on an independent basis.

The BHI is the unit that generates the Annual Administration Report and all statistical reports, excluding those relating to the RCH programme. It is also responsible for collection and collation of information on health indicators, including the macro indicators from the RCH programme. One important responsibility of the BHI is collection and processing of data relating to morbidity and mortality.

It would be evident that if the planning process in the health sector has to be unified, as indeed it should, it would be necessary to recognize the need for basic structural changes. Such changes would include (a) unifying the statistical functions at all levels and of the various units, (b) the inclusion of the reports of distinct projects such as the IPP and KHSDP within the unified reporting system, and (c) coordination within the Department with the Chief Accounts Officer / Financial Advisers of the Department itself and of the special projects.

The distribution of the posts in the various statistical / reporting units, as would be seen from the table above, is very uneven. There is no uniformity in the work load and the levels of posts seem to have been determined more by what was acceptable to the sanctioning authorities than any rational considerations of work load, position in the hierarchy, etc.

The efficiency of the HMIS and GIS, the ensuring of quality of data, the management of the computerized system of maintenance and analysis of data and production of monitoring reports for better management would depend on the structure of the reporting and statistical system. If the system has to perform at peak efficiency and be able to serve its purpose, it would be necessary to consider certain structural changes.

In principle, it would be desirable to have a unified statistical and reporting system so that the planning and monitoring requirements are adequately met. The Planning unit in the office of

the DHS may be designated as the Planning and Monitoring Division, as suggested earlier, and assigned a central role of information management and appraisal, with the functions indicated.

Structural changes at Headquarters

The Planning and Monitoring Division should be constituted with the following sections:

- The Reporting and Monitoring Section for production of reports based on the analytical statements generated by the Computer Section, and for preparation of all monitoring reports required by Government or needed for internal management;
- The Computer Section for information processing
- The GIS Section for assisting in monitoring and planning
- A Perspective Planning Section which would formulate the Five Year Plans and the annual plans, monitor plan implementation, prepare and continuously update the perspective plan of the Department and monitor implementation of the Health and Population Policy of the State.

This Division should be responsible for the following:

- Strategic Planning of activities of the entire health system, including long term planning;
- Coordination with the Zilla Panchayats to ensure that the health plans of the districts are formulated, including taluka and Gram Panchayat plans, and integrate them into the State Health Plan;
- Assess budget resources for current and future needs, taking into consideration population, level of services, norms for services and other relevant parameters;
- Assess human resources and all material resources on a continuing basis.

All statistical and reporting functions in the headquarters should be unified. The various wings and units referred to earlier would form part of the Planning and Monitoring Division. These would include the BHI and the D & E Cell. There is a senior officer of the rank of Joint Director on deputation from the Directorate of Economics and Statistics, who heads the D & E Cell. This officer could be the Joint Director in charge of HIMS, the GIS and all statistical reporting within the Directorate. This Joint Director could be designated as **Joint Director, Health Information System.** This officer would be the Chief Statistical Officer and Head of the HIMS / Monitoring Section.

Structural changes at District level

Strong statistical units would have to be established in the offices of the DHO / DMO and all reporting and statistical functions in the district should be placed under them so far as their jurisdictions are concerned. A computer cell in their offices would also have to be set up. These cells would generate reports in standardized formats, which would be sent to Headquarters for consolidation and analysis. However, analysis at the district level would also be carried out so that monitoring by the DHO / DMO is possible at the district level. The Programme Officers of the district would get the reports in the formats they need from this cell

The central role of the Planning and Monitoring Division

The role of the Planning and Monitoring Division, as envisaged herein, is much wider than what it is at present and its responsibilities are much heavier. It is the Division that **plans for and monitors the performance of the Department**. In view of this expanded role, the Planning and Monitoring Division may be headed by an Additional Director. This Division would function as the secretariat for the Commission on Health that has been recommended to be established. The division will use an evidence-based approach & hence have close links with the HMIS & Surveillance system. It will need to establish good inter-sectoral linkages with departments dealing with nutrition, water supply and sanitation, education, Panchayati Raj, etc. The unit needs to develop multidisciplinary capacities in Epidemiology, Health Planning and Management, Health Economics, Bio-statistics, Anthropology, Social Sciences etc.

Strengthening the capacity for Strategic Planning had been identified as a key objective under KHSDP. However, mechanisms to ensure that Strategic Planning begins to take place are yet to get institutionalized. There is an immediate need to fill up the newly created positions in the Strategic Planning Cell (SPC) so that studies, research, and planning functions can start taking place. These initiatives planned under KHSDP need to be carried forward in to the present project as well.

2.19 Project implementation and integration

Earlier experience with national health programmes, and more recently with externally aided projects, teach us that:

a) Basic objectives and strategies, even if explicitly outlined in policy documents/ project proposals, are often re-interpreted or forgotten, in such major ways that expected outcomes are not achieved.

b) The focus of attention and activity tends to be on construction, purchase of equipment/consumables and appointments. 'Softer' service issues such as quality of care, access to care, establishment of referral services, surveillance and health management information system etc. have not yet become functional. Training of health personnel has been undertaken but outcomes of this activity have been variable.

c) The Department of Health, as a whole, does not manifest a sense of ownership of important health programmes. Responsibilities and systems have become fragmented with vertical programmes and specific projects.

Hence, during the next five years, the PRIMARY FOCUS of this project will be to ensure, IMPLEMENTATION and INTEGRATION, particularly at the critical point of interface between the public and service provider at sub-centres, PHCs, CHCs, schools, anganwadi centres, Mahila sanghas and hospitals at different levels.

Special planned efforts will be made to internalise and embed processes and factors that ensure implementation, into the institutional functioning of the system.

2.20 Safeguards to ensure implementation

a. Involvement of credible and knowledgeable NGOs, people's movements, academic institutions, i.e. representatives of civic society in the steering committees. The choice of representatives is critical, as the objective is to bring in openness, transparency, accountability, knowledge of field realities and alternative expertise. It will also enhance collaboration, cooperation and a joining together of forces if appropriately facilitated.

b. Make public the annual statements of income and expenditure of the project. Explanatory notes to be given for non-utilization of funds.

c. The Annual Report of the DHFW, under which achievements of the different programmes and projects are given, need to be more widely disseminated. The DHFW could also have a Website on which reports are made available. With increasing computerization of the Department these reports will be easily available to peripheral/ all health institutions and their staff.

d. The supervisory and senior management staff to take responsibility and be accountable for implementation at all levels. For this there needs to be adequate delegation of authority and financial powers – i.e. a decentralization within the department. This is separate from decentralization under Panchayati Raj.

e. Supervisory staff to provide technical guidance, problem solving advice and encouragement, rather than focusing on fault finding and inspection. Maintaining motivation, morale and job satisfaction of field staff is an important responsibility of senior staff.

f. DHFW staff needs to be given strong feedback on the wide gap between the people's expectations and the health services. At the same time, the good committed and competent work by several government personnel needs to be recognised and appreciated. Recognizing that this factor is critical to implementation, the department will introduce a series of measures to facilitate behaviour change, e.g. sessions on group dynamics, personal growth, interpersonal relations, and management techniques. The Task Force on Health has also recommended steps to be taken to reduce corruption and political interference in appointments, transfers, and promotions.

g. While taking steps to provide a good working atmosphere, the DHFW will also tighten its administrative functioning by taking disciplinary action, as per the rules; clarifying job responsibilities and ensuring that they are carried out; keeping to time frames.

2.21 Project management structure

The KHSDP has built up a fairly extensive management structure, headed by a super-time IAS officer. Another super-time officer is heading the project team dealing with IPP VIII and IX. The government has recently also put in place the post of Commissioner, who is also a very senior, Secretary-rank IAS officer. A team of senior Doctors and Engineering staff supports both the KHSDP as well as IPP projects. Given the nature of the project which is very ambitious both in size and scope, and the limited capacity, at the present moment, within the Directorate, there is need to have a strong management team to lead the project. Multi-disciplinarity, and management capacity will need to be part of the long-term leadership structure in the health sector. The experience of KHSDP has been that the presence of a dynamic leadership is able to give the necessary momentum to the project. At the same time, in view of the large size and scope of the civil works and equipment procurement requirements, the project team is unable to give the required attention to service delivery and some other "software components'. The KHSDP staffing structure will be continued at the end of the project and integrated into the health system as a dedicated, specialised, professional management support agency of the department for all civil works construction and maintenance, equipment procurement and maintenance, and other specified "hardware components". This wing will continue, as at present, to be headed by a senior IAS officer. This wing will also manage all the civil works and procurement components of the new project. This will free the project director, who is proposed to be a full time super-time IAS officer to concentrate on actual service delivery. He will lead a project team that will work

closely with the Commissioner and the Director and directly with the state programme officers so that there is full integration from the commencement of the project.

A dedicated management structure will also be put in place for the special project initiatives proposed for the backward category C districts of the state.

2.22 Project Governing Board, Project Steering Committee and Project Implementation Committee

The Project Governing Board constituted under the KHSDP with the Chief Secretary as Chairperson has worked well and it is proposed to retain the same structure for the proposed Project. Similarly, the Project Steering Committee has also provided a structure that has facilitated quick decision-making. In addition to these two structures there is need to ensure that decisions taken at the Project Steering Committee are implemented and there is constant monitoring in respect of all components of the Project. There is also need to integrate the Project management structure with the DHS. It is therefore proposed to have a Project Implementation Committee under the Chairmanship of the Commissioner Health and Family Welfare.

2.23 Local project consultancies

The project has several new uncharted thrust areas, such as in the area of women's health, health promotion, and community participation, HMIS etc. where the services of experienced NGOs and other professionals will be required from the commencement of the Project. They will support not only the project team but more critically be asked to directly work with the State Programme Officers to ensure that the department has a feeling of "oneness' with this external team and vice versa. Their main role will be in providing both expertise as well as elements of "capacity building" into the department.

2.24 Capacity building for programme implementation

Cadre of professional managers

Over time the DHFWS has created at Taluka, District and State level an adequate number of positions to supervise and implement various National Health and Family Welfare programmes. In recent years, it has been noticed that at all levels the Taluka Health Officers, DHOs, as well as Deputy Directors/Joint Directors have very short tenures and are unable to spend time on management of national health programmes.

In many States and in several countries around the world health programme managers and hospital managers are non-medical professionals in public health, and hospital administration. The Project therefore seeks to develop a cadre of professional managers to help in programme management at the district level, state level and to help in hospital management. It is proposed to recruit young graduates, preferably with post-graduates/diploma in management, Hospital administration, Masters in Social Work (MSW), Masters in Economics, Masters in Nutrition/ Communication and related disciplines to function as Assistant Programme Managers at the District level, in major Hospitals, and at the State level. These officers will be recruited at the Group B level and will have opportunities for career advancement based on their performance and merit. They will be recruited through a very transparent system based on their qualifying marks and a Common Entrance Test and will undergo specialized training for six months before being assigned any responsibilities. About 150 posts will be created for this purpose. To ensure management teams including this new cadre become effective, there will also be a need to develop manuals on integrated health care responsibilities for different institutional levels and various programmes.

Introducing merit and competence in respect of some crucial posts

Currently all senior positions are filled by seniority, except the post of Director. There is therefore no incentive for good performance or any system to reward good work. Private sector structures need to be brought in at least to man crucial positions at the district and State levels. Meritocracy and transparency would be introduced and seen in the overall context of good governance. A study has been commissioned by the Task Force to review the organisational structure and design job responsibilities. The DHFWS is a very large organisation in terms of manpower and responsibilities, with about 60,000 personnel of which more than 4700 are grade A officers. There are several levels of technical expertise. The study makes a systematic effort to identify requirements at various levels & to develop job responsibilities. The Task Force final recommendations and study findings will be incorporated to the project proposal.

Engineering wing

Under the KHSDP an Engineering Wing has been established which is exclusively dedicated to designing, constructing and maintaining all the facilities taken up under the Project. A Chief Engineer heads the Engineering wing while a Deputy Chief Architect heads the Design wing. These positions are supported by the necessary complement of supporting staff. All these positions will require to be continued to support the Civil Works in the present Project. The present proposal envisages the renovation of a large number of primary health institutions scattered throughout the rural parts of the State. There is a need to prepare detailed estimates, design renovation, for each of the over 1000 buildings proposed for renovation/expansion in the project.

There is also need to ensure that the major civil works component is taken up and completed quickly so that more substantive programme components get full attention during the project. IPP VIII has successfully demonstrated capacity to take up construction of a large number of small institutions in quick time by employing the services of a consultancy agency on a "turn key" basis. There is need to identify an appropriate Civil Works consultancy Agency to survey all the institutions, make detailed estimates for renovation and expansion well in advance of the Project start, as a pre-project activity. The Agency can be selected through a bidding process.

Routine maintenance of sub-centres, PHCs and Taluka hospitals will have to continue to be looked after by the Zilla Panchayat engineering divisions and the engineering divisions.

Enabling work environment

One reason for poor work culture at the state and district levels is due to the shabby physical environment in which the offices are maintained which is also an expression of work culture. It is expected that an integrated office complex for all health programmes, including for the Project staff will be constructed under KHSDP. The building will require maintenance expenditure etc. Similarly provisions will require to be made for the DHOs office buildings, including the seven new districts.

2.25 Implementation challenges and strategies of the integrated health project

Karnataka has had mixed experience in implementation of health programmes and services. Health programmes so far have largely used a top-down problem centred approach, that is largely rational (focusing on major decisions), linear and prescriptive. Implementation has been on the whole hierarchical and techno managerial, attempting measurable outputs and compliance, with people often seen as target groups or objects. Evaluations of several

programmes report big implementation gaps even in programmes and projects with well thought out health goals, objectives and strategies. In Karnataka this is seen in the National Tuberculosis Programme (NTP and RNTCP), the Reproductive and Child Health (RCH) programme, the National Programme for Control of Blindness (NPCB), the National AIDS Control Programme etc. The Karnataka Task Force on Health has raised poor implementation capacity as an issue of serious concern by senior government officials and. The public have expressed a lack of confidence and trust in the services through elected representatives, through peoples health dialogues conducted as a part of the peoples health assembly process, and through increasing protest as recorded by the media. It is imperative that implementation processes are given importance and viewed as being as critical as decision-making, resource allocation and proposal writing. It is what happens between front line implementators and the public that really determines policy.

Current opportunities and strengths

It is therefore suggested that using the same policy and programme / project management approach may not improve functioning of the system adequately. Achieving good quality performance or implementation should be the key strategic objective or mantra of the entire Department of Health during the next five-year phase. There is a window of opportunity presently open with government showing signs of greater political commitment to health; with the participatory processes already initiated by the Karnataka Task Force on Health; with a small but critical mass of good leadership at the top; and with the possibility of augmenting financial and technical resources through a healthy process of dialogue with partner donor agencies. Therefore a slightly different approach will be utilized in this implementation plan. It will build incrementally on the several good initiatives of the past decade including the mechanisms and management systems that are functioning well. It will use the learning points and evidence gathered from studies already undertaken and then planned.

Broad approach

It will use the bottom up integrative approach that is process orientated, recognizing the political, iterative, interactive and evolutionary dimensions of policy process. This will require a major change in mindset, through regular workshops and training programmes. It will consciously build motivation, capacity, work strategies, work culture and ethics of implementors, especially at front line and different levels. It will increase inter-organizational and inter-departmental interaction. People and communities will be given opportunities to become active participants in decision-making and in becoming change agents of health services and of their own health status.

The social construction and complexity of disease, ill health, poorly functioning health services and programmes are accepted, including underlying iniquitous social relations and issues of power and conflict. Hence, no magic or perfect solutions are offered, nor miraculous changes expected. However, planned, systematic efforts that are responsive to ground realities will be made, to use public health policy to move towards some leveling of social inequity.

Specifics

Some of the factors important for implementation are:

Health policy so far has not been explicit but has developed in an ad hoc, add on manner, often driven by national health programmes or by externally aided projects. A Comprehensive Integrated Draft Health Policy has been recently written by the Karnataka Task Force on

Health and published for wide discussion within the government health sector by the Government of Karnataka (KHSDP) and with others. After modification and adoption this will provide a cohesive framework for the next five-year period.

Developing leadership at state district, taluka and local levels. State leadership for all components should have the ability and acumen to mobilise power, political, financial and other resources for health and to positively influence implementation. Leadership that nurtures encourages and supports its teams to perform better. Leadership that is open to questioning, demands and pressures from the public and civil society organizations, seeing these as a positive sign of interest and support and not as a threat. Leadership that looks ahead, beyond and is inspirational. Leadership that is sometimes willing to follow. Selection of leadership will necessarily need to depend on competence and capacity and will have to be free of political interference. Leadership for district and state level will depend on track record of past performance, with seniority coming as the lower criteria.

This is a complex project and **selection of the Project Director (PD)** is critical. The PD will require having good management skills, good interpersonal skills, a firm administrative hand, and an understanding of the project goals and objectives, especially the technical, health aspects. It is advisable that the PD is available to steer the project for a period of 5 years.

Develop a core implementation team working with the Commissioner and Director of Health and the Project Director; with a mandate to see that implementation of all key aspects outlined above occurs on time, maintaining quality. Members of the Project Preparation Committee who have been active will continue in the Implementation Team.

Taking forward the Task Force recommendations - The recommendations of the Task Force, especially Health Systems Management and on Implementation will influence all programmes. Mechanism for implementation of recommendations will be initiated in 2001 and will carry over into the integrated health project being proposed. The preliminary steps in brief suggested by the Task Force are:

a) Formation of a **small core group** to process, prioritize and set time frames for implementation of recommendations;
b) Formation of an **Implementation Committee** (for health system reform and reorganization);
c) Formation of **Subject Matter Sub-Committee** reporting to the above;
d) Formation of a **small secretariat or cell** to support the Implementation Committee and follow up on action points; this function to be taken over by the Planning and Monitoring division or unit;
e) Formation of a **Commission for Health**.

The Task Force recommendation broadly fall into four categories:

a) **Structural changes** to re-institutionalise public health and primary health care, with district and state cadres and increased professional capacities in public health, management and administration, primary health care and curative care;
b) **Governance issues** – transparent appointment and transfer policies; mechanisms for motivation and morale building; personal appraisal systems; supervisory systems; monitoring finances and performance; relationship with elected Panchayat bodies; access of the public to information; feedback systems from the public and patients; improving ethical and legal aspects of work;

c) **Building of institutional capacity** – through training and continuing education; good intra and inter-organizational communication systems; partnerships with NGOs and private sector; developing administrative and management skills at PHC's, CHC's, taluka and district hospitals; assessment of need and impact through studies and research;

d) **Those relating to equity, quality, integrating access** and to technical aspects.

The department will be taking action on the recommendations that are accepted by the government. Mechanisms evolved will link with the project.

The KHSDP and IPP IX **systems for construction and procurement** will be integrated into the department and will be utilized for this project. Maintenance functions will be allocated to the same unit. Minor repair and maintenance work will be undertaken locally upto a specified financial level. Annual maintenance contracts for equipment may be made with companies concerned after studying the cost effectiveness of such arrangements.

Good communication systems will be evolved to keep all functionaries or team members of the Dept. of Health (DOH) informed on a monthly (or two monthly basis to start with) of the process and activities in the project and the department. The public should also be kept informed through information boards in each institution and through the mass media, especially the radio and press. Specific communication systems for specific aspect, such as surveillance and referrals, make use of faxes, telephone, and emails. These systems will have to be introduced. Rapid and free flow of information is important for optimal functioning.

NP 2

ACTIVITIES AT VILLAGE LEVEL (AND SUB-CENTRE)

(Approx. Population 1000 - 3000)

ANM

1. Delivery of New Born Babies (NBB) and training of dais (OJT)
2. Immunization of NBB
   - of Infants
   - of Under 5's
   - PPI's, Measles etc
3. Recording of Births, Deaths and Marriages
4. Basic curative services
5. Family Planning activities
6. Maternal and Child Health
   - ANC, PNC, Care of Newborn
   - Training of Dais
   - Prevention and treatment of Anemia
   - Well baby clinic
7. Health Education, IEC, HNE
8. Identification of Cataract and Night Blindness
   - Children
   - Pregnant Women
9. School Health

TRAINED / UNTRAINED DAIS

1. Inform and Assist in Delivery of NBB or actual Home delivery.
2. Inform of Births, Deaths, Marriages.
3. Bring eligibles for FP.
4. Assist ANM in MCH services.

HEALTH WORKER MALE/FEMALE

1. Collection of Water samples from drinking water sources and chlorination.
2. Collection of blood slides of fever cases and treatment.
3. Notification of Communicable disease outbreak.
4. Health Education, IEC, HNE.
5. Basic curative services.
6. Assist in outdoor activities .
7. Reporting to PHC's.
8. Liaison with Private Practitioners
   - Surveillance
   - Provision of Health Care
9. Arrangements for tpt of seriously ill, emergency cases including EmOC.
10. Environment sanitation vector control.
11. Male involvement in FP, in other health issues.

ANGANWADI WORKER (AWW)

1. Assist in Imunization of
   - Infants
   - Under 5's
   - PPI's Measles, etc
2. Health Education, IEC, HNE.
3. Distribution of Nutrition Supplements and Micronutrients
   - Weaning foods (where applicable)
   - Under 6yrs
   - Pregnant & Lactating mothers
   - Adolescent girls (who will also assist the AWW)
4. Medical check-up of children by PHC doctor.
5. Maintenance of Growth chart.
6. Basic curative services (ORS, Fever, Deworming, cuts, etc)

SCHOOL TEACHERS

1. Health Education, HNE, IEC.
2. School Health.
3. Adolescent girls.
4. Reach the dropouts
5. Toilets and drinking water in school.

GRAM PANCHAYAT MEMBERS

1. Arrangement for tpts.
2. Community participation.
3. Coordination, Monitoring of various activities in the village.
4. Environmental Sanitation of the village.
   - Garbage disposal / Refuse collection.
   - Toilets
   - Water collections
   - Piggery
5. Inclusion of Marginalised in all activities.
6. Social issues – Alcoholism, violence against women, etc.

OTHERS

(SHE group leader, AH department, NGO representatives, PP, AW helper)

1. Assist in different activities as per their capabilities.
2. Women's empowerment.

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Indicators and Targets

Indicator	Present position	Target in 2007
Crude birth rate	22 per 1000 population	17
Infant mortality rate	58 per1000 live births	40
Maternal mortality rate	195 per 100,000 live births	150
Severe malnutrition	6.2%	3%
Moderate malnutrition	45.4%	30%
Immunisation coverage with maintenance of cold chain	60%	85%
Safe deliveries with access to emergency obstetric care	51%	>80%
TB case detection and cure rates	60% and <40%	75% and 85%
HIV/AIDS prevalence	1% of adult population	< 3% of adult population
Hospital utilization	N.A.	25% above current level
Client satisfaction	N.A.	25% above current level

Note: Refinement of indicators is currently going on.

Monitoring

The indicators listed above will be monitored through Sample Registration Surveys, RCH Surveys, National Family Health Survey, and Special Surveys commissioned once in 3 years by the department. In addition disaggregated monitoring at district and sub-district levels will be strengthened through a comprehensive and improved Health MIS and strengthening of the Civil Registration System.

Resources as per Medium term Fiscal Plan

The Resources as per the Medium Term Fiscal Plan indicated by the Finance department is shown at Table 1.

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Table 1: Resources as per MTFP indicated by Finance Department

(Rs. crore)

Category/Year	2000-01 BE	2001-02 Projection	2002-03 Projection	2003-04 Projection	2004-05 Projection
Health	1069	1304	1464	1666	2026
Salaries	606	688	728	770	815
Non-wage O&M	373	529	619	709	815
Capital	90	88	117	187	396

The above resource projections include the resource flows from the proposed Karnataka Integrated Health Nutrition Family Welfare Services Project (KIHNFWP) to be substantially funded by the World Bank and estimated at $170 million (approx. Rs. 800 crore). The Project is slated to commence in 2002-03 and continue till 2006-07. The proposed Karnataka Integrated Health Nutrition, and Family Welfare Services Project will address all the key health sector issues. It will have three major components, viz.

I. Management development and institutional strengthening;
II. Improving access, service quality and effectiveness; and,
III. Innovations to enhance partnerships with communities and private sector.

The year-wise projected Resource flows through this Project is indicated below at Table 2.

Table 2: Resource flows through the Karnataka Integrated Health, Nutrition and Family Welfare Services Project (KIHNFWP)

(Rs. crore)

Category/Year	2000-01 BE	2001-02 Proj.	2002-03 Proj.	2003-04 Proj.	2004-05 Proj.	2005-06 Proj	2006-07 Proj.
KIHNFWP			80	150	215	175	175
Salaries			15	20	25	30	35
Non-wage O&M			15	30	40	45	50
Capital			50	100	150	100	90

The Health sector comprises the following departments/divisions: i) Health ii) Family Welfare iii) Medical Education iv) Indian Systems of Medicine & Homeopathy v) Drug Controller vi) Karnataka Health System Development project and vii) IPP VIII and IX. The MTFP needs to adequately reflect the priorities and needs of each of the above departments/divisions. A detailed exercise with each department/division has been undertaken. Based on this exercise the MTFP has been slightly modified in terms of the projected flows for different components, keeping the overall projections within the amounts indicated by the Finance Department. The modified projections may be seen in Table 3 below. The projected resource flows through the KIHNFW Project has been included. Committed liabilities and essential expenditures to be continued at the end

of the KHSDP (ends in March 2002) and at the end of IPP VIII and IX (ends in December 2001) have also been included.

Table 3: Resources as per MTFP now proposed by the Health and Family Welfare Department

(Rs. crore)

Category/Year	2000-01 RE	2001-02 Projection	2002-03 Projection	2003-04 Projection	2004-05 Projection
Health	1025	1304	1464	1666	2026
Salaries	550	650	700	770	840
Non-wage O&M	275	475	574	676	840
Capital	200	180	190	220	346

Health Sector Issues

Human Resource Development – All vacant posts in the Department must be filled up to eliminate shortage of qualified staff. Simultaneously, capacity- building measures must be initiated to increase accountability and efficiency of the existing staff. This requires an ongoing system of training based on a broad range of principles of public health management. There is also need to further increase transparency in the selection, posting and transfer of health personnel, and to introduce a system of performance rating and incentives for medical staff to work in remote areas.

Governance – The planning, administration, monitoring and evaluation systems of the health sector must be improved to increase accountability at all levels. All vertical programmes of health, nutrition and family welfare services must be integrated at the primary health centre, rather than implemented piece-meal, as is the current practice. Such integration will result in greater programme effectiveness, and accountability to the communities for whom they are intended. Convergence of programmes at the PHC level must also be accompanied with a well functioning referral system. There is also need to improve inter-sectoral coordination and increase partnerships with general practitioners, traditional health providers, voluntary organizations, civic society and the private sector.

Funding – The sectoral share of funds for the health sector must be increased. In addition, systems to improve efficiency in the utilisation of funds must to be redesigned, perhaps with greater decentralization and devolution of powers, ensuring however, that primacy in funding of the primary and secondary health sectors is maintained. The funding of essential non-wage O&M costs such as on essential drugs, maintenance of buildings, vehicles, etc. requires to significantly improve. There is also need to look at alternative sources of financing, including community financing, insurance and a judicious application of user charges, which ensures exemption to the poor.

Equity, Regional Disparities and Quality – Regional disparities require to be adequately addressed. Gender and caste inequities also need to be given increased

attention. There has also been inadequate attention to establishment and maintenance of quality of care standards.

Programme and project issues

During the coming years the focus will be on key health system issues that deal with the concerns identified in the previous section. These will be addressed both through regular programme funding as also through the proposed Karnataka Integrated Health, Nutrition and Family Welfare Services Project. In specific terms the issues identified for attention are spelt out below.

Access, quality and effectiveness of Primary Health care Services – Access to the poor, especially to women and SC/ST will be fully ensured. Through more effective use of existing resources as well as Project funding, the State will put in place an integrated and responsive primary health care system supported by a well functioning referral system. Maintenance of quality standards in health care will receive special attention.

Institutional Strengthening -- The organizational structure will be thoroughly revamped to provide for a more responsive health system. These efforts will also include improved planning, programme management, human resource development, a modern IT based HMIS, and an improved surveillance system.

Reduction in Regional Disparities –Policies and programmes, including project funding will focus on reducing regional equities; districts with poor health indicators will receive increased attention and priority.

Improving Governance, forging partnerships and community partnerships – Measures introduced recently to improve transparency in selections, postings and transfers will be further enhanced. All key health personnel posts will be filled up. Performance monitoring will be introduced and incentives provided to motivate health personnel to work in remote rural areas. Partnerships with the private sector and NGOs will be forged. Community empowerment and participation in the implementation of all health programmes will be encouraged and supported.

Improving allocative efficiency – In addition to striving for increasing the share of the health sector, the share of the primary and secondary sectors within the health sector will be maintained and further enhanced. Other innovative mechanisms such as community based financing mechanisms linked with health insurance will be introduced.

India
Karnataka Integrated HNP Services Development

UNIT 1

Project Concept Document

HNP-3

South Asia Regional Office
Country Department

Date:
Country Manager/Director: Edward Lim
Project ID:
Lending Instrument: Specific Investment Loan

Team Leader: Tawhid Nawaz
Sector Manager/Director: Richard Lee Skolnik
Sector: HY - Other Population, Health & Nutrition
Theme(s): Health/Nutrition/Population
Poverty Targeted Intervention: [X] Yes [] No

Project Financing Data
[X] Loan [] Credit [] Grant [] Guarantee [] Other [Specify]

For Loans/Credits/Others:
Total Project Cost (US$m)
Cofinancing:
Total Bank Financing (US$m)

Borrower: Government of Karnataka
Guarantor: Government of India
Responsible agency: Department of Health and Family Welfare Services
Project implementation period:
Implementing Agency:
Contact person:
Address:
Tel: Fax: E-mail:

For Dr SKK, Sabu → HNP file

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JW
12/2/01

A: Project Development Objective

1. Project development objective: (see Annex 1)

The objectives of the proposed project are:

- to improve efficiency in the allocation of health resources through policy and institutional development
- to enhance performance of the health systems at the primary level.

2. Key performance indicators: (see Annex 1)

- Increased public resources to health sector, with increased share to primary and secondary levels of care
- Increased referral between levels of care, between health, family welfare, and nutrition programs, and between private and public sectors
- Increased utilization of primary health services, especially by the poor
- Increased patient and community satisfaction with primary health services

B: Strategic Context

1. Sector-related Country Assistance Strategy (CAS) goal supported by the project: (see Annex 1)

Document number: Date of latest CAS discussion:

The objectives of this proposed project reflect the goals and priorities identified by the CAS and India's Ninth Five-Year Plan and National Population Policy, 2000. The CAS recommends focusing Bank-Group financed investments on states that are undertaking economic restructuring programs and supporting sectoral policy reform. Karnataka is one of the states that have initiated important fiscal, sectoral, and governance reforms. Furthermore, it supports the CAS objectives by strengthening institutional capacity, improving governance, engaging the private sector, expanding access to services, upgrading effectiveness and quality of services and enhancing community participation and empowerment. Furthermore, the project's objective to meet the health needs of under-served populations, such as the poor, scheduled castes and tribes (SC/STs), women, and children, is at the core of poverty reduction strategies in India.

2. Main sector issues and Government strategy:

HNP Sector Issues in India

India has made considerable progress in improving the health status of its population over the past fifty years. The State of Karnataka reflects some of this gain, standing slightly above average in improvements in life expectancy and declines in fertility, infant mortality, maternal mortality, and severe and moderate malnutrition. Despite these broad favorable trends in both the country and the state, a significantly high proportion of the population, particularly those living in poverty, continue to suffer and die from preventable infections, pregnancy- and childbirth-related complications, and under-nutrition. An epidemiological transition is also taking place in which there are simultaneously high rates of communicable and non-communicable diseases and where rapid urbanization is resulting in new health problems. Furthermore, disparities between regions, men and women, and the poor and non-poor

continue to widen.

Experience with project implementation and findings of the sector work indicate that the principal constraints in the health, nutrition, and population (HNP) sector in India include: (i) inadequate institutional arrangements and weak program management; (ii) limited financial resources; (iii) poor governance; (iv) low quality of HNP services in both the public and private sectors; (v) limited access to health services for the poor; and (vi) inadequate framework for engaging the private sector.

Inadequate institutional arrangement and weak program management. The existing fiscal and administrative set up is complex, thereby hindering effective financing and accountability for decentralized management of health facilities and deterring effective coordination across the health, population, and nutrition sectors. More field level integration of the various health programs and coordination of HNP services at the primary level are critical to improving health outcomes. In addition, management skills at all levels are poor.

Limited financial resources. Overall spending on HNP services in India is sizeable, albeit lower than in comparable countries, and far less than the amount recommended to provide basic services. Spending on preventive and promotive primary care services has not kept up with the growing need for services, particularly for people below the poverty line. In addition to overall revenue constraints, weak mechanisms for reallocating resources according to priorities, particularly operating and maintenance expenditures, impede the delivery of effective public HNP services.

Poor governance. A major problem related to governance, which affects the performance of Karnataka's public sector in HNP is a lack of accountability and transparency in areas such as management of human resources, particularly with respect to staff recruitment, appointment and transfer.

Low quality of health services. Most Indians expect little, and receive little, from their health services. Health facilities are often in disrepair, poorly equipped, and under-supplied, reflecting the low levels of health spending. They are further constrained by staffing limitations, particularly in poor and remote areas, by inappropriate skill-mix as well as by shortages of drugs and supplies and lack of attention to supervision and maintenance. In both the public and private sectors, there are few standards and quality improvement systems in place. Quality private health services are inaccessible for the poorest and most vulnerable sections of society, and they do not address public health issues of national significance. As a result, substantial gaps remain in the effective delivery of health care services that are provided to the population, especially for the poor and vulnerable populations.

Limited access for the poor. Those comprising the most vulnerable sections of society suffer the deepest from the inadequacies of the public health system. Rural populations, women, children, the disabled, and people belonging to the scheduled tribes and scheduled castes have the worst health outcomes, are allocated the least resources, and receive the fewest services to compensate for their increased risks. The poor also pay relatively more for health care and receive worse care.

Inadequate framework for engaging the private sector. The private sector in India accounts for about 80 percent of overall health expenditures, one of the highest proportions of private expenditure on health in the world. Services provided by the private sector are highest for primary health care, such as visits to formal and informal health providers, and are financed almost entirely by out-of-pocket sources, placing a disproportionate burden on the poor. The private sector, however, remains largely neglected in the government's policy formulation and program implementation. Appropriate policies to engage the private sector, particularly with respect to providing information, licensing, and regulations to protect and empower consumers, especially poor consumers, need to be clearly articulated and implemented.

Government of India

India has made substantial progress in improving the health status of its population over the past two decades. GOI has determined that public investments in health are critical for the sustainability of development and poverty alleviation in India. Health is one of the six priority areas identified in the Ninth Plan (1997-2002) which emphasizes successful preventive and promotive activities, better control of communicable and non-communicable diseases, strengthened community and beneficiary participation, and improved surveillance and systemic efficiency. The Central Council of Health and Family Welfare has noted the importance of linking preventive and promotive care with selective aspects of curative care as well as highlighted the importance of a well functioning referral system. Since the states are largely responsible for the financing and implementation of health programs, these issues need to be addressed at the state level.

Government of Karnataka

The Government of Karnataka (GOK) has had a long standing commitment to human development and public health. In 1999 the GOK, prepared its first Human Development Report outlining developmental disparities based on gender, income and region, as well as bringing to the fore issues of access and equity. Building on the report, in early 2000 the Chief Minister of Karnataka commissioned a review of the health system to ensure "Health for All", with an emphasis on equity and quality. In order to ensure a participatory process, a Task Force on Health consisting of key stakeholders in the government and civil society was formed. The Task Force has developed a proposal outlining priorities for the health sector. The priorities include developing an integrated health, nutrition and population project for the State building on the gains of the existing Health System Development project, improving the existing primary health care system with a special emphasis on equity and quality, increasing the health sector's responsiveness to the needs of populations with special needs, strengthening management, and developing a comprehensive health management information system.

3. Sector issues to be addressed by the project and strategic choices:

Achieving health and nutritional goals set by the Government of Karnataka —reduced infant and maternal mortality, reduced malnutrition, control of communicable diseases—will require concerted action from the health sector, as well as from other sectors such as education, water, sanitation, and rural and social development. Important determinants of poor health and nutritional status include extreme poverty, low educational status of women, lack of access to clean water and sanitation, and gender and caste-based inequities; these factors cannot be adequately or directly addressed by interventions in the health sector. To assist the GOK in reaching the state's desired health and nutritional outcomes for its people, the Bank has adopted a systemic and broad based approach to addressing the health system and has financed projects and programs which include centrally sponsored disease control, nutrition, and family welfare, as well as state health system development that focuses on increasing efficiency of resources and enhancing the performance of health systems at the secondary level of health care.

The proposed project will establish an integrated and responsive primary health care system supported by a well functioning referral. It will build upon and expand the investment operation financed by the Bank, Karnataka State Health Systems Development Project (KHSDP), and integrate delivery of health services with family welfare services and disease control at the primary level. Furthermore, it will complement fiscal and governance reforms planned under the economic restructuring program, which is also supported with the Bank assistance.

The project will address the key sector issues in the following way:

Strengthening institutional arrangement and program management. The project will address institutional problems through improving overall planning and management, manpower development, procurement of

drugs and equipment, referral, HMIS, surveillance, and training. Furthermore, the project will strengthen institutions to enable integration and coordination between health, nutrition, and family welfare services, as well as to work with the private sector at the primary care level.

Increasing financial resources. The project will supplement ongoing efforts by the Bank-financed investment KHSDP, to (i) ensure adequate budgetary allocations to the health sector, (ii) increase the share of health sector resources provided to the primary and secondary levels; and (iii) allocate adequate resources for drugs, essential supplies, and operations and maintenance. In addition, under the fiscal reforms supported by the Bank, Government of Karnataka (GOK) Medium Term Fiscal Plan envisages increased spending on priority social sector programs, of which health is one. The project will also address regional (intra-state) disparities in allocation of resources within the health sector, by intensifying interventions in under-served areas.

Improving governance. GOK has initiated measures to improve governance, such as civil service reform and human resource management, which will be expanded under the Bank's structural adjustment program. Within the health sector, KHSDP has already made considerable progress in increasing transparency in the transfer of medical personnel and contracting out non-clinical services at secondary level hospitals to private agencies. The proposed project will also adopt measures to improve governance in the health sector, such as providing incentives for medical personnel to work in remote areas and with vulnerable populations, mechanisms to establish merit-based selection and increase transparency in the performance rating of personnel, and promoting the role of the public in monitoring health services.

Enhancing quality of health services. The project will support policies and activities to improve the quality of health services through supply-, as well as demand-side interventions. Supply side interventions include upgrading primary health care facilities, putting in place service norms, and addressing manpower gaps and skills mismatches, and strengthening linkages between public and private providers. Furthermore, this project will empower communities with information and mechanisms for redress and quality improvement. The role of the community in increasing accountability of the health systems will also be strengthened.

Expanding access for poor and vulnerable populations. The project will increase access by expanding services in areas where poverty is concentrated, and health status poor. The project will intensify interventions with respect to physical infrastructure, staffing, IEC, and community involvement in the northern districts of Karnataka, which have suffered from neglect and therefore, exhibit the lowest human development. Furthermore, NGOs and community based organizations (CBOs), in addition to local private practitioners, will be engaged to deliver clinical and non-clinical services, such as IEC and outreach, to communities difficult to access by the public health system.

Partnering with the private sector. The proposed project will promote private sector participation through innovative schemes to involve traditional healers, NGOs, and other private practitioners in areas such as referral, training, health financing, development of accountability and transparency measures, and monitoring and evaluation.

C: Project Description Summary

1. Project components: (see Annex 1)

The project consists of three main components:

1. **Management development and institutional strengthening** component would consist of (i) strengthening management and implementation capacity, in the areas of financial management, procurement, technical management, and monitoring and evaluation; (ii) strengthening disease surveillance and management information system; and (iii) improving institutional framework for policy

development. The component would finance professional services, local training, vehicles, equipment, including computers, furniture, studies, fellowships, workshops, operational expenses, and salaries of incremental staff on a declining basis. This component

2. **Improving access and service quality and effectiveness** component would consist of (i) upgrading primary health care facilities; (ii) improving human resource development and management, and curative, preventive and support services; (iii) strengthening referral system between levels of care, between HNP programs, and between public and private sectors; and (iv) expansion of health services in underserved areas. The component would finance civil works, professional services, furniture, medical and other equipment, local training, workshops, vehicles (purchase, hire, and maintenance), IEC, operational expenses, and salaries of incremental staff on a declining basis.

3. **Innovations to enhance partnership with communities and private sector** component would consist of (i) strengthening community capacity to identify health needs and solutions and to monitor and evaluate health services; (ii) piloting community driven schemes in the areas of health financing and health promotion; and (iii) piloting public-private partnership schemes. It would finance professional services, NGOs, local training, IEC, workshops, studies, vehicles (purchase, hire, and maintenance), operational expenses, and salaries of incremental staff on a declining basis.

Component	Sector	Indicative Costs (US$M)	% of Total	Bank financing (US$M)	% of Bank financing
1. Management development and Institutional strengthening					
2. Improving access and service quality and effectiveness at the primary care level					
3. Innovations to enhancing partnership with communities					
Total		0	0	0	0
Total Project Costs					
Interest during construction					
Front-end fee					
Total Financing Required					

2. Key policy and institutional reforms to be sought:

Many of the following key policy and institutional reforms have been initiated by GOK with the support of KHSDP. The Task Force on Health and Family Welfare has also commissioned studies, financed by KHSDP, to help inform these policy decisions and reforms. In addition to increasing support for current efforts, the proposed project would expand particularly in the areas affecting primary care and involvement of communities to improve health services and financing.

- Increasing financing and improving resource allocation to the health sector, in particular primary and secondary levels

- Developing policy and strategy to promote public-private partnerships, including traditional health care providers
- Improving manpower policy and procedures within the health sector by improving recruitment, deployment, transfer, training, performance appraisal, sanctions, and incentives
- Improving technical efficiency by developing and strengthening management systems in the areas of planning and budgeting, finance, information, manpower, equipment procurement, and maintenance
- Strengthening institutions to better manage and deliver integrated health, family welfare, and nutrition services at the primary level
- Improving financial protection for the poor ?
- Enhancing role of community based organizations (CBOs) in health promotion, service delivery, and monitoring and evaluation and financial protection
- Enhancing public involvement and accountability of health services and financing

3. Benefits and target population:

Add

4. Institutional and implementation arrangements:

Institutional arrangements are currently under preparation. Our experience from implementing health systems development projects indicates the following arrangements. The top of the proposed structure would be composed of Project Governing Board, chaired by the Chief Secretary and including other Principal Secretaries from other concerned departments of GOK—Health and Family Welfare, Women and Child Development, Indigenous Medicine, Education, Sanitation (and possibly representatives from the private sector, consumer groups, and NGOs), which would have responsibility for overall project coordination and policy. A Project Steering Committee (PSC), led by the Secretary, Health and Family Welfare Services, and composed of high level managers from the State Health and Family Welfare Directorates, would be the second tier. The PSC would supervise and guide the implementation of the project, in addition to coordinating with other health sector projects. The next tier would be the Project Management Unit (PMU) to be headed by the Project Director. The Unit would consist of Financial Management Wing, Equipment Procurement and Maintenance, Engineering and Architectural Wing, Quality Improvement Cell, HMIS Cell, Community Empowerment Cell, and Training Cell, all composed of professionals. The PMU situated at the Department of Health and Family Welfare Services, would work with Directorates of Health, Medical Education, and Family Welfare and would be responsible for day-to-day project implementation.

D: Project Rationale

1. Project alternatives considered and reasons for rejection:

The major alternatives considered include:

(a) Focus on selected parts of the State. Implementing exclusively in selected parts of the state would be politically infeasible, and would miss the opportunity to address key state-wide policy issues such as increasing financing and improving resource allocation in the health sector, allocating adequate resources for drugs, essential supplies and operations and maintenance, and institutional strengthening such as rationalized service norms, referral mechanism, health care waste management system, equipment management system, HMIS and surveillance of major diseases, procurement and financial management arrangements. By addressing needs in only parts of the state, this alternative would not address the health needs in a coherent and effective manner. Experience in the six states where State Health Systems

Development projects are currently being implemented indicates that the broad-based approach is the appropriate mechanism to address systemic health sector issues.

(b) **Leave the provision of basic services entirely to the private sector.** There are several rationale for undertaking this operation through the public sector: (i) the private sector provides mainly curative care, and does not provide the most appropriate services to those in greatest need; (ii) both sector work and beneficiary assessment studies in several states in India indicate that more than 60% of the beneficiaries belong to the poorest sections of society and much of the remaining 40% are marginally above the poverty line. They are unable to afford the costly fees for private services, which are paid almost entirely from out-of-pocket sources. Since this project wishes to address the needs of the poor leaving the provision of services to the private sector will fail to In addition, public health measures and essential interventions is an important priority for government financing.

(c) **Use an Adaptable Program Loan (APL).** The advantage of the APL is that it encourages progress against defined benchmarks, adds flexibility, cuts down on subsequent preparation time by focusing on implementation and monitoring, signals a long-term commitment to assisting on long-term problems, while keeping the whole problem under consideration in a phased manner. Due to limits on program loans in the overall lending program, Regional Management prefers to use flexible lending instruments such as the APL for sectors which are more conducive to phased reform monitoring, such as the power sector (?).

(d) **Use a Sector –Wide Approach (SWAp)** was considered but rejected as a feasible alternative due to the GOK's weak institutional capacity to implement disparate elements of health sector operations under one umbrella program. The GOK has clearly outlined as its' main priority in the health sector to build its' own technical and managerial capacity and strengthen the existing health system. The government has opted for a systems development approach within the framework of a broad based sector dialogue.

2. **Major related projects financed by the Bank and/or other development agencies (completed, ongoing and planned):**

Sector issue	Project	Latest Supervision (Form 590) Ratings (Bank-financed projects only)	
		Implementation Progress (IP)	Development Objective (DO)
Bank-financed	Population VIII	S	S
	Population IX	S	S
	Reproductive and Child Health	S	S
	Immunization Strengthening	S	S
	State Health Systems II	S	S
	Andhra Pradesh First Referral Health System	S	S
	Orissa Health Systems Development	S	S
	Maharashtra Health Systems Development	S	S
	Utter Pradesh Health Systems Development	S	S
	National HIV/AIDS Prevention and Control	S	S
	Cataract Blindness Control	S	S
	Malaria Control	S	S
	Tuberclosis Control	U	U
Other development agencies			
KfW	Secondary Health Development (Gulbarga)		

IP/DO Ratings: HS (Highly Satisfactory), S (Satisfactory), U (Unsatisfactory), HU (Highly Unsatisfactory)

3. Lessons learned and reflected in proposed project design:

The project design takes into account key lessons learned from implementation of social sector projects in India, and specifically four State Health Systems Development Projects currently under implementation in six states, findings from sector work, and evaluations from Operations Evaluation Department (OED).

Lessons from implementation of State Health Systems Development Projects: (i) maintain continuity in project management and key project actors; (ii) empower Project Management Unit and Project manager appropriately to ensure timely and adequate flow of funds, especially when the project is implemented by a government line department; (iii) strengthen project management by providing greater autonomy with respect to management and supervision, adequate staffing of key project management personnel and improving management procedures; (iv) pay attention to quality aspects of the project through development of staffing and technical norms, referral mechanism, clinical and management training programs, incentives for medical personnel, staff selection based on merit, and addressing skill-mix during preparation; (v) emphasize software aspects, such as IEC, quality, and referral, to be implemented in conjunction with hardware; (vi) improve HMIS to facilitate policy and institutional strengthening and ensure information collected through M & E be used for management decision-making; (vii) use independent agency in areas of M & E and IEC; and (viii) undertake early preparation of procedures and mechanisms to select and monitor NGOs and other private agencies contracted by the project.

Findings from sector work:

Keys lessons from implementation of social sector and other HNP projects in India: (i) ensure timely and adequate flow of funds to the project entity; (ii) undertake advanced preparation of hardware and software aspects of the project prior to approval; and (iii) speed up implementation and increase supervision by strengthening implementation capacity of the line agency to resolve problems in procurement and disbursement early in the project cycle, and develop detailed implementation plans prior to appraisal.

Key recommendations from OED: (i) place greater emphasis on institutional development and governance issues in order to make a greater impact on development; (ii) engage in policy development and debate; (iii) tackle the personnel problems and incentives structures in the sector; (iv) support integration of referral system; (v) engage the private sector; and (vi) introduce performance-based budgeting.

4. Indications of borrower commitment and ownership:

Political commitment and ownership for the project are high. The commitment of GOK to health sector reform is reflected in the constitution of the Task Force on Health and Family Welfare, which is composed of prominent persons in the field of medicine and public health from academia, and the private and NGO sectors. The principal responsibility of the Task Force is to provide strategic vision and formulate recommendations for improving the health care system in the State. Furthermore, Karnataka is one of the states partnering with the Bank to undertake broad reform measures, mainly fiscal, sectoral, and governance changes to strengthen the enabling environment for poverty reduction.

5. Value added of Bank support in this project:

IDA is best suited to provide funds to complement the medium and long-term policy initiatives of the government. IDA's approach to policy dialogue, which includes up front, and long-term engagement, are useful in supporting the types of changes envisaged. The project would help consolidate the investment made by a number of other IDA and donor-supported projects in the health, nutrition, and population

sector, and provide a critical link to these investments. The project would also strengthen IDA's strategy of poverty reduction in India through its focus on the poor and under-served populations.

E: Issues Requiring Special Attention

1. Economic

[ ] Summarize issues below (e.g., fiscal impact, pricing distortions)
[ ] To be defined (indicate how issues will be identified) [ ] None

Economic evaluation methodology:

[ ] Cost benefit [X] Cost effectiveness [X] Other [specify]

The following economic analysis will be completed by appraisal and will contribute to project design (i) a public expenditure review in the health sector addressing financial sustainability and the ability to increase resources and protecting non-salary recurrent items. (ii) an analysis of private sector provision and financing to assure that public investments are not simply trying to substitute for private services, and to examine who is benefiting from the proposed investments.

2. Financial

[X] Summarize issues below (e.g., cost recovery, tariff policies, financial controls and accountability)
[ ] To be defined (indicate how issues will be identified) [ ] None

Project preparation will pay special attention to the fiscal impact of the proposed project as it relates to the medium term expenditure framework and to issues relating to financial controls, accountability, and sustainability, including (i) recurrent cost implications of the project, with the understanding that the project would finance recurrent costs on a sliding scale (ii) an assessment of the resource flows into the health sector . This analysis will examine issues of sustainability and the ability of the state to finance incremental recurrent costs of the proposed project as well as the sustainability of IPP VIII, IPP IX and the Karnataka Health System Development Project.;(iii) mechanisms to ensure adequate flow of funds; (iv)an assessment of financial control mechanisms to identify capacity, to collect and analyze financial information, handle cash flow/disbursement issues, procure goods, and contract services. The assessment will examine staffing and systems development and the need to develop financial management capacity to better understand and manage public budgets, and improve financial accountability and controls. There will also be an analysis conducted to outline feasible alternatives for health financing that will be piloted during the project.

3. Technical

[X] Summarize issues below (e.g., appropriate technology, costing)
[ ] To be defined (indicate how issues will be identified) [ ] None

Technical issues to be analyzed by project preparation include (i) integration of the health, family welfare and nutrition services at the primary health care level, supported by a well functioning referral system. (ii) the development of a comprehensive management information system (iii) human resource management particularly in the area of skill mismatch, disruptive staff vacancies, performance based rewards and incentives. A series of workshops and consultations will be held to clarify these issues. These workshops will build on the workshops on staffing and service norms conducted under the State Health Systems Development Project II

4. Institutional

[X] Summarize issues below (e.g., project management, M&E capacity, administrative regulations)
[ ] To be defined (indicate how issues will be identified) [ ] None

An institutional assessment is being planned to provide guidance on how to implement the proposed institutional reforms for the project. An analysis of the existing relationship between the public and private sectors will be conducted to better identify and plan how the government can work with the private sector in the area of referral, quality improvement and disease surveillance. As well, a study will be conducted to examine the institutional arrangements needed to increase community involvement and increase the community's capacity to provide feedback and monitor and evaluate the health system.

Executing agencies:
The project will build on existing arrangements developed through the Karnataka Health Systems Development Project

Project Management
The project will build on existing arrangements developed through the Karnataka Health Systems Development Project

Procurement Issues
As a result of the existing KHSDP project, the GOK is well versed in the Bank procurement guidelines thus there are no foreseen problems in this area.

Financial management issues
As a result of the existing KHSDP project, the GOK is well versed in the Bank procurement guidelines thus there are no foreseen problems in this area.

5. Social

[ ] Summarize issues below (e.g., significant social risks, ability to target low income and other vulnerable groups)
[ ] To be defined (indicate how issues will be identified) [ ] None

One of the key issues to be addressed in this project is how to overcome socio-economic and cultural barriers, as well as gender discrimination and thereby increase access for vulnerable populations. Additionally, an assessment of the potential impact of the project and any changes in health policy on the various stakeholders will be conducted. A special focus will be on the poor, SC/ST, women, disabled groups and under-served districts in North-East Karnataka. A mapping exercise will also be conducted in these under-served areas. The project preparation will also review the evaluation of the Yellow-Card Scheme implemented under KHSDP to expand access to the scheduled tribes.

6. Environmental

a. Environmental issues:
[ ] Summarize issues below (distinguish between major issues and less important ones)
[ ] To be defined (indicate how issues will be identified) [ ] None

Other:

b. Environmental category: [] A [] B [X] C

c. Justification/Rationale for category rating:

The project is expected to have no adverse environmental impact given that the project only involves upgrading of existing facilities. With regards to waste management, the project will ensure that it complies with WHO standards

d. Status of Category A assessment: EA start-up date:
Date of first EA draft:
Current status:

e. Proposed Actions:

f. Status of any other environmental studies: Government has conducted audits of each secondary level facility.

g. Local groups and NGOs consulted (list names): Not Applicable

h. Resettlement Not Applicable

[ ] Summarize issues below (e.g., resettlement planning, compensation)

[ ] To be defined (indicate how issues will be identified) [ ] None

i. Borrower permission to release EA: [ ] Yes [ ] No [ ] N/A

j. Other remarks:

7. Participatory Approach:

a. Primary beneficiaries and other affected groups:
[X] Name and describe groups (how involved, and what they have influenced or may influence.)
[ ] Not applicable (describe why participatory approach not applicable with these groups)

End beneficiaries, community groups, NGOs, private providers and local government officials, will participate in the preparation phase through consultation workshops, exit interviews at health facilities, and focus group discussions to define performance indicators and plans for monitoring and evaluation during the course of the project, to identify needs and barriers to obtaining quality care and expanding access. Monitoring of use by end beneficiaries, and of patient and community satisfaction with the health services will be incorporated into the HMIS and will be used for local planning and management and performance assessment of the project.

MOH will prepare the Project Implementation Plan (PIP)
b. Other key stakeholders:
[X] Name and describe groups (how involved, and what they have influenced.)
[ ]Not applicable (describe why participatory approach not applicable with these groups)

Local academic groups will be involved in the design and preparatory studies and in advising technical elements of the drafting of the PIP. NGOs, and other technical agencies, WHO and KfW will be consulted in the design phase and their inputs will be coordinated and shared.

8. Checklist of Bank Policies

a. Safeguard Policies (check applicable items):

	Policy	Risk of Non-Compliance (H, M, L)
	Environmental Assessment (OD 4.01)	
	Natural Habitats (OP/BP/GP 4.04)	
	Forestry (OP 4.36)	
	Pest Management (OP 4.09)	
	Cultural Property (OPN 11.03)	
√	Indigenous Peoples (OD 4.20)	
	Involuntary Resettlement (OP 4.30)	
	Safety of Dams (OP 4.37)	
	Projects on International Waterways (OP 7.50)	
	Projects in Disputed Areas (OP 7.60)	

b. Business Policies (check applicable items):

√	Financing of recurrent costs (OMS 10.02)
	Cost sharing above country 3-yr average (OP/BP/GP 6.30)
	Retroactive financing above normal limit (OP/GP/BP 12.10)
√	Financial management (OP/BP 10.02)
√	Involvement of NGO's (GP 14.70)
	Other (provide necessary details)

c. Describe issue(s) involved, not already discussed above:

F: Sustainability and Risks

1. Sustainability:

Financial, social, technical, and managerial sustainability is being addressed in the design and preparation of the project. The economic analysis and monitoring of expenditures will determine whether the incremental costs of the project are affordable, and whether they will remain so as the program develops. Institutionalizing a process to justify major capital investments is intended to maintain a sustainable program. Social sustainability is addressed by instituting mechanisms to increase the involvement and voice of consumers in the design of the project, and in routine provision of health services in both public and private sectors. Updating the technical paradigms, streamlining services and integrating the referral chain, working with the private sector, and focusing on management training and systems are steps taken to ensure that the system is more technically and managerially sustainable than before the project.

2. Critical Risks: (reflecting assumptions in the fourth column of Annex 1)

Risk		
From Outputs to Objective		
Institutional arrangements are not effective in integrating centrally sponsored health and family welfare and state health concerns (M)		Institutional strengthening will be emphasized in the proposed project. Financing would be linked to performance
Productive institutional linkages with the private sector are not established (G,M)		Information sharing, pilot studies, and self-regulation will be encouraged. Financing would be linked to performance.
Competent staff and managers are not placed in project management units and health facilities (M)		Address through Letter of Health Sector Development Program, appoint key personnel prior to negotiations
Provider behavior cannot be changed (S,O)		Emphasize consumer feedback and provider incentives as part of the project design
Strategic approach to behavior change communication will not increase demand for and accountability of health services (S)		Use research-based communications and monitor results carefully
From Components to Outputs		
Flow of funds from GOI to State project are inadequate		Address through Letter of Health Sector Development Program, and financial monitoring
Staff and consultants are not assigned in a timely manner		Appoint key staff prior to negotiations
Key staff and managers are not retained for sufficient time		Include provision at negotiations to retain well-performing staff
Procurement is not managed in a timely manner		Develop robust procurement plans and appoint key staff prior to negotiations
Funds are not made available for non-wage recurrent expenditures, especially drugs and mobility		Address through Letter of Health Sector Development Program, and continued monitoring of health expenditures. Link financing to performance
Overall Risk Rating:		

Risk Rating - H (High Risk). S (Substantial Risk). M (Modest Risk). N (Negligible or Low Risk)

G: Project Preparation and Processing

1. Has a project preparation plan been agreed with the borrower: (see Annex 2 to this form)

[X] Yes, date submitted: MM/DD/YY [ ] No, date expected: MM/DD/YY

2. Advice/consultation outside country department:

[√] Within the Bank:
[ ] Other development agencies:

3. Composition of Task Team: (see Annex 2)

Tawhid Nawaz (Team Leader-Task Manager)
David Peters (Sr. Public Health Specialist)
Sadia Chowdhury (Sr. Public Health Specialist)

Preeti Kudesia (Sr. Public Health Specialist)
Hnin Hnin Pyne (Public Health Specialist)
Maj-Lis Voss (Economist)
Abdo Yazbeck (Economist)
Tazim Mawji (Health Specialist)
Rajat Narula (Financial Management Specialist)
Mam Chand (Procurement Specialist)
_____ (Legal Officer)
Vijay Rewal (Architect)
Shrelata Rao (Social Scientist)
Pradeep Kakkar (IEC)

4. Quality Assurance Arrangements: (see Annex 2)

External Peer Reviewers:
Internal Peer Reviewers

5. Management Decisions:

Issue	Action/Decision	Responsibility

Total Preparation Budget: (US$000) Bank Budget: (US$000) Trust Fund: (US$000)
Cost to Date: (US$000)

[ ] GO [ ] NO GO Further Review [Expected Date]

(signature)
Team Leader: Tawhid Nawaz

(signature)
Sector Manager/Director: Richard L. Skolnik

(signature)
Country Manager/Director: Edwin R. Lim

Annex 1: Project Design Summary
India: Karnataka Integrated HNP Services Development

Hierarchy of Objectives	Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
Sector-related CAS Goal: Health and nutritional status of Karnataka's population, particularly the poor, women, children, and schedule castes and tribes, is improved.	Sector Indicators: Decline in infant mortality Decline in maternal mortality Decline in malnutrition Decline in anemia Increase in immunization coverage Increase in TB case detection and cure	Sector / Country Reports:	(from Goal to Bank Mission) Focusing on reforming states and human development will contribute to poverty reduction in India Improving quality of life and health and nutritional status will increase opportunities and productivity
Project Development Objective: Improve efficiency in the allocation of health resources through policy and institutional development Performance of health system strengthened through improvements in quality, effectiveness, and coverage of primary health care services	Outcome / Impact Indicators: 1. Increased public resources to health sector, with increased share to primary and secondary levels of care 2. Increased utilization of primary health facilities, esp. by the poor and SC/STs* 3. Increased patient and community satisfaction with primary health services* 4. Increased referral between levels of care, programs, and private and public providers)	Project Reports:	(from Objective to Goal) Political commitment continues Continuing investment in other sectors, such as water and sanitation, and education, affecting health and nutritional status Continuing support for centrally sponsored programs, currently assisted by the Central Government, the Bank, UN agencies, and bilaterals Continuing support for improving quality, effectiveness and coverage of secondary level care, currently financed by the Bank

	Indicators need further input: QQT		
Output from each component: 1. Access to primary health services expanded, particularly in under-served districts and tribal areas.	Output Indicators: 1.1. Increased awareness of primary health services offered, particularly among SC/STs, women, and poor* 1.2. Increased number of primary health care facilities (functioning according to service and staff norms) in underserved districts and tribal areas* 1.3. Increased number of NGOs contracted to conduct outreach and deliver services in tribal and remote areas*	Project Reports:	(from Outputs to Objective) Competent staff and managers are placed project management units and health facilities, particularly in remote areas Synchronization of project inputs: flow of funds, provision of training, development of norms and contractual arrangements. Timely start-up of civil works, training programs, and other soft ware components, such as IEC and HMIS, and procurement of drugs and equipment.
2. Effectiveness and quality of primary health services improved	2.1. Number of primary health care facilities rehabiliated, equipped versus planned 2.2. Percentage of facilities meeting staffing, equipment, and medicines norms 2.3. Increased number of medical staff trained (clinical, management, patient-provider communication, MIS, referral, waste management) 2.4. Use of disease surveillance and HMIS		
3. Well functioning referral system (between levels of care and between programs) in place	3.1. Increased referral between levels of care 3.2. Increased referral between HNP programs 3.3. Increased referral between private and public providers		
4. Human resource development and management capacity at the primary level strengthened	4.1. IT system developed 4.2. FM system in place 4.3. Manpower gaps filled, esp. vacancies in underserved areas 4.4. Transparency in transfer of medical staff (% of counseling used for transfer) 4.5. Incentives system in place		
5. Communities involved and empowered to demand better services and to identify health needs and problems	5.1. Mechanisms/channels for communities to voice complaint and demand for better services ?? 5.2. Involvement of CBOs in M&E (rating of services, etc.) 5.3. Training of CBOs and community leaders in identifying health problems/needs and barriers to access		
Project Components/Sub-components: 1. Management development and institutional strengthening 2. Improvements in access and service quality and effectiveness 3. Innovations to enhance partnership with communities and private sector	Inputs: (budget for each component)	Project Reports:	(from Components to Outputs) Flow of funds from GOI to State project are inadequate Staff and consultants are not assigned in a timely manner

Project Preparation Plan

A project preparation plan is normally discussed and agreed in principle with the borrower during the identification mission. A one-two page summary of the plan is attached to the PCD as Annex 2 (see sample developed by the LAC Region in page 2 of this annex). The plan should cover the following:

Role, responsibility and staffing of the borrower for project preparation, including designation of a project preparation team (Bank and Borrower).
Bank assistance to be provided during project preparation.*
Arrangements for local/foreign consultant inputs.*
Outline of Project Implementation Plan (see Attachment) to be prepared by the borrower.
Timetable for project preparation (including deadline for submission of the PIP).
Milestones for progress review and any discussions by the Bank.
Key outputs of project preparation, e.g. technical/economic feasibility studies; environmental assessments; institutional, beneficiary, and social analyses; tariff studies; financial models.
Depth of analysis required for each specialist area, e.g., cost benefit analysis, skills/gap analysis.
Issues to be addressed in parallel with project preparation (parallel track or likely loan conditions).
Modalities of project preparation and analytical tools, e.g., beneficiary participation in project design, beneficiary surveys, use of logical framework
The proposed public consultation/participation process

Items indicated above that are covered elsewhere in the main text of the PCD can be omitted from the summary but should form part of the project preparation plan agreed with the borrower.

*Costs are reflected in the project preparation budget (see Annex 3).

KARNATAKA INTEGRATED HEALTH, NUTRITION AND FAMILY WELFARE SERVICES DEVELOPMENT PROJECT

TERMS OF REFERENCE FOR FORMULATING AN INFORMATION SYSTEM STRATEGY PLAN.

1. BACKGROUND:

The Government of Karnataka has received a TA grant in response to preparation of an integrated Health, Nutrition and Family Welfare Services Development Project (P 071160). The proposed PHRD fund are primarily to finance key studies required in finalization of the project.

Amongst the six studies envisaged, information technology strategy plan needs to be formulated. Karnataka is well known in the field of IT. An integration of Health, Family Welfare and Nutrition Services requires careful monitoring and synthesis of the various information systems from existing vertical programmes. Apart from strengthening the health information system, the project will establish a system that facilitates sharing and utilizing information, as well as validating of data emanating from the field.

2. OBJECTIVES:

- The objective of the study is to develop a Health Management Information System (HMIS) strategy plan.
- To review the existing HMIS in the state and National level (and literature of HMIS system in developing and developed countries) and work out modalities of strengthening the system in the state.
- To the state work out strategies to validate all data emanating from the sub-centre-level to District level and upwards to the state.
- To establish a system or careful monitoring and synthesis of various information systems from existing vertical National Health Programmes.
- To establish a system of feedback or sharing and utilization of information to the sources of information as well as all concerned agencies.
- To improve management and increase staff productivity thereby enhancing health care delivery and services.

3. OUTLINE OF THE TASK TO BE CARRIED OUT AND TIME LINES.

- Appointment of three consultants who are experts in the field of Information Technology, Epidemiology / Public Health and Health Management and familiar with the existing system in the State Health Services. - 1 month.
- Review of the HMIS at state level, National level and literature available of HMIS in developing and developed countries. – 1 month.
- Preparation of a detailed plan of implementational study, activity, month and costings wise - 2nd month.

- Preparation of a monthwise programme for each consultants for office work weeks and field tour weeks - 2nd month.
- Develop a comprehensive information systems strategy plan, define short-term and long-term requirements of the sector, recommend technology architecture and prepare system implementation. – 3rd –5th month.
- Preparation plan for procurement of equipment, connectivity, Internet, based technologies, local area networks (LAN) and computer / server, fax-machines, modems and other hardware and software required for a comprehensive HMIS. – 3rd –5th month.
- Develop detailed information schedules / proforma for disease surveillance, National Health Programmes and information feed back required for a comprehensive data base & HMIS. – 3rd –5th month.
- Develop in-built monitoring and evaluation system especially with regard to validation of data in the field and also to disseminate information to all concerned at all levels. -3rd-5th month
- Develop a strategy to recruit and train staff to operate the HMIS effectively at all levels. – 5th –7th month
- Submission of draft interim report. – 5th month.
- Submission of final report. – 8th month.

4. OUTPUTS:

- Inception report.
- Information schedules / proforma.
- Plan for procurement of equipment, hardware and software.
- Plan for a comprehensive HMIS.
- Plan for monitoring, evaluation and validation of data.
- Strategy for training staff.
- Monthly reports, interim reports, draft final report and final report.

5. REVIEW COMMITTEE:

HNP Pre-project studies review committee will consist of
Chairman - Commissioner of Health and Family Welfare, GOK.
Members - Director of Health F&W services.
- Demographer of Director of H & FW services.
- One member of KTF on Health (Dr. C.M. Francis)
- Joint Director Communicable Diseases, Director of H&FW.

6. INPUTS FROM THE CLIENTS:

- Existing HMIS proformas, protocols of National Health Programmes.
- Details of SC's, PHC's Taluk Hospital, District Hospitals and Channel of communication.

- HMIS inputs and surveillance activities from KHSDP.

7. STUDY PROGRESS MONITORING:

There will be a monthly meeting of all the key consultants with the Commissioner for monitoring the progress of the studies as per the time schedules.

8. COSTING AND PAYMENT SCHEDULE:

Total INR – 33.12 lacs.

The agency will be paid 40% of the contacted amount on signing of the agreement. 40% on submission of the draft final report and 20% when final report is accepted.

Pre- Project Studies and Activities

List of Pre-Project studies/activities which may be required to be conducted is given below. It is reiterated that,

- No external consultants will be required, as qualified consultants are available locally.
- It is also mentioned that $ 6,80,000 (PHRD grant) would be required for carrying out the studies.
- Setting up of a **Research Advisory Group** to brainstorm and monitor the pre-project studies.

1. a) Facility Survey for repair and renovation of 1000 Primary Health Centres (PHCs) and SCs, as well as staff quarters, including preparation of implementation documents and manuals.

   b) Siting and developing architectural designs for 100 new building for PHCs (preference to Category C districts).

   c) Selection of 100 PHCs for upgradation into FRUs (First level referral units).

2. Study of health care financing in private and voluntary sector in urban and rural areas in Karnataka .

3. Patient satisfaction (OPD and in-patient) surveys for public and private / voluntary sector and utilization (beneficiary assessment).

4. Institutional analysis / management capacity.

5. Information technology strategy plan including validation of data emanating from the field.

6. Evolving a health promotion strategy.

7. Availability of EmOC (Emergency Obstetric Care), EssOC (Essential Obstetric Care) in rural areas.

8. Evaluation of nutrition interventions in rural areas and evolution of strategy to improve service delivery.

NOTE: No funds would be required to formulate a Comprehensive Health Nutrition and Family Welfare policy for Karnataka as the same is already being carried out under the Karnataka Task Force on Health.

A. **Facility survey for repair and renovation of 1000 Primary Health Centres (PHCs) as well as staff quarters including preparation of implementation documents and manuals.**

B. **Siting and developing architectural designs for 100 new buildings for PHCs (preference to category C districts).**

C. **Selection of 100 PHCs for upgradation into First level referral units (FRUs).**

Facility survey will not merely be an engineering exercise. Specific selection of institutions for renovation with objective of increased access and quality of care. Therefore it has to relate to institutional capacity including staffing and past record of work done there e.g. surgeries if there is an OT, deliveries, tubectomies, and family planning procedures, cataract surgery etc.

Siting- selection of site not just on availability of free land. It is better to purchase land in a locality where people can reach the facility conveniently. Focus group discussions with communities particularly Dalits and women would help in siting. Use of community mapping exercise for selection (as in water supply &sanitation in Maharashtra with DFID support).

Therefore this exercise will need social perspective, public health and health management inputs. The selected group to do this possibly in collaboration with others, with research advisory group, and survey teams should have all these components. There is need for constant interaction with the Commissioner, the HNP project team and the Health Directorate.

FRUs - What happens to PHC activities, staff and accommodation for additional staff. Assess a sample of upgraded FRUs/ CHCs- are they playing the referral role they are supposed to, are they adequately staffed and equipped for the purpose. Do they have mobility and communication facilities.

Estimates need to be detailed and need to reflect expected rise in prices during the five year period. Accountability at different levels needs to be fixed.

Agencies- TOR Steel
MECON
L & T
Zila Parishad Engineering Divisions

Study of Health Care Financing in private and voluntary sector in urban and rural areas in Karnataka.

To study options for community financing, analyzing experiences in social health insurance in India. These have been largely in the voluntary sector and have been studied by CEHAT, Mumbai and others. A literature review and some field visits have to be carried out. Health co-operatives e.g. in Mallur, Kolar district to be studied. Some experimental work maybe initiated as in the UNDP initiative in T. Narsipur.

To study community pre-payment schemes and other forms of insurance.

To study out of pocket expenditure particularly the poor in different districts in Karnataka.

Agencies: ISEC
Kaveri Bopaiah
Gita Sen
Centre for Budget Studies
Dharwar Institute of Management

Patient Satisfaction (OPD and in-patient) Surveys for Public & Private / Voluntary Sector and Utilization (beneficiary assessment).

Stratified sample for gender, age, social class, language groups in different districts in Karnataka. (for public, private and voluntary sector)

OPD –
Waiting time
Staff attitude and behaviour
Availability of Doctors and staff
Investigations
Feed back on user fee
Feed back on informal payments, private practice linkages
Referral for investigations, prescriptions
Feed back on physical facilities – water, toilet, electricity, chairs etc.
Any form of discrimination
Referral system functioning

Selection – choose patients suffering from diseases covered by National Health Programmes – TB, HIV/AIDS, Malaria, MCH and minor ailments

Cost per visit – direct, indirect (loss of wages, accompanying person)

In- patients
Average duration of stay
Nurses on duty – 24 hours or not
Number of doctors visits

Agencies: Population Research Centre
Ramesh Kanbargi
PAC
ISEC

Institutional Analysis and Management Capacity

Will be prepared after discussions with CM Francis and Ravi Narayan

Agencies: RN, CMF
IIM
XIME
Ferguson

Information Technology Strategy Plan including validation of data emanating from the field.

Technical aspects
Connectivity
Electrical Connections
Requirements – physical
Staff- training at different levels
Data Quality- validating
Training of field staff
Supervision
Analysis
Discussion regarding data analysis at institutional level for decision making
Communication facilities and systems including maintenance at different levels – district, taluk, CHC, PHC (telephone, fax, cell phones for DHOs, beepers/pagers for key hospital personnel)
Costing of the above per unit/institute per district and at state level

Phased planning.

Agencies: BPL Innovision
NICNET

Evolving Health Promotion Strategy (make use of Dr. Bassappa's study report to Karnataka Task Force on Health and Family Welfare)

Action research
Costing
Strategy for different groups- urban, rural, women, children in/out of school etc.

Formation of expert group/think tank
Capacity building of directorate staff (identifying and sending competent staff for training)
Revision of school curriculum – for different age groups
Converging different health education activities of different agencies
Ongoing assessment including accountability

Agencies: Institute of Communications- Ahmedabad (MICA?)
IUHE
VOICES
Madhyam
Jayashree Ramakrishnan
Dr. Neela Patel
Wigan & Leigh

Availability and Utilization of Emergency & Essential Obstetric care in rural areas with recommendations / strategies to reduce maternal morbidity and mortality

Assessment of existing approaches
Developing district specific strategies
Belaku study – Dr. Saraswati Ganapathy
Developing indicators for rapid / on going district based assessment of MMR
Reasons for decline in developed countries (literature review)
Tackling women's empowerment, health education, referral, transportation
Extent of illegal abortions
Measuring maternal mortality – impact indicators, sisterhood surveys, reproductive age mortality study, maternal death review etc.

Agencies: Medical Colleges
Dr. S.K. Krishnan

Evaluation of Nutrition Interventions in Rural Areas and Evolution of Strategy to improve service delivery.

Quality & effectiveness of nutrition education
Impact of feeding of under fives.
Iron and folic acid supplementation
Vitamin A deficiency prevalence studies
Anthropometry
ICDS – operational aspects
Weaning foods – costing, delivery, logistics, methods
Efficiency of NGO programmes

Agencies: Dr. Padmasini Asuri (with Dr Sabu George & Dr. Anup Radhakrishnan)
NIN
CFTRI
NIPCCD

Research Advisory group to be constituted

KIND ATTN: MR. SANJAY KAUL, I.A.S
18 January 2001

Pre- Project Studies and Activities

List of Pre-Project studies/activities which may be required to be conducted is given below. It is reiterated that no external consultants will be required, as qualified consultants are available locally. It is also mentioned that $ 6,80,000 (PHRD grant) would be required for carrying out the studies.

WB 1. A. Facility Survey for repair and renovation of 1000 Primary Health Centres (PHCs) and ~~SCs~~, as well as staff quarters, including preparation of implementation documents and manuals. TOR steel MEASON L&T

B. Siting and developing architectural designs for 100 new building for PHCs (preference to Category C districts).

C. Selection of 100 PHCs for upgradation into FRUs (First level referral units).

later D.? Urban health facility survey and urban health needs assessment. – get STEM report from KHSDP

later E. Distribution (including qualifications and work practices) of private sector general practitioners.

✓ F. Study of health care financing in private and voluntary sector in urban and rural areas in Karnataka – community financing ISEC, Centre for Budget Studies, Kaveri Rajaram, Geeta Sen

✓ G. Patient satisfaction (OPD and in-patient) surveys for public and private / voluntary sector and utilization (beneficiary assessment). Dhanwad Institute Bangalore — Ramesh Kanbargi — economist Hardagar — PAC, ISEC — pop research cell, RCH

WB ✓ H. Institutional analysis / management capacity. – IIM, XIM, Ferguson

WB ✓ I. Information technology strategy plan including validation of data emanating from the field.

✓ J. Evolving a health promotion strategy. – IIHE, Dr Neela Patel email, Jayashree Ramakrishna, Wipro + Neighbourhood Voices + Nadhajan & Dr CHF IRN Dr Sheeran

later K. Study of women's health needs.

KTPP L. ~~Evolving mechanisms and systems for integration in health services.~~ Human Resource Dev + process plan of primary health system

✓ M. Availability of EmOC (Emergency Obstetric Care), EssOC (Essential Obstetric Care) and utilisation in rural areas, with recommendation for strategies to reduce maternal morbidity & mortality (Medical colleges) – BJ

✓ N. Evaluation of nutrition interventions in rural areas and evolution of strategy to improve service delivery. NIPCD? NIN, CFTRI ? medical colleges Dr Vasundhara

in service activity — O. Costing and modalities of hiring vehicles for health services.

Federal as part of primary ✓ P. Study of Regional Disparities.

✓ Q. Development of curriculum towards school health/ health education in schools. CHAI / Rayoma.

NOTE: No funds would be required to formulate a Comprehensive Health Nutrition and Family Welfare policy for Karnataka as the same is already being carried out under the Karnataka Task Force on Health.

10. Human Resource

IT - Technical aspects
connectivity
electrical connections
requirements - physical
staff - training
- at different levels

Data quality - reliability
- type of field staff
- supervision
- analysis
- discussion rep. data analysis
at. each administrative level for
decision making

communication facilities - at different levels - Taluk
CHC
PHL.
telephone; fax; mobile phones for DHO's
beepers/pagers for hospital staff

costing of the above - per unit/institution
- per district
- State level

Phased planning.

Sample stratified for gender, age, social class, language groups in different districts of Karnataka.

Patient Satisfaction — using standard format for public, private, voluntary sector.

OP - waiting time

a) staff attitudes + behaviour
- availability of doctor/staff.
- availability of investigations
- feedback on user fee

b) - feedback on informal payments, private practice linkages, referral for investigations, prescriptions

c) - any form of discrimination.

d) - feedback on physical facilities, water, toilet, electricity, chairs etc

e) referral system functioning.

f) selection ? choose pts suffering from diseases covered by NHPs - TB, HIV/AIDS, Malaria, STDs, MCH
- nutritional

g) cost per visit - direct
indirect - earning paying person.
loss of output

Inputs

a) average duration of stay
b) nurse on duty - through TTo day/night
c) number of doctors visit

Health Care Financing – may require external consultant

a) To study options for community financing analysing expenditures in Social Health Insurance in India. These have been largely in the voluntary sector and have been studied by CEHAT, Mumbai & others. A literature review & some field work may be carried out. Health expenditures of in Mallur in Kolar district to be studied. Some experimental work may be initiated as in the UNICEF initiative in T. Narsipur.

b) To study out of pocket expenditures particularly by the poor in different districts in Karnataka.

c) To study pre-payment schemes & other forms of insurance.

d) To study health care financing in the private sector with special emphasis on rural poor, on ability and willingness to pay & on economic & social consequences to individuals & families.

1. Facility Survey – not merely an engineering exercise
specific selection of institutions for renov.
with objective of ↑ access + quality of care
∴ it has to relate to institutional capacity including staffing + past record of work done eg enquiries if there is an OT, deliveries, tubectomies + VFP procedures, cataract surgery etc.

siting – selection of site not just on availability of free land
– it is better to purchase land in a locality where people can ~~avail~~ reach the facility.
– FGDs with communities particularly dalits + women would help in siting
– ? use community mapping exercise for selection as in Water Supply + Sanitation – Maharashtra with DFID support.

∴

This exercise will need Social perspectives + public health + health management inputs
The selected group to do this possibly in collaboration with Others, with research advisory group and the survey team should have all these components.

There is need for constant interaction with The Commissioner HNP the project team + the Directorate.

FRUs — ? What happens to PHC activities, staff
+ accomodation for staff.
- assess a sample of upgraded FRUs
are they playing the referral role they are
supposed to, are they adequately staffed
+ equipped for this purpose. Do they have mobility,
communication facilities

estimates need to be detailed + need to project expected
rise in prices during the 5 year period.
Accountability at different levels needs to be fixed.

Action Research

Health Promotion

(Make copy of Dr Basappa's study report to KTFH)

Costing

Strategy - for different groups - urban/rural
consider women
children (in/of school

formation of ~~a~~ expert group / Think Tank

capacity building of ~~the~~ directorate staff identify it Sensitise staff for training

Revision of school curriculum - for different age groups

Converging different HE activities of different agencies

ongoing assessment, including accountability

(Ahmedabad - Institute of communications)

- Reduction of maternal mortality & morbidity
  - assessment of existing approaches
  - developing district specific strategies.
    (Belahu study) — Dr Saraswathy Ganapathy
    Send her TOR. for comments)
  - developing indicators for rapid/ongoing district based assessment.

Nutrition Interventions

- a) quality, effectiveness of nutrition education
- b) impact of feeding of underfives
  - iron & folic acid supplt.
  - vit A deficiency prevalence study

- anthropometry
- ICDS - operational aspects
- mid day meal - costing / delivery logistics + methods
- efficacy of NGO programmes.

Dr. Anup Radhakrishnan
- for 2nd study for HNP?

1. Primary Health Centres and Subcentres

The Task Force for Health and Family Welfare had, inits Short Term Recommendations, focussed on Primary Health Care. To achieve this objective, among others, the following recommendations had been made:

- "At least 1000 PHCs in the State must be made fully functional". The Government has taken action to fill the vacancies of staff and increased the allotment for essential drugs to be available at all PHCs. But many PHCs and Subcentres do not have their own buildings or the buildings need repairs and renovation to be fully functional.
- "All key staff, including doctors, staff nurses/ANMs and other essential staff attached to the Primary Health Centres must stay in the quarters. Where repairs are necessary they should be carried out immediately; where there are no quarters, action may be taken to construct them".
- There is a large deficit of Community Health Centres (FRUs) as per the norms of upgrading one in 4 Primary Health Centres.

To implement the above recommendations, efficiently and effectively, the following studies may be undertaken:

1(a) — —.

(b) — — —

(c) — — — —

- Study what happens to the functions served by the PHC which is upgraded to CHC.

2. Study the Primary Health Centres in the State with respect to the population and area covered, the number of subcentres, the facilities and the staff available and the activities carried out at the Primary Health Centre so as to reorganise the PHCs on a rational basis.

Study the present varying patterns of PHCs
Determine the advantages and disadvantages of each of them
Suggest an effective and efficient pattern for
(a) new PHCs
(b) remodelling the existing PHCs

3.3. Study of health care financing in private and voluntary sectors in
(a) urban and rural areas
(b) in 4 selected districts ~~in~~ one each in a revenue division
What are possibilities of health insurance for the poor and the disadvantaged sections of the Society?

4. Study the inter-relationships between ~~under~~nutrition and immunity. How does undernutrition affect infections diseases? What are the health care interventions necessary to reduce morbidity and mortality in infections in persons with malnutrition?

A very large proportion of people in the State are undernourished (throughout the life cycle). They are prone to diseases like diarrhoea, measles, acute respiratory infections and other infections. It is necessary to have data regarding the extent of vulnerability to infections in the malnourished persons at different phases of the life cycle. How can health care interventions help?

5. Quality of health care

Not enough attention has been paid to quality of health care whether for the individual or the population. It is necessary to work out the standards of health care in hospitals and other health care institutions and in public health interventions, such as the maintenance of cold chains in immunizations.

Study the process of determining standards (structure, process and outcome) of care under different conditions (geographical, rural/urban, size and type of the institutions) so that there can be quality assurance at all levels.

6. Management training

A major drawback in institutional functioning has been poor management and lack of motivation.

Study the situation regarding management skills. How can they be improved? Prepare a programme and manuals for teaching/learning management skills and promoting motivation.

7#. Information technology strategy; validation of data emanating from the field.

How can the information be utilized optimally?

8. Study the relative effectiveness of different strategies in community health promotion
   - media
   - health care services
   - voluntary agencies ; private agencies
   - other sectors such as education, women & child welfare, etc

Objectives

2.3 ?

2.4 ? Health needs favourites of people

2.5 ? Equity

2.6 ? Include planning

NP 7

Dear Mr.Sanjay Kaul,

Forwarded herewith are the draft TORs for HNP Project.

Thanking you,

Yours sincerely,

Dr. Sampath K. Krishnan
CHC

Attachment of type application/msword name TOR.doc
please download the attachment

KARNATAKA INTEGRATED HEALTH, NUTRITION & FW SERVICES DEVELOPMENT PROJECT.

TERMS OF REFERENCE FOR:

a) **Facility survey for repair and renovation of 1000 Primary Health Centres (PHCs) as well as staff quarters, including preparation of implementation documents and manuals.**

b) **Siting and developing architectural designs for 100 new buildings for PHC's (Preference to category 'C' districts).**

c) **Selection of 100 PHC's for upgradation into FRU's (First level referral units).**

1. BACKGROUND

The Government of Karnataka has received a TA grant in response to preparation of an Integrated Health, Nutrition and Family Welfare Services Development Project (P 071160). The proposed PHRD fund is primarily to finance key studies required in finalisation of the project.

Amongst the six studies envisaged Facility survey and preparation of implementation manuals is required so that preparatory work on procurement can be done in advance. Improving quality of services and increasing utilization will involve renovating and upgrading of PHC's, labs and equipments. The study will concentrate on the access of services to the poor and vulnerable populations.

2. OBJECTIVES

- Identifying ways to improve quality of services and optimum utilisation of facilities.
- Identification, upgradation and renovation of Primary Health Centres and their equipment.
- To indicate, pattern of utilisation of services and barriers to access.
- Identify reasons for preference of private and public sector health services.
- Concentration of efforts to reach far-flung areas, women, scheduled castes and tribes, marginalised and below poverty line population.
- To prepare the implementation manuals (Architectural and Engineering) for the new buildings after identifying 100 PHC's which do not have buildings.

3. OUTLINE OF THE TASK AND TIME LINES

- Appointment of six consultants with expertise in Health, Planning, Management, Engineering and Architecture. ---- 1st month.
- Preparation of a detailed plan of implementational study, activity, Month and costings wise ---- 2nd month.
- Preparation of a month-wise programme for each consultant for office work weeks and field tour weeks. ---- 2nd month.
- Facility survey of all PHC's to short-list 1000 functional PHC's which require repair / renovation and construction of staff quarters. ---- 3rd-5th month.
- Identification of 100 PHC's which require new buildings (preference to Category 'C' districts and other poorly served areas) ---- 3rd-5th month.
- Selection of 100 PHC's for upgradation to FRU's. ---- 3rd-5th month.
- Collection of data on use of professional Health Services and peoples access to primary health care. ---- 3rd-5th month.
- Assessment of the effectiveness of FRU's and functioning of their areas of referral. ---- 6th month.
- Preparation of engineering documents and manuals for buildings (1st phase). ---- 7th month.
- Preparation of procurement plan of the project for equipment, transport (limited) and drugs. ---- 7th month.

4. OUTPUTS

- Inception reports.
- Facility survey report of 1000 PHC's.
- Selected list of 100 new buildings for PHC's.
- Selected list of 100 PHCs to be upgraded to FRU's.
- Engineering documents (including Blueprints) and manuals for buildings.
- Procurement plan for equipment, drugs and transport.
- Report on the studies carried out on use of professional health services and effectiveness of FRU's.

5. REVIEW COMMITTEE

HNP Pre-project review committee will consist of :

Chairman - Commissioner of H & FW, GOK.
Member - Director of H & FW Services.
- Chief Engineer KHSDP.
- Member of KTF on Health.
- Joint Director of Primary Health Care.

6. INPUTS FROM THE CLIENTS

- List of all PHC's and FRU's, taluk-wise and District wise.
- Map of each taluk showing outreach villages and boundaries of each PHC's and Sub Centres.
- List of essential drugs and equipment identified by KTF on Health.
- Status of vehicles taluk wise.

7. STUDY PROGRESS MONITORING

There will be monthly meeting of all the consultants with the Commissioner for monitoring the progress of the studies as per the time schedules.

8. COSTINGS AND PAYMENT SCHEDULE

Total INR 92.9 lacs.
The agency will be paid 40% of the contract amount on signing of the agreement. 40% on submission of the draft final report and 20% when the final report is accepted.

NOTE:No funds would be required to formulate a Comprehensive Health Nutrition and Family Welfare policy for Karnataka as the same is already being carried out under the Karnataka Task Force on Health.

A. **Facility survey for repair and renovation of 1000 Primary Health Centres (PHCs) as well as staff quarters including preparation of implementation documents and manuals.**

B. **Siting and developing architectural designs for 100 new buildings for PHCs (preference to category C districts).**

C. **Selection of 100 PHCs for upgradation into First level referral units (FRUs).**

Facility survey will not merely be an engineering exercise. Specific selection of institutions for renovation with objective of increased access and quality of care. Therefore it has to relate to institutional capacity including staffing and past record of work done there e.g. surgeries if there is an OT, deliveries, tubectomies, and family planning procedures, cataract surgery etc.

Siting- selection of site not just on availability of free land. It is better to purchase land in a locality where people can reach the facility conveniently. Focus group discussions with communities particularly Dalits and women would help in siting. Use of community mapping exercise for selection (as in water supply &sanitation in Maharashtra with DFID support).

Therefore this exercise will need social perspective, public health and health management inputs. The selected group to do this possibly in collaboration with others, with research advisory group, and survey teams should have all these components. There is need for constant interaction with the Commissioner, the HNP project team and the Health Directorate.

FRUs - What happens to PHC activities, staff and accommodation for additional staff. Assess a sample of upgraded FRUs/ CHCs- are they playing the referral role they are supposed to, are they adequately staffed and equipped for the purpose. Do they have mobility and communication facilities.

Estimates need to be detailed and need to reflect expected rise in prices during the five year period. Accountability at different levels needs to be fixed.

Agencies- TOR Steel
MECON
L & T
Zila Parishad Engineering Divisions

In- patients
Average duration of stay
Nurses on duty – 24 hours or not
Number of doctors visits

Agencies: Population Research Centre
Ramesh Kanbargi
PAC
ISEC

Institutional Analysis and Management Capacity

Will be prepared after discussions with CM Francis and Ravi Narayan

Agencies: RN, CMF
IIM
XIME
Ferguson

Information Technology Strategy Plan including validation of data emanating from the field.

Technical aspects
Connectivity
Electrical Connections
Requirements – physical
Staff- training at different levels
Data Quality- validating
Training of field staff
Supervision
Analysis
Discussion regarding data analysis at institutional level for decision making
Communication facilities and systems including maintenance at different levels – district, taluk, CHC, PHC (telephone, fax, cell phones for DHOs, beepers/pagers for key hospital personnel)
Costing of the above per unit/institute per district and at state level

Phased planning.

Agencies: BPL Innovision
NICNET

Evolving Health Promotion Strategy (make use of Dr. Bassappa's study report to Karnataka Task Force on Health and Family Welfare)

Action research
Costing
Strategy for different groups- urban, rural, women, children in/out of school etc.

Formation of expert group/think tank
Capacity building of directorate staff (identifying and sending competent staff for training)
Revision of school curriculum – for different age groups
Converging different health education activities of different agencies
Ongoing assessment including accountability

Agencies: Institute of Communications- Ahmedabad (MICA?)
IUHE
VOICES
Madhyam
Jayashree Ramakrishnan
Dr. Neela Patel
Wigan & Leigh

Availability and Utilization of Emergency & Essential Obstetric care in rural areas with recommendations / strategies to reduce maternal morbidity and mortality

Assessment of existing approaches
Developing district specific strategies
Belaku study – Dr. Saraswati Ganapathy
Developing indicators for rapid / on going district based assessment of MMR
Reasons for decline in developed countries (literature review)
Tackling women's empowerment, health education, referral, transportation
Extent of illegal abortions
Measuring maternal mortality – impact indicators, sisterhood surveys, reproductive age mortality study, maternal death review etc.

Agencies: Medical Colleges
Dr. S.K. Krishnan

KARNATAKA INTEGRATED HEALTH, NUTRITION AND FAMILY WELFARE SERVICES DEVELOPMENT PROJECT

TERMS OF REFERENCE FOR FORMULATING AN INFORMATION SYSTEM STRATEGY PLAN.

1. BACKGROUND:

The Government of Karnataka has received a TA grant in response to preparation of an integrated Health, Nutrition and Family Welfare Services Development Project (P 071160). The proposed PHRD fund are primarily to finance key studies required in finalization of the project.

Amongst the six studies envisaged, information technology strategy plan needs to be formulated. Karnataka is well known in the field of IT. An integration of Health, Family Welfare and Nutrition Services requires careful monitoring and synthesis of the various information systems from existing vertical programmes. Apart from strengthening the health information system, the project will establish a system that facilitates sharing and utilizing information, as well as validating of data emanating from the field.

2. OBJECTIVES:

- The objective of the study is to develop a Health Management Information System (HMIS) strategy plan.
- To review the existing HMIS in the state and National level (and literature of HMIS system in developing and developed countries) and work out modalities of strengthening the system in the state.
- To the state work out strategies to validate all data emanating from the sub-centre-level to District level and upwards to the state.
- To establish a system or careful monitoring and synthesis of various information systems from existing vertical National Health Programmes.
- To establish a system of feedback or sharing and utilization of information to the sources of information as well as all concerned agencies.
- To improve management and increase staff productivity thereby enhancing health care delivery and services.

3. OUTLINE OF THE TASK TO BE CARRIED OUT AND TIME LINES.

- Appointment of three consultants who are experts in the field of Information Technology, Epidemiology / Public Health and Health Management and familiar with the existing system in the State Health Services. - 1 month.
- Review of the HMIS at state level, National level and literature available of HMIS in developing and developed countries. – 1 month.

- Preparation of a detailed plan of implementational study, activity, month and costings wise - 2nd month.
- Preparation of a monthwise programme for each consultants for office work weeks and field tour weeks - 2nd month.
- Develop a comprehensive information systems strategy plan, define short-term and long-term requirements of the sector, recommend technology architecture and prepare system implementation. – 3rd –5th month.
- Preparation plan for procurement of equipment, connectivity, Internet, based technologies, local area networks (LAN) and computer / server, fax-machines, modems and other hardware and software required for a comprehensive HMIS. – 3rd –5th month.
- Develop detailed information schedules / proforma for disease surveillance, National Health Programmes and information feed back required for a comprehensive data base & HMIS. – 3rd –5th month.
- Develop in-built monitoring and evaluation system especially with regard to validation of data in the field and also to disseminate information to all concerned at all levels. -3rd-5th month
- Develop a strategy to recruit and train staff to operate the HMIS effectively at all levels. – 5th –7th month
- Submission of draft interim report. – 5th month.
- Submission of final report. – 8th month.

4. OUTPUTS:

- Inception report.
- Information schedules / proforma.
- Plan for procurement of equipment, hardware and software.
- Plan for a comprehensive HMIS.
- Plan for monitoring, evaluation and validation of data.
- Strategy for training staff.
- Monthly reports, interim reports, draft final report and final report.

5. REVIEW COMMITTEE:

HNP Pre-project studies review committee will consist of
Chairman - Commissioner of Health and Family Welfare, GOK.
Members - Director of Health F&W services.
- Demographer of Director of H & FW services.
- One member of KTF on Health (Dr. C.M. Francis)
- Joint Director Communicable Diseases, Director of H&FW.

6. INPUTS FROM THE CLIENTS:

- Existing HMIS proformas, protocols of National Health Programmes.
- Details of SC's, PHC's Taluk Hospital, District Hospitals and Channel of communication.
- HMIS inputs and surveillance activities from KHSDP.

7. STUDY PROGRESS MONITORING:

There will be a monthly meeting of all the key consultants with the Commissioner for monitoring the progress of the studies as per the time schedules.

8. COSTING AND PAYMENT SCHEDULE:

Total INR – 33.12 lacs.

The agency will be paid 40%of the contracted amount on signing of the agreement. 40% on submission of the draft final report and 20% when final report is accepted.

To Dr. SKK

N18

TERMS OF REFERENCE FOR THE (A) INSTITUTIONAL ANALYSIS AND BENEFICIARY (B) COMMUNITY/PEOPLE'S ASSESSMENT STUDY FOR THE KARNATAKA INTEGRATED HEALTH, NUTRITION AND FAMILY WELFARE SERVICES PROJECT

1.0 Background

1.1. The Government of Karnataka has received a TA grant from the PHRD fund for preparation of an integrated Health, Nutrition and Family Welfare Services Development Project (Po71160). The proposed is primarily to finance key studies required for the finalisation of the project.

1.2. The Government of Karnataka has built up a vast primary health care and first referral network in the State comprising 1676 Primary Health Centres, 582 Primary Health Units and 359 Community Health Centres. Under the World Bank assisted Karnataka Health Systems Development Project (KHSDP) there have been major improvements made to the first referral infrastructure. Despite these improvements, the Task Force on Health set-up by the Government of Karnataka has identified many lacunae in the functioning of the primary health care and first referral institutions. The primary health care system is expected to delivery a wide range of services including maternal and child health and nutrition services, general curative care, management of communicable diseases, and health education & promotion. A major gap in the System is poor quality of delivery of primary health care services. The level of utilisation of the infrastructure already built up is uneven in the State. The system is also somewhat alienated from its clientele, the beneficiaries, making it unresponsive to beneficiary needs. It is therefore, essential to make an objective institutional analysis of the Primary Health care system including the referral structure and carry out a beneficiary assessment. This analysis and assessment will identify cost effective investments with a view to increasing utilisation of the existing facilities, improving both access and quality of services, as well as making the system more responsive to the poor and vulnerable sections of the population, especially women, SC/ST groups and children. The Study will also provide a base-line, on the basis of which future benchmarking can take place.

2. Objectives of the Study

2.1 **Key objectives:** Against the above background, the key objectives of the study will be

a) An objective institutional analysis on the utilisation and quality of the primary health care system;

b) A ~~beneficiary needs~~ assessment of the various beneficiary groups, especially the poor, women, SC/ST and children,

c) A set of recommended strategies to improve the level of utilisation , ~~improve~~ the quality of ~~services~~, and ~~improve~~ the responsiveness of the primary health care system..

2.2 **Specific objectives:** Within the broad objectives enumerated in 2.1 above, the specific objectives will be to:

a) Identify critical institutional strengths and weaknesses in the present primary health care system;

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PL make 3 copies – TN/RN/CMF for comments.
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b) Identify inherent institutional differences, if any, between the Primary health system as it exists in the identified backward districts and the remaining districts and the reasons for such differences.

c) Measure the levels of utilisation of the primary health infrastructure built up, including the PHCs, PHUs, sub-centres as well as the first level referral system in terms of inpatients, out patients, bed utilisation rates, usage of lab facilities, usage of equipment, and other standard criteria;

d) Assess the quality of services in terms of availability of doctors and para medical staff such as ANMs and male health workers, the utilisation of residential quarters, the quality of diagnosis, rational use of drugs, quality of referrals, level of upkeep and maintenance of facilities and other standard criteria.

e) Assess the quality of services with respect to the delivery of National and State Health and Family Welfare programmes, specifically, RCH services, TB control, HIV/AIDS prevention and management, RTI/STD management, malaria, other communicable diseases.

f) Make an assessment of the availability and quality of services as perceived by different groups of beneficiaries – women, SC/ST and poor.

g) Assess the percentage of beneficiaries who access the Government facilities for various types of ailments and the percentage who first contact other health service providers such as private allopathic doctors, practitioners practicing Indian Systems of medicine and homeopathy, traditional unqualified practitioners, and quacks,

h) Indicate whether is any significant variation in beneficiary assessment as between

i) Assess the degree and extent of corruption in the delivery of primary health care and in the referral system at various levels and at different levels of health providers.

j) Assess the work load among various health functionaries, Doctors, lab technicians, pharmacists, male health workers, clerical and other PHC staff, and health educators.

k) Assess the quality of supervision and management capacities among various levels of health providers.

l) Recommend a set of strategies to strengthen and improve the primary health care system and make it more responsive. This could include Citizens charters, steps to beneficiaries, enhance community participation etc. (Plans to improve and maintain the physical infrastructure and equipment as well as training are being separately addressed, and therefore these aspects will need not be specifically addressed in this Study).

3.0 THE TASKS

3.1 The selected agency will be expected to constitute a core full time Project team comprising a Sociologist/Social Work specialist and a Public Health manager that will function until the Agency submits its Final Report. This team will be responsible for the designing and implementation all the activities mentioned in the study.

3.2 The Agency will carry out the institutional analysis through visits of Study teams to atleast 2% of the Primary Health centres, PHUs, CHCs and other first referral units in the State. In addition the Study teams will also visit 50 sub-centres both

with buildings and those without. The institutions will be randomly selected and will include a sizeable number in the backward districts of the State.

3.3 The Agency will carry out its beneficiary assessment study through questionnaires, interviews and focus group discussions. The questionairre will be addressed to both health care providers as well as to different beneficiary groups including women, SC/ST and the poor. In addition the questionnaire will be addressed to Grama Panchayat members, members of self-help groups and members of Mahila Swasthya Sanghas. Interviews will be both structured as well as unstructured.

3.4 The Agency will conduct 4-5 Workshops in various parts of the State to discuss institutional strengthening, strengthening of management capacities, improvements in the quality of services, and measures to make the system more responsive. The participants could be "mixed" or different Workshops could be held for health providers, local elected representatives and NGOs.

3.5 The questionnaires, interviews, focus group discussions and the Workshops will be properly tabulated and documented.

3.6 The data from the Study visits, questionnaires, interviews, focus group discussions, and the Workshops will be collectively utilised for developing a set of strategies for improving the primary health care system.

4.0 DELIVERABLES

The Facility Survey should result in the following reports, which should be presented to s to the Review Committee at various stages of the Study.

4.1 A Status Report containing an Institutional Analysis for each type of facility, viz. PHCs/PHUs/CHCs/subcentres.

4.2 A Status Report containing an analysis and performance at each level and each type of health care provider, Doctors, ANMs, male health worker, lab technicians, health educators, pharmacists, etc.

4.3 A Beneficiary Assessment Report covering all aspects of the Primary Health Care system and identified gaps between expectations and performance.

4.4 A set of Recommendations containing workable and cost effective strategies addressing the key concerns brought out by the Reports and analysis covered

5.0 Resource support and review

5.1 The consultants will receive assistance and support from a Working Group of knowledgeable individuals drawn from the various functional areas of the Karnataka Health, Nutrition & Family Welfare Services units.

5.2 A Review Committee of the Karnataka Health, Nutrition & Family Welfare Services will be responsible for the review, supervision, and approval of the Plans. This committee will be chaired by the Commissioner of Health & Family Welfare and consist of senior government officials.

5.3 The consultants will be provided necessary assistance from the Health & Family Welfare Department for smooth conduct of the Study.

6.0 Work Plan

A tentative schedule of the Work Plan is presented below. Once approved by the Review Committee the schedule will require to be adhered to strictly.

7.0 **Review Committee:**

The review committee will consist of

Chairman: Commissioner of Health &Family Welfare.
Members:

- Project Director IPP IX
- Additional Director PHC
- Project Director RCH
- Demographer
- Joint Director (Planning)

71. Selection criteria

Selection of the Agency will be through National Competitive bidding on the basis of quality based selection, providing for negotiating with the highest ranked bidder.

Name of the Activity	Description Of the Activity	Deliverables	Time Frame
Appointment of core Project team	Appointment of a core Project team	Core team to be appointed and approved by review Committee.	1 week
Finalise sampling design	The Project team will finalise the sampling design, structure of questionnaires, interviews, focus group discussions and workshops.	Finalisation of Study design and time-phasing	1 month
Identify Tasks	Listing of all the tasks that come under the purview of the study.	Activity list	3 weeks
Prepare a Study Document	Prepare document that will list the responsibilities. deliverables and time frames; in short an MOU	MOU	3 weeks
Finalisation of Workshop design	This will be done in close consultation with the Department	Workshop formats and workshop time table	3 weeks
Appointment of Study teams	Appointment of full time Study teams comprising of two social work/public health specialists, including one woman specialist.	Approved Study teams	3 weeks
Conduct of workshops	Workshops along with medical officers, NGOs, elected representatives and health staff	Workshop Reports	8 weeks
Conduct of Survey of identified facilities	On site visits to randomly selected institutions	Institutional Analysis Reports	16 weeks
Conduct of beneficiary assessment	The assessment will be conducted through questionnaires, interviews, focus group discussions, and Workshops	Benficiary Assessment Report	16 weeks
Finalisation of Recommendations	An approved set of recommendations and strategies.	Final Report including Analysis, Benficiary Assessment and Recommendations	18 weeks

MOP-UP POLIO IMMUNISATION OPERATION IN BIJAPUR DISTRICT DURING 2001

(OCTOBER-14, 15, 16 - 2001)

TALUKA-WISE PLAN OF ACTION

(POPULATION, ESTIMATED CHILDREN, NO. OF H-t-H TEAMS AND MAN POWER REQUIRED)

Sl. No.	Taluka	Population			Estimated Children under 5 Years(As per March-01 Mop_up Coverage)			Estimated Houses (As per March-01 Mop_up Coverage)			Total No. of Booths			Total No. H-t-H Teams			Manpower Required (4 persons/Booth)			No. of Supervisors (1 Supervisor/ 5 Booths)		
		Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
1	B.Bagewadi	274632	28582	303214	38893	5470	44363	48712	5309	54021	156	22	178	312	44	356	624	88	712	31	4	35
2	Bijapur	315574	252807	568381	45642	34138	79780	89182	46064	135246	183	137	320	366	274	640	732	548	1280	37	27	64
3	Indi	325285	31483	356768	45643	5463	51106	56375	5504	61879	183	22	205	366	44	410	732	88	820	37	4	41
4	Muddebihal	199207	54953	254160	28517	8291	36808	38057	11113	49170	114	33	147	228	66	294	456	132	588	23	7	30
5	Sindagi	298592	27748	326340	44271	3771	48042	55095	4616	59711	177	15	192	354	30	384	708	60	768	35	3	38
	Total	1413290	395573	1808863	202966	57133	260099	287421	72606	360027	813	229	1042	1626	458	2084	3252	916	4168	163	45	208

District Health & F.W. Officer,
BIJAPUR

REGULAR IMMUNIZATION PERFORMANCE IN BIJAPUR DISTRICT DURING 2001-02 UP TO AUGUST-2001

Sl. No.	Item	Annual Target 2001-02	Achievement							Remarks
			April-01	May -01	June-01	July-01	Aug-01	Total	%age to annual Target	
1	BCG	43737	3250	2902	3562	3858	4308	17880	40.80	
2	DPT	43737	3256	3097	3340	3431	3634	16758	38.30	
3	Polio	43737	3255	3183	3338	3446	3637	16859	38.50	
4	Measles	43737	3168	3018	3502	3517	3478	16683	38.10	
5	D & T	48223	59	279	267	1978	9118	11701	24.20	
6	T.T. 10 Years	46415	257	608	565	2506	7232	11168	24.00	
7	T.T. 16 Years	42352	268	583	855	1100	4256	7062	16.20	
8	T.T. Mothers	45206	3435	3558	3950	4557	4098	19598	43.30	

District Health & F.W. Officer,
BIJAPUR

MOP-UP IMMUNISATION OPERATION 2001 IN BIJAPUR DISTRICT

TALUKA WISE AFP CASES OCCURRED FROM 1992 TO AUGUST-2001 IN BIJAPUR DISTRICT

Sl. No.	Taluka	1992 Jan to Dec	1993 Jan to Dec	1994 Jan to Dec	1995 Jan to Dec	1996 Jan to Dec	1997 Jan to Dec	1998 Jan to Dec	1999 Jan to Dec	2000 Jan to Dec	2001 Jan to August	1992 to 2001 Total Cases
1	B.Bagewadi	15	3	25	0	0	3	7	4	2	4	63
2	Bijapur	19	10	29	2	0	1	3	0	3	5	72
3	Indi	33	5	5	0	0	3	0	4	1	1	52
4	Muddebihal	3	2	17	3	0	2	3	2	0	1	33
5	Sindagi	14	2	34	3	1	3	2	1	1	1	62
	District Total	**84**	**22**	**110**	**8**	**1**	**12**	**15**	**11**	**7**	**12**	**282**

District Health & F.W. Officer,
BIJAPUR

ANNEXURE

ACTIVITIES AND EXPENDITURE (APRIL-2001TO AUTUST-2001) DISTRICT BIJAPUR

Sl. No.	PARTICULARS							REMARKS
1	Number and place of the CHCs in the district	1. B.Bagewadi	2. Muddebihal	3. Sindagi	4. Kalagi	5. Talikoti	6. Tadavalga	
2	a) Number and Place ofthe MNP PHCs identified for contractual appointment of Doctors. (19 MNP PHCs)	**B.Bagewadi Taluka**	1. Kolhar	2. Ronihal	3. Golasangi	4. Wadavadagi	5. K.Salawadagi	
		Bijapur Taluka	1. Kanamadi	2. Mamadapur	3. Nagathan	4. Kannur		
		Indi Taluka	1. Horti	2. Tamba	3. Atharga	4. Agarkhed		
		Muddebihal Taluka	1. Madikeshwar					
		Sindagi Taluka	1. D.Hipparagi	2. Moratagi	3. Aski	4. Yankanchi	5. Chandkawate	
	b) Vacancy position of contractual doctors with name of the MNP PHCs	**B.Bagewadi Taluka**	1. Kolhar	2. Ronihal	3. Golasangi			11 Doctors appoinement is under process
		Bijapur Taluka	1. Mamadapur					
		Indi Taluka	1. Atharga	2. Agarkhed				
		Muddebihal Taluka	1. Madikeshwar					
		Sindagi Taluka	1. D.Hipparagi	2. Yankanchi	3. Chandkawate	4. Aski		
3	Major civil works - No. and name of NMP PHCs identifioed for construction of O.T. and labour room	**B.Bagewadi Taluka**	1. Ronihal					
		Bijapur Taluka	1. Kannur					
		Indi Taluka	1. Horti	2. Tamba				
		Muddebihal Taluka	1. Madikeshwar					
		Sindagi Taluka	1. D.Hipparagi					

District Health & F.W. Officer,
Bijapur

MONTH WISE ACTIVITIES AND EXPENDITURE (APRIL-2001TO AUTUST-2001) DISTRICT BIJAPUR

Sl. No.	PARTICULARS	Apr-01	May-01	Jun-01	Jul-01	Aug-01	Sept-01 up to 12-09-01	Total	Remarks
4	a) Number of SM Clinics and number of beneficiaries	-	-	-	-	-	-	-	
	b) Expenditure incurred	-	-	-	-	-	-	-	
5	a) Number of Beneficiaries who utilized Anaesthetist Services.	-	-	-	-	-	-	-	
	b) Expenditure incurred	-	-	-	-	-	-	-	
6	a) Number of Contractucal Doctors working	8	8	8	8	8	8	8	
	b) Expenditure incurred	Rs. 14,904	Rs. 44,731	Rs. 83,000	Rs. 30,000	Rs. 42,000	Rs. 12,000	Rs. 226,635	
7	a) Number of Contractucal Staff Nurses working	25	25	25	25	25	25	25	5 Staff Nurses appointment is under process
	b) Expenditure incurred	Rs. 87,400	Rs. 87,400	Rs. 152,000	Rs. 15,200	Rs. 74,541	Rs. 148,808	Rs. 565,349	
8	a) Number of women who utilized Referal Tansport for safe delivery	-	-	-	5	67	20	92	
	b) Expenditure incurred	-	-	-	Rs. 1,000	Rs. 13,400	Rs. 4,000	Rs. 18,400	
9	a) Total No. of Deliveries in PHCs and number of night deliveries	234/49	231/47	141/60	252/35	327/16		1185/207	DC bills prepared and submitted by MOs for counter signature to DHO office
	b) Expenditure incurred	-	-	-	-	-	-		
10	a) No. of vehicles hired every month	-	-	6	7	7			3 Months vehicles hired payment bill is prepared and submitted to ZP for counter signature
	b) Name of PHCs utilized vehicles	-	-	15 PHCs Except Bijapur taluka 4 PHCs	All 19 MNP PHCs	All 19 MNP PHCs			
	c) Expenditure incurred	-	-	Rs. 75,000	Rs.105,000	Rs.105,000		Rs. 285,000	
11	a) Number of AWWs utilized	60	60						AWWs honorarium of June. July & August will be paid in Sept-2001
	b) Expenditure incurred	Rs. 15,000	Rs. 15,000						
12	a) IEC activities through ZSS					Not applicable			
	b) expenditure incurred								

District Health & F.W. Officer,
Bijapur

Cold Chain Planning Form for areas undertaking Booth plus House-to-House Stareagy or Exclusive House to House Stareagy.
SNID. Name of the District – Koppal. Round / October - 2001

Name of the area Taluk	Vaccine distribution center	Vaccine carries		Ice peaks For Vaccine carries		Additional cold chain equipment		Cold boxes		Ice peaks for cold box		ILRS Functioning	Deep freezens Functioning	Daily ICE Required (KG)	Number days ICE is required	Total ICE required (KG) for each rounds	Comments (Availability of power supply stabilizers thermometry ect).
		Req.	A. Able	Req.	A. Able	Req.	A. Able	Req.	A. Able	Req.	A. Able						
KOPPAL	14	--	281	--	896	--	--	--	13	--	--	15	13	--	--	--	
GANGAVATI	13	--	244	--	1129	--	--	--	25	--	--	13	12	--	--	--	
KUSTAGI	09	--	247	--	1153	--	--	--	17	--	--	10	10	--	--	--	
YELBURGA	13	--	215	--	899	--	--	--	18	--	--	12	11	--	--	--	
TOTAL	49	--	987	--	4077	--	--	--	73	--	--	50	46	--	--	--	

Dist. Health & F.W.Officer,
Koppal

UP9

9	Total No of mobile team members		118
		Urban	20
		Rural	98
10	Total No of Supervisors for transit & mobile teams		24
		Urban	04
		Rural	20
11	Total OPV Doses required		238178
		Urban	40486
		Rural	197692
12	Total OPV Vial Required		11910
		Urban	2026
		Rural	9884
13	Total No of General Hospital		04
14	Total No of PHC's		38
		Urban	01
		Rural	37
15	Total No of PHU's		01
16	Total No of Community Health Centers		05
17	Total No of Sub – Centers		172
18	Total No of Jr H.A. (Female)		134
19	Total No of Jr H.A. (Male)		72
20	Anganawadi		883
21	Total No of Community Health Guides		517

Dist. Health & F.W.Officer,
Koppal.

SNID PROGRAMME GENERAL INFORMATION
KOPPAL DISTRICT.

Sl.NO	Particulars		Numbers.
1	Total Estimated Population		1209734
		Urban	209934
		Rural	999800
2	Total Estimated 0 – 5 Years Children		179078
		Urban	30438
		Rural	148640
3	Total Estimated Houses		241946
		Urban	41987
		Rural	199959
4	Total No of House-to-House team		1934
		Urban	335
		Rural	1599
5	Total No of House-to-House team members available		1288
		Urban	224
		Rural	1064
6	Total No of House-to House teams available		644
		Urban	112
		Rural	532
7	Total No of Supervisors		129
		Urban	23
		Rural	106
8	Total No of Transit team members		10
		Urban	10
		Rural	--

FORM I A

PROGRAMME

FORM 2.

INTENSIFIED PULSE POLIO IMMUNIZATION PROGRAMME
COLD CHAIN PLANNING FORM

For areas undertaking Booth Plus House-to -house Strategy or exclusive House-to-house Statergy.

Name of Dist/Block/Urban Area: Gulbarga. Round(Circle):October 2001.

Sl. No.	Name of the Area.	Vaccine Distribution Centres.	Vaccine Carriers Required.	Vaccine Carriers Available.	Ice-packs for Vaccine Carriers. Required.	Ice-packs for Vaccine Carriers. Available.	Additional Cold chain equipment Required.	Additional Cold chain equipment Available.	Cold Boxes Required.	Cold Boxes Available.	ICE Packs for Cold Boxes. Required.	ICE Packs for Cold Boxes. Available.	ILRs Functioning.	Deep Freezers functuning.	Daily Ice required KG.	No. of Days Ice is required.	Total Ice required Kg.
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1.	Afzalpur	8	98	82	392	348	-	10	3	5	75	125	-	-	-	-	-
2.	Aland	12	199	129	796	646	-	65	7	6	175	150	-	-	-	-	-
3.	Chincholi	10	174	142	696	610	-	36	5	6	125	150	-	-	-	-	-
4.	Chitapur	11	223	203	892	812	-	40	2	8	500	200	-	-	-	-	-
5.	Gulbarga(R)	8	106	144	424	576	-	-	5	6	155	150	-	-	-	-	-
	Gulbarga(U)	5	10	330	40	1714	-	197	10	17	250	425	-	-	-	-	-
6.	Jewargi	8	156	108	624	492	-	30	4	6	100	150	-	-	-	-	-
7.	Sedam	7	150	90	600	480	-	60	2	6	50	150	-	-	-	-	-
8.	Shahapur	11	249	189	996	846	-	45	6	6	150	150	-	-	-	-	-
9.	Shorapur	10	222	126	888	594	-	45	5	8	125	200	-	-	-	-	-
10.	Yadgir	14	223	143	892	672	-	50	8	8	200	200	-	-	-	-	-
Dist. Total		104	1810	1686	7240	7790	-	578	57	82	1425	2050	12	12	-	-	-	-

DIST. HEALTH & F.W.OFFICER
GULBARGA.

INTENSIFIED PULSE POLIO IMMUNIZATION PROGRAMME

FORM I A

MANPOWER AND VACCINE PLANNING FORM

For Areas Undertaking Booth Plus House-to-House Stategy.

Name of the District/Block/Urban Area: Gulbarga Round (Circle): October 2001.

Sl. No.	Name of the Area	Population 2001 (provisional) Urban (Rural)	Rural (Urban)	Total	Estimated Children below 5yrs. @ 14% of Populn.	Vaccination Booths	Booth Team Members Required.	Supervisors for Booth/ Teams required.	Transit Team members required.	Mobile Team members Required.	Supervisors for transit & mobile Teams Required	Total OPV, Doses Required.	Total OPV Vials Required
A		B	C		D	E	F	G	H	I	J	K	L
1.	Afzalpur	160702	19114	179816	25175	90	360	18	4	-	1	33483	1675
2.	Aland	259530	35308	294838	41275	164	656	33	8	-	1	54896	2745
3.	Chincholi	206319	17158	223477	31285	158	632	32	4	-	1	41610	2080
4.	Chitapur	238766	127758	366524	51315	213	852	42	12	12	1	68250	3412
5.	Gulbarga(R)	- 247161	~~247161~~	247161	34600	125	500	25	4	-	1	46018	2301
	Gulbarga(U)	430108	430108	430108	60215	170	680	34	12	12	1	80086	4004
6.	Jewargi	215651	19174	234825	32875	132	528	26	8	-	1	43724	2186
7.	Sedam	155974	40113	196087	27450	120	480	24	8	-	1	36509	1826
8.	Shahapur	249683	34347	284030	39765	219	876	44	10	-	1	52888	2645
9.	Shorapur	293098	43591	336689	47135	174	696	35	12	12	1	62690	3135
10.	Yadgir	250051	75729	325780	45610	183	732	37	12	-	1	60662	3033
Dist. Total		2276935	842400	3119335	436700	1740	6992	350	94	36	11	580816	29041

DIST. HEALTH & F.W. OFFICER
GULBARGA.

MACRO PLAN OF ACTION OF PPI (SNID + NID) OF RAICHUR DISTRICT 2001 – 2002

Name of the Taluka	Estimated Eligible children Below 5 years	No of Booths	Vaccinators			Supervisors			Vaccine Carriers			Vehicles		
			Avai lable	Req Uired	Total	Avail Able	Requ ired	Total	Avail able	Requ ired	Total	Avail able	Requ ired	Total
Raichur	72061	289	64	1092	1156	36	22	58	364	214	578	15	56	71
Devodurga	32842	130	38	482	520	18	8	26	123	137	260	03	40	43
Manvi	50657	203	54	758	812	25	16	41	134	272	406	01	65	66
Lingasugur	48144	191	62	702	764	25	15	40	167	215	382	05	61	66
Sindhnoor	56226	220	57	823	880	20	25	45	154	286	440	04	60	64
Total	**259930**	**1033**	**275**	**3857**	**4132**	**124**	**86**	**210**	**942**	**1124**	**2066**	**28**	**282**	**310**

01) Estimated eligible children have been taken as per the performance report of NID January 2001.
02) No of Booths calculated at the rate of one booth per 250 childrens.
03) Vaccinators 4/booth – they shall break into two batches for H-t-H
04) 9800/- Ice packs are available. No. V.C. 4 I P – 624, V.C. 2 I. P. 138. Required V.C. 4 IP / 2 IP 1124.
05) As many of the Govt. Sister departmental vehicles will be reported as sick or some are the other repairs. Hence it may be permitted to utilize hired vehicles.
06) IEC materials to be supplied at the earliest - minimum 15 days prior to the SIND / NID.
07) All reporting formats, tally sheets, and supervisors check list etc., be supplied well in advance. So that during the training of personnel they can be explained.
08) Gention Violet / Marker pens be supplied when in advance. So that they shall reach the teams in time.
09) H-t-H teams are 2066. Hence the number of vaccine carriers is calculated as one per H-t-H Team.

COLD CHAIN WORKING STATUS IN RAICHUR DISTRICT MONTH AUGUST 2001

Sl. No.	Equipment	Total Nos. Supplied	Total Nos Installed	Total Nos Working	No of Repairable Units	Beyond repairs due to internal gas leak			Action Taken
						Total Nos till date	Replacement Received	Replacement required	
	WITH C.F.C.								
01	Electrollux TCW 1151	--	--	--	---	--	--	--	--
	VEST FROST								
02	SB 300 / 303 / 304	4	4	3	1	--	--	--	---
03	MK 300 / 302 / 304	2	2	2	--	--	--	--	---
04	SB 140 / 142 / 144	44	44	33	--	11	--	11	--
05	MK 140 / 142 / 144	63	63	59	--	4	8	4	
	INDIAN MAKE								
06	FREEZS 130 LIT	1	1	1	--	--	--	--	--
07	FREEZA 225/300LIT	6	6	5	1	--	--	--	--
	TOTALS:	120	120	103	2	15	8	15	--
	NON C.F.C.								
01	ELECTROLUX TCW 1990	6	6	5	1	--	--	--	--
	VEST FORST								
02	ILR (SMALL)	13	13	12	1	--	--	--	--
03	ILR (LARGE)	3	3	3	--	--	--	--	--
04	D.Fr. (SMALL)	29	29	29	--	--	--	--	--
05	D.Fr. (LARGE)	02	02	02	--	--	---	--	--
	TOTALS:	53	53	51	2	--	---	--	--
STATUS OF WIC / WIF WITH C.F.C. MACHINES									

INTENSIFIED PULSE POLIO IMMUNIZATION PROGRAMME

Form 2

COLD CHAIN PLANNING FORM

For areas undertaking booth plus House-to-House Strategy or exclusive House-to-House Strategy

Name of the District / Block / Urban Area: Bellary Round (circle): October 2001 / December 2001 / January2002

Name of the Area	Vaccine Distribution Centers	Vaccine Carriers		Ice packs for Vaccine carriers		Additional cold chain equipment		cold Boxes		Ice packs for cold boxes		ILRs functioning	Deep Freezers functioning	Daily Ice Required (Kg)	Number of Days Ice is required	Total Ice Required (kg) for each round	Comments (Availability of power supply, stabilizers,thermometers,etc)
		Required	Available	Required	Available	Required	Available	Required	Available	Required	Available						
Bellary Dist	All Taluka Head Quarters of PHC's	400	950	12600	3550	30ILR	128	20	70	620	60	65	63	2500	3	2500	Stabilizers 40
						30DF											Thermometers 50 required

MICRO PLAN FOR MOP-UP IMMUNISATION

District : Bellary

Sl.No.	Name of the Taluk	Population			Eligible Children	No of House Teams		
		Urban	Rural	Total		Urban	Rural	Total
1	Bellary	300000	340000	640000	95000	157	201	358
2	Siruguppa	61000	170000	231000	32000	32	112	144
3	Sandur		200000	200000	27000		100	100
4	Hospet	230000	152000	382000	53000	120	101	221
5	Hagari Bommanahalli		165000	165000	20000		80	80
6	Hadagalli		179500	179500	35500		98	98
7	Kudligi	30000	197745	227745	41500	14	130	144
	Total	621000	1404245	2025245	304000	323	822	1145

District Health &
Family Welfare Officer
Bellary

Form 1 B

Intensified Pulse Polio Immunization Programme

Manpower and Vaccine Planning Form

for areas undertaking exclusive House-to-House Strategy

Name of District / Block / Urban Area: BAGALKOT (R) Round (Circle): October 2001 / December 2001 / January 2002

Name of the Area	Urban / Rural	Estimated Population	Estimated Children below 5 years (D = Last Mop-up or IPPI figure)	Estimated Houses (E = Last Mop-up figure or C / 5 or 6)	House-to-House Team Days Required (F = E / 100 or 125)	House-to-House Team Members Available	House-to-House Teams Available (H = G / 2)	Days of Activity (I = F / H)	Supervisors for House-to-House Teams Required (J = H / 5)	Transit Team Members Required	Mobile Team Members Required	Supervisors for Transit and Mobile Teams Required	Total OPV Doses Required Each Round (N = D x 1.33)	Total OPV Vials Required Each Round (O = N / 20)
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Bagalkot	Rural	159228	22164	38201	305	204	102	3	20	—	4	—	29490	1474
Badami	Rural	230075	31597	45418	364	242	121	3	24	—	8	1	42040	2102
Hunagund	Rural	227941	31610	39926	319	212	106	3	21	—	8	1	42040	2102
Jamkhandi	Rural	269122	37738	53110	424	282	141	3	28	—	14	1	50200	2510
Mudhol	Rural	202741	29040	41944	335	224	112	3	22	—	6	1	38640	1932
Bilgi	Rural	133686	19308	26939	215	144	72	3	14	2	4	—	25680	1284
Total		1222793	171457	245538	1962	1308	654	3	129	2	44	4	228080	11404

NPP

Form 1 B

Intensified Pulse Polio Immunization Programme

Manpower and Vaccine Planning Form

for areas undertaking exclusive House-to-House Strategy

Name of District / Block / Urban Area: BAGALKOT (U) Round (Circle): October 2001 / December 2001 / January 2002

Name of the Area	Urban / Rural	Estimated Population	Estimated Children below 5 years (D = Last Mop-up or IPPI figure)	Estimated Houses (E = Last Mop-up figure or C / 5 or 6)	House-to-House Team Days Required (F = E / 100 or 125)	House-to-House Team Members Available	House-to-House Teams Available (H = G / 2)	Days of Activity (I = F / H)	Supervisors for House-to-House Teams Required (J = H / 5)	Transit Team Members Required	Mobile Team Members Required	Supervisors for Transit and Mobile Teams Required	Total OPV Doses Required Each Round (N = D x 1.33)	Total OPV Vials Required Each Round (O = N / 20)
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Bagalkot		86826	12125	17769	142	96	48	3	9	4	2	—	16140	807
Badami		21140	3159	4689	37	26	13	3	3	4	2	—	4200	210
Guledgud		34682	5001	7336	58	40	20	3	4	2	2	—	6660	333
Kerur	N	17905	2625	3265	26	18	09	3	2	2	—	—	3500	175
Hunagund	&	16240	2601	2947	23	16	08	3	2	2	—	—	3460	173
Ilkal	E	45988	7692	9685	77	52	26	3	5	2	2	—	10240	512
Jamkhand		56205	8595	11884	95	64	32	3	6	2	2	—	11440	572
R.Bangalkot (Total)	R	61928	10785	13784	110	74	37	3	7	2	2	—	14360	718
Teradal		24840	3898	5440	43	28	14	3	3	2	2	—	5200	260
Mudhol	U	33480	6562	7129	57	38	19	3	4	2	2	—	8740	437
Rabakavi		30205	3930	6040	48	32	16	3	3	2	2	—	5240	262
Total		429439	67003	89968	858	484	242	3	48	26	18	—	89180	4459

Form 2

Intensified Pulse Polio Immunization Programme

Cold Chain Planning Form

for areas undertaking Booth plus House-to-House Strategy or exclusive House-to-House Strategy

Name of District / Block / Urban Area: BAGALKOT Round (Circle): October 2001 / December 2001 / January 2002

Name of the Area Rural+Urban	Vaccine Distribution Centres	Vaccine carriers		Ice packs for vaccine carriers		Additional cold chain equipment		Cold boxes		Ice packs for cold boxes		ILRs functioning	Deep Freezers functioning	Daily Ice Required (kg)	Number of Days Ice is Required	Total Ice required (kg) for each round	Comments (Availability of power supply, stabilizers, thermometers, etc)
		Required	Available	Required	Available	Required	Available	Required	Available	Required	Available						
Bagalkot	02	—	135	—	440	—	—	—	10	—	240	8	8	5	3	15	
Badami	03	—	195	—	580	—	—	—	13	—	312	12	11	10	3	30	
Hunagund	03	—	170	—	540	—	—	—	14	—	336	15	14	10	3	30	
Jamkhand	03	—	222	—	784	—	—	—	10	—	240	9	9	10	3	30	
Mudhol	02	—	140	—	464	—	—	—	07	—	168	9	8	10	3	30	
Bilgi	01	—	84	—	276	—	—	—	04	—	096	4	4	5	3	15	
Total	14	—	946	—	3094	—	—	—	58	—	1392	57	54	50	3	150	

FORM No.: 4.8/1

MUSTER ROLL FOR PARTICIPANTS (MRF)

NPHP

Details of Training / Workshop / Meeting : SNID Strategy Planning Meet
Purpose : Microplanning for SNID's
Location : Directorate of Health F/W Services, Bangalore
Date : 15/09/2001

Field Unit Office : Bangalore
Approved Budget Proposal for
for TWM Ref. : Yes

Sl. No.	Name of Participant	Designation	Participant Signature in Confirmation of Attendance
1	NARAYANASWAMY.	CEO, ZP. KOPPAL DIST.	
2	DR. P. Kullayappa.	I/C. R.C.H. Officer Koppal	
3	Dr D.R. Hiregoudar	DHO Gadag	
4	Dr. S A Kathari	DRCHO Davangere	
5)	Dr. S.R. KONDED.	DHO Koppal.	
6	ಡಿ॥ ಡಿಆರ್. ಮೆಲ್ಲಹಳ್ಳಿಕಟ್ಟಿ	DIC RCH officer ಬಳ್ಳಾರಿ	
7	ಡಿ॥ ಎಸ್.ಎ. ಮಂಜುನಾಥ್	ಜಿಲ್ಲಾ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಅಧಿಕಾರಿಗಳು ರಾಯಚೂರು	
8	DR. S C. Dharwad.	DHO Raichur.	
9	Dr. G. A. MANJUNATH	Dist RCH Offr RAICHUR	
10	S. BALADEV	Consultant (IEC) RCH Proj	
11.	Tushar Giri Nath	D.C - Koppal.	
12	DDP-Narayana	Rotary Volunteer	
13	Dr M. Chandra Thoma	RCH Consultant	
14	Sh H.T. METI	Dist Health Edn Officer	

Signature; DR. RADHA.R.: _____
Surveillance Medical Officer

Signature : DR. PAVANA MURTHY _____
Regional Coordinator – South

FORM No.: 4.8/

MUSTER ROLL FOR PARTICIPANTS (MRF)

Details of Training / Workshop / Meeting : SNID Strategy Planning Meet
Purpose : Microplanning for SNID's
Location : Directorate of Health F/W Services, Bangalore
Date : 15/09/2001

Field Unit Office : Bangalore
Approved Budget Proposal for
for TWM Ref. : Yes

Sl. No.	Name of Participant	Designation	Participant Signature in Confirmation of Attendance
15	DR. C.S. Hebbalki.	D.H.O. Bagalkot	
16.	Dr. M.R. Bidari	DHO Haveri	
17	Dr (Capt) V.N. Holla	SMO Belgaum	
18	K.H. Aswatha Narayana Gowda. IAS	CEO, ZP, Bellary	15/09/2001
19.	Dr. R.P. Hiremath	Dy RCH Officer Gadag	
20	Dr H.S. Gaur	DHO Belg	
21	M.M. Rao	CEO ZP Gulbarga	
22	Dr. S.B. DODHMANI	DIST. RCH Officer Bagalkot	
23	Dr. G. Kasi Reddy	Deputy Director (RCH)	
24	Dr P.R Madi	DDL RCH officer Haveri HAVERI	
25	Dr. Mukund. Gulagali	SMO Bijapur	
26	Dr. Lalitha Kameswari	SMO, Gulbarga	
27	Dr G Shiremath	SMO, Koppal	
28	Dr PRATHAP CHANDRAN-C	SMO- BANGALORE	

Signature; DR. RADHA.R.: _____
Surveillance Medical Officer

Signature : DR. PAVANA MURTHY _____
Regional Coordinator -- South

GOVERNMENT OF KARNATAKA

DIRECTORATE OF HEALTH & FAMILY WELFARE SERVICES, BANGALORE-560009

MONTHLY EPIDEMIOLOGICAL SITUATION REPORT FOR THE MONTH OF JUNE 2001

NATIONAL ANTI MALARIA PROGRAMME (Revised Proforma)

Sl. No	DISTRICT	YEAR	DURING THE MONTH								PROGRESSIVE TOTAL Upto June 2001							
			B/s Collected	B/s Examined	Malaria Cases		Pf Cases		Confirmed Deaths		B/s Collected	B/s Examined	No. of Malaria cases		P.F.CASES		Confirmed Deaths	
					Female	Total	Female	Total	Female	Total			Female	Total	Female	Total	Female	Total
1	Bangalore (U)	2000	15654	15654	17	42	5	13			89081	89081	42	146	15	55	1	1
		2001	18393	16308	24	69	10	22			93886	91801	63	180	26	68	0	0
2	Bangalore (R)	2000	22746	22746	42	83	1	4			135359	135359	85	201	17	49	0	0
		2001	27812	27812	52	113	11	8			130955	130955	116	294	19	32	0	0
3	Kolar	2000	38105	38105	279	761	48	131			198943	198943	738	1993	154	417	0	0
		2001	35276	31382	319	656	103	148			192635	188741	1276	2449	341	594	0	0
4	Tumkur	2000	91918	91918	1496	3360	155	348			298341	298341	2652	7313	351	1021	0	1
		2001	78991	72025	1826	4033	463	939			357295	350329	5648	13800	1315	3116	1	1
5	Chitradurga	2000	43539	43539	93	3152	10	337			191042	191042	1874	6917	301	952	0	0
		2001	54584	54584	3766	8143	1116	2412			261019	261019	13166	33145	3403	8495	0	1
6	Davanagere	2000	21541	21541	5	16	2	3			100137	100137	16	45	4	7	0	0
		2001	29849	26590	30	100	11	37			136750	133491	119	366	36	113	0	0
7	Shimoga	2000	18682	18682	10	38	2	9			105886	105886	43	144	16	54	0	1
		2001	27722	27458	120	272	26	49	0	0	125770	125506	273	634	57	123	1	1
8	Belgaum	2000	48543	48543	29	373	5	68	1	1	296444	296444	442	1336	131	362	1	1
		2001	50500	50500	44	113	5	15			275803	275803	243	553	41	95	0	0
9	Bijapura	2000	25569	25569	199	465	22	53			136811	136811	1114	2578	142	276	1	1
		2001	26426	26426	218	440	9	27			128399	128399	760	1564	73	159	0	0
10	Bagalkot	2000	25399	25399	319	620	17	34			132926	132926	715	2118	80	254	0	0
		2001	26816	26816	190	393	27	86			148719	148719	754	1612	141	332	0	0
11	Dharwad	2000	16729	16729	4	18	2	1			98731	98731	32	75	6	9	0	0
		2001	22820	22820	20	42	2	5			116959	116959	59	147	8	21	0	0
12	Gadag	2000	14324	14324	17	42	0	2			87550	87550	39	154	4	23	0	0
		2001	16236	16236	21	54	3	1			90007	90007	67	186	6	11	0	0
13	Haveri	2000	25508	25508	7	18	0	0			149974	149974	19	76	0	1	0	0
		2001	27679	27679	5	21	0	1			157113	157113	12	132	0	7	0	0
14	U.Kannada	2000	17041	17041	1	6	0	3			98492	98492	20	82	2	12	0	0
		2001	19160	19160	7	16	0	1			102084	102084	25	97	1	5	0	0

NP 15

MF 4 june 01 (RP)

FOR REPORTING DRUG DISTRIBUTION CENTRES. FEVER TREATMENT DEPOTS AND MALARIA CLINICS IN KARNATAKA FOR MAY 2001 JUNE

Sl No	DISTRICT	Drug Distribution Centres				Fever Treatment Depots				MALARIACLINICS			
		Number established	Number functioning	Number of cases treated during the month	Cumulative number of cases treated upto date	Number established	Number functioning	Number of cases treated during the month	Cumulative number of cases treated upto date	Number established	Number functioning	Number of cases treated during the month	Cumulative number of cases treated upto date
1	Bangalore (U)	0	0	0	0	0	0	0	0	1	1	4	292
2	Bangalore (R)	0	0	0	0	0	0	0	0	31	4	224	513
3	Kolar	229	151	594	2958	5	3	15	41	46	24	293	1123
4	Tumkur	846	784	6205	27703	52	36	161	655	23	23	2518	7572
5	Chitradurga	238	218	1556	3617	467	450	570	0	55	24	9569	10866
6	Davanagere	282	252	1359	5820	187	137	170	656	22	21	623	2150
7	Shimoga	355	305	861	3851	9	8	12	27	57	46	1079	3749
8	Belgaum	0	0	0	0	0	0	0	0	143	62	560	3181
9	Bijapura	68	46	242	1398	31	4	123	192	18	6	391	1090
10	Bagalkote	86	53	127	617	21	14	24	368	5	5	416	459
11	Dharwar	65	50	464	858	71	57	235	377	20	20	72	342
12	Gadag	90	50	237	946	32	14	16	81	28	25	11	53
13	Haveri	0	0	0	0	0	0	0	0	26	26	30	214
14	Uttara Kannada	158	46	260	1153	42	16	54	243	25	10	87	334
15	Gulbarga	21	10	10	140	9	0	0	29	13	10	14	248
16	Bidar	296	91	836	4573	227	6	18	219	42	31	449	2634
17	Bellary	358	229	1174	4715	59	27	163	762	29	29	123	498
18	Raichur	255	155	998	4010	208	12	80	586	34	21	125	702
19	Koppal	70	59	374	4335	42	8	39	426	29	29	186	687
20	Mysore	404	312	3802	15104	0	0	0	0	63	62	501	2865
21	Chamarajanagar	6	6	30	68	6	0	0		3	3	12	32
22	Mandya	937	891	5916	28716	62	2	7	129	42	42	1050	5543
23	Hassan	1528	1468	10707	62130	0	0	0	0	59	40	1342	5018
24	Dakshina Kannada	0	0	0	0	89	78	138	786	69	69	2752	11854
25	Udupi	0	0	0	0	0	0	0	0	38	35	254	1654
26	Chikmagalur	572	536	5258	24915	227	191	575	21634	35	27	904	3155
27	Kodagu	0	0	0	0	68	10	54	171	22	8	64	283
Projects:													
28	UKP Narayanapur	30	29	334	1951	0	0	0	0	0	0	0	0
29	AMU Kembhavi	12	12	89	282	0	0	0	0	0	0	0	0
30	AMU Almatti	0	0		0	0	0	0	0	0	0	0	0
31	AMU B Gudi	0	0		0	1	0	0	5	1	1	4	41
Total		6906	5775	41433	199862	1915	1075	2454	29323	979	704	23557	76721

GOVERNMENT OF KARNATAKA

NO:CMD/DSU/109/2001-02

OFFICE OF THE MEDICAL OFFCIER
DIST. SURVEILLANCE UNIT
KOLAR DIST. DATED:18-8-2001

TO,

THE DEPUTY DIRECTOR
AND OFFICER I/C N.I.C.D,
PLAGUE SURVEILLANCE UNIT,
BALLARY ROAD,
BANGALORE.

Sir,

Sub:- Out break report of suspected Dengue fever in Two villages of Kolar taluk

** ** **

While drawing your attention towards the Dengue out breaks in Kolar taluk. I would like to inform you that the surveillance team of Kolar has investigated in the following two villages immediately after getting an early warning signal of fever Myalgia etc... the details are as follows

Village	Thotly	Settyhalli
PHC	Sugatur	Vemagal
Population	1402	734
Houses	249	151
No. of fever cases	83	18
No. of screened B/S for MP	83	18
Results	Negative	Negative
No. of samples sent for Serology	10	The date of onset of fever is only 2 days back hence no samples collected but Ades Aegypti larive are found in 4 houses
Results	Awaited	--
Total no. of Thottyes in the village	83	63
Total no. of Thottyes found larva	56	04
No. of deaths	Nil	Nil

Action taken:

In both villages all containment measures including IEC are taken up meticulously and fever is under control. The concerned Gramapanchayaths are gearedup to taken action on their part by maintaining sanitation and clean of water storages etc.. Fogging is at present not possible because both villages are rearing silk worms.

Note: Please fax this to N.I.C.D. Delhi, the weekly reports Will follow in the concernned formates

Yours faithfully,

MEDICAL OFFICER,
DIST. SURVEILLANCE UNIT
KOLAR DISTRICT

Weekly Report of NSPCD

1. Week Starting 11 - 8 - 2001

2. Week Ending 18 - 8 - 2001.

3. Out Break Suspected Dengue fever cases in two village of Kolar Tq Kolar Dist.

   (A) No: ① Thottly village 83 fever cases, 83 Blood Smears
   (B) Nature: Drown for M.P. and found negative, 10 Blood Samples Sent for Serology awaited for results.
   ② Settyhally village. 18 fever cases, 18 Blood Smears Drown for M.P and found negative

4. News Paper Cutting ——— Nil ———

5. Report of Epidemiological Investigations. ——— YES ———

Details have been faxed to N.I.C.D Bangalore in a Seperate sheet with a request to fax the same along with this request to N.I.C.D. Delhi.

P.S Kolar

MEDICAL OFFICER
District Surveillance Unit
Kolar District
KOLAR-563101

No. of fever cases	83	18
No. of screened B/S for MP	83	18
Results	Negative	Negative
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Note: Please fax this to N.I.C.D. Delhi, the weekly reports Will follow in the concernned formates

Yours faithfully,

P.S Kolar

MEDICAL OFFICER,
DIST. SURVEILLANCE UNIT
KOLAR DISTRICT

nicdpsu

From: Director, NICD <dirnicd@bol.net.in>
To: NICD,RJY <patnaiks@hd2.dot.net.in>; NICD, Varanasi <mrai89@satyam.net.in>; NICD, Coonoor <ajpurty@tr.dot.net.in>; NICD, Bangalore <nicdpsu@kar.nic.in>; NICD, Alwar <nicdalwr@jp1.dot.net.in>; NDSP-Orrisa state lab <prof_hodmicrobiology@123india.com>; NDSP-Kottayam-Nodal Off. <ndspktym@md5.vsnl.net.in>; NDSP-Hyd nodal officer <dhsh@pol.net.in>; NDSP-E. Godavari -DMHO <dmho_egdt@pol.net.in>; NDSP, Satara - CDHO <epcell@vsnl.net>; NDSP, Jamnagar - CDHO <surendranagar@yahoo.com>; NDSP, Goa - State Epid. <ssygoa@goatelecom.com>; NDSP - Secretary Health <Secyhlth@mohfw.delhi.nic.in>; NDSP - JS(BT) <jsbt@nb.nic.in>; NDSP - Dr. Vijay Kumar <vijayk@whosea.org>; NDSP - Dr. Kim Farley, WR <wrindia@whoindia.org>; NDSP - Dr. Ira Ray, AddlDG <iraray@nb.nic.in>; NDSP - AS(PR) <nacodel@vsnl.com>; NDSP - AS(H) - P <asp@nb.
Sent: Wednesday, August 22, 2001 6:00 PM
Attach: ATT00113.txt
Subject: Todays News - Outbreak Watch-21-8-2001

National Institute of communicable Diseases
22-Shamnath Marg, Delhi – 110 054

National Surveillance programme for communicable Diseases (NSPCD)

Outbreak News –Weekending 21 August 2001 in the pilot districts under NSPCD

During the week under report, the following districts reported outbreaks of communicable diseases. The details are as follows:

1) **Bijapur district (Karnataka)** An outbreak of Acute Gastroenteritis was noted in village Hanchinal, Bijapur Taluk, by the district surveillance team. The rapid response team is carrying out the investigation

* *The detail information about the cases in respect of their age, gender and other risk factor may be provided. The results of the outbreak investigation along with the laboratory results and present status of the outbreak may also be provided.*

2) **Dhule district (Maharashtra)**: An outbreak of gastroenteritis noted in village, Chilane, Taluka Shindkheda on 15th August. A total of thirteen cases were detected in a village with a population of 13,934. The investigation revealed the cause of outbreak as contaminated hand pump water.

** *The information in respect of age, sex and other related variables for the notified cases may be provided. The laboratory results of the investigation may also be provided*

8/24/01

2) **Hamirpur District (Himachal Pradesh):** An outbreak of acute diarrhoea reported in Punjab Kesri newspaper. The outbreak affected the village, Chatrail under PHC Bhareri on 10.8.2001. The rapid response team of the district investigated the episode. A total of 15 cases were detected by house-to-house search. It affected person of all age groups. Further investigation revealed the cause of outbreak as contaminated well water.

*** *The detail information about the cases in respect of their age, gender and other risk factor may be provided. The results of the outbreak investigation along with the laboratory results and present status of the outbreak may also be provided.*

DISEASE SURVEILLANCE

Meeting with Dr Shyamal Biswas Dy Director NICD Bangalore & Sohanlal on 27 Aug 01.

NSPCD (National Surveillance Programme for Communicable Diseases) started about 5 years ago in 45 pilot Districts in the country. Has been effective in Karnataka since past two years in 3 Districts - Bellary, Bijapur & Kolar. Surveillance is carried out for 21 communicable diseases.

Weekly report (covering period Monday to Sunday) is sent by Fax on Mondays. Supposed to be sent by all MO PHC's to DHO. (25% compliance only). DSO compiles and sends to NICD & DHS. Nil report also sent.(photocopy of Kolar enclosed). Very simple format designed by NSPCD and also includes newspaper reports. PHC conducts immediate investigation and forwards report along with lab samples for confirmation of diagnosis and initiates control measures.

Weekly Outbreak Watch Report is then prepared and circulated to all pilot districts (by e-mail post, photocopy attached).

All districts also send a **monthly compiled report** (copy attached). Private Hospitals/ practitioners not presently involved in the surveillance.

Training : Training in Surveillance conducted by NICD in all three districts to all PHC MO's for five days who in turn trained their staff (Budget given by NSPCD). Additional budget given for telephone, Fax, Reagents, training not yet utilised by the State.

Discussed other aspects of Surveillance:

Basically NICD is conducting **lab diagnosis of Plague and Leptospirosis** (reagent for leptospirosis not available since June from NICD Delhi. Dr Nagraj of ROHFW confirms by Mart test). Presently outbreak reported from Shimoga district with two deaths.

Is of the view that **district labs should be able to conduct most tests** (except for plague & viral). NIV Bangalore and some private hospitals like Manipal Hospital also are diagnosing dengue infections.

Stated that he and Dr Murgendrappa had prepared the detailed surveillance plan for KHSDP **including duties of each category of staff.**

Agrees that action is usually taken after a death and/or the outbreak is reported in the media which emphasizes **surveillance failure.**

Endorsed that many MO's have been trained in **what lab samples are required, methodology, preservation, transportation precautions** and which referral lab to be sent clarified.

Confirmed that the **three months course in Epidemiology conducted** at NICD is continuing and presently one MO PHC is currently attending the course.

Comments:

Reporting formats should be as simplistic as possible.

Monitoring of reporting units (RU's) by frequent visits by DSO vital and he should cover each RU once in three months. Action against non-reporting must be taken or the surveillance system collapses (pattern followed by NPSP should be followed).

DSO should not be chair bound but always mobile.

Surveillance failure (report in the press, etc.) should be identified and measures to improve surveillance constantly updated.

In case of occurrence of case/ cases MO should not wait for weekly report but report immediately, followed by daily report till epidemic tapers off.

Spot Map and Line List imperative and all MO's trained in preparation of the same.

Importance of proper collection of samples, preservation, transportation to referral labs, is vital for confirmation of diagnosis.

Training of Junior Health Assistants (Male & Female) is the only way to improve quick reporting.

Suitable payment for collection, transportation of samples should be in-built in the system.

NP 16

Subject: Surveillance for Karnataka
Date: Thu, 23 Aug 2001 18:15:14 +0530
From: "Devadasan, Dr. N." <DEVADASANN@whoindia.org>
To: "'sochara@vsnl.com'" <sochara@vsnl.com>

Dear Krishnan,
Thanks for your mail. How are you? And how is CHC? Kindly convey my regards to Ravi and Thelma

Regarding the disease surveillance in Karnataka, the current status is as follows

* The vertical programmes continue to submit independent reports about diseases - TB, MALARIA etc.
* The state has a list of notifiable diseases (17 i think) that is submitted monthly to the state health authorities (and which is probably not looked into at all)
* The GoI has developed a National Surveillance prg for communicable diseases (NSPCD) which is operational in a few select districts. Currently Bellary Bijapur and Kolar are the 3 districts covered under this prg. It has a multi disease approach and is a little better than the above. But being in the pilot stage still, nobody at the state level looks at the data generated by this prg.
* I think that Karnataka has a WB Health system development project also. If yes, then it will have a surveillance prg under this also (which differs from state to state).
* Finally the GoI is planning to implement an Integrated disease surveillance prg throughout india by mid next year. (WB funded) this will incorporate public/pvt sectors; urban and rural; communicable diseases/ncd; >From what i gather this will be the final word on disease surveillance in the country (tho what the states think about it is another issue).

So that is the current state of surveillance. If there are any further queries - kindly do feel free to ask. And if you feel the need for me to come down and discuss this with anybody, please just make a request and i shall be most happy to do so.

So long and with regards

Deva

I think it would be a good idea to invite him during one of the discussions with state officials.
[signature] 27/8.

→ SKK
[initials] 27/08

DRAFT NATIONAL HEALTH POLICY - 2001

1. INTRODUCTORY

1.1 A National Health Policy was last formulated in 1983 and since then, there have been very marked changes in the determinant factors relating to the health sector. Some of the policy initiatives outlined in the NHP-1983 have yielded results, while in several other areas, the outcome has not been as expected.

1.2 The NHP-1983 gave a general exposition of the recommended policies required in the circumstances then prevailing in the health sector. The noteworthy initiatives under that policy were :-

i. A phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves;
ii. Intermediation through 'Health volunteers' having appropriate knowledge, simple skills and requisite technologies;
iii. Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level;
iv. An integrated net-work of evenly spread speciality and super-speciality services: encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government's facilities is limited to those entitled to free use.

1.3 Government initiatives in the pubic health sector have recorded some noteworthy successes over time. Smallpox and Guinea Worm Disease have been eradicated from the country; Polio is on the verge of being eradicated; Leprosy, Kala Azar, and Filariasis can be expected to be eliminated in the foreseeable future. There has been a substantial drop in the Total Fertility Rate and Infant Mortality Rate. The success of the initiatives taken in the public health field are reflected in the progressive improvement of many demographic / epidemiological / infrastructural indicators over time – (Box-I).

Box-1 : Through The Years - 1951-2000Achievements

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	110	70 (99 SRS)

Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no of cases)	>44,887	Eradicated	
Guineaworm (no. of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries &Hospitals(all)	9209	23,555	43,322 (95–96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors(Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

1.4 While noting that the public health initiatives over the years have contributed significantly to the improvement of these health indicators, it is to be acknowledged that public health indicators / disease-burden statistics are the outcome of several complementary initiatives under the wider umbrella of the developmental sector, covering Rural Development, Agriculture, Food Production, Sanitation, Drinking Water Supply, Education, etc. Despite the impressive public health gains as revealed in the statistics in Box-I, there is no gainsaying the fact that the morbidity and mortality levels in the country are still unacceptably high. These unsatisfactory health indices are, in turn, an indication of the limited success of the public health system to meet the preventive and curative requirements of the general population.

1.5 Out of the communicable diseases, which have persisted over history, incidence of Malaria has staged a resurgence in the1980s before stabilising at a fairly high prevalence level during the 1990s. Over the years, an increasing level of insecticide-resistance has developed in the malarial vectors in many parts of the country, while the incidence of the more deadly P-Falciparum Malaria has risen to about 50 percent in the country as a

whole. In respect of TB, the public health scenario has not shown any significant decline in the pool of infection amongst the community, and, there has been a distressing trend in increase of drug resistance in the type of infection prevailing in the country. A new and extremely virulent communicable disease – HIV/AIDS - has emerged on the health scene since the declaration of the NHP-1983. As there is no existing therapeutic cure or vaccine for this infection, the disease constitutes a serious threat, not merely to public health but to economic development in the country. The common water-borne infections – Gastroenteritis, Cholera, and some forms of Hepatitis – continue to contribute to a high level of morbidity in the population, even though the mortality rate may have been somewhat moderated. The period after the announcement of NHP-83 has also seen an increase in mortality through 'life-style' diseases- diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem. The changed circumstances relating to the health sector of the country since 1983 have generated a situation in which it is now necessary to review the field, and to formulate a new policy framework as the National Health Policy-2001.

1.6 NHP-2001 will attempt to set out a new policy framework for the accelerated achievement of Public health goals in the socio-economic circumstances currently prevailing in the country.

2. CURRENT SCENARIO

2.1 FINANCIAL RESOURCES

The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 20 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual per capita public health expenditure in the country is no more than Rs.160. Given these statistics, it is no surprise that the reach and quality of public health services has been below the desirable standard. Under the constitutional structure, public health is the responsibility of the States. In this framework, it has been the expectation that the principal contribution for the funding of public health services will be from States' resources, with some supplementary input from Central resources. In this backdrop, the contribution of Central resources to the overall public health funding has been limited to about 15 percent. The fiscal resources of the State Governments are known to be very inelastic. This itself is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget. If the decentralized pubic health services in the country are to improve significantly, there is a need for injection of substantial resources into the health sector from the Central Government Budget. This approach, despite the formal Constitutional provision in regard to public health, is a necessity if the State public health services - a major component of the initiatives in the social sector - are not to become entirely moribund. The NHP-2001 has been formulated taking into consideration these ground realities in regard to the availability of resources.

2.2 EQUITY

2.2.1 In the period when centralized planning was accepted as a key instrument of development in the country, the attainment of an equitable regional distribution was considered one of its major objectives. Despite this conscious focus in the development process, the statistics given in Box-II clearly indicate that attainment of health indices have been very uneven across the rural – urban divide.

Box II : Differentials in Health Status Among States

Sector	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mort-ality per 1000 (NFHS II)	Weight For Age- % of Children Under 3 years (<-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 popula-tion	Malaria +ve Cases in year 2000 (in thousands)
India	**26.1**	**70**	**94.9**	**47**	**408**	**3.7**	**2200**
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharastra	25.02	48	58.1	50	135	3.1	138
TN	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

Also, the statistics bring out the wide differences between the attainments of health goals in the better- performing States as compared to the low-performing States. It is clear that national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country. Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide

inter-State disparity implies that, for vulnerable sections of society in several States, access to public health services is nominal and health standards are grossly inadequate. Despite a thrust in the NHP-1983 for making good the unmet needs of public health services by establishing more public health institutions at a decentralized level, a large gap in facilities still persists. Applying current norms to the population projected for the year 2000, it is estimated that the shortfall in the number of SCs/PHCs/CHCs is of the order of 16 percent. However, this shortage is as high as 58 percent when disaggregated for CHCs only. The NHP-2001 will need to address itself to making good these deficiencies so as to narrow the gap between the various States, as also the gap across the rural-urban divide.

2.2.2 Access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially disadvantaged sections of society. The statistics given in Box-III highlight the handicap suffered in the health sector on account of socio-economic inequity.

Box-III : Differentials in Health status Among Socio-Economic Groups

Indicator	Infant Mortality/1000	Under 5 Mortality/1000	% Children Underweight
India	70	94.9	47
Social Inequity			
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

2.2.3 It is a principal objective of NHP-2001 to evolve a policy structure which reduces these inequities and allows the disadvantaged sections of society a fairer access to public health services.

2.3 DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES

2.3.1 It is self-evident that in a country as large as India, which has a wide variety of socio-economic settings, national health programmes have to be designed with enough flexibility to permit the State public health administrations to craft their own programme package according to their needs. Also, the implementation of the national health programme can only be carried out through the State Governments' decentralized public health machinery. Since, for various considerations, the responsibility of the Central Government in funding additional public health services will continue over a period of time, the role of the Central Government in designing broad-based public health initiatives will inevitably continue. Moreover, it has been observed that the technical and managerial expertise for designing large-span public health programmes exists with the

Central Government in a considerable degree; this expertise can be gainfully utilized in designing national health programmes for implementation in varying socio-economic settings in the states.

2.3.2 Over the last decade or so, the Government has relied upon a 'vertical' implementational structure for the major disease control programmes. Through this, the system has been able to make a substantial dent in reducing the burden of specific diseases. However, such an organizational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain. Over a long time-range, 'vertical' structures may only be affordable for diseases, which offer a reasonable possibility of elimination or eradication in a foreseeable time-span. In this background, the NHP-2001 attempts to define the role of the Central Government and the State Governments in the public health sector of the country.

2.4 THE STATE OF PUBLIC HEALTH INFRA-STRUCTURE

2.4.1 The delineation of NHP-2001 would be required to be based on an objective assessment of the quality and efficiency of the existing public health machinery in the field. It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services. As a result of such inadequate public health facilities, it has been estimated that less than 20 percent of the population seeks the OPD services and less than 45 percent avails of the facilities for in-door treatment in public hospitals. This is despite the fact that most of these patients do not have the means to make out-of-pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition.

2.5 EXTENDING PUBLIC HEALTH SERVICES

2.5.1 While in the country generally there is a shortage of medical manpower, this shortfall is disproportionately impacted on the less-developed and rural areas. No incentive system attempted so far, has induced private medical manpower to go to such areas; and, even in the public health sector it has usually been a losing battle to deploy medical manpower in such under-served areas. In such a situation, the possibility needs to be examined for entrusting some limited public health functions to nurses, paramedics and other personnel from the extended health sector after imparting adequate training to them.

2.5.2 India has a vast reservoir of practitioners in the Indian Systems of Medicine and Homoeopathy, who have undergone formal training in their own disciplines. The possibility of using such practitioners in the implementation of State/Central Government public health Programmes, in order to increase the reach of basic health

care in the country, is addressed in the NHP-2001.

2.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

2.6.1 Some States have adopted a policy of devolving programmes and funds in the health sector through different levels of the Panchayati Raj Institutions. Generally, the experience has been a favourable one. The adoption of such an organisational structure has enabled need-based allocation of resources and closer supervision through the elected representatives. NHP- 2001 examines the need for a wider adoption of this mode of delivery of health services, in rural as well as urban areas, in other parts of the country.

2.7 MEDICAL EDUCATION

2.7.1 Medical Colleges are not evenly spread across various parts of the country. Apart from the uneven geographical distribution of medical institutions, ,the quality of education is highly uneven and in several instances even sub-standard. It is a common perception that the syllabus is excessively theoritical, making it difficult for the fresh graduate to effectively meet even the primary health care needs of the population. There is an understandable reluctance on the part of graduate doctors to serve in areas distant from their native place. NHP-2001 will suggest policy initiatives to rectify these disparities.

2.7.2 Certain medical discipline, such as, molecular biology and gene-manipulation, have become relevant in the period after the formulation of the previous National Health Policy. Also, certain speciality disciplines – Anesthesiology, Radiology and Forensic Medicines – are currently very scarce, resulting in critical deficiencies in the package of available public health services. The components of medical research in the recent years have changed radically. In the foreseeable future such research will rely increasingly on such new disciplines. It is observed that the current under-graduate medical syllabus does not cover such emerging subjects. NHP-2001 will make appropriate recommendations in this regard.

2.8 NEED FOR SPECIALISTS IN 'PUBLIC HEALTH' AND 'FAMILY MEDICINE'

2.8.1 In any developing country with inadequate availability of health services, the requirement of expertise in the areas of 'public health' and 'family medicine' is very much more than the expertise required for other specialized clinical disciplines. In India, the situation is that public health expertise is non-existent in the private health sector, and far short of requirement in the public health sector. Also, the current curriculum in the graduate / post-graduate courses is outdated and unrelated to contemporary community needs. In respect of 'family medicine', it needs to be noted that the more talented medical graduates generally seek specialization in clinical disciplines, while the remaining go into general practice. While the availability of postgraduate educational facilities is 50 percent of the total number of the qualifying graduates each year, and can be considered adequate, the distribution of the disciplines in the postgraduate training facilities is overwhelmingly in favour of clinical specializations. NHP-2001 examines the need for ensuring adequate availability of personnel with specialization in the 'public health' and 'family medicine' disciplines, to discharge the public health responsibilities in the country.

2.9 URBAN HEALTH

2.9.1 In most urban areas, public health services are very meagre. To the extent that such services exist, there is no uniform organisational structure. The urban population in the country is presently as high as 30 percent and is likely to go up to around 33 percent by 2010. The bulk of the increase is likely to take place through migration, resulting in slums without any infrastructure support. Even the meagre public health services available do not percolate to such unplanned habitations, forcing people to avail of private health care through out-of-pocket expenditure. The rising vehicle density in large urban agglomerations has also led to an increased number of serious accidents requiring treatment in well-equipped trauma centres. NHP-2001 will address itself to the need for providing this unserved population a minimum standard of health care facilities.

2.10 MENTAL HEALTH

2.10.1 Mental health disorders are actually much more prevalent than are visible on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families. Serious cases of mental disorder require hospitalization and treatment under trained supervision. Mental health institutions are perceived to be woefully deficient in physical infrastructure and trained manpower. NHP-2001 will address itself to these deficiencies in the public health sector.

2.11 INFORMATION, EDUCATION AND COMMUNICATION

2.11.1 A substantial component of primary health care consists of initiatives for disseminating, to the citizenry, public health-related information. Public health programmes, particularly, need high visibility at the decentralized level in order to have any impact. This task is particularly difficult as 35 percent of our country's population is illiterate. The present IEC strategy is too fragmented, relies heavily on mass media and does not address the needs of this segment of the population. It is often felt that the effectiveness of IEC programmes is difficult to judge; and consequently, it is often asserted that accountability, in regard to the productive use of such funds, is doubtful. NHP-2001, while projecting an IEC strategy, will fully address the inherent problems encountered in any IEC programme designed for improving awareness in order to bring about behavioural change in the general population.

2.11.2 It is widely accepted that school and college students are the most receptive targets for imparting information relating to basic principles of preventive health care. NHP-2001 will attempt to target this group to improve the general level of health awareness.

2.12 MEDICAL RESEARCH

2.12.1 Over the years, medical research activity in the country has been very limited. In the Government, such research has been confined to the research institutions under the Indian Council of Medical Research, and other institutions funded by the States/Central Government. Research in the private sector has assumed some significance only in the last decade. In our country, where the aggregate annual health expenditure is of the order

of Rs. 80,000 crores. the expenditure in 1998-99 on research, both public and private sectors, was only of the order of Rs. 1150 crores. It would be reasonable to infer that with such low research expenditure, it would be virtually impossible to make any dramatic break-through within the country, by way of new molecules and vaccines: also, without a minimal back-up of applied and operational research, it would be difficult to assess whether the health expenditure in the country is being incurred through optimal applications and appropriate public health strategies. Medical Research in the country needs to be focused on therapeutic drugs/vaccines for tropical diseases, which are normally neglected by international pharmaceutical companies on account of limited profitability potential. The thrust will need to be in the newly-emerging frontier areas of research based on genetics, genome-based drug and vaccine development, molecular biology, etc. NHP-2001 will address these inadequacies and spell out a minimal quantum of expenditure for the coming decade, looking to the national needs and the capacity of the research institutions to absorb the funds.

2.13 ROLE OF THE PRIVATE SECTOR

2.13.1 Considering the economic restructuring underway in the country, and over the globe, since the last decade, the changing role of the private sector in providing health care will also have to be addressed in NHP 2001. Currently, the contribution of private health care is principally through independent practitioners. Also, the private sector contributes significantly to secondary-level care and some tertiary care. With the increasing role of private health care, the need for statutory licensing and monitoring of minimum standards of diagnostic centres / medical institutions becomes imperative. NHP-2001 will address the issues regarding the establishment of a regulatory mechanism to ensure adequate standards of diagnostic centres / medical institutions, conduct of clinical practice and delivery of medical services.

2.13.2 Currently, non-Governmental service providers are treating a large number of patients at the primary level for major diseases. However, the treatment regimens followed are diverse and not scientifically optimal, leading to an increase in the incidence of drug resistance. NHP-2001 will address itself to recommending arrangements, which will eliminate the risks arising from inappropriate treatment.

2.13.3 The increasing spread of information technologt raises the possibility of its adoption in the health sector. NHP-2001 will examine this possibility.

2.14 ROLE OF THE CIVIL SOCIETY

2.14.1 Historically, the practice has been to implement major national disease control programmes through the public health machinery of the State/Central Governments. It has become increasingly apparent that certain components of such programmes cannot be efficiently implemented merely through government functionaries. A considerable change in the mode of implementation has come about in the last two decades, with an increasing involvement of NGOs and other institutions of civil society. It is to be recognized that widespread debate on various public health issues have, in fact, been initiated and sustained by NGOs and other members of the civil society. Also, an increasing contribution is being made by such institutions, in the delivery of different components of public health services. Certain disease control programmes require close

inter-action with the beneficiaries for regular administration of drugs: periodic carrying out of the pathological tests; dissemination of information regarding disease control and other general health information. NHP-2001 will address such issues and suggest policy instruments for implementation of public health programmes through individuals and institutions of civil society.

2.15 NATIONAL DISEASE SURVEILLANCE NETWORK

2.15.1 The technical network available in the country for disease surveillance is extremely rudimentary and to the extent that the system exists, it extends only up to the district level. Disease statistics are not flowing through an integrated network from the decentralized public health facilities to the State/Central Government health administration. Such an arrangement only provides belated information, which, at best, serves a limited statistical purpose. The absence of an efficient disease surveillance network is a major handicap in providing a prompt and cost effective health care system. The efficient disease surveillance network set up for Polio and HIV/AIDS has demonstrated the enormous value of such a public health instrument. Real-time information of focal outbreaks of common communicable diseases – Malaria, GE, Cholera and JE – and other seasonal trends of diseases, would enable timely intervention, resulting in the containment of any possible epidemic. In order to be able to use an integrated disease surveillance network, for operational purposes, real-time information is necessary at all levels of the health administration. NHP-2001 would address itself to this major systemic shortcoming in the administration.

2.16 HEALTH STATISTICS

2.16.1 The absence of a systematic and scientific health statistics data-base is a major deficiency in the current scenario. The health statistics collected are not the product of a rigorous methodology. Statistics available from different parts of the country, in respect of major diseases, are often not obtained in a manner which make aggregation possible, or meaningful.

2.16.2 Further, absence of proper and systematic documentation of the various financial resources used in the health sector is another lacunae witnessed in the existing scenario. This makes it difficult to understand trends and levels of health spending by private and public providers of health care in the country, and to address related policy issues and formulate future investment policies.

2.16.3 NHP-2001 will address itself to the programme for putting in place a modern and scientific health statistics database as well as a system of national health accounts.

2.17 WOMEN'S HEALTH

2.17.1 Social, cultural and economic factors continue to inhibit women from gaining adequate access to even the existing public health facilities. This handicap does not just affect women as individuals; it also has an adverse impact on the health, general well-being and development of the entire family, particularly children. NHP 2001 recognises the catalytic role of empowered women in improving the overall health standards of the community.

2.18 MEDICAL ETHICS

2.18.1 Professional medical ethics in the health sector is an area, which has not received much attention in the past. Also, the new frontier areas of research – involving gene manipulation, organ/human cloning and stem cell research _ impinge on visceral issues relating to the sanctity of human life and the moral dilemma of human intervention in the designing of life forms. Besides these, in the emerging areas of research, there is an un-charted risk of creating new life forms, which may irreversibly damage the environment, as it exists today. NHP – 2001 recognises that moral and religious dilemma of this nature, which was not relevant even two years ago, now pervades mainstream health sector issues.

2.19 ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS

2.19.1 There is an increasing expectation and need of the citizenry for efficient enforcement of reasonable quality standards for food and drugs. Recognizing this need, NHP – 2001 makes an appropriate policy recommendation.

2.20 REGULATION OF STANDARDS IN PARA MEDICAL DISCIPLINES

2.20.1 It has been observed that a large number of training institutions have mushroomed particularly in the private sector, for several para medical disciplines – Lab Technicians, Radio Diagnosis Technicians, Physiotherapists, etc. Currently, there is no regulation/monitoring of the curriculum, or the performance of the practitioners in these disciplines. NHP-2001 will make recommendations to ensure standardization of training and monitoring of performance.

2.21 OCCUPATIONAL HEALTH

2.21.1 Work conditions in several sectors of employment in the country are sub-standard. As a result of this, workers engaged in such activities become particularly prone to occupation-linked ailments. The long-term risk of chronic morbidity is particularly marked in the case of child labour. NHP-2001 will address the risk faced by this particularly vulnerable section of the society.

2.22 PROVIDING MEDICAL FACILITIES TO USERS FROM OVERSEAS

2.22.1 The secondary and tertiary facilities available in the country are of good quality and cost-effective compared to international medical facilities. This is true not only of facilities in the allopathic disciplines, but also to those belonging to the alternative systems of medicine, particularly Ayurveda. NHP-2001 will assess the possibilities of encouraging commercial medical services for patients from overseas.

2.23 IMPACT OF GLOBALIZATION ON THE HEALTH SECTOR

2.23.1 There are some apprehensions about the possible adverse impact of economic globalisation on the health sector. Pharmaceutical drugs and other health services have always been available in the country at extremely inexpensive prices. India has established a reputation for itself around the globe for innovative development of original process patents for the manufacture of a wide-range of drugs and vaccines within the ambit of the existing patent laws. With the adoption of Trade Related

Intellectual Property (TRIPS), and the subsequent alignment of domestic patent laws consistent with the commitments under TRIPS, there will be a significant shift in the scope of the parameters regulating the manufacture of new drugs/vaccines. Global experience has shown that the introduction of a TRIPS-consistent patent regime for drugs in a developing country, would result in an increase in the cost of drugs and medical services. NHP-2001 will address itself to the future imperatives of health security in the country, in the post-TRIPS era.

2.24 NON – HEALTH DETERMINANTS

2.24.1 Improved health standards are closely dependent on major non-health determinants such as safe drinking water supply, basic sanitation, adequate nutrition, clean environment and primary education, especially of the girl child. NHP-2001 will not explicitly address itself to the initiatives in these areas, which although crucial, fall outside the domain of the health sector. However, the attainment of the various targets set in NHP 2001 assumes a reasonable performance in these allied sectors.

2.25 POPULATION GROWTH AND HEALTH STANDARDS

2.25.1 Efforts made over the years for improving health standards have been neutralized by the rapid growth of the population. Unless the Population stabilization goals are achieved, no amount of effort in the other components of the public health sector can bring about significantly better national health standards. Government has separately announced the 'National Population Policy – 2000'. The principal common features covered under the National Population Policy-2000 and NHP-2001, relate to the prevention and control of communicable diseases; priority to containment of HIV/AIDS infection; universal immunization of children against all major preventable diseases; addressing the unmet needs for basic and reproductive health services; and supplementation of infrastructure. The synchronized implementation of these two Policies – National Population Policy – 2000 and National Health Policy-2001 – will be the very cornerstone of any national structural plan to improve the health standards in the country.

2.26 ALTERNATIVE SYSTEMS OF MEDICINE

2.26.1 Alternative Systems of Medicine – Ayurveda, Unani, Sidha and Homoeopathy – provide a significant supplemental contribution to the health care services in the country, particularly in the underserved, remote and tribal areeas. The main components of NHP-2001 apply equally to the alternative systems of medicine. However, the policy features specific to the alternative systems of medicine will be presented as a separate document.

3. OBJECTIVES

3.1 The main objective of NHP-2001 is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country. Emphasis will be given to increasing

the aggregate public health investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the State level to render effective service delivery. The contribution of the private sector in providing health services would be much enhanced, particularly for the population group, which can afford to pay for services. Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation. Emphasis will be laid on rational use of drugs within the allopathic system. Increased access to tried and tested systems of traditional medicine will be ensured. Within these broad objectives, NHP-2001 will endeavour to achieve the time-bound goals mentioned in Box-IV.

Box-IV: Goals to be achieved by 2000-2015

• Eradicate Polio and Yaws	2005
• Eliminate Leprosy	2005
• Eliminate Kala Azar	2010
• Eliminate Lymphatic Filariasis	2015
• Achieve Zero level growth of HIV/AIDS	2007
• Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
• Reduce Prevalence of Blindness to 0.5%	2010
• Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
• Improve nutrition and reduce proportion of LBW Babies from 30% to 10%	2010
• Increase utilisation of public health facilities from current Level of <20 to >75%	2010
• Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
• Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
• Increase share of Central grants to Constitute at least 25% of total health spending	2010
• Increase State Sector Health spending from 5.5% to 7% of the budget Further increase to 8%	2005 2010

4. NHP-2001 - POLICY PRESCRIPTIONS

4.1 FINANCIAL RESOURCES

The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, the Central Government will have to play a key role in augmenting public health investments. Taking into account the gap in health care facilities under NHP-2001 it is planned to increase health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010. The State Governments would also need to increase the commitment to the health sector. In the first phase, by 2005, they would be expected to increase the commitment of their resources to 7 percent of the Budget; and, in the second phase, by 2010, to increase it to 8 percent of the Budget. With the stepping up of the public health investment, the Central Government's contribution would rise to 25 percent from the existing 15 percent, by 2010. The provisioning of higher public health investments will also be contingent upon the increase in absorptive capacity of the public health administration so as to gainfully utilize the funds.

4.2 EQUITY

4.2.1 To meet the objective of reducing various types of inequities and imbalances – inter-regional; across the rural – urban divide; and between economic classes – the most cost effective method would be to increase the sectoral outlay in the primary health sector. Such outlets give access to a vast number of individuals, and also facilitate preventive and early stage curative initiative, which are cost effective. In recognition of this public health principle, NHP-2001 envisages an increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targetted for 35 percent and 10 percent respectively. NHP-2001 projects that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms for such facilities.

4.3 DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES

4.3.1 NHP-2001, envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, NHP-2001 envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, Malaria and HIV/AIDS would need to be continued till moderate levels of prevalence are reached. The integration of the programmes will bring about a desirable optimisation of outcomes through a convergence of all public health inputs. The policy also envisages that programme implementation be effected through autonomous bodies at State and district levels. State Health Departments' interventions may be limited to the overall monitoring of the achievement of programme targets and other technical aspects. The relative distancing of the programme implementation from the State Health Departments will give the project team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-informed

decision-making.

4.4 THE STATE OF PUBLIC HEALTH INFRASTRUCTURE

4.4.1 As has been highlighted in the earlier part of the Policy, the decentralized Public health service outlets have become practically dysfunctional over large parts of the country. On account of resource constraint, the supply of drugs by the State Governments is grossly inadequate. The patients at the decentralized level have little use for diagnostic services, which in any case would still require them to purchase therapeutic drugs privately. In a situation in which the patient is not getting any therapeutic drugs, there is little incentive for the potential beneficiaries to seek the advice of the medical professionals in the public health system. This results in there being no demand for medical services, and medical professionals, and paramedics often absent themselves from their place of duty. It is also observed that the functioning of the public health service outlets in the four Southern States – Kerala, Andhra Pradesh, Tamil Nadu and Karnataka – is relatively better, because some quantum of drugs is distributed through the primary health system network, and the patients have a stake in approaching the Public health facilities. In this backdrop, NHP-2001 envisages the kick-starting of the revival of the Primary Health System by providing some essential drugs under Central Government funding through the decentralized health system. It is expected that the provisioning of essential drugs at the public health service centres will create a demand for other professional services from the local population, which, in turn, will boost the general revival of activities in these service centres. In sum, this initiative under NHP-2001 is launched in the belief that the creation of a beneficiary interest in the public health system, will ensure a more effective supervision of the public health personnel, through community monitoring, than has been achieved through the regular administrative line of control.

4.4.2 Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment through public funding in the primary health sector. Box-V gives statistics which show clearly that the standards of health are more a function of accurate targeting of expenditure on the decentralised primary sector (as observed in China and Sri Lanka), than a function of the aggregate health expenditure.

Box-V: Public Health Spending in select Countries

Indicator	%Population with income of <$1 day	Infant Mortality Rate/1000	%Health Expenditure to GDP	%Public Expenditure on Health to Total Health Expenditure
India	44.2	70	5.2	17.3
China	18.5	31	2.7	24.9
Sri Lanka	6.6	16	3	45.4
UK	-	6	5.8	96.9
USA	-	7	13.7	44.1

Therefore, NHP-2001, while committing additional aggregate financial resources, places strong reliance on the strengthening of the primary health structure, with which to attain improved public health outcomes on an equitable basis. Further, it also recognizes the practical need for levying reasonable user-charges for certain secondary and tertiary public health care services, for those who can afford to pay.

4.5 EXTENDING PUBLIC HEALTH SERVICES

4.5.1 NHP-2001 envisages that, in the context of the availability and spread of allopathic graduates in their jurisdiction, State Governments would consider the need for expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Systems of Medicine and Homoeopathy. Simple services/procedures can be provided by such practitioners even outside their disciplines, as part of the basic primary health services in under-served areas. Also, NHP-2001 envisages that the scope of use of paramedical manpower of allopathic disciplines, in a prescribed functional area adjunct to their current functions, would also be examined for meeting simple public health requirements. These extended areas of functioning of different categories of medical manpower can be permitted, after adequate training and subject to the monitoring of their performance through professional councils.

4.5.2 NHP-2001 also recognizes the need for States to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in under-served areas.

4.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS.

4.6.1 NHP-2001 lays great emphasis upon the implementation of public health programmes through local self Government institutions. The structure of the national disease control programmes will have specific components for implementation through such entities. The Policy urges all State Governments to consider decentralizing implementation of the programmes to such Institutions by 2005. In order to achieve this, financial incentives, over and above the resources allocated for disease control programmes, will be provided by the Central Government.

4.7 MEDICAL EDUCATION

4.7.1 In order to ameliorate the problems being faced on account of the uneven spread of medical colleges in various parts of the country, NHP-2001, envisages the setting up of a Medical Grants Commission for funding new Government Medical Colleges in different parts of the country. Also, the Medical Grants Commission is envisaged to fund the upgradation of the existing Government Medical Colleges of the country, so as to ensure an improved standard of medical education in the country.

4.7.2 To enable fresh graduates to effectively contribute to the providing of primary health services, NHP-2001 identifies a significant need to modify the existing curriculum. A need based, skill-oriented syllabus, with a more significant component of practical training, would make fresh doctors useful immediately after graduation.

4.7.3 The policy emphasises the need to expose medical students, through the undergraduate syllabus, to the emerging concerns for geriatric disorders, as also to the cutting edge disciplines of contemporary medical research. The policy also envisages that the creation of additional seats for post-graduate courses should reflect the need for more manpower in the deficient specialities.

4.8 NEED FOR SPECIALISTS IN 'PUBLIC HEALTH' AND 'FAMILY MEDICINE'

4.8.1 In order to alleviate the acute shortage of medical personnel with specialization in 'public health' and 'family medicine' disciplines, NHP-2001 envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these discipline in medical training institutions, to reach a stage wherein ¼ th of the seats are earmarked for these disciplines. It is envisaged that in the sanctioning of post-graduate seats in future, it shall be insisted upon that a certain reasonable number of seats be allocated to 'public health' and 'family medicine' disciplines. Since, the 'public health' discipline has an interface with many other developmental sectors, specialization in Public health may be encouraged not only for medical doctors but also for non-medical graduates from the allied fields of public health engineering, microbiology and other natural sciences.

4.9 URBAN HEALTH

4.9.1 NHP-2001, envisages the setting up of an organised urban primary health care structure. Since the physical features of an urban setting are different from those in the rural areas, the policy envisages the adoption of appropriate population norms for the urban public health infrastructure. The structure conceived under NHP-2001 is a two-tiered one: the primary centre is seen as the first-tier, covering a population of one lakh, with a dispensary providing OPD facility and essential drugs to enable access to all the national health programmes; and a second-tier of the urban health organisation at the level of the Government general Hospital, where reference is made from the primary centre. The Policy envisages that the funding for the urban primary health system will be jointly borne by the local self-Government institutions and State and Central Governments.

4.9.2 The National Health Policy also envisages the establishment of fully-equipped 'hub-spoke' trauma care networks in large urban agglomerations to reduce accident mortality.

4.10 MENTAL HEALTH

4.10.1 NHP – 2001 envisages a network of decentralised mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would envisage diagnosis of common disorders by general duty medical staff and prescription of common therapeutic drugs.

4.10.2 In regard to mental health institutions for in-door treatment of patients, the policy envisages the upgrading of the physical infrastructure of such institutions at Central Government expense so as to secure the human rights of this vulnerable segment of society.

4.11 INFORMATION, EDUCATION AND COMMUNICATION

4.11.1 NHP-2001 envisages an IEC policy, which maximizes the dissemination of information to those population groups, which cannot be effectively approached through the mass media only. The focus would therefore, be on inter-personal communication of information and reliance on folk and other traditional media. The IEC programme would set specific targets for the association of PRIs/NGOs/Trusts in such activities. The programme will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programmes on the targeted groups. The Central/State Government initiative will also focus on the development of modules for information dissemination in such population groups who normally, do not benefit from the more common media forms.

4.11.2. NHP-2001 envisages priority to school health programmes aiming at preventive health education, regular health check-ups and promotion of health seeking behaviour among children. The school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'. This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but the future generation as well.

4.12 MEDICAL RESEARCH

4.12.1 NHP-2001 envisages the increase in Government-funded medical research to a level of 1 percent of total health spending by 2005; and thereafter, up to 2 percent by 2010. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and Malaria, as also the Sub-types of HIV/AIDS prevalent in the country. Research programmes taken up by the Government in these priority areas would be conducted in a mission mode. Emphasis would also be paid to time-bound applied research for developing operational applications. This would ensure cost effective dissemination of existing / future therapeutic drugs/vaccines in the general population. Private entrepreneurship will be encouraged in the field of medical research for new molecules / vaccines.

4.13 ROLE OF THE PRIVATE SECTOR

4.13.1 NHP-2001 envisages the enactment of suitable legislations for regulating minimum infrastructure and quality standards by 2003, in clinical establishments/medical institutions; also, statutory guidelines for the conduct of clinical practice and delivery of medical services are to be developed over the same period. The policy also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages.

4.13.2 To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as 'deemed exports' and will be made eligible for all fiscal incentives extended to export earnings.

4.13.3 NHP-2001 envisages the co-option of the non-governmental practitioners in the national disease control programmes so as to ensure that standard treatment protocols are followed in their day-to-day practice.

4.13.4 NHP-2001 recognizes the immense potential of use of information technology applications in the area of tele-medicine in the tertiary health care sector. The use of this technical aid will greatly enhance the capacity for the professionals to pool their clinical experience.

4.14 ROLE OF THE CIVIL SOCIETY

4.14.1 NHP-2001 recognizes the significant contribution made by NGOs and other institutions of the civil society in making available health services to the community. In order to utilize on an increasing scale, their high motivational skills, NHP-2001 envisages that the disease control programmes should earmark a definite portion of the budget in respect of identified programme components, to be exclusively implemented through these institutions.

4.15 NATIONAL DISEASE SURVEILLANCE NETWORK

4.15.1 NHP-2001 envisages the full operationalization of an integrated disease control network from the lowest rung of public health administration to the Central Government, by 2005. The programme for setting up this network will include components relating to installation of data-base handling hardware; IT inter-connectivity between different tiers of the network; and, in-house training for data collection and interpretation for undertaking timely and effective response.

4.16 HEALTH STATISTICS

4.16.1 NHP-2001 envisages the completion of baseline estimates for the incidence of the common diseases – TB, Malaria, Blindness – by 2005. The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology. The policy also recognizes the need to establish in a longer time frame, baseline estimates for : the non-communicable diseases, like CVD, Cancer, Diabetes; accidental

injuries; and other communicable diseases, like Hepatitis and JE. NHP-2001 envisages that, with access to such reliable data on the incidence of various diseases, the public health system would move closer to the objective of evidence-based policy making.

4.16.2 In an attempt at consolidating the data base and graduating from a mere estimation of annual health expenditure, NHP-2001 emphasis on the needs to establish national health accounts, conforming to the 'source-to-users' matrix structure. Improved and comprehensive information through national health accounts and accounting systems would pave the way for decision makers to focus on relative priorities, keeping in view the limited financial resources in the health sector.

4.17 WOMEN'S HEALTH

4.17.1 NHP-2001 envisages the identification of specific programmes targeted at women's health. The policy notes that women, along with other under privileged groups are significantly handicapped due to a disproportionately low access to health care. The various Policy recommendations of NHP-2001, in regard to the expansion of primary health sector infrastructure, will facilitate the increased access of women to basic health care. NHP-2001 commits the highest priority of the Central Government to the funding of the identified programmes relating to woman's health. Also, the policy recognizes the need to review the staffing norms of the public health administration to more comprehensively meet the specific requirements of women.

4.18 MEDICAL ETHICS

4.18.1 NHP – 2001 envisages that, in order to ensurethat the common patient is not subjected to irrational or profit-driven medical regimens, a contemporary code of ethics be notified and rigorously implemented by the Medical Council of India.

4.18.2 NHP – 2001 does not offer any policy prescription at this stage relating to ethics in the conduct of medical research. By and large medical research within the country is limited in these frontier disciplines of gene manipulation and stem cell research. However, the policy recognises that a vigilant watch will have to be kept so that appropriate guidelines and statutory provisions are put in place when medical research in the country reaches the stage to make such issues relevant.

4.19 ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS

4.19.1 NHP – 2001 envisages that the food and drug administration will be progressively strengthened, both in terms of laboratory facilities and technical expertise. Also, the policy envisages that the standards of food items will be progressively tightened at a pace which will permit domestic food handling / manufacturing facilities to undertake the necessary upgradation of technology so as not to be shut out of this production sector. The policy envisages that, ultimately food standards will be close, if not equivalent, to codex specifications; and drug standards will be at par with the most rigorous ones adopted elsewhere.

4.20 REGULATION OF STANDARDS IN PARAMEDICAL DISCIPLINES

4.20.1 NHP-2001 recognises the need for the establishment of statutory professional

councils for paramedical disciplines to register practitioners. maintain standards of training, as well as to monitor their performance.

4.21 OCCUPATIONAL HEALTH

4.21.1 NHP-2001 envisages the periodic screening of the health conditions of the workers, particularly for high risk health disorders associated with their occupation.

4.22 PROVIDING MEDICAL FACILITIES TO USERS FROM OVERSEAS

4.22.1 NHP-2001 strongly encourages the providing of health services on a commercial basis to service seekers from overseas. The providers of such services to patients from overseas will be encouraged by extending to their earnings in foreign exchange, all fiscal incentives available to other exporters of goods and services.

4.23 IMPACT OF GLOBALISATION ON THE HEALTH SECTOR

4.23.1 NHP-2001 takes into account the serious apprehension expressed by several health experts, of the possible threat to the health security, in the post TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines. To protect the citizens of the country from such a threat, NHP-2001 envisages a national patent regime for the future which, while being consistent with TRIPS, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries. The Policy also sets out that the Government will bring to bear its full influence in all international fora – UN, WHO, WTO, etc. – to secure commitments on the part of the Nations of the Globe, to lighten the restrictive features of TRIPS in its application to the health care sector.

5. SUMMATION

5.1 The crafting of a National Health Policy is a rare occasion in public affairs when it would be legitimate, indeed valuable, to allow our dreams to mingle with our understanding of ground realities. Based purely on the clinical facts defining the current status of the health sector, we would have arrived at a certain policy formulation; but, buoyed by our dreams, we have ventured slightly beyond that in the shape of NHP-2001 which, in fact, defines a vision for the future.

5.2 The health needs of the country are enormous and the financial resources and managerial capacity available to meet it, even on the most optimistic projections, fall somewhat short. In this situation, NHP-2001 has had to make hard choices between various priorities and operational options. NHP-2001 does not claim to be a road-map for meeting all the health needs of the populace of the country. Further, it has to be recognized that such health needs are also dynamic as threats in the area of public health keep changing over time. The Policy, while being holistic, undertakes the necessary risk of recommending differing emphasis on different policy components. Broadly speaking, NHP – 2001 focuses on the need for enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also, the policy is focused on those diseases which are principally contributing to the disease burden – TB, Malaria and Blindness from the category of historical diseases; and HIV/AIDS from the category of 'newly emerging

diseases'. This is not to say that other items contributing to the disease burden of the country will be ignored: but only that, resources as also the principal focus of the public health administration, will recognize certain relative priorities.

5.3 One nagging imperative, which has influenced every aspect of NHP-2001, is the need to ensure that 'equity' in the health sector stands as an independent goal. In any future evaluation of its success or failure, NHP-2001 would like to be measured against this equity norm, rather than any other aggregated financial norm for the health sector. Consistent with the primacy given to 'equity', a marked emphasis has been provided in the policy for expanding and improving the primary health facilities, including the new concept of provisioning of essential drugs through Central funding. The Policy also commits the Central Government to increased under-writing of the resources for meeting the minimum health needs of the citizenry. Thus, the Policy attempts to provide guidance for prioritizing expenditure, thereby, facilitating rational resource allocation.

5.4 NHP-2001 highlights the expected roles of different participating group in the health sector. Further, it recognizes the fact that, despite all that may be guaranteed by the Central Government for assisting public health programmes, public health services would actually need to be delivered by the State administration, NGOs and other institutions of civil society. The attainment of improved health indices would be significantly dependent on population stabilisation, as also on complementary efforts from other areas of the social sectors – like improved drinking water supply, basic sanitation, minimum nutrition, etc. - to ensure that the exposure of the populace to health risks is minimized.

Suggestions on the draft policy are welcome. Kindly mail your suggestions to aeabop@nb.nic.in within 30 days.

ಮುಂದಿನ ದಿನಗಳಲ್ಲಿ / FOLLOW UP

ಮುಂದಿನ ದಿನಗಳಲ್ಲಿ / FOLLOW UP

ಕರ್ನಾಟಕ ಸರ್ಕಾರ
ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ
ಬೇರೆ ಆಸ್ಪತ್ರೆಗಳಿಗೆ ರೋಗಿಗಳನ್ನು ಕಳುಹಿಸಿದಾಗ ನೀಡುವ

ಉಲ್ಲೇಖನ ಪತ್ರ
REFERRAL CARD

ಆಸ್ಪತ್ರೆ / Referring Hospital :

_____

ಉಲ್ಲೇಖಿಸಲಾಗಿದ್ದ ಆಸ್ಪತ್ರೆ ಹೆಸರು / Name of Referred hospital :

_____

ರೋಗಿಯ ಹೆಸರು / Patient's Name :

_____

ತಂದೆ / ಗಂಡನ ಹೆಸರು / Father / Husband's Name :

_____

ವಯಸ್ಸು / Age : ಲಿಂಗ / Sex : _____

ವಿಳಾಸ / Address :
ಮನೆ ಸಂಖ್ಯೆ / House No. : _____

_____

ಗ್ರಾಮ / Village : _____

ತಾಲ್ಲೂಕು / Taluk : _____

ಜಿಲ್ಲೆ / District : _____

ಕಾರ್ಯನಂತರದ ಮಾಹಿತಿ
FEEDBACK INFORMATION

ರೋಗದ ತಾತ್ಕಾಲಿಕ ತಿರ್ಮಾನ
(Examination findings & Provisional Diagnosis)

ಉಲ್ಲೇಖಿಸುತ್ತಿರುವ ಆಸ್ಪತ್ರೆಯವರು ತುಂಬಬೇಕಾದ ವಿವರ
I. To be filled by Referral Unit

ರೋಗಿಯ ಬಂದ ದಿನಾಂಕ ಮತ್ತು ಸಮಯ
Date & Time of receiving patients

ವೈದ್ಯರು / ಉಲ್ಲೇಖಿಸುವ ವಿಭಾಗ
Doctor / Dept. to whom referred

ಉಲ್ಲೇಖನದ ಉದ್ದೇಶ
(Purpose of Referral)

ಸಹಿ / Signature

ಉಲ್ಲೇಖಿತ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ಚಿಕಿತ್ಸೆ ಮಾಡುತ್ತಿರುವ ವೈದ್ಯರು ಬಿಡುಗಡೆ ಮಾಡುವ ಸಮಯದಲ್ಲಿ ತುಂಬಬೇಕಾದ ವಿವರ
II. (to be filled by attending Doctor, referral unit at time of Discharge)

ಪರಿಕ್ಷೆಗಳ ವಿವರಗಳು
(Investigations done / reports)

1. ರೋಗಿಯ ಸ್ಥಿತಿ / Condition of Patient

2. ಸಲಹೆ ಮಾಡಿರುವ ಬಗ್ಗೆ / Investigations done

ರೋಗಿಗೆ ಸ್ಥಿರೀಕರಣ ಚಿಕಿತ್ಸೆ ಮಾಡಿದ ವಿವರಗಳು
Treatment given for stabilizing patient

3. ಸಲಹೆ ಮಾಡಿದ ಚಿಕಿತ್ಸೆ / Treatment Advised

ವೇಳೆ / Time :
ದಿನಾಂಕ / Date :

4. ಮತ್ತೆ ಬರಬೇಕಾದ ದಿನಾಂಕ / Date of Review

ಕಳುಹಿಸುತ್ತಿರುವ ವೈದ್ಯರ ಸಹಿ
(Signature)

ದಿನಾಂಕ / Date :
ಸಹಿ / Signature :

ಮುಂದಿನ ದಿನಗಳಲ್ಲಿ / FOLLOW UP

Printed and Binded on RISO at
Project Secretariat, KHSDP

ಮುಂದಿನ ದಿನಗಳಲ್ಲಿ / FOLLOW UP

ಮುಂದಿನ ದಿನಗಳಲ್ಲಿ / FOLLOW UP

ಕರ್ನಾಟಕ ಸರ್ಕಾರ
ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ
ಬೇರೆ ಆಸ್ಪತ್ರೆಗಳಿಗೆ ರೋಗಿಗಳನ್ನು ಕಳುಹಿಸಿದಾಗ ನೀಡುವ

ಉಲ್ಲೇಖಿನ ಪತ್ರ
REFERRAL CARD

ಆಸ್ಪತ್ರೆ / Reffering Unit :

ಉಲ್ಲೇಖಿಸಲಾಗಿರುವ ಆಸ್ಪತ್ರೆ / Institution to which referred :_____

ಹೆಸರು / Name :_____

ತಂದೆ/ಗಂಡನ ಹೆಸರು / Father/Husband's Name :_____

ವಯಸ್ಸು / Age: ಲಿಂಗ / Sex:

ವಿಳಾಸ / Address: _____

_____

ಮನೆ ಸಂಖ್ಯೆ / House. No:_____

ಗ್ರಾಮ / Village:_____

ತಾಲ್ಲೂಕು / Taluk:_____

ಜಿಲ್ಲೆ / District:_____

ಮುಖ್ಯ ತೊಂದರೆಗಳು
(MAIN COMPLAINTS)

ರೋಗಲಕ್ಷಣಾ ವಿವರಗಳು
(CLINICAL FINDINGS)

ಪರೀಕ್ಷೆಗಳ ವಿವರಗಳು
(INVESTIGATIONS DONE / REPORTS)

ರೋಗಿಗೆ ಸ್ಥಿರೀಕರಣ ಚಿಕಿತ್ಸೆ ಮಾಡಿದ ವಿವರಗಳು
Treatment given for stabilizing patient

ವೇಳೆ / Time:
ದಿನಾಂಕ / Date:

ಕಳುಹಿಸುತ್ತಿರುವ ವೈದ್ಯರ ಸಹಿ
(Signature)

ಉಲ್ಲೇಖಿಸುತ್ತಿರುವ ಆಸ್ಪತ್ರೆಯವರು ತುಂಬಬೇಕಾದ ವಿವರ
I. To be filled by Referral Unit

ರೋಗಿಯು ಬಂದ ದಿನಾಂಕ ಮತ್ತು ಸಮಯ
Date & Time of receiving patients

ವೈದ್ಯರು / ಉಲ್ಲೇಖಿಸುವ ವಿಭಾಗ
Doctor / Dept. to whom referred

ಸಹಿ / Signature

ಉಲ್ಲೇಖಿತ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ಚಿಕಿತ್ಸೆ ನೂಡುತ್ತಿರುವ ವೈದ್ಯರು ಬಿಡುಗಡೆ ಮಾಡುವ ಸಮಯದಲ್ಲಿ ತುಂಬಬೇಕಾದ ವಿವರ
II. (to be filled by attending Doctor, referral unit at time of Discharge

1. ರೋಗಿಯ ಸ್ಥಿತಿ
1. Condition of Patient

2. ಪರೀಕ್ಷೆಗಳು ಮಾಡಿರುವ ಬಗ್ಗೆ
2. Investigations done

3. ಸಲಹೆ ಮಾಡಿದ ಚಿಕಿತ್ಸೆ
3. Treatment Advised

4. ಮತ್ತೆ ಬರಬೇಕಾದ ದಿನಾಂಕ
4. Date of Review

ದಿನಾಂಕ / Date:
ಸಹಿ / Signature;

ಮುಂದಿನ ದಿನಗಳಲ್ಲಿ / FOLLOW UP

KHSDP

RISO

NP 18

ಪೂರಕ ಟಿಪ್ಪಣಿ

198- ರಿಂದ 2000ನೇ ವರ್ಷದ ಆಗಸ್ಟ್ ತಿಂಗಳ ಅಂತ್ಯದವರೆಗೆ 613 ಮಂದಿ ಏಡ್ಸ್‌ನಿಂದ ಬಳಲುತ್ತಿದ್ದು, 106 ಮಂದಿ ಏಡ್ಸ್‌ನಿಂದ ಮೃತಪಟ್ಟಿರುತ್ತಾರೆ. ಹೆಚ್‌ಐವಿ ಸೋಂಕು ಪ್ರಕರಣಗಳು ಸ್ವಯಂ ಪ್ರೇರಿತ ಪರೀಕ್ಷಾ ಕೇಂದ್ರಗಳಿಂದ ವರದಿಯಾಗುತ್ತದೆ. ಈ ಕೇಂದ್ರಗಳು ಹೆಚ್‌ಐವಿ/ಏಡ್ಸ್ ಬಗ್ಗೆ ಸಮೀಕ್ಷೆ ನಡೆಸುತ್ತವೆ ಅಲ್ಲದೆ ಪ್ರತಿ ವರ್ಷ 3 ತಿಂಗಳ ಸಮಯದಲ್ಲಿ ಅಂದರೆ ಆಗಸ್ಟ್, ಅಕ್ಟೋಬರ್ ತಿಂಗಳುಗಳಲ್ಲಿ ಸೆಂಟಿನೆಲ್ ಸಮೀಕ್ಷೆಗಳನ್ನು 14 ನಿಗದಿತ ಕೇಂದ್ರಗಳಲ್ಲಿ ಮಾಡಲಾಗುವುದು. ಈ ಸಮೀಕ್ಷೆಗಳಿಂದ ಹೆಚ್ಚಿಗೆ ತೊಂದರೆಗೆ ಒಳಗಾಗುವ ಗುಂಪುಗಳಲ್ಲಿ ಹಾಗೂ ಸಾಮಾನ್ಯ ಜನರಲ್ಲಿಯೂ ಕೂಡಾ ನಡೆಸಲಾಗುವುದು, ಇದರಿಂದಾಗಿ ಈ ಗುಂಪುಗಳಲ್ಲಿ ಹೆಚ್‌ಐವಿ ಸೋಂಕಿನ ಪರಿಮಾಣವನ್ನು ತಿಳಿಯಲಾಗುವುದು ಹಾಗೂ ಹೆಚ್‌ಐವಿ ಸೋಂಕು ಹೆಚ್ಚುತ್ತಿರುವ ಬಗ್ಗೆ ಮಾಹಿತಿಯನ್ನು ಪಡೆಯಲಾಗುವುದು.

ಜಿಲ್ಲಾವಾರು ವಿವರಗಳು ಈ ಕೆಳಕಂಡಂತಿದೆ.

198- ರಿಂದ 2000ನೇ ವರ್ಷದ ಆಗಸ್ಟ್ ತಿಂಗಳ ಅಂತ್ಯದವರೆಗೆ ಏಡ್ಸ್ ರೋಗದಿಂದ ಬಳಲುತ್ತಿರುವವರ ಹಾಗೂ ಮೃತಪಟ್ಟವರ ಜಿಲ್ಲಾವಾರು ಸಂಖ್ಯೆಗಳು ಈ ಕೆಳಕಂಡಂತಿದೆ.

ಕ್ರಮ ಸಂಖ್ಯೆ	ವಿಭಾಗ/ಜಿಲ್ಲೆಗಳು	ಹೆಚ್.ಐ.ವಿ ಸೋಂಕು ಪ್ರಕರಣ	ಏಡ್ಸ್ ರೋಗದಿಂದ ಬಳಲುತ್ತಿರುವವರು	ಮೃತ ಪಟ್ಟವರು
ಬೆಂಗಳೂರು ವಿಭಾಗ				
1	ಬೆಂಗಳೂರು ನಗರ	2685	100	28
2	ಬೆಂಗಳೂರು ಗ್ರಾಮಾಂತರ	178	9	4
3	ತುಮಕೂರು	156	11	1
4	ಶಿವಮೊಗ್ಗ	170	29	2
5	ಚಿತ್ರದುರ್ಗ	117	7	2
6	ರಾಮನಗರ	33	7	0
-	ಕೋಲಾರ	150	11	2
ಮೈಸೂರು ವಿಭಾಗ				
8	ಮೈಸೂರು	122	10	5
9	ಚಾಮರಾಜನಗರ	3	1	0
10	ಮಂಡ್ಯ	272	18	5
11	ಮಂಗಳೂರು	743	16	9
12	ಉಡುಪಿ	437	120	10
13	ಮಡಿಕೇರಿ	11	2	1
14	ಚಿಕ್ಕಮಗಳೂರು	81	11	2
15	ಹಾಸನ	103	9	2
ಬೆಳಗಾಂ ವಿಭಾಗ				
16	ಬೆಳಗಾಂ	85	9	0
17	ಬಿಜಾಪುರ	114	0	0
18	ಬಾಗಲಕೋಟೆ	9	3	0
19	ಧಾರವಾಡ	268	119	4
20	ಹಾವೇರಿ	23	13	1
21	ಗದಗ್	12	4	0
22	ಕಾರವಾರ	171	35	5

ಗುಲ್ಬರ್ಗಾ ವಿಭಾಗ				
23	ಗುಲ್ಬರ್ಗಾ	63	4	3
24	ರಾಯಚೂರು	144	11	5
25	ಬೀದರ್	7	2	2
26	ಬಳ್ಳಾರಿ	508	9	0
27	ಕೊಪ್ಪಳ	18	2	0
	ಒಟ್ಟು	6682	562	93
1	ಹೊರ ರಾಜ್ಯದವರು	509	47	9
2	ವಿದೇಶಿಯರು	15	4	4
	ಒಟ್ಟು	7206	613	106

ಹೆಚ್‌ಐವಿ/ಏಡ್ಸ್ ರೋಗ ಪ್ರಕರಣಗಳನ್ನು ಪತ್ತೆಮಾಡುವ ವಿಧಾನವನ್ನು ಭಾರತ ಸರ್ಕಾರದ ಮಾರ್ಗದರ್ಶನದ ಮೇರೆಗೆ ಮಾಡಲಾಗುವುದು. ಈ ವಿಷಯದಲ್ಲಿ ಯಾವುದೇ ಒಂದು ವ್ಯಕ್ತಿಗೆ ಪರೀಕ್ಷೆಗೆ ಒಳಪಡಿಸಲು ಅವರಿಗೆ ಮುಂಚಿತವಾಗಿ ಹಾಗೂ ಪರೀಕ್ಷೆಯ ನಂತರ ಸೂಕ್ತ ತಿಳುವಳಿಕೆಗಳನ್ನು ನೀಡಬೇಕಾಗಿದೆ ಹಾಗೂ ಪರೀಕ್ಷೆಗೆ ಅವರ ಒಪ್ಪಿಗೆಯನ್ನು ಕೂಡಾ ಪಡೆಯಬೇಕಾಗಿದೆ. ಏಡ್ಸ್ ರೋಗದ ಬಗ್ಗೆ ಜನ ಸಮುದಾಯದಲ್ಲಿ ತಳಂಕ ಮತ್ತು ತಾರತಮ್ಯತೆ ಹಾಗೂ ಸಹಿಸದ ಇರುವಂತಹ ಪರಿಸ್ಥಿತಿಗಳ ಪರಿಣಾಮದಿಂದಾಗಿ ಪರೀಕ್ಷಾ ಪದ್ಧತಿಗಳನ್ನು ಗೋಪ್ಯತೆಯಿಂದ ಇಡಲಾಗುವುದು ಹಾಗೂ ಕೇವಲ ಪರೀಕ್ಷೆಗೆ ಒಳಪಡುವ ವ್ಯಕ್ತಿಗೆ ಅಥವಾ ಅವರ ಹತ್ತಿರದ ಕುಟುಂಬ ವರ್ಗದವರಿಗೆ ತಿಳಿಸಲಾಗುವುದು. ಈ ವಿಷಯದಲ್ಲಿ ಪರೀಕ್ಷಾ ಕೇಂದ್ರಗಳಿಂದ ಹೆಚ್‌ಐವಿ/ಏಡ್ಸ್ ರೋಗಿಗಳ ಬಗ್ಗೆ, ವಯಸ್ಸು, ಲಿಂಗ ಮತ್ತು ಯಾವ ಜಿಲ್ಲೆಗೆ ಸಂಬಂಧಿಸಿದವರು ಎಂಬ ಮಾಹಿತಿ ಮಾತ್ರ ವರದಿ ಮಾಡಲಾಗುವುದು ಹಾಗೂ ಹೆಸರು ಮತ್ತು ವಿಳಾಸಗಳನ್ನು ಗೌಪ್ಯವಾಗಿ ಇಡಲಾಗುವುದು.

ಇತ್ತೀಚೆಗೆ ಮಾಡಲಾದ ಅಂದಾಜಿನ ಮೇರೆಗೆ ರಾಜ್ಯದಲ್ಲಿ ಎರಡು ಲಕ್ಷ ಜನರಿಗಿಂತಲೂ ಹೆಚ್ಚಿನವರಲ್ಲಿ ಹೆಚ್‌ಐವಿ ಸೋಂಕಿಗೆ ಒಳಗಾಗಿರುವುದು ಗಮನಕ್ಕೆ ಬಂದಿದೆ. ಆದರೆ ಸಮರ್ಪಕವಾಗಿ ಅಂದಾಜಿನ ಅಂಕಿ ಅಂಶಗಳು ಲಭ್ಯವಿಲ್ಲ.

ಕರ್ನಾಟಕ ರಾಜ್ಯದಲ್ಲಿ ಏಡ್ಸ್ ರೋಗ ನಿಯಂತ್ರಣದ ಸಲುವಾಗಿ ರಾಷ್ಟ್ರೀಯ ಏಡ್ಸ್ ನಿಯಂತ್ರಣ ಕಾರ್ಯಕ್ರಮವನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲಾಗಿದೆ. ಈ ಕಾರ್ಯಕ್ರಮವು ಶೇಕಡಾ 100 ರಷ್ಟು ಕೇಂದ್ರ ಪುರಸ್ಕೃತ ಯೋಜನೆ ಹಾಗೂ ವಿಶ್ವಬ್ಯಾಂಕ್ ನೆರವಿನಿಂದ ಭಾರತ ಸರ್ಕಾರವು ಅನುದಾನವನ್ನು ಬಿಡುಗಡೆ ಮಾಡುತ್ತಿದೆ. ಈ ಕಾರ್ಯಕ್ರಮದ ಮುಖ್ಯ ಉದ್ದೇಶ ಜನಸಾಮಾನ್ಯರಲ್ಲಿ ಏಡ್ಸ್ ಸೋಂಕು ಹರಡುವುದನ್ನು ತಡೆಗಟ್ಟುವುದು ಹಾಗೂ ಜನಸಾಮಾನ್ಯರಲ್ಲಿ ಹೆಚ್‌ಐವಿ/ಏಡ್ಸ್ ನ ಬಗ್ಗೆ ಅರಿವು ಮೂಡಿಸುವುದು ಮುಖ್ಯ ಉದ್ದೇಶವಾಗಿದೆ. ಸದರಿ ಕಾರ್ಯಕ್ರಮದ ಕಾರ್ಯಚಟುವಟಿಕೆಗಳನ್ನು ಭಾರತ ಸರ್ಕಾರದ ರಾಷ್ಟ್ರೀಯ ಏಡ್ಸ್ ನಿಯಂತ್ರಣ ಸಂಸ್ಥೆಯ ಮಾರ್ಗದರ್ಶನದಲ್ಲಿ ಅನುಷ್ಠಾನಗೊಳಿಸಲಾಗುತ್ತಿದೆ. ಈ ವಿಷಯದಲ್ಲಿ ಎಲ್ಲಾ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಕಾಲಾನುಕಾಲಕ್ಕೆ ಸರಿಯಾಗಿ ಅನುಷ್ಠಾನಗೊಳಿಸಲು ಅನುಕೂಲವಾಗುವಂತೆ ರಾಜ್ಯ ಏಡ್ಸ್ ಪ್ರಿವೆನ್‌ಷನ್ ಸೊಸೈಟಿಯನ್ನು 1997 ರಿಂದ ಈಚೆಗೆ ಸ್ಥಾಪಿಸಲಾಗಿದೆ.

ರಾಷ್ಟ್ರೀಯ ಏಡ್ಸ್ ನಿಯಂತ್ರಣ ಯೋಜನೆಯ ಉದ್ದೇಶಗಳು:

1. ಕರ್ನಾಟಕ ರಾಜ್ಯದಲ್ಲಿ ಹೆಚ್‌ಐವಿ ಸೋಂಕು ಹರಡುವುದನ್ನು ಕಡಿಮೆಗೊಳಿಸುವುದು.
2. ಹೆಚ್‌ಐವಿ/ಏಡ್ಸ್ ಬಗ್ಗೆ ಕ್ರಮ ಕೈಗೊಳ್ಳುವಲ್ಲಿ ಕರ್ನಾಟಕ ರಾಜ್ಯದ ಪ್ರಯತ್ನಗಳನ್ನು ಬಲಗೊಳಿಸುವುದು.

ಯೋಜನೆಯ ಮುಂಜಾಗ್ರತಾ ಕ್ರಮಗಳು:

1. ಕರ್ನಾಟಕ ರಾಜ್ಯದ ಜನತೆಯಲ್ಲಿ ಹೆಚ್‌ಐವಿ ಪ್ರಿವೆಲನ್ಸ್ ದರವನ್ನು ಶೇಕಡಾ 3 ಕ್ಕಿಂತ ಕಡಿಮೆಗೊಳಿಸುವುದು.
2. ರಕ್ತದಾನದ ಮುಖಾಂತರ ಹೆಚ್‌ಐವಿ ಸೋಂಕು ಹರಡುವುದನ್ನು ಶೇಕಡಾ 1 ಕ್ಕಿಂತಲೂ ಕಡಿಮೆಗೊಳಿಸುವುದು.
3. ಜನಸಾಮಾನ್ಯರಲ್ಲಿ ಹಾಗೂ ಯುವಕರಲ್ಲಿ ಮತ್ತು ಗೃಹಕಾಯ ವಯಸ್ಸಿನವರಲ್ಲಿ ಶೇಕಡಾ 90 ರಷ್ಟು ಅರಿವು ಮೂಡಿಸುವುದು

4. ಹೆಚ್ಚಾಗಿ ಹೆಚ್‌ಐವಿ ಸೋಂಕಿನ ತೊಂದರೆಗೊಳಗಾಗುವಂತಹ ಸಮುದಾಯದ ಗುಂಪುಗಳಲ್ಲಿ ಶೇಕಡಾ 90 ರಷ್ಟು ನಿರೋಧ್ ಬಳಕೆಯನ್ನು ಉತ್ತೇಜಿಸುವುದು.

ಯೋಜನೆಯ ಕಾರ್ಯಚಟುವಟಿಕೆಗಳು:

ಕ್ರ.ಸಂ	ಕಾಂಪೋನೆಂಟ್ ಸಂಖ್ಯೆ	ವಿವರಗಳು
1	ಕಾಂಪೋನೆಂಟ್ - I	ನಿರ್ದಿಷ್ಟವಾದ ಗುಂಪುಗಳನ್ನು ಗುರ್ತಿಸಿ ಮುಂಜಾಗ್ರತಾ ಕ್ರಮಗಳನ್ನು ಕೈಗೊಳ್ಳುವುದು ಲೈಂಗಿಕ ರೋಗಗಳನ್ನು ಹಾಗೂ ಪ್ರಜನಾಂಗ ಮಾರ್ಗ ಸೋಂಕುಗಳಿಗೆ ಚಿಕಿತ್ಸೆ ಏರ್ಪಡಿಸುವುದು ಹಾಗೂ ನಿರೋಧ್ ಬಳಕೆಯನ್ನು ಉತ್ತೇಜಿಸುವುದು.
2	ಕಾಂಪೋನೆಂಟ್ - II	ಮಾಹಿತಿ , ಶಿಕ್ಷಣ ಸಂಪರ್ಕ , ರಕ್ತ ಸುರಕ್ಷತೆ ಮತ್ತು ಸ್ವಯಂ ಪ್ರೇರಿತ ತಪಾಸಣಾ 33ಕೇಂದ್ರಗಳು
3	ಕಾಂಪೋನೆಂಟ್ - III	ಸಾಂಸ್ಥಿಕ ಬಲವರ್ಧನೆ
4	ಕಾಂಪೋನೆಂಟ್ -IV	ಕಡಿಮೆ ವೆಚ್ಚದ ಸಮುದಾಯ ಚಿಕಿತ್ಸಾ ಆರೈಕೆ ಕೇಂದ್ರಗಳು ಮತ್ತು ಅವುಗಳ ಬಲವರ್ಧನೆ
5	ಕಾಂಪೋನೆಂಟ್ - V	ಸಮಾಜದ ಇತರೆ ಸಂಘ ಸಂಸ್ಥೆಗಳು ಹಾಗೂ ಕೈಗಾರಿಕಾ ಕೇಂದ್ರಗಳಲ್ಲಿ ಮತ್ತು ಶಾಲೆಗಳಲ್ಲಿ ಏಡ್ಸ್ ನಿಯಂತ್ರಣದ ಬಗ್ಗೆ ಮಾಹಿತಿ , ಶಿಕ್ಷಣ ಮತ್ತು ಇತರೆ ಚಟುವಟಿಕೆಗಳನ್ನು ಹಮ್ಮಿಕೊಳ್ಳುವುದು.

ಆರ್ಥಿಕ ವಿವರಣೆ:

ವರ್ಷ	ನ್ಯಾಕೋ ಸಂಸ್ಥೆಯ ಅನುಮೋದಿತ ಕಾರ್ಯಯೋಜನೆ	ನ್ಯಾಕೋ ಸಂಸ್ಥೆಯಿಂದ ಬಿಡುಗಡೆಯಾದ ಮೊತ್ತ ಮತ್ತು ಹಿಂದಿನ ವರ್ಷಗಳಿಂದ ಖರ್ಚಾಗದೆ ಬಾಕಿ ಉಳಿದ ಹಣ	ಖರ್ಚಾದ ಮೊತ್ತ	ಉಳಿಕೆ ಹಣ
1999-2000	ರೂ. 1067.70 ಲಕ್ಷಗಳು	ರೂ.950.28 ಲಕ್ಷಗಳು	ರೂ. 556.942 ಲಕ್ಷಗಳು	ರೂ. 393.34 ಲಕ್ಷಗಳು
2000-2001	ರೂ. 700.00 ಲಕ್ಷಗಳು	ರೂ.584.00 ಲಕ್ಷಗಳು	ರೂ. 318.00 ಲಕ್ಷಗಳು	ರೂ. 266.00 ಲಕ್ಷಗಳು

ಕರ್ನಾಟಕ ರಾಜ್ಯ ಎಡ್ಸ್ ಪ್ರಿವೆನ್‌ಷನ್ ಸೊಸೈಟಿ ಮುಖಾಂತರ ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳಿಗೆ ನಿರ್ದಿಷ್ಟ ಗುಂಪುಗಳಲ್ಲಿ ತೊಡಗಿಸಿಕೊಳ್ಳಲು ಸಹಕಾರ:

2000-2001 ನೇ ಸಾಲಿನಲ್ಲಿ ಒಟ್ಟು 18 ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು ಕೆಲವು ನಿರ್ದಿಷ್ಟ ಗುಂಪುಗಳಲ್ಲಿ (ಲಾರಿ ಚಾಲಕರು , ವೇಶ್ಯಾವಾಟಿಕೆಯಲ್ಲಿ ತೊಡಗಿರುವವರು , ಬೀದಿ ಮಕ್ಕಳು ಹಾಗೂ ಕೂಲಿ ಕಾರ್ಮಿಕರು ಮತ್ತು ಇತರರಲ್ಲಿ) ಹೆಚ್‌ಐವಿ/ಏಡ್ಸ್ ನಿಯಂತ್ರಣ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲು ಒಟ್ಟು ರೂ.16 ,21 ,695.00 ಗಳನ್ನು ಬಿಡುಗಡೆ ಮಾಡಲಾಗಿದೆ.

ಏಡ್ಸ್ ರೋಗ ನಿಯಂತ್ರಣಕ್ಕಾಗಿ ಮುನ್ನೆಚ್ಚರಿಕೆ ಕ್ರಮಗಳನ್ನು ಮಹಿಸಲು ಈ ಕೆಳಕಂಡ ಐದು ಸ್ವಯಂ ರಕ್ತ ತಪಾಸಣಾ ಕೇಂದ್ರಗಳನ್ನು ಸ್ಥಾಪಿಸಲಾಗಿದೆ.

1) ಏಕ್ಸೋರಿಯಾ ಆಸ್ಪತ್ರೆ , ಬೆಂಗಳೂರು
2) ರಾಷ್ಟ್ರೀಯ ಮಾನಸಿಕ ಆರೋಗ್ಯ ಮತ್ತು ನರ ವಿಜ್ಞಾನ ಸಂಸ್ಥೆ ಬೆಂಗಳೂರು (NIMHANS]
3) ಕಸ್ತೂರು ಘಾ ವೈದ್ಯಕೀಯ ವಿದ್ಯಾಲಯ , ಮಣಿಪಾಲ
4) ಕರ್ನಾಟಕ ವೈದ್ಯಕೀಯ ವಿದ್ಯಾಲಯ ಹುಬ್ಬಳಿ (KIMS)
5) ವೈದ್ಯಕೀಯ ವಿದ್ಯಾಲಯ , ಬಳ್ಳಾರಿ (VIMS)

ಈ ಕೇಂದ್ರಗಳಲ್ಲಿ ಹೆಚ್‌ಐವಿ ಸೋಂಕು ಪರೀಕ್ಷೆಗೆ ವ್ಯವಸ್ಥೆ ಕಲ್ಪಿಸಲಾಗಿದೆ ಹಾಗೂ ಸೋಂಕಿನ ಪರಿಮಾಣವನ್ನು ತಿಳಿಯಲು ಸಹಿಷ್ಣೆಗಳನ್ನು ನಡೆಸಲಾಗುತ್ತಿದೆ.

ರಕ್ತ ಸುರಕ್ಷತೆಗಾಗಿ 10 ವಲಯ ರಕ್ತ ತಪಾಸಣಾ ಕೇಂದ್ರಗಳನ್ನು ಈ ಕೆಳಕಂಡ ಆಸ್ಪತ್ರೆಗಳ ರಕ್ತನಿಧಿ ಕೇಂದ್ರಗಳಲ್ಲಿ ಸ್ಥಾಪಿಸಲಾಗಿದೆ.

1) ಕೆ ಸಿ ಜನರಲ್ ಆಸ್ಪತ್ರೆ ಬೆಂಗಳೂರು 2) ಹೆಚ್ ಎಸ್ ಐ ಎಸ್ ಘೋಷಾ ಆಸ್ಪತ್ರೆ ಬೆಂಗಳೂರು
3) ಕಿದ್ವಾಯಿ ಸ್ಮಾರಕ ಗಂಥಿ ಸಂಸ್ಥೆ 4) ಏರ್‌ಫೋರ್ಸ್ ಕಮಾಂಡ್ ಆಸ್ಪತ್ರೆ, ಬೆಂಗಳೂರು
5) ವೈದ್ಯಕೀಯ ಮಹಾವಿದ್ಯಾಲಯ, ಹುಬ್ಬಳಿ (KIMS)
6) ವೈದ್ಯಕೀಯ ಮಹಾವಿದ್ಯಾಲಯ, ಬಳ್ಳಾರಿ (VIMS)
7) ಜೆ ಎನ್ ವೈದ್ಯಕೀಯ ಮಹಾವಿದ್ಯಾಲಯ, ಬೆಳಗಾವಿ
8) ಎಂ ಆರ್ ವೈದ್ಯಕೀಯ ವಿದ್ಯಾಲಯ, ಗುಲ್ಬರ್ಗಾ
9) ಕಸ್ತೂರುಬಾ ವೈದ್ಯಕೀಯ ವಿದ್ಯಾಲಯ, ಮಂಗಳೂರು
10) ಕಸ್ತೂರುಬಾ ವೈದ್ಯಕೀಯ ವಿದ್ಯಾಲಯ, ಮಣಿಪಾಲ

ಎಲ್ಲಾ ರಕ್ತನಿಧಿ ಕೇಂದ್ರಗಳನ್ನು ಏಡ್ಸ್ ಸೋಂಕು ಪರೀಕ್ಷೆಗಾಗಿ ವಲಯ ರಕ್ತ ತಪಾಸಣಾ ಕೇಂದ್ರಗಳಿಗೆ ಜೋಡಣೆ ಮಾಡಲಾಗಿದೆ. ರಾಜ್ಯದಲ್ಲಿ ಒಟ್ಟು 52 ರಕ್ತನಿಧಿ ಕೇಂದ್ರಗಳನ್ನು ಹಂತ ಹಂತವಾಗಿ ಆಧುನೀಕರಣಗೊಳಿಸಲಾಗುತ್ತಿದೆ. ಜಿಲ್ಲಾ ಮಟ್ಟದ ರಕ್ತನಿಧಿ ಕೇಂದ್ರಗಳಿಗೆ ರಕ್ತಸುರಕ್ಷತೆಗಾಗಿ ತುರ್ತ ಪರಿಸ್ಥಿತಿಯಲ್ಲಿ ಪರೀಕ್ಷೆ ಸಲುವಾಗಿ ಹೆಚ್‌ಐವಿ ರ್ಯಾಪಿಡ್ ಟೆಸ್ಟ್ ಕಿಟ್‌ಗಳನ್ನು ಒದಗಿಸಲಾಗಿದೆ. ರಾಜ್ಯದಲ್ಲಿ ಖಿಂiಯ ಆಸ್ಪತ್ರೆಗಳ, ಜಿಲ್ಲಾ ಆಸ್ಪತ್ರೆಗಳ ಹಾಗೂ ತಾಲ್ಲೂಕು ಮಟ್ಟದ ಆಸ್ಪತ್ರೆಗಳ ಒಟ್ಟು 30 ಲೈಂಗಿಕ ಚಿಕಿತ್ಸಾಲಯಗಳನ್ನು ಫಲಪರ್ದನೆ ಮಾಡಲಾಗಿದೆ ಮತ್ತು ಚಿಕಿತ್ಸೆ ಜೊತೆಗೆ ಸುರಕ್ಷಿತ ಲೈಂಗಿಕತೆ ಬಗ್ಗೆ ತಿಳುವಳಿಕೆ ನೀಡಲಾಗುತ್ತಿದೆ.

ಏಡ್ಸ್ ನಿಯಂತ್ರಣದ ಬಗ್ಗೆ ಅರಿವು ಮೂಡಿಸಲು **ಮಾ**ಹಿತಿ ನೀಡಲು ಸಮೂಹ ಶಿಕ್ಷಣ ಸಂಪರ್ಕ ಚಟುವಟಿಕೆಗಳನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲಾಗಿದೆ. ಎಲ್ಲಾ ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಸಮರ್ಪಕವಾಗಿ ಸಂಸ್ಕರಣೆ ಮಾಡಿದ , ಸೂಜಿ , ಸಿರಿಂಜುಗಳನ್ನು ಮತ್ತು ಉಪಕರಣಗಳನ್ನು ಬಳಸಲು ಸೂಚಿಸಲಾಗಿದೆ. ಸಮೂಹ ಶಿಕ್ಷಣ ಸಂಪರ್ಕ ಚಟುವಟಿಕೆಗಳನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲು ಎಲ್ಲಾ ಮಾಧ್ಯಮಗಳನ್ನು ಬಳಗೊಂಡಂತೆ ಆಕಾಶವಾಣಿ , ದೂರದರ್ಶನ ಹಾಗೂ ಮುಖ್ಯ ದಿನಪತ್ರಿಕೆಗಳ ಮೂಲಕ ಸಂದೇಶಗಳನ್ನು ಹಾಗೂ ಜಾಹೀರಾತುಗಳನ್ನು ಫಿತ್ತರಿಸಲಾಗುತ್ತಿದೆ. ಅಲ್ಲದೆ ನಿರ್ಧಾರ್ಕ ಮತ್ತು ಪಿಳಗಾಗುವ ತನಕ್ಕ ಎಂಬ ಸಾಕ್ಷ್ಯ ಚಿತ್ರ ಹಾಗೂ ರಾಜ್ಯದಲ್ಲಿ ಮತಾಧೀಶರುಗಳ ಸಹಕಾರದಿಂದ ತಯಾರಿಸಲಾದ ಹೆಚ್‌ಐವಿ/ಏಡ್ಸ್ ನ ಬಗ್ಗೆ ಮಾಹಿತಿ ಇರುವ ಟಿ ವಿ ಸ್ಪಾಟುಗಳನ್ನು ತಯಾರಿಸಿ ಮೂರದರ್ಶನದ ಮೂಲಕ ವಿತ್ತರಿಸಲಾಗಿದೆ ಮತ್ತು ವಿಡಿಯೋ , ಆಡಿಯೋ ಕ್ಯಾಸೆಟ್ಟು ಕೂಡ ತಯಾರಿಸಿ ಜಿಲ್ಲಾ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಅಧಿಕಾರಿಗಳ ಮುಖಾಂತರ , ವಾರ್ತಾ ಮತ್ತು ಪ್ರಚಾರ ಇಲಾಖೆ ಮೂಲಕ ಹಾಗೂ ಭಾರತ ಸರ್ಕಾರದ ಫೀಲ್ಡ್ ಪಬ್ಲಿಸಿಟಿ ಇಲಾಖೆ ಮುಖಾಂತರವೂ ಕೂಡಾ ಪ್ರಚಾರ ಕಾರ್ಯಕ್ರಮವನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲಾಗಿದೆ. ಅಲ್ಲದೇ ಬೀಧಿ ನಾಟಕ ಇತ್ಯಾದಿಗಳ ಮೂಲಕ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲಾಗಿದೆ. ಪ್ರತಿ ವರ್ಷವೂ ಜನಸಾಮಾನ್ಯರಲ್ಲಿ ಹೆಚ್ಚಿನ ಅರಿವು ಮೂಡಿಸಲು ಅಕ್ಟೋಬರ್ ಒಂದನೇ ರಾಷ್ಟ್ರೀಯ ಸ್ವಯಂಪ್ರೇರಿತ ರಕ್ತದಾನ ದಿನಾಚರಣೆಯನ್ನು ಹಾಗೂ ಡಿಸೆಂಬರ್ ಒಂದನೇ ವಿಶ್ವ ಏಡ್ಸ್ ದಿನ ವನ್ನು ರಾಜ್ಯದಾದ್ಯಂತ ಆಚರಿಸಲಾಗತ್ತಿದೆ. ಅಲ್ಲದೆ ವಿಶೇಷವಾಗಿ 199-2000ನೇ ಸಾಲಿನಲ್ಲಿ 14 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಕುಟುಂಬ ಆರೋಗ್ಯ ಅರಿವು ಅಂಡೋಲನವನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲಾಗಿತ್ತು. ಹಾಗೂ 2000-2001 ನೇ ಸಾಲಿನಲ್ಲಿ ಮುಲೈ 1 ರಿಂದ 15 ರ ವರೆಗೆ ರಾಜ್ಯದ 27 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಕುಟುಂಬ ಆರೋಗ್ಯ ಅರಿವು ಅಂಡೋಲನವನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲಾಗಿದೆ.

ಕುಟುಂಬ ಆರೋಗ್ಯ ಅರಿವು ಅಂಡೋಲನ ಕಾರ್ಯಕ್ರಮದಡಿಯಲ್ಲಿ ಜನಸಾಮಾನ್ಯರಲ್ಲಿ ನಗರ ಹಾಗೂ ಗ್ರಾಮಾಂತರ ಪ್ರದೇಶದಲ್ಲಿ ಹೆಚ್‌ಐವಿ/ಏಡ್ಸ್ ಹಾಗೂ ಲೈಂಗಿಕ ರೋಗಗಳ ನಿಯಂತ್ರಣದ ಬಗ್ಗೆ ಅರಿವು ಮೂಡಿಸುವ ಕಾರ್ಯಕ್ರಮವನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲಾಗಿದೆ. ಅಲ್ಲದೆ ಲೈಂಗಿಕ ರೋಗಗಳಿಗೆ ಮತ್ತು ಪ್ರಜನಾಂಗ ರೋಗಗಳ ಸೋಂಕುಗಳಿಗೆ ಚಿಕಿತ್ಸೆ ನೀಡುವ ವ್ಯವಸ್ಥೆಯನ್ನು ಎಲ್ಲಾ ಸರ್ಕಾರಿ ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಹಾಗೂ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಲ್ಲಿ ಕಲ್ಪಿಸಲಾಗಿದೆ. ಲೈಂಗಿಕ ರೋಗ ಸೋಂಕುಗಳು ಮತ್ತು ಪ್ರಜನಾಂಗ ಸೋಂಕುಗಳಿಗೆ ಪ್ರಾಥಮಿಕ ಹಂತದಲ್ಲಿಯೇ ಆರೋಗ್ಯ ಕಾರ್ಯಕರ್ತರುಗಳ ಮುಖಾಂತರ ಗುರ್ತಿಸಿ ಚಿಕಿತ್ಸೆ ಪಡೆಯಲು ಜನಸಾಮಾನ್ಯರಲ್ಲಿ ಮನವೊಲಿಸುವ ಮುಖಾಂತರ ಚಿಕಿತ್ಸೆ ವ್ಯವಸ್ಥೆಯನ್ನು ಅವ್ಯತೆಯ ಮೇರೆಗೆ ಕಲ್ಪಿಸಲಾಗಿದೆ. ಅವರಲ್ಲೂ ಹೆಚ್ಚಾಗಿ ಏಡ್ಸ್ ಸೋಂಕಿನ ತೊಂದರೆಗೆ ಒಳಗಾಗುವ ಗುಂಪುಗಳನ್ನು ಗುರ್ತಿಸಿ ಅಂತಹ ಸಮುದಾಯದಲ್ಲಿ

ಹೆಚ್.ಐ.ವಿ/ಏಡ್ಸ್ ನಿಯಂತ್ರಣದ ಬಗ್ಗೆ ಮಾಹಿತಿಗಳನ್ನು ಸ್ವಯಂ ಸೇವಾ ಸಂಸ್ಥೆಗಳ ಮುಖಾಂತರ ಒದಗಿಸಲು ಕ್ರಮ ಕೈಗೊಳ್ಳಲಾಗಿದೆ. ಅಲ್ಲದೆ ಅಂತಹ ಗುಂಪುಗಳಲ್ಲಿ ಹೆಚ್ಚಐವಿ/ಏಡ್ಸ್ ಪರಡದಂತೆ ಮುಂಜಾಗ್ರತಾ ಕ್ರಮಗಳನ್ನು ಅನುಸರಿಸುವಂತೆ ಕಾಯಕ್ರಮಗಳನ್ನು ಹಮ್ಮಿಕೊಳ್ಳಲಾಗಿದೆ.

ಏಡ್ಸ್ ರೋಗದ ಬಗ್ಗೆ ಜಾಗೃತಿಯನ್ನು ಮೂಡಿಸಲು ಕೇಂದ್ರ ಸರ್ಕಾರದಿಂದ 2000-2001ನೇ ಸಾಲಿಗೆ ರೂ.223.61 ಲಕ್ಷ ಅನುದಾನ ಒದಗಿಸಲಾಗಿದ್ದು , ರೂ.115.74 ಲಕ್ಷ ಗಳು 30 ಸೆಪ್ಟೆಂಬರ್ 2000 ಅಂತ್ಯಕ್ಕೆ ಖರ್ಚು ಮಾಡಲಾಗಿದೆ. ವಿವರಗಳು ಈ ಕೆಳಕಂಡಂತಿವೆ.

(ರೂ.ಗಳಲ್ಲಿ)

1	ವಿಶ್ವ ಆರೋಗ್ಯ ದಿನಾಚರಣೆ	10,45,553.00
2	ಕುಟುಂಬ ಆರೋಗ್ಯ ಅರಿವು ಅಂದೋಲನ	85,86,504.00
3	ಆಕಾಶವಾಣಿ	2,58,300.00
4	ಮೂರಮರ್ಶನ	6,30,000.00
5	ಕೋಸ್ ಸರ್ಕೂಟ್ ಟೆಲಿವಿಷನ್ ನೆಟ್‌ವರ್ಕ್	3,82,032.00
6	ಸ್ವಯಂ ಪ್ರೇರಿತ ರಕ್ತದಾನ ದಿನಾಚರಣೆ	3,00,812.00
7	ಪ್ಲೈನಸುಮಳಿಗಳು	1,20,540.00
8	ಟಿ.ವಿ. ಸ್ಪಾಟ್‌ಗಳು	2,50,600.00
	ಒಟ್ಟು	1,15,74,341.00

ಯೋಜನಾ ನಿರ್ದೇಶಕರು ,
ಕರ್ನಾಟಕ ರಾಜ್ಯ ಏಡ್ಸ್ ಪ್ರಿವೇನ್‌ಷನ್ ಸೊಸೈಟಿ ಹಾಗೂ
ಆಯುಕ್ತರು , ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳು

Supplementary Note

From 1987 till end of August 2000, 613 persons are reported to be suffering from AIDS. Out of this 106 people have been died due to AIDS. The HIV cases are reported from Voluntary Testing and Counselling Centres. These centres serve as surveillance centres. The State conduct sero-surveillance on a regular basis at five voluntary testing centres. In addition, every year for a period of three month from August to October sentinel surveillance is carried out at 14 sites. This gives trend of increase of HIV infection in high risk groups as well as general population.

District wise details are below:

Sl. No.	Division/ Districts	HIV +Ve	AIDS Cases	Death due to AIDS
BANGALORE DIVN.				
1	Bangalore (U)	2685	100	28
2	Bangalore (R)	178	9	4
3	Tumkur	156	11	1
4	Shimoga	170	29	2
5	Chitradurga	117	7	2
6	Davanagere	33	7	0
7	Kolar	150	11	2
MYSORE DIVN.				
8	Mysore	122	10	5
9	Chamarajanagara	3	1	0
10	Mandya	272	18	5
11	Mangalore	743	16	9
12	Udupi	437	120	10
13	Madikeri	11	2	1
14	Chickmangalore	81	11	2
15	Hassan	103	9	2
BELGAUM DIVN.				
16	Belgaum	85	9	0
17	Bijapur	114	0	0
18	Bagalkote	9	3	0
19	Dharwad	268	119	4
20	Haveri	23	13	1
21	Gadag	12	4	0
22	Karwar	171	35	5
GULBARGA DIVN.				
23	Gulbarga	63	4	3
24	Raichur	144	11	5
25	Bidar	7	2	2
26	Bellary	508	9	0
27	Koppal	18	2	0
KARNATAKA TOTAL		**6682**	**562**	**93**
1.	Other States	509	47	9
2.	Foreigners	15	4	4
GRAND TOTAL		**7206**	**613**	**106**

HIV testing procedures are followed as per the National HIV testing policy of Government of India. Hence unlinked anonymous testing procedures are followed to keep the result confidential. The testing procedure will be done by giving pre and post test counselling to the client on getting explicit consent and the result will be revealed to the patient or his close relatives since stigma and sensitivity is attached to the disease. In view of this the testing centres are providing only the age, sex and the district to which the case belong and the names and addresses are kept confidential.

As per the current estimates the HIV infection in the State may be upward of 2 lakhs though exact estimates are not available.

To control AIDS disease, National AIDS Control programme is being implemented in the State. This is a 100% centrally sponsored scheme. The activities under this programme are being implemented as per the guidelines of National AIDS Control Organisation, Ministry of Health & Family Welfare, Government of India with World Bank assistance. The main objective of this programme is to prevent the spread of HIV transmission in the community and to create awareness on HIV/AIDS. The activities under the programme are being implemented as per the guidelines of National AIDS Control Programme, Government of India. In view of this and to enable the time bound implementation of activities the Karnataka State AIDS Prevention Society is established during 1997.

Objectives:

1. To reduce the spread HIV infection in Karnataka State
2. To strengthen Karnataka State's capacity to respond to HIV/AIDS on long term basis.

Project interventions:

a) To keep HIV prevalence rate below 3% of adult population in Karnataka.
b) To reduce blood borne transmission of HIV to less than 1%.
c) To attain awareness level of not less than 90% among the youth and others in the reproductive age group.
d) To achieve condom use of not less than 90% among high risk behavior groups.

Programme components:

Sl.No	Component No.	Description
1	Component - I	Targetted Intervention, STD/RTI Services including & Condom Promotion
2	Component - II	IEC, Blood Safety & VTC
3	Component - III	Institutional Strengthening
4	Component - IV	Low Cost Care & Capacity Building
5	Component - V	Intersectoral Collaboration including AIDS Education in Schools.

Financial statement:

(Rs.in Lakhs)

Year	Approved action plan by NACO	Releases by NACO + unspent balance amount of previous year	Expenditure	Balance
1999-2000	Rs.1067.70 lakhs	Rs.950.28 lakhs	Rs.556.942 lakhs	Rs.393.34 lakhs
2000-2001	Rs.700.00 lakhs	Rs.584.00 lakhs	Rs. 318.00 lakhs	Rs.266.00 lakhs

NGO involvement in targetted intervention in Karnataka through Karnataka State AIDS Prevention Society:

18 Non-governmental organizations have received the grants to take up targetted interventions programmes among high risk groups such as Commercial Sex workers, Truck drivers, Migrant labourers and Street children's etc., to bring behavioral communication change.

Rs.16,21,695.00 (Sixteen lakhs twenty one thousand six hundred ninety five only) have been released 18 non-governmental organisation for the year 2000-2001.

To control AIDS and to take up preventive measures the following five voluntary blood testing centres are established.

1. Victoria Hospital, Bangalore
2. National Institute of Mental Health and Nuerosciences (NIMHANS)
3. Kasturba Medical College, Manipal
4. Karnataka Institute of Medical Sciences (KIMS), Hubli
5. Vijayanagara Institute of Medical Sciences (VIMS), Bellary

In these centres HIV testing facility is provided and to know the tense of infection surveillance activities are undertaken. To ensure blood transfusion safety ten voluntary blood-testing centres are established in the blood banks of the following hospitals.

1. K. C.General Hospital, Bangalore
2. HSIS Gosha Hospital, Bangalore
3. KIDWAI Memorial Institute of Oncology, Bangalore
4. Airforce Common Hospital, Bangalore
5. Karnataka Institute of Medical Sciences (KIMS), Hubli
6. Vijayanagara Institute of Medical Sciences (VIMS), Bellary
7. J.N. MedicalCollege, Belgaum
8. M.R.Medical College, Gulbarga
9. Kasturba Medical College, Mangalore
10. Kasturba Medical College, Manipal

All blood banks are linked to these zonal blood-testing centres for HIV testing. A total of 52 blood banks in the State are being modernized in a faced manner. District level blood banks are being provided with HIV rapid test kits to take up testing during emergencies. 30 STD (Sexually Transmitted Diseases) clinics attached to major hospitals and district level hospitals are being strengthened in addition to treatment advice on safe sexually practices are given.

To create awareness on AIDS disease in the community, information, education and communication activities are being implemented. Guidelines are being issued to all hospitals to use properly sterilized syringes, needles and other equipments. In addition to implementation information, education and communication activities other medias like All India Radio, Doordarshan and leading Daily news papers are also utilised for release of advertisements and documentary films "NIRDHARA" and "BELAGAGUVA TANAKA" and TV spots on HIV/AIDS with the involvement of religious leaders are being advertised through Doordrshan. Video and Audio cassette are produced and provided to District Health and Family Welfare Officers, Information and Publicity Department and Field Publicity Department, Government of India to take up publicity activities. In addition to this street plays are also being takenup. Every year to create awareness on a intensified way National Voluntary Blood Donation Day is being observed on 1st October, World AIDS Day is being observed on 1st December in the State. During the year 1999-2000 Family Health Awareness Campaign was conducted in 14 districts and during the year 2000-2001 the Family Health Awareness Campaign was observed from 1st to 15th July 2000 in all the 27 districts as a special event.

During Family Health Awareness Campaign awareness activities on HIV/AIDS and Sexually transmitted diseases prevention are taken up in both Urban and Rural areas. And treatment facility for STD cases and reproductive tract infection cases were provided at all governmental hospitals and primary health centres. The health workers were entrusted with the work of identification and motivation of the sexually transmitted infections and reproductive tract infections cases to avail the facility of treatment during the primary stage. Priority targetted intervention programmes on HIV/AIDS control are being taken up in high-risk groups (vulnerable groups for HIV infection with the involvement of non-governmental organization.

For the year 2000-2001 the Government of India have provided an amount of Rs.223.61 lakhs out of this as of 30th September 2000 Rs.115.74 lakhs is spent for awareness creation activities. Details as follows:

(amount in Rs.)

1	World Health Day	10,45,553.00
2	Family Health Awareness Campaign	85,86,504.00
3	All India Radio	2,58,300.00
4	Doordarshan	6,30,000.00
5	CCTV	3,82,032.00
6	Blood Donation Day	3,00,812.00
7	Audio Cassettee	1,20,540.00
8	TV Spots	2,50,600.00
		1,15,74,341.00

Project Director,
Karnataka State AIDS Prevention Society &
Commissioner, Health & Family Welfare Services

NP/9

GOVERNMENT OF KARNATAKA
KARNATAKA STATE AIDS PREVENTION SOCIETY®

No.13, 5th Main, 10th Cross, 12th Block, Kumara Park (West), Behind BDA, Bangalore – 20
✆ 080 3349057 ,3349142 Fax No. 080 /3349142

NO/KAPS/AIDS/STC/05/98-99 4 th September 2000

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TO.
DR.P.L.JOSHI
JOINT DIRECTOR(TECH)
NATIONAL AIDS CONTROL ORGANISATION
MINISTRY OF HEALTH & FW.GOVT.OF INDIA.
NIRMAN BHAVAN, NEW DELHI-110 001

Sir,

Sub:- Monthly report of HIV/AIDS for the month of July 2000

Please find in herewith enclosed the monthly update report along with the surveillance report for the month of July 2000 for your reference.

Yours faithfully,
Sd/-
Additional Project Director (TI),
Karnataka state AIDS Prevention Society, Bangalore.

Copy to :-

1. Dr P.SALEEL. Joint Director (Blood Safety) National Aids Control Organisation, Ministry of Health, &FW.Govt. of India , Nirman Bhavan New Delhi –110 001.

2. Regional Director ,Regional Office of Health & FW Govt.of india , II Floor (F Wing) Kendriya Sadana Koramangala, Bangalore-560 034.

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11/9/2000
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Additional Project Director (TI),
Karnataka state AIDS Prevention Society, Bangalore.

13/9

GOVERNMENT OF KARNATAKA

KARNATAKA STATE AIDS PREVENTION SOCIETY®

No.13, 5th Main, 10th Cross, 12th Block, Kumara Park (West), Behind BDA, Bangalore – 20
℗ 080 3349057 ,3349142 Fax No. 080 /3349142

NO/KAPS/AIDS/STC/05/98-99 4 th September 2000

TO.
DR.P.L.JOSHI
JOINT DIRECTOR(TECH)
NATIONAL AIDS CONTROL ORGANISATION
MINISTRY OF HEALTH & FW.GOVT.OF INDIA.
NIRMAN BHAVAN, NEW DELHI-110 001

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Additional Project Director (TI),
Karnataka state AIDS Prevention Society, Bangalore.

GOVERNMENT OF KARNATAKA

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KARNATAKA STATE AIDS PREVENTION SOCIETY ®

No.13, 5th Main, 10th Cross, 12th Block, Kumara Park (West), Behind BDA,
Bangalore -- 560 020

MONTHLY UPDATE ON HIV INFECTION IN KARNATAKA

(based on reports received at KSAPS)
(subject to retrospective corrections on receipt of more accurate data from centres)

1. Period of report upto end of :- **JULY 2000**

2. SERO SURVEILLANCE REPORT :- From 1987 To June 2000 | July. 2000

i. total number of samples screened	:	4,24,538	2,560
ii. number confirmed by second test	:	6,860	191
Cummulative total HIV + ve	:	7,051	
iii.Sero- positivity rate(per thousand)	:	16.51	

iv.AIDS cases :-

	M	F	Total
a) Karnataka	450	83	533
b) Other states	41	4	45
c) Foreigners	4	-	4
			582

3. Breakup of sero-positives

- Hetro sexuals promiscuent & others	:	2625	37.23
- Homosexuals	:	-	-
- Blood Donors	:	588	08.34
- Antenatal Mothers	:	91	1.29
- Suspected AIDS/ ARC cases	:	3729	52.88
- Foreigners	:	14	0.20
- I . V . Drug users	:	04	0 .06
Total	:	**7051**	**100 .00 %**

4. Year Wise Blood sample screened for HIV +Ve

Year	Blood Samples	Blood samples found		Death due to AIDS
		HIV +Ve	AIDS cases	
1987	913	0	0	0
1988	2,264	6	2	2
1989	25,928	32	1	1
1990	48,348	58	1	1
1991	66,828	86	1	1
1992	1,02,336	168	2	2
1993	76,237	868	9	9
1994	24,209	425	15	13
1995	11,583	439	12	12
1996	8,877	697	22	7
1997	15,452	847	58	17
1998	15,912	1,023	44	12
1999	16,702	1,319	200	20
July 2000	11,509	1083	215	6
TOTAL	4,27,098	7,051	582	103

The report received from Voluntary Blood Testing Centre, Kasturaba Medical College Manipal & Vijayanagar Institute Medical Sciences Bellary on HIV Cases , AIDS Cases & Death due to AIDS during the month of March 2000 & June 2000 ,which was related the year 1999 is compiled accordingly.

NATIONAL AIDS CONTROL PROGRAMME

AIDS CASES SURVEILLANCE REPORT

Name of the State :- KARNATAKA Reporting Month :- July 2000

I.Morbidity & Mortality Data

	During the Month			During the Year (from January)		
	M	F	TOTAL	M	F	TOTAL
No of AIDS Cases	36	10	46	170	45	215
No.of AIDS Deaths	1	0	1	5	1	6
Children	0	0	0	0	1	1
Adults	1	0	1	5	0	5

II. AGE/SEX Distribution of AIDS Cases

Age in Years	Male	Female	Not specified	Total
0-5	0	0	0	0
6-14	2	0	0	2
15-19	0	0	0	0
20-29	7	3	0	10
30-39	12	4	0	16
40-49	6	2	0	8
50-59	4	1	0	5
60 +	5	0	0	5
Not Specified	0	0	0	0
Total	36	10	0	46

III. Risk/Transmission Categories

		Male	Female	Total
Adult	- Sexual Route	33	10	43
	- Through Blood & Blood products	0	0	0
	- Through infected syringes & needles	0	0	0
	- Others	0	0	0
	- Not specified	1	0	1
Children	- Perinatal	1	0	1
	- Through Blood & Blood products	0	0	0
	- Others	1	0	1
	- Not specified	0	0	0

VI. Frequency of Presenting Sign and Symptoms :-

		No. of Cases		
Sl.No.	Presenting Sing / Symptoms	Male	Female	Total
1.	Weight loss	7	2	9
2.	Diarrhoea	7	3	10
3.	Fever (Low grade)	21	6	27
4.	Asthenia,Fatique &Malaise	5	2	7
5.	Caugh	12	5	17
6.	Presistent Generalized lymphadenopathy	5	0	5
7.	Others, Specify	3	0	3

V. Opputunistic Infections

		No. of Cases		
Sl.No.	Opputunistic Infections	Male	Female	Total
1.	M. Tuberculosis	16	6	22
2.	Candiadiasis	3	0	3
3.	P . C . P	0	0	0
4.	Cryptosporidium	2	0	2
5.	Toxoplasma	1	0	1
6.	Herpes	3	1	4
7.	Kaposi Sarcoma	0	0	0
8.	Parasitic Infections	5	3	8
9.	Othres /Cryptococcal Meningitis	3	0	3
	TOTAL	33	10	43

Date :- 31 – 08 – 2000
Place:- Bangalore

Additional Project Director (TI),
Karnataka state AIDS Prevention Society, Bangalore.

NATIONAL AIDS CONTROL PROGRAMME

MONTHLY REPORT - BLOOD TESTING CENTRES

Name of the STATE :- KARNATAKA

Number of Blood Testing in the State :- 8 Month :- July

Number of Reporting Centres :- 5 Year :- 2000

1. Diagnosis of Clinically Suspected HIV/AIDS Cases

1.1 Route of Transmission

Route of Transmission	During the Month		Cumulative since January	
	Samples Screened	Samples +tive	Samples Screened	Samples +tive
Sexual Route	765	104	4892	565
Through Blood & Blood Products	22	1	186	9
Through Infected Syringes And Needles	11	0	112	4
Perinatal Transfusion	18	1	159	25
Other (Specified)	50	5	407	45
Total	866	111	5756	648

1.2 Age & Sex Distribution of HIV/AIDS Cases

Age Group in Years	During the Month			Cummulative		
	Male	Female	Total	Male	Female	Total
0-14	3	0	3	18	9	27
15-29	17	17	34	138	92	230
30-44	43	14	57	257	58	315
45 & above	13	4	17	54	22	76
Total	76	35	111	467	181	648

2.Voluntary HIV Testing :-

Age Group in Years	During the Month		Cummulative	
	Samples Tested	No.found +Ve	Samples Tested	No.found +Ve
0-14	26	4	126	18
15-29	1391	35	3599	190
30-44	171	31	1502	179
45 & above	106	10	526	48
Total	1694	80	5753	435

3.Counselling Services :-

i. Number of counselors Working :- 12

ii. Counseling Services

	During the Month			Cummulative since January		
	Male	Female	Total	Male	Female	Total
No.of Persons Counseled	1483	971	2454	5934	5156	11090

Date :- 31 - 08 - 2000
Place :- Bangalore

Additional Project Director (TI)
Karnataka state AIDS Prevention Society, Bangalore.

5. DISTRICT WISE HIV+VE CASES , AIDS CASES, DEATH DUE TO AIDS.

Sl. No.	Division / Districts	1987 to June 2000			July 2000			Cumu -lative
		HIV +Ve	AIDS Cases	Death due to AIDS	HIV +Ve	AIDS Cases	Death due to AIDS	
BANGALORE DIVN.								
1.	Bangalore (U)	2596	98	28	50	2	0	2646
2.	Bangalore (R)	172	9	4	2	0	0	174
3.	Tumkur	148	11	1	7	0	0	155
4.	Shimoga	169	28	2	0	0	0	169
5.	Chitradurga	115	7	2	1	0	0	116
6.	Davangere	32	6	0	1	1	0	33
7.	Kolar	147	11	2	3	0	0	150
MYSORE DIVN.								
8.	Mysore	122	10	5	0	0	0	122
9.	Chamarajnagar	2	1	0	0	0	0	2
10.	Mandya	268	18	5	3	0	0	271
11.	Mangalore	742	16	9	0	0	0	742
12.	Udupi	396	107	8	21	7	0	417
13.	Madikeri	8	1	1	3	1	0	11
14.	Chickmangalore	77	11	2	2	0	0	79
15.	Hassan	100	9	2	1	0	0	101
BELGAUM DIVN.								
16.	Belgaum	82	6	0	1	1	0	83
17.	Bijapur	113	0	0	1	0	0	114
18.	Bagalkote	6	1	0	1	1	0	7
19.	Dharwad	210	71	2	33	23	1	243
20.	Haveri	19	9	1	3	3	0	22
21.	Gadag	8	2	0	2	2	0	10
22.	Karwar	164	31	5	3	2	0	167
GULBARGA DIVN.								
23.	Gulbarga	63	4	3	0	0	0	63
24.	Raichur	138	10	5	4	1	0	142
25.	Bidar	7	2	2	0	0	0	7
26.	Bellary	436	9	0	43	0	0	479
27.	Koppal	15	1	0	0	0	0	15
KARNATAKA TOTAL		6355	489	89	185	44	1	6540
1.	Other States	490	43	9	6	2	0	496
2.	Foreigners	15	4	4	0	0	0	15
GRAND TOTAL		6860	536	102	191	46	1	7051

6.AGE & SEX WISE HIV POSITIVE CASES,AIDS CASES,DEATH DUE TO AIDS
FROM 1987 TO JULY 2000

Age Years	HIV + VE			AIDS Cases			Death due to AIDS		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1 -10	87	72	159	11	7	18	1	1	2
11-20	171	262	433	9	5	14	0	2	2
21-30	2416	1052	3468	199	39	238	33	8	41
31-40	1794	394	2188	194	21	215	36	5	41
41-50	518	134	652	56	7	63	13	0	13
51 & >	121	30	151	26	8	34	2	2	4
TOTAL	5107	1944	7051	495	87	582	85	18	103

Additional Project Director (TI) .
Karnataka state AIDS Prevention Society, Bangalore.

NP 20

GOVERNMENT OF KARNATKA

No. CMD/ III /D.S.U /98-99. 2001-02
Encls:

Office of the Dist.Health & FW Officer, Kolar Dist, Kolar, Date: 18/8/2001

To,
The Statiotical Officer,
B.H.I. (Section)
Directorate of Health & F.W. Services,
Bangalore-560009.

Sir,

Sub:- Submission of Monthly Progress report for the Month of July. 2001. ~~1998.02~~

I am herewith submitting the Monthly Progessd report of Health Condition report for the Month of July. 2001. ~~1998~~ 2001 pertaining to Kolar District for your kind information and needful.

Yours faithfully,

MEDICAL OFFICER
Dist.Health & FW Officer,
District Surveillance Unit
Kolar District
KOLAR-563101
20/8/2001

c) Copy submitted to the Deputy Director and Officer I/c N.G.C.D. plague Servillance Unit Ballary Road Bangalore. for kind information.

Paj/-

NSPCD KGR K
24/8/2001

MONTHLY STATEMENT SHWOING INSTITUTIONAL CASES AND DEATHS DUE TO COMMUNICABLE DISEASES

1. Name of the District: KOLAR

2. Month/year: July 2001-02

3. Total Numbers of existing Institutions in Dist. 78

4. Total Number of reporting institutions in the month in District/U.T. 60

5. Total Number of Defaulting institutions in the month in District/U.T. 18

6. Reported cases and deaths due to communicable diseases:

Sl: No:	Name of the Diseases	OPD M	OPD F	OPD C	IPD M	IPD F	IPD C	Total M	Total F	Total C	Deaths M	Deaths F	Deaths C
1	2		3						5				
1.	Accute diarrhoel diseases (including) Gastro inteitis and cholera.	2559	2659	1209	124	33	42	2683	2692	1251	1	1	
2.	Tdiptheria (032)	—	—		—	—		—	—		—	—	
3.	Acute poliomyelities (045)	—	—		—	—		—	—		—	—	
4.	Tetanus other than neonatal (037)	—	—		—	—		—	—		—	—	
5.	Neonatal tetanus (771.3)	—	—		—	—		—	—		—	—	
6.	Whooping cough (033)	—	—		—	—		—	—		—	—	
7.	Measleas (055)	—	—		—	—		—	—		—	—	
8.	Acute Resposibility infection (including influenze and excluding phenumoni) (460-466)(487)	9420	10057	3442	200	228	55	9620	10285	3497			
9.	Pheumonia (480-486)	1440	1472	268	19	16	12	459	1188	286			
10.	Entrie Fever (302)	397	258	297	33	33	23	430	291	320			
11.	Viral Hepemitis (070)	35	25	40	1	1	1	36	26	11			
12.	Japaness encesphalities (002.0)	—	—	—	—	—	—	—	—	—			
13.	Meninge meningintis (036.0320)	—	—	—	—	—	—	—	—	—			
14.	Rabies (071)												
15.	Syphilis (056-057)	1	2	—				1	2				
16.	Pulemoney tuberculosis (011)	61	55	11	7	8	—	82	63	11			

1	2	3			4				
		M	F	C	M	F	C	M	
17. Genoccecal infection (000)		53	43	25	10	8	5	63	43	30
18. All other diseases treated in institutions excluding above mentioned diseases		3133	98010							
19. Total:		1519	102							

Including communicable and Non-communicable diseases.

Total = 16759.2

NOTE: 1. ICT Inpatient.

2. OPD: out patient.

3. All The medical institutions etc. In the Govt/U.T. Under Govt clinics, Municipalities etc. should be covered. Private voluntary organisation should be covered.

4. The cases and deaths due to various diseases other than these treated in medical institutions whether not should be given in seperate report.

5. Only confirmed cases of rabies in Human beings/Animals be included and no the dog bites/Animal bites cases defaukting district wise should be furnished.

6. A list of total number of institutions existing and defaulting district wise should be furnished.

7. Acute diarrhoeal diseases should include dysentery cases in cases, with three more loo water motions a day, irrespective of actiology conditions.

8. Date of Japanese encephalities should tally with furnish to national Malaria Eradication programme.

9. Date as vaccine prevementable diseases should tally UIP date being furnished by state Epro, officer/to of Health.

10. Only new case of acute pollomylities which have been should be given.

NOTE:- Please take care not to include simple dogbite cases including communicable & non communicable diseases.

MEDICAL OFFICER
District Surveillance Unit
Kolar District
KOLAR-563101

Ref: CHC/Mis-/2001 04 Sep 2001

To,
Dr. N Devadasan,
National Surveillance Coordinator,
World Health Organisation,
New Delhi.

Subject: Disease Surveillance

Dear Dr. Devadasan,

Greetings from CHC!

Thank you for your prompt reply with the relevant information. The KHSDP (WB funded) has a HMIS (State to taluk level, not including the PHC's) and rudimentary surveillance but is yet to develop fully.

I have spoken to the NICD regional office regarding the NSPCD and some of my comments are enclosed.

I feel that for effective disease surveillance, surveillance for symptoms (e.g. fever with rash for smallpox and AFP for polio) is of paramount importance, if cases are not to be missed. Also, proper epidemiological investigation (preliminary and final), prompt reporting (including nil reporting) and lab confirmation are essential/vital for any successful surveillance programme. (Some of my rough jottings for surveillance are enclosed for your valuable comments).

We would like to receive any further information regarding the integrated disease surveillance programme (WB funded) which you have mentioned, and will definitely take you up on your offer to involve you in future discussions with the state Government when it is scheduled.

I am also sending a copy of the final report of the Task Force on Health- GOK

Best regards to you, Roopa and the children, from all of us at CHC.

Thanking you,
Yours sincerely,

Dr. Sampath K Krishnan
Fellow (Training & Health Promotion)

Proposal for conducting a Trainers Training workshop (from 7.5.2000 to 9.5.2000 both-days-inclusive) at Health and Family Welfare Training Centre, Magadi Road, Bangalore under the auspices of K.H.S.D.P.

N021

Aims and objectives of the 3 days workshop are:-

1. To Train one District Surveillance Officer and one Senior Laboratory Technician from each of 27 districts (Total 54 participants) in laboratory investigation / procedures carried out at Primary Health Centre (PHC) Laboratories.
2. To impart communication and supervisory skills,
3. To enable them, to train newly recruited laboratory Technicians of their respective districts.

List of investigations: To be carried out at Primary Health Care:

1. Urine	:	Albumin, Sugar, Ketone Bodies, Bile salts and Bile pigments. Microscopic examination of the sediment.
2. Stool	:	Ova and cyst of parasites (Normal saline and iodine preparation) Test for occult blood.
3. Blood	:	Hb, TC, DC, ESR, BT, CT M.P, Microfilaria A.B.O. grouping
4. Serology	:	VDRL and Widal
5. Sputum	:	Staining and identification of AFB in sputum smears
6. Skin	:	Drawing the skin smear, stain with modified ZN stain and identification of lepra bacilli.
7. Vaginal smear	:	Hanging drop for Trichomonas, Grams stain for Gonococci.
8. Cervical smear	:	Taking the smear and fixing for PAP stain

9. Pregnancy Test

10. Semen Analysis

NP 22

PARTICULARS OF TRAINING PROGRAMMES PLANNED TO BE CONDUCTED FOR VARIOUS CATEGORY OF HEALTH PERSONNELS IN THE STATE

1) Foundation Training to Medical Officers who are going to be Recruited every year:-

In the Department on an average 200-300 Doctors being recruited every year due to Superannuation and Voluntory Retirement of Officers, etc., As they are coming fresh from the Medical Colleges, they will not be aware of Administration and Management Matters. Further, they also need Orientation towards all the on going National Health Programmes. Hence, it is desired to conduct Foundation Training to the Newly Appointed Medical Officers for a period of six months. This six months Training includes 3 months of theory classes at State Institute of Health and Family Welfare and 3 months of Field work at selected PHCs/Sub-Centres in the State.

The 3 months theory classes will be conducted at State Institute of Health and Family Welfare, by the Faculty of State Institute of Health and F.W. and expert Guest Faculty from the Department and outside.

During 3 months of Field work Medical Officers will work at different levels as follows:-

a) Sub-Centre Level:- One week to get familiarised with the working of Jr.H.A.(M & F).

b) At PHC Level:- They will work at PHC Level as Sr.H.A.(F) for one week, Sr.H.A.(M) for one week and B.H.E. two weeks to get acquanted with the supervisory and guiding role of above said Category of Staff (total 4 weeks).

c) He will also undergo Training in P.H.C. Administration and Management for one month staying at PHC with Administrative Medical Officer.

d) At District Level:- He will work at District Laboratory for one week for skills of various Laboratory tests.

. . . 2

He will also work at District Hospital for acquiring Knowledge and Skills in dealing with Medico-legal cases including post mortem for two weeks.

These Newly Appointed Doctors will be attached to State Institute of Health and F.W., Bangalore and the pay and allowances will have to be drawn by State Institute of Health and F.W. The approximate pay and allowances of each Newly Recruited Doctors at present rate will be around Rs.12,000/-. The total expenditure for 300 Doctors for 6 months will be Rs.12,000 x 6 months x 300 = 2,16,00,000/- (Two hundreden sixteen Lakhs only).

As these 300 Doctors have to work at field for 3 months. Their T.A during field duty will be at the rate of Rs.500/- approximate/person, so for the 300 Doctor total, T.A. Expenditure will be Rs.1,50,000/-.(Rs. One lakh fifty thousand only)

The daily allowances payable during these 90 days at the rate of Rs.200 per day(at current rate)will be Rs.54,00,000/-

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II. Inservice Training for Medical Officers of less than 6 years of Service at Health and F.W.Training Centres for one month:-

Inservice Doctors need Re-Orientation Training in various National Health Programmes periodically to up-date their knowledge and skill so that the Programmes are Implemented effectively.

Hence, it is desired to have one month Inservice Training for above Category of Staff at Health and F.W. Training Centres once in every five years. At present total strength of General duty Doctors is approximately about 2000 and every year about 400 Doctors are to be Trained. There are 4 Health and F.W.Training Centres in the State and each Health and F.W.Training Centres has to train about 100 Doctors every year. They will have to conduct about 3 batches in a year in batch size of 30 each. The total cost per batch will be Rs. 2,70,000 approximately and total cost for Training of 2000 Doctors at 04 Health and F.W.Training Centres in 70 batches will be Rs. 1,89,00,000. details are enclosed in an Annexure-

III. Hospital Management and Programme Management Training 2 weeks each to Specialists and Sr.Specialists:-

A. There are about 1500 Specialists(6 to 13 years service) in the State. They need re-orientation Training once in 5 years in Hospital Management and Programme Management of 2 weeks each (totally 4 weeks). These 1500 Specialists have to be trained at 04 Health and F.W.Training Centres at the rate of about 400 Specialists per Health and F.W.Training Centres during 5 years period. The total batches per year per Health and F.W.Training Centres will be about 3 of 30 persons. The cost per batch is Rs. 1,35,000 and the total cost for 50 batches for 5 years period will be Rs. 67,50,000.

(4)

B. There are about 1500 Sr.Specialist(13 years and above service) in the Department. They need Re-orientation Training once in 5 years in Hospital and Programme and Management of:2 weeks each(total 4 weeks). These 1500 Sr.Specialists have to be trained at State Institute of Health and F.W., Bangalore in 50 batches over a period of 5 years. Each year 10 batches will have to be trained. The cost per batch will be Rs. 1,35,000 and cost for total 50 batches pver a period of 5 years will be Rs. 15,00,000.

IV. Orientation Training in Administration and Programme Management to District Health and F.W.Officers/Dist. Surgeons and Dy.Directors for a period of 3 weeks at State Institute of Health and F.W.:-

There are about 100 Officers in the above Category. They are holding key posts of Administration at District and State Level and also they are the main Implementing Officers of the Programmes. Hence, they need Orientation Training in Administration and Programme Management for a period of 3 weeks at State Institute of Health and F.W., once in 5 years. Each year one batch consisting of 20 persons will be trained. The cost per batch is Rs. 1,66,000 and for all 5 batches is Rs. 8,30,000.

V.(A) Trainer of Training(TOT) in Training Technology for Faculty of State Institute of Health and F.W./ Health and F.W.Training Centre/District Training Centre/L.H.V.Training Centre/A.N.M.Training Centres:-

The Faculty of above said Training Centres are involved in imparting Training to various Category of Staff. There is need for enhancing the teaching and Training skills of these Staff.

The teaching faculty of State Institute of Health and F.W. and Health and F.W.Training Centre have to be trained outside the State in Nationalyrecognised Training Institutions and also some at Abroad.

V(B). Similarly, Faculty of District Training Centres, L.H.V. Training Centres and A.N.M.Training Centres have to be trained at State Institute of Health and F.W. There are 19 District Training Centres, 19 A.N.M.Training Centres and 4 L.H.V. Training Centres in the State and the total Faculty will be about 150 in these Training Centres. They will be trained in 5 batches in one year itself. The cost per batch is Rs.72,500, and for 5 batches is Rs. 3,62,500.

VI. Specialised Skill Based Training in Specialities like Cardiology, Endoscopy, Trauma Care, I.C.C.U.,Etc.,:-

There are about 600 Specialists with P.G.Qualification in various Specialities. Since Medical Technology is fast developing the Specialists have to be hope-up with recent Technologies and Skills. Hence, they have to be trained in their respective Specialities once in 5 years at selected Institutions in India and Abroad for a period of one month

VII. Non-Technical Group - 'B' Officers like Lay Secretaries/ Gazetted Assistants:-

The Lay Secretaries/Gazetted Assistants are working in District Hospitals/District Health and F.W.Offices/Taluk Health Offices, other Offices of the Departments. They are assisting the Officers in Administration and Hospital Management including Programme Management. They have to be trained in the above matters for a period of 4 weeks at Health and F.W.Training Centres once in 5 years.

There are about 150 Group 'B' Officers and they are to be trained in any one of the Health and F.W.Training Centres preferably at Bangalore in 5 batches over a period of 5 years The cost per batch will be Rs. 2,17,500, and for 5 batches will be Rs.10,87,500.

VIII. Training to Technical Supervisory Officers like District Health Education Officers/District Nursing Officers/ Dy.Health Education Officers/Asst.Statistical Officers/ A.L.O and Health Supervisors etc., in I.E.C Strategy and Programme Supervision for 2 weeks at State Institute of Health and F.W., Bangalore:-

There are about 250 Technical Supervisory Officers to attached to District Health and F.W.Officer and some Programme Officers. Since, I.E.C Component has become very important tool for effective and quality Implementation of the Programmes these Officers are to be trained in I.E.C. Strategy and Programme Supervision. They will be trained at State Institute of Health and F.W. for a period of 2 weeks once in 5 years. So these Officer have to be trained in 9 batches over a period of 5 years. The cost per batch will be Rs.1,16,250 and for 9 batches total cost will be Rs. 10,46,250.

IX. Orientation Training to Jr.Health Asst.(F & M) for 3 weeks at District Training Centres:-

These Male and Female Health Workers are working at gross root level of the Department and are actually responsible for effective Implementation of the various Health Programmers. To make the Programmes qualitativ ly Superior and also acceptable to Community, these gross root level Workers are to be re-oriented once in 5 years for a period of 3 weeks at Dist. Training Centres.

There are about 10,000 Jr.Health Assts(F) and 6,000 Jr.Health Assts(M) in the Department. They have to be trained once in 5 years in 19 District Training Centres. These 16,000 Officials are to be trained in 533 batches of 30 participant each and 19 District Training Centres have to train 6 batches every year. The cost per batch will be Rs. 1,04,250 and for total 533 batches cost will be Rs. 5,55,65,250.

X. Re-orientation Training to Supervisory Staff like Sr.Health Assts(M & F)/B.H.E's/M.MS. etc., for period of 2 weeks at District Training Centres:-

(7)

There are about 4,000 Supervisory Staff of above Categories. They are involved in guiding, Supervising and Monitoring of various Programmes Implemented by Jr.Health Assts(M & F). Hence, their Supervisory Skills have to be improved and they have to be trained at District Training Centres for a period of 2 weeks Once in every five years. They will have to be trained in 133 batches over a period of 5 years in 19 District Training Centres. The cost per batch will be Rs. 74,250 and 133 batches total cost will be Rs. 98,75,250.

XI(A) LABORATORY TECHNICIANS:-

A. Induction Training to Newly Appointed Lab Technicians:-

It is expected that about 1,000 Jr.Lab.Technicians are going to be recruited/appointed in the coming years. Most of these Technicians are trained in Private Institutions, they have to be inducted to manage the Laboratory work of Hospitals including Special Skills of examining Smears for Malaria, T.B. and Leprosy etc.,

These Technicians are to be trained in Medical Colleges and Public Health Institute, Bangalore for a period of 4 weeks The total cost will be around Rs. 43,12,500.

XI(B) Inservice Re-orientation Training to Lab Technicians:-

There are about 1,500 Inservice Lab. Technicians in the Department and they need Orientation in improving their Laboratory testing skills once in 5 years. They have to be trained in District Laboratory/Dist.Training Centres for a period of 2 weeks in batches 10 participants each. Total batches will be 150 in 5 years. The cost per batch will be Rs.28,750, and for 150 batches will be Rs.43,12,500.

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XII. Orientation Training to Pharmacists at District Training Centres and Hospital based for 2 weeks:-

The Pharmacists are working in the various Health Institutions like Primary Health Units/Primary Health Centres/ Community Health Centres/Taluk Hospitals and District Hospitals They are responsible for maintainance of stores and stocks. They are also responsible for maintaining disease statistics and dispensing of drugs. As these are very vital functions these Pharmacists are to be given re-orientation for 2 weeks. This Training should involve Clinical Pharmacy, maintainance of Disease Statistics etc.,'

There are about 2,660 Pharmacists(Junior and Senior) working in the Department. They should be trained at District Training Centres along with Hospital based Training. The Assistant Drug Controller ofDistricts should be involved while, getting this Training, Duration of this Training should be 2 weeks, once in every five years.

These 2,660 Pharmacists will be trained in 266 batches of 10 participants each over a period of 5 years and each District Training Centre has to conduct 3 batches every year. The total cost for one batch will be Rs. 28,750 and for 266 batches for 5 years will be Rs. 76,47,500.

XIII. REFRACTIONISTS:-

Orientation Training to Refractionist for a period of 02 weeks at Minto Hospital, Bangalore.

There is need of enhancing the knowledge and skills of Refractionists working in various Hospitals. They are involved in vital National Blindness Control Programme. Theyhave be trained for 2 weeks at Minto Hospital, Bangalore, once in 5 years.

There are 515 Refractionists working in the Department. They will be Trained in 52 batches of 10 participants each over a period of 5 years. The cost per batch will be Rs.38,750 and for 52 batches will be Rs.20,15,000.

ORIENTATION TRAINING TO STAFF NURSES:-

A) General Training to all Staff Nurses is required for one week once in a 5 years, So that their Knowledge and Skills in maintaining wards and patients care is enhanced.

Hence, it is proposed to train about 5,317 Staff Nurses (Junior and Senior) at District Hospitals for one week, in batch size of 10 participants. The total batches will be 532 over a period of 5 years in 27 District Hospitals. i.e., each District Hospital has to train about 4 batches per year The total cost per batch will be Rs. 13,000 and for 532 batches will be Rs. 69,16,000.

Orientation Training to X - Ray Technicians for one week at Medical Colleges and District Hospitals attached to Medical Colleges:-

There are 375 X - Ray Technicians working in the Department and they will be trained for one week at 10 selected Medical Colleges/District Hospitals. They will be trained in 190 batches of 2 participants each in 10 centres for one week over a period of 5 years i.e., 4 batches per centre/ year. The cost per batch will be Rs. 5,000 and total cost for 190 batches will be Rs. 9,50,000.

Training to First Division Assts and Second Division Assts. in record keeping at District Training Centres for one week:-

There are 3,746 First Division Assts.and Second Division Assts. in the Department. They will be trained in record keeping for one week at 19 District Training Centres, over a period of 5 years. They will be trained in 125 batches of 30 persons each and each District Training Centres will be Training 1 - 2 batches per year for a period of 5 years. The cost per batch will be Rs. 33,000 and total cost will be Rs. 41,25,000.

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Information Technology Skill Training to Faculty of State Institute of Health and F.W./Health and F.W.Training Centres:-

Karnataka is pioneer State in Information Technology in India. The use of Computer in Monitoring the various Training Programmes in the State is very exxential. Hence, the Faculty of State Institute of Health and F.W./Health and F.W.Training Centres have to be trained in Information Technology. There is need to develop Computer Centre at State Institute of Health and F.W./Health and F.W.Training Centres.

Computer Training to different Category of Health Staff:-

There is need to train various Category of Staff in basic Computer Training at District Level to copy up with Information Technology Advance. F.D.As/S.D.As/Gazetted Assistants/A.S.Os/ Medical Officers/Taluk Health Officers/District Health and F.W. Officers and State Level Programme Managers have to be trained for minimum of 2 weeks.

STATEMENT SHOWING THE PLANNED VARIOUS ... NING PROGRAMMES TO THE CATEGORY OF HEALTH PERSONNELS

IN THE STATE (KARNATAKA)

Sl No.	Name of the Training Programme	Category of Personnel	Dura-tion	No.of Pers-ons	Venue of Training	Batch size	PER BATCH EXPENDITURE (Calculate as per IPP-IX(K) Expenditure Norms)					Total Batches	Total Funds required	Remarks
							T.A.	D.A.	Honorarium to Guest Faculty	Contin-gency	Total			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
01.	Foundation Training to Medical Officers(Newly Recruited)	Medical Officer	06 months	300	SIHFW & Periperal Institute									
02.	Inservice Training for Medical Officers of less than 6 years of Service.	"	30 days	2,000	HFWTC's	30	15,000	1,80,000	30,000	45,000	2,70,000	70	1,89,00,000	400 M.Os have be trained ev year.
03(A)	a)Hospital Management and Programme Management Training to Specialist.	"	02 weeks	1,500	"	30	15,000	90,000	12,000	18,000	1,35,000	50	67,50,000	"
03(A)	b) Hospital Manag ent and Programme Management Training to Sr.Specialist	"	"	1,500	SIHFW	30	30,000	90,000	12,000	18,000	1,50,000	50	75,00,000	300 Specialis have to be trained every year.
04.	Orientation Training in Administration and Management to Dist. Health and F.W.Officers/Dist. Surgeons/Dy.Director,	Dist./ State Level Officers	21 days	100	SIHFW	20	40,000	84,000	21,000	21,000	1,66,000	05	8,30,000	one batch in a year.
* 05(B)	a)T.O.T.for Faculty of SIHFW/ HFWTC	Faculty		26 (4 from each HFWTC, 10 from SIHFW)	They should be trained in any of the Institute in India or Abroad.									Budget not calculated
05(B)	b)T.O.T.for Faculty of DTC/ ANMTC/LHVTC	"	05 days	150	SIHFW	30	30,000	30,000	5,000	7,500	72,500	05	3,62,500	All of them ha to be trained in a year
* 06.	Specialised Skill Based Training in Specialities like Cardiology, Endoscopy, Truma Care, I.C.C.U	Specia-lists		600	They should be trained in their Speciality wise in 5 years, in any of the recognised Institute in India or Abroad.									Budget not calculated
07.	Programme Management	G.A/Lay Secretary	30 days	150	HFWTC	30	30,000	1,12,500	30,000	45,000	2,17,500	05	10,87,500	30 persons have to be trained i a year.
08.	Programme Supervision Training	DHEO/DNO/ Dy.HEO/ASO/ ALO/H.S.	02 weeks	250	SIHFW	30	30,000	56,250	12,000	18,000	1,16,250	09	10,46,250	60 persons have to be trained i a year.
09.	Orientation Training	Jr.H.A.(M) and(F)	03 weeks	16,000	DTC	30	3,000	78,750	9,000	13,500	1,04,250	533	5,55,65,250	06 batches hav to be conducte in each DTC, each year.

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
10.	Re-orientation to Supervisory Staff.	Sr.H.A.(M) and(F)/BHE/ Etc.,	02 weeks	1,500	D.T.C.	30	3,000	56,250	6,000	9,000	74,250	133	98,75,250	02 batches to b conducted in ea DTC, in a year.
11a)	Induction Training to Newly Appointed Lab.Technicians	Lab-Tech-nicians	"	1,500	"	10	1,000	18,750	6,000	3,000	28,750	150	43,12,5000	300 persons hav to be trained i each year.
11.b)	Re-orientation Training to Inservice Lab.Technicians	"	"	1,500	"	10	1,000	18,750	6,000	3,000	28,750	150	43,12,500	"
12.	Orientation Training	Pharmasist	"	2,660	"	10	1,000	18,750	6,000	3,000	28,750	266	76,47,500	500 persons hav to be traine i each year.
13.	"	Refractionist	"	515	Minto Hosp.	10	5,000	18,750	12,000	3,000	38,750	52	20,15,000	100 persons hav to be trained i each year.
14.	"	Staff Nurse	06 days	5,317	DTC/ Dist.Hosp.	10	1,000	7,500	3,000	1,500	13,000	532	69,16,000	1000 persons ha to be trained i each year.
15.	"	X - ray Technicians	"	375	"	02	200	1,500	3,000	300	5,000	190	9,50,000	80 persons have to be trained i each year.
16.	"	FDA/SDA	"	3,746	DTC	30	3,000	22,500	3,000	4,500	33,000	125	41,25,000	750 persons hav to be trained i each year.
	Total												12,61,95,250	
	a) Salary and allowance to the Doctors of Sl.No.1, 12,000 Pay x 6 months x 300 x 5 years)												10,80,C0,000	
	b) Amount required for the componant of T.A of Sl.No.1												7,50,000	
	c) Amount required for the componant of D.A. of Sl.No.1												54,00,000	
													24,03,45,250	

* Budget could be calculate for Sl.No.5(A) & 6 Training Programmes as and when the Training started.

RESPONSE FOR THE DISCUSSIONS HELD ON JULY 5TH, 2000
IN CONNECTION WITH HEALTH, NUTRITION AND POPULATION FOR KARNATAKA
A PROJECT TO BE INITIATED WITH WORLD BANK ASSISTANCE.

1. What Is the Rationale of the Project ?

   To bridge the gap between the existing situation and the expected outcomes

2. How do you initiate to identify the gaps?

   By considering the data from :

National Family Health Survey.

   * NFHS- 1992-93 - Ist round
   * NFHS- 1999 - IInd round
   * Disaggregated data - RCH survey - 10 Districts- 1998 ✓
     RCH Survey- 20 Districts - 1999 ✓

3. What supplement is required to complete the picture of "gaps" ?

   * Mortality and Morbidity data of communicable and Non communicable diseases across the districts.

4. What are Medico - Social Problems apart from poverty and illiteracy ?
   * Low age at Marriage
   * Anaemia
   * High unmet need interms of spacing

5. What are Priority problems of the State ?
   * High perinatal mortality - High IMR
   * High Child Mortality
   * High Maternal Mortality
   * Epidemics of Malaria, Japanese Encephalitis, Kasanur Forest disease, Dengue,
   * Low immunization coverage levels
   * Low levels of Institutional Deliveries

6. Would you like to keep a uniform package of project interventions for the entire state ?

   Cluster District Approach needs to be adopted to take care of Regional Imbalance as determined by baseline data of the district.

7. Any thing about subcentre functioning ?
   * ANMs are overloaded with multifarious activities
   * Allocation of population should be reduced or activities restricted to no.of house holds

Not acceptable

* A trial should be given to upgrade the functioning of subcentre for " Institutional Services" instead of routine "outreach services"

* Jobs and responsibilities should be redefined to be more accountable

VIP

Get Philosophies of each.

8. Does the project incorporate the issues contained in the National Nutrition Policy. National Health Policy and National Population Policy ?

TO BE ADDRESSED ..

9. What is the crucial issue in setting right Regional imbalance ?

Pros & Cons

A separate organizational a structure of personnel with Non Medical Public Health Managers who will closely work with the Health System should be considered.

10. Any thing to say about Primary Health Centres ?

* The Needs of the people for PHC services should be assessed

* Demand for Drugs should be assessed

Modalities for providing (this).

* Higher inputs for atleast 50% of the Institutions to make them to provide round the clock services.

Yes.

* Mobility of the staff and Physical facilities should be supported

11. Which are priority training programmes ?

* Dai training

On-the-job training to be emphasised.

* IUD training

* Training for PRI's

* Public Health Training for all Doctors

12. What is the answer to improve the Health in the Urban slums ?

PIH

* Contractual services

No. e.g. : Immunization by private sector on payment basis

13. What others need strengthening ?

* Non communicable diseases - Mental Health, Diabetics and Disability Cancer Heart diseases etc.,

14. How do you rationalise curative care in PHCs ?

* Treatment protocol for each sickness / diseases eg. : Malaria , Pneumonia, Diarrohoea, TB, Respiratory infection, GI diseases, General weakness.

Work on these Protocols or Anograms

The treatment protocal should be uniform and documented and be made available to all Doctors.

15. What is lacking at PHCs for creating awareness through Inter Personal Communication ?

* Counselling centres with good counselling techniques and personnel

16. How do you create demand for services ?

* We must take each priority issue as a campaign approach through vigorous IEC activities on the lines of Pulse Polio Immunization Programme,

* Large no.of Health Educational Materials both for the staff and community

17 How can we ensure better and fast results ?

* Quality assurance
* Indicators of quality
* Who will measure ? How often ?
* Instrument for measurement

18. Is there any better strategy to bring down Maternal death rates ?

* Focussed attention to the "Safe Motherhood"
* Separate "preventive care" structure of Doctors to take care of ANC registration, identification of High risk pregnancy, referral, follow up etc.,

19. Is there any scope for better utilization of work force?

Yes, redefining the roles and responsibilities of BHEs, Pharmacisits, Projectionists, will result in optimal utilization

20. Which areas NGO could support ?

a. Area approach
b. Gap filling e.g. : Immunization
c. Awareness building
d. Training of community volunteers
e. Referral Services
f. Contractual Services.

Director
Health & FW Serivices
AR. Circle, Bangalore

Identification of Specific Essential Public Health Functions

The Round 2 Questionnaire focused on reaching consensus on a list of Essential Public Health Functions. The respondent group was presented with a generic list of 46 public health functions, which were categorized under the following main headings:

- Monitoring the Health Situation
- Protecting the Environment
- Health Promotion
- Prevention, Surveillance, and Control of Communicable and Non-communicable Diseases
- Occupational Health
- Specific Public Health Services
- Public Health Legislation and Regulations
- Personal Health Care to Vulnerable/High Risk Groups

Essential Public Health Function
Prevention, surveillance, and control of communicable and noncommunicable diseases • Ensuring immunization coverage • Ensuring disease outbreak control • Ensuring disease surveillance • Ensuring the prevention of injury
Monitoring the health situation • Ensuring the monitoring of morbidity and mortality • Ensuring the monitoring of the determinants of health • Ensuring the evaluation of the effectiveness of promotion, prevention and service programmes • Ensuring the assessment of the effectiveness of Public Health Functions • Ensuring the assessment of population needs and risks to determine which subgroups require services
Health Promotion • Ensuring the promotion of community involvement in public health • Ensuring the provision of information and education for health and life skill enhancement in school, home, work and community settings including the use of mass media • Ensuring the maintenance of linkages with politicians, other sectors and the community in support of Health Promotion and public health advocacy
Protecting the environment • Ensuring the production and protection of, and access to, safe water • Ensuring the control of food quality and safety • Ensuring the provision of adequate drainage, sewerage and solid waste disposal services • Ensuring hazardous substances and wastes are adequately controlled • Ensuring the provision of adequate vector control measures • Ensuring the prevention and control of atmospheric pollution
Public health legislation and regulations • Ensuring the review, formulation and enactment of health legislation, regulations and administrative procedures • Ensuring health inspection and licensing • Ensuring the enforcement of health legislation, regulations and administrative procedures
Occupational health • Ensuring the setting of occupational health and safety standards
Specific public health services • Ensuring school health services • Ensuring public health laboratory services • Ensuring emergency disaster services
Personal health care to vulnerable/high risk populations • Ensuring maternal and reproductive health care and family planning • Ensuring infant and child care

PRIMARY HEALTH CARE

SATISFACTORY?
UNSATISFACTORY?

WHO DELIVERS THE CARE?

- Primary health care teams
- In govt. medical service
- In voluntary organizations
- In private medical practice

WHY UNSATISFACTORY?

- Accessibility problems
- Ignorance
- Poverty
- Poor Reception
- Lack of trust

DOCTORS

- No personal stake
- Corruption
- Arrogance
- Poor training
- Lack of commitment
- Lack of motivation

SOLUTIONS PATIENTS

- Education as to their rights
- Improved accessibility
- Health care at the door
- Better interaction
- Health education

SOLUTIONS DOCTORS

- [illegible] education and training
- General medical practice a separate specialty
- Promotional opportunities for PG GPS [NBE,MD In F.M]
- Instilling a sense of pride
- Eradication of corruption???
- Patient is a person with dignity

Education Doctors [Contd.]

- Should have a stake in running the unit
- This could be personal/financial
- Unit can be run by groups of local and trained GPs
- Involvement of peoples representatives in the management
- Doctor as a public health person and a team leader.

Education doctors[contd.]

- General practice. Speciality?
- Incentives to the post graduation in GP
- Depts. of General Practice in Medical Colleges
- Grades of service same as other specialists
- Additional incentives
- Encourage General Medical Practice as a career.

PEOPLES INVOLVEMENT In health care delivery

- Monitoring the activity of the health team
- Right to demand and access to records
- Stake in running the institutions
- How not to corrupt officials
- learn to treat doctors as their friends
- Self management of illnesses

PRIVATE MEDICAL PRACTICE

- Satisfactory?
- Unsatisfactory?

From whose point of view?

- Mine
- General public's

MY VIEW

- Very Unsatisfactory.

WHY

- NOT COMPREHENSIVE
- NOT ROUND THE CLOCK
- INEFFICIENT
- OVERMEDICATION
- SYMPTOMATIC TREATMENT
- UNEDUCATED.

PEOPLE'S VIEW

- SATISFACTORY??

People's view contd.

- APPROACHABLE
- KIND
- PRODUCES RESULTS
- COMES TO THE HOMES
- KNOWS THE FAMILY
- LIVES IN THE COMMUNITY

WHAT THEY DONOT KNOW

- HE PRACTICES OUTDATED MEDICINE
- HE OVERTREATS
- UNDERDIAGNOSES
- HIDES HIS IGNORANCE EFFECTIVELY
- TAKES CUTS FROM OTHERS

WHY THEY DONOT KNOW?

- LACK OF EDUCATION
- INABILITY TO DEMAND QUALITY SERVICE
- APATHY
- DOCTORS HAVE KEPT THEM THAT WAY?

ARE GPS HAPPY?

- SOME THINK SO
- BUT MOST ARE NOT

WHY?

- Knowledge that they are not true to their professional ethics
- Working in professional isolation
- No avenues of professional advancement
- Insufficient financial returns
- Loss of paying and educated patients to other doctors

WHAT IS THE SOLUTION

- BE COMPETENT AND UPTODATE
- PROVIDE COMPREHENSIVE SERVICE
- START GROUP PRACTICES
- PURPOSE BUILT PREMISES
- 24 HOURS COVERAGE
- DONOT EARN UNETHICAL MONEY

THANK YOU

FOR A PATIENT HEARING

NP-24

A proposal for CHC to work with the Department of Health and Family Welfare (DHFW) to develop strategic approaches towards a comprehensive health care system for the State, that will be part of a project proposal to the World Bank for the next phase of funding.

-- A discussion note for the EC meeting on 19th June 2000.

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1. Background

1.1 The Commissioner of Health & Family Welfare, Mr. Sanjay Kaul, in a first meeting on 1st June 2000, and in a subsequent meeting with the CHC team and consultants, on 5th June, requested CHC to become a partner with the DHFW and STEM (a consultancy group) in developing the above project proposal.

1.2 Karnataka currently has a relatively small number of projects (all sectors) with World Bank funding. Those pertaining to health are :

a&b) India Population Project (IPP) VII and IX (primarily geared to infrastructure support for population/ family planning/ MCH/ work in urban and rural areas respectively).

c) The Karnataka Health Systems Development Project (KHSDP) for strengthening of secondary level health care institutions (taluk and district general hospitals).

d) RCH (Reproductive & Child Health)

e) HIV/AIDS – through NACO) as part of the National

f) Blindness control) Programme

g) RNTCP – State proposal currently under preparation and negotiation.

These projects cover specific components of the State Health Systems and have functioned in relative isolation with duplication of efforts. Several of the bigger projects (IPP VIII, IX, KHSDP) are nearing the end of the project cycle. They have performed reasonably well mainly in the area of brick and mortar infrastructure building and to some extent in training, development of manuals and HMIS system for secondary care institutions. Health Directorate staff express having not felt involved as a whole. The vision in terms of health gains, in decision making and planning health agendas and activities have not been clear and have got further lost in the process of implementation. Utilization of funds has been low e.g., 33 % in IPP IX and 50 % in KHSDP indicating a low implementation capacity and unrealistic planning.

1.3 There are fiscal constraints in the Government of Karnataka with only Rs 15-20 crores being available for services per annum in the DHFW, for the entire State, after payment of salaries etc. Government of Karnataka is therefore planning to approach the World Bank for another project in Health & Family Welfare going up to Rs 750 crores, over a 5 to 7 year period, commencing probably from 2001-2.

1.4 The present government has proactively approached the World Bank for funding to several sectors and being one of the "reforming" states is likely to receive preferential attention.

1.5 The DHFW, Government of Karnataka will use the recommendations of the Karnataka Task Force on Health and Family Welfare (KTFH) in the project proposal. It has already used the Interim Report to prepare a base paper for the last visit of the World Bank team. It states that it is interested in evolving a comprehensive, integrated health policy and approach. The World Bank is also moving in this direction with its Health, Nutrition and Population (HNP) department.

2. Proposal to CHC

2.1 This has been through discussion so far. If CHC is agreeable, we have to write our own Terms of Reference (TOR) very soon.

2.2 The specific request is for CHC to help the State Government, DHFW, to develop and write up operational strategies by which a ***comprehensive health, nutrition and population policy can become implementable through existing public, voluntary and private health service providers.***

2.3 This will require analytical working that derives from documentation and studies of the existing system, an identification of needs and gaps, and adequate justification or rationale for whatever strategies are proposed.

2.4 **Time frame:** The final project document should be ready by July to September 2001 (possibly by March 2001). More immediately there is need for an initial concept paper for a first round of discussion, around 17th July, between World Bank staff (Dr. Nawaz/ Dr. Peter Heywood) and the government.

The process of evolving a World Bank proposal involves frequent Mission visits, many revisions, pre-appraisal, appraisal and finalization. The actual project period is for 5 to 7 years.

2.5 There could be 3-4 people taken on to work full time on this project. It was suggested that we calculate person-months required and work around it for CHC to put up a TOR covering objectives and specific tasks required to develop a strategy document for Health, Nutrition and Population.

A project proposal could be developed covering person time, infrastructure support, field work, number of short studies necessary, travel, computer time, office staff time, stationery, etc.

2.6 **Linkages:** A ***Project Preparation Committee*** of 10-15 members will be set up with senior government Directorate staff and others. It was also suggested that we could link up with a strategic group of researchers through Strategic Management Board, as was done in U.P.

STEM Consultancy will be a partner and will develop unit costs, actual positions, etc. the relationship with these structures will need clarity.

The Strategic Planning Cell of KHSDP and the planning body in the Directorate, will need to be involved and strengthened through this process.

2.7 Dialogues and communications with the Task Force and Task Force Studies will need to be close. This project proposal will in fact be operationalising the recommendations of the Task Force.

2.8 Mechanisms will need to be set up for regular discussions/ communications between the CHC group working on the proposal, with the concerned Secretariat & Directorate Staff, with a larger group of researchers/ institutions who will be contributing to this process.

2.9 A process of consultation/ discussion with the CHC team and the EC will be undertaken before responding to this request. If we do take on this responsibility, it will impact greatly on existing and ongoing CHC work. This will need discussion. Our other major partners will also need to be kept informed.

TRAINING IN HEALTH MANAGEMENT

GOAL:

- To develop managerial skill and technical competency among government health functionaries in Karnataka through problem based, Task Oriented and Participatory Learning Techniques.
  ("*A shift in emphasis from form filling to the actual utility of the health activity*")

PROBLEM STATEMENT:

- The curriculum for basic MBBS degree does not adequately prepare a person to handle managerial responsibilities of the Primary Health Centre.
- Training in medical colleges is often inadequate in the actual field level management of National Health Programs and implementation of National and State level policies.
- Introduction of Medical Ethics as a compulsory subject in medical colleges is a recent directive of the Health Sciences University.
- Forensic Medicine and handling of Medico-legal cases is very often dealt with only theoretically, with little or no actual practical experience in the medical colleges.
- Medical Officers in position often have inadequate technical support and no definite contact person or contact Institute for help in management of day to day problems or issues that arise at the primary Health Centre.
- The change in position from PHC medical officer to higher administrative levels is not always accompanied by adequate training in additional administrative competency.
- Continuing Public Health Education programs are very often not available and if available are not adequately utilised by the medical officers.
- Promotion from ANM to Lady Health Visitor is not always accompanied by any formal additional training in administrative skills.

OBJECTIVES:

- To train doctors who have just been recruited to government primary health centres/urban health centres in administrative skills to manage staff and activities at the given centre through problem based and participatory learning techniques.

- To train these doctors in grass root level implementation of National Health Programs and the National and State level Health Policy through guided discussions, simulation exercises and exposure to field level activities.

- To sensitise doctors in the government health system to ethical and legal issues relevant to their practice.

- To make the medical officers aware of the continuing public health education facilities available and incentives offered for successfully completing the same.

- To train doctors in additional administrative skills when they have been promoted to higher administrative levels.

- To train the LHVs in additional administrative skills when they have been promoted from the post of ANM.

'TYPES' OF TRAINING:

❖ Continuing Public Health Education:

Continuing Public Health Education is a necessity and medical officers attending these programs must be given incentives in the form of additional increments. Continuing Public Health Education may be through:

- IGNOU (Indira Gandhi National Open University) and distance learning modules or programs.
- Short-term training programs at Rural Institutes such as Gandhigram Institute of Rural Health or Rural Unit for Health and Social Awareness (RUHSA), Christian Medical College
- Refresher Courses in clinical practice as applicable in a primary health care setting for Primary Health Centre Medical Officers at St. John's Medical College.
- Attending Training programs on specific National program updates or revised strategies in a specific program conducted by apex institutes responsible for the same. Eg. Training program on the RNTCP (Revised National Tuberculosis Control Program) at NTI (National Tuberculosis Institute)

❖ INDUCTION TRAINING:

TARGET GROUPS FOR INDUCTION TRAINING:

1. **Medical Officers** at Primary Health Centre & Taluk Level:
   - New Appointments
   - Change of postings to different department/higher administrative level.
   - Contract postings.
- The training should be compulsory before joining duty.
- There may be a pilot phase to assess if this pre-employment training is workable. If it is not it must be made mandatory that every person of the above target category successfully completes the training within six months of joining. This may be made a mandatory criteria for confirmation of a probationary post to permanent or for continuation of a contract appointment.

2. Auxiliary Nurse Midwives who have been promoted to take on additional responsibilities as an LHV and junior health assistants male who have been promoted to Health Assistant (male) must also attend a training program for development of managerial skills related to health.

VENUE for Induction Training:

- The venue for the Induction Training Programs will be the Regional Health Training Institutes.

FACULTY for Induction Training:

- This could include:
  1. Faculty of the Regional Institutes
  2. Co-opted faculty from Medical Colleges and NGOs, preferable with a background of Community Health and with experience of working with government health centres and government programs.

- The Regional Institutes may need to have "Training of Trainers" (TOT) program to equip these faculty to effectively use Participatory Learning Techniques. Trainers who are co-opted from Medical Colleges will also have to undergo this (TOT) training program, before they are recruited as faculty.

- The TOT training's may be conducted by faculty from medical colleges or NGOs, who have been trained and are experienced in using these participatory learning techniques. (St. John's Medical College, Department of Community Health has been using participatory learning techniques in most of its training programs)

ADMINISTRATIVE CONTROL:

- A "Public Health Education Council" to be formed under Rajiv Gandhi University and the Government, to guide and supervise the Regional Institutes. This council may consist of experts in Community Health, Medical Ethics, Legal Medicine, Clinical faculty such as Obstetrics, Paediatrics or General Medicine, Health Education, Sociology & Anthropology and Personal and Financial Management.

DURATION OF TRAINING:

- The duration of Induction Training will be of at least two weeks for new appointments.
- One week is considered sufficient when there is a change of posting with promotion.

CONTENT OF TRAINING:

The content of the induction-training program will include:

I. Training to develop **Administrative skills**
II. Training to develop **Technical skills.**

I. Administrative skills:
I.1: Communication Skills.
I.2: Skills for effective supervision of staff and activities.
I.3: Skills for effective monitoring and evaluation.
I.4: Skills for optimum use of resources.
I.5: Skills to liaison with other governmental or non-governmental agencies.

II. Technical Skills include:
II.1: Skills in curative health care
II.2: Skills for preventive and promotive health care
II.3: Skills for training and facilitation of staff and their activities.

I.1: Communication skills:

- Communicating with staff of the PHC
- Communicating with higher level administrative staff
- Communicating with other governmental agencies
- Communicating with the community and community members.

I.2: Skills for effective supervision of staff and activities:-

- Supervision skills
- Personnel Policies
- Performance Appraisal
- Resolving Conflict
- Building team work

I.3: Skills for effective monitoring and evaluation:

- Skills to develop or identify indicators for monitoring, control and evaluation of inputs, outputs and outcomes.
- Skills for register maintenance and documentation.

I.4: Skills for optimum use of resources.

- Skills for better time management
- Skills for optimum use of moneys (budget) allocated.
- Skills for effective indenting and control of drugs, vaccines and equipment or vehicles.

I.5:Skills to liaison with other governmental or non-governmental agencies.

Skills to effectively communicate with:

- Block development Officer.
- Village Panchayat
- Non-Governmental Organisations
- Village level Health Committee

II. Technical Skills:

II.1: Curative skills for:

- Effective running of the OPD (Out Patient Department) & (In-patient).
- Emergency care and referral.
- Appropriate Management of medico legal cases.
- Effective and efficient use of laboratory services.

II.2: Preventive and Promotive Skills:

- Reproductive and Child Health program implementation, including family planning.
- Epidemic Containment measures.
- School Health Services.
- Anganawadi worker training and supervision.
- Sanitation.

II.3: Training Skills to:

- ❖ Conduct or facilitate inservice training of PHC staff in program activities and register maintenance.
- ❖ Identify staff training needs.
- ❖ Identify appropriate resources to depute staff for development and training.

METHODOLOGY OF TRAINING:

The training methodology must include techniques, which encourage participation of the trainees. Problems must be based on field level realities. Suggested methods that may be used in the process of training include:

- Case studies.
- Epidemiological exercises.
- Role-play.
- Group discussion.
- Simulation exercises at individual and group level.
- Simulation games
- In addition to Lecture discussions and Panel discussions.

Follow up and Evaluation:

It is an accepted fact that follow up and evaluation of any training program is an integral part tc its success in achieving desired objectives. It is therefore suggested that:

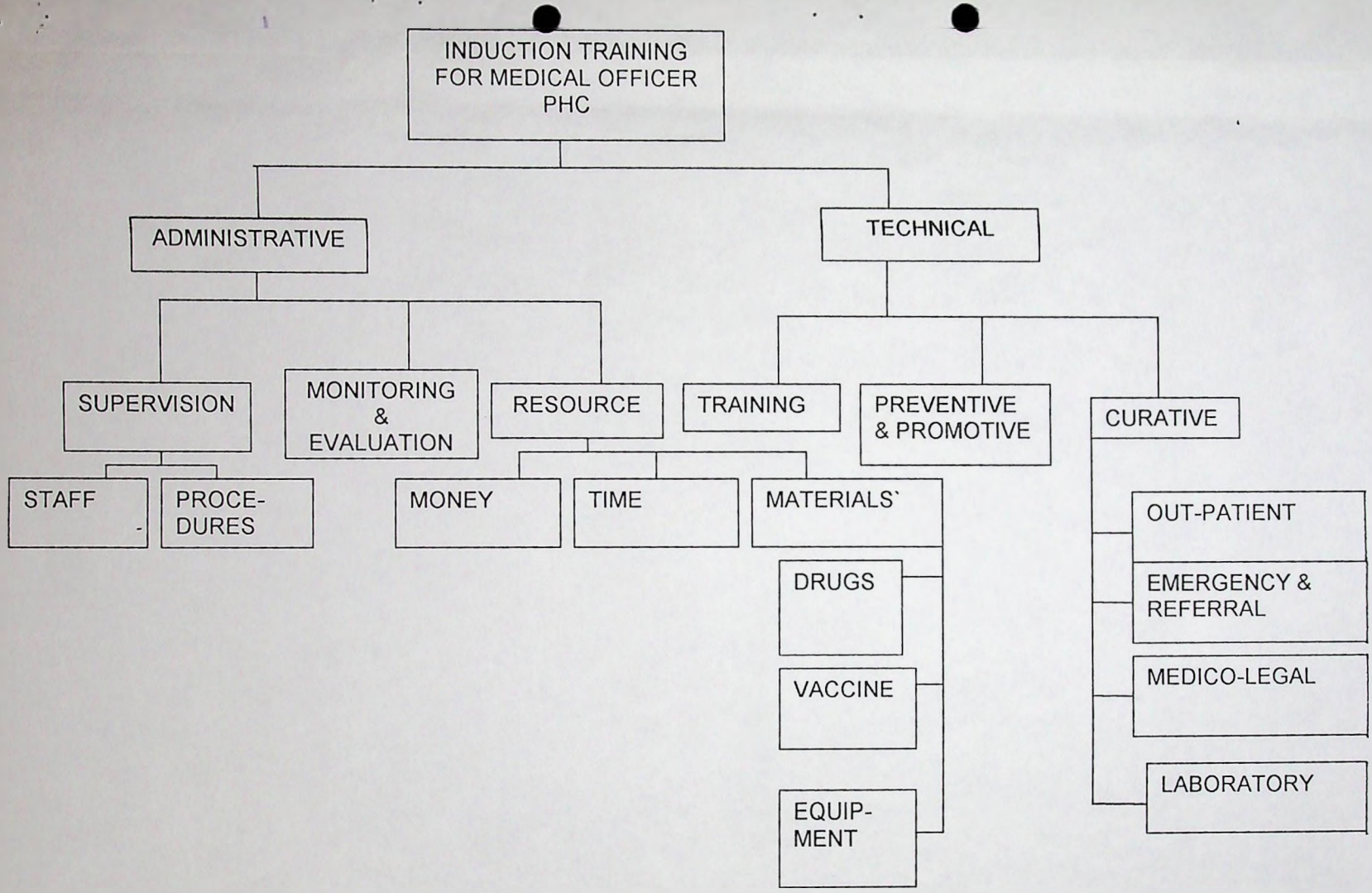
There be at least one follow up meeting of the participants about 3-6 months after the training program. During this alumni meet, issues that are relevant but were not dealt with during the training program may be identified through a participatory process. These may be addressed to the extent possible during the alumni meet. However, suggestions, which arise during this meet, must also be incorporated into future courses.

In addition, it will be useful some of the training programs are evaluated by external faculty, who are appointed for the purpose. The evaluation must include both process and content of training.

An annual evaluation of the training programs may also be carried out by experts, internal and external, to determine to what extent objectives of the training have been achieved and the impact of the training program. Constructive suggestions arising from the evaluation must be incorporated into future training programs.

Suggested reference materials:

1. Management Training Modules for the Medical Officer, Primary Health Centre, NIHFW, New Delhi.
2. On being in charge: A guide for middle level management in Primary Health Care, McMahon (Rose Mary) et al, WHO 1980.
3. On being in charge: A guide for middle level management in Primary Health Care, McMahon (Rose Mary) et al, WHO 1992.
4. Epidemiology and Management for Health Care for All : P.V. Sathe and A.P. Sathe, Popular Publications, 1990


INDUCTION TRAINING FOR MEDICAL OFFICER PHC
ADMINISTRATIVE
TECHNICAL
SUPERVISION
MONITORING & EVALUATION
RESOURCE
TRAINING
PREVENTIVE & PROMOTIVE
CURATIVE
STAFF
PROCE-DURES
MONEY
TIME
MATERIALS`
DRUGS
VACCINE
EQUIP-MENT
OUT-PATIENT
EMERGENCY & REFERRAL
MEDICO-LEGAL
LABORATORY

Proposed Schedule, Methodology and Duration *(in Italics)*

Date/Day/ Theme	Session 1	Session 2	Session 3	Session 4
Day:1 Monday: Introduction to participants and course	Registration & Inauguration. Self Introduction (Ice-breakers) (Duration: 60 minutes)	Introduction to the course: overall objectives, Expectations: *Lecture discussion, verbal & written expectations from course-linking expectations with course content. (Duration 60 minutes)*	Roles & responsibilities of trainers and participants: *Exercise & discussion (Duration: 30 minutes)*	Introduction to Management in the context of PHC MOH: *Reading, discussion individual & group exercises. (Duration: 90 minutes)*
Day:2 Tuesday Organisation of Health Care Services:	Organisation of Health Care Services – a brief review: *Lecture discussion (Duration: 60 minutes)*	Primary Health care revisited, National Health Policy in the context of 2000 and beyond: *Lecture discussion (Duration: 60 minutes)*	Overview of National Health programs: *Panel discussion (Duration: 75 minutes)*	Membership roles and responsibilities of health teams at PHC, subcentre and village levels: *Group exercise (Duration: 45 minutes)*
Day:3 Wednesday: Ethics & RCH	Medical Ethics in PHC settings: *Lecture & Exercises (60 minutes)*	Essential Obstetric care during pregnancy, delivery & postnatal period. *(Handout + Lecture discussion with exercises: 90 minutes)*	Essential Care for the Newborn & Infants *(Lecture discussion with demonstration on model of baby) Duration: 90 minutes)*	Open Session on RCH & related programs *(Question answer) Duration: 30 minutes)*
Day:4 Thursday Monitoring, Control & Evaluation, Supervision	Handling Medico-legal cases in a PHC: *Lecture discussion & case study (60 minutes*	Monitoring, Control, Evaluation-Terms & Definitions: *Lecture discussion Duration:30 minutes*	Development of indicators for monitoring and evaluation at PHC: *group exercise (Duration: 90 minutes)*	Supervision: its role in the PHC *Lecture discussion* Format, content and use of supervisory checklist: *Group exercise (Duration: 90 minutes)*
Day:5 Friday: Supervision & Team work	*Field Exercise on testing the supervisory Checklist* *Duration: 180 minutes*		Discussion & finalisation of supervisory checklist (Duration: 45 minutes)	Characteristics of a team and importance of team work: *Group exercise & role play- 45 minutes)*
Day:6 Saturday: Leadership, motivation,	Styles of leadership: *Lecture discussion, Individual Exercise Duration: 45 minutes)*	Motivation : *Exercise & handout (Duration: 60 minutes)*	Evaluation of the week's learning: *(Formal & Informal feedback-written & verbal- 45 minutes*	

Date/Day/ Theme	Session 1	Session 2	Session 3	Session 4
Day:7: Monday: Effective Communication & Community participation	Definition of types of communication & barriers to communication: *lecture discussion* *Duration: 60 minutes*	*Exercises on effective communication, conduct of staff meeting.* *Duration: 90 minutes*	Community, community organisation, community participation in Health: *Lecture discussion* *Duration: 45 minutes*	Indicators for assessing community participation: *Group exercise based on case studies (video based) –45 minutes*
Day:8: Tuesday Personnel management & Vehicle management	Personnel policies for government health personnel: grades/salaries/benefits/allowances/ promotion/recruitment/ disciplinary measures / transfer/retirement: *Lecture discussion* *Duration: 90 minutes*	Staff conflict: *group exercise (45 minutes)*	Performance appraisal: *Lecture discussion* *(30 minutes)* Confidential report: *Role play and exercise.* *(45 minutes)*	Vehicle management- priorities, policies and procedures: *Exercise, discussion & reading (60 minutes)*
Day:9: Wednesday Management analysis and cold chain	Management analysis of the PHC system: *Field visit* Improving management systems: *Field visit followed by discussion* *(Duration: 180 minutes)*		Cold chain system and vaccine storage requirements: *Demonstration, Lecture discussion & exercise* *(Duration: 180 minutes, includes visit)*	
Day:10: Thursday: Material & financial management Training skills	Materials management:- Policies and process: *Lecture discussion & Exercises* *Duration: 90 minutes*	Financial procedures, budgetting, imprest, TA/DA, festival advance,: *Lecture discussion* *Duration: 90 minutes*	Training for staff of PHC: methods and evaluation: *Lecture discussion* *(Duration: 45 minutes)*	Drawing up a lesson plan for training program & micro-teaching session *group exercise* *Duration: 90 minutes*
Day:11: Friday Patient referral system & Action Plans	Patient Referral system:TriageConcept Policies, procedures and referral slips: *Lecture discussion & Exercise – 45 minutes*	Types of data and methods of data collection at PHC: *Lecture discussion* *Duration: 45 minutes)*	Action Plans & Gantt Charts: *Group exercise* *(Duration: 90 minutes)*	Implementation & coordination of PHC health Services: *Group Exercise* *(60 minutes)*
Day:12: Saturday: Evaluation	Formal Evaluation of the course and informal feedback	Valedictory function & distribution of certificates		

NP 25

OFFICE OF THE COMMISSIONER HEALTH AND FAMILY WELFARE SERVICES, IPP BUILDING, ANAND RAO CIRCLE, BANGALORE.

URGENT/TOP PRIORITY

FAX MESSAGE

To

All DHOs in the State.

Sub: State level meeting of DHOs on 24th and 25th January 2001
Agenda: Integrated Health, Nutrition and Family Welfare Services Project with World Bank assistance

PLEASE COME WITH THE FOLLOWING INFORMATION TO THE MEEETING ON 24TH AND 25 JANUARY 2001 WITHOUT FAIL.

LIST, WITH FULL NAMES, OF ALL PHCS SANCTIONED TO YOUR DISTRICT UNDER THE FOLLOWING HEADINGS:

A) LIST, WITH FULL NAMES, OF ALL PHCS HAVING THEIR OWN BUILDINGS.
B) OUT OF A) ABOVE LIST OF PHCS HAVING i) MO QUARTERS, AND ii) ANM/STAFF NURSE QUARTERS. i) AND ii) SHOULD BE BROUGHT SEPARATELY.
C) LIST OF PHCS WHERE i)MO QUARTERS AND ii) ANM QUARTERS ARE URGENTLY REQUIRED. PRIORITY TO BE GIVEN WHERE RENTED ACCOMODATION IS NOT AVAILABLE.
D) LIST OF PHCS, WITH FULL NAMES, OF PHCS PRESENTLY FUNCTIONING FROM i) RENTED BUILDINGS AND ii) PHU BUILDINGS. i) AND ii) SHOULD BE BROUGHT SEPARATELY.
E) OUT OF) ABOVE, LIST OF PHCS WHERE BUILDINGS ARE REQUIRED URGENTLY. SELECTION SHOULD BE BASED ON AVAILABILITY OF SITE, AND POPULATION BEING SERVED.
F) LIST OF PHCS SANCTIONED BUT NOT OPERATIONALISED OR FUNCTIONING AT PRESENT BECAUSE OF ABSENCE OF BUILDING, AND NON-SANCTION OF STAFF.
G) LIST OF PHCS UPGRADED TO CHCS BY GOVERNMENT ORDER BUT NO CHC BUILDING HAS BEEN SANCTIONED.
H) LIST OF PHCS REQUIRING MAJOR REPAIRS OR IN A VERY DELAPI—DATED STATE.

THE ABOVE INFORMATION SHOULD BE PROPERLY VERIFIED PERSONALLY BY YOU AND CROSS-CHECKED WITH RECORDS. IF INFORMATION IS NOT AVAILABLE A SPECIAL MEETING OF MOS OF PHCS MAY BE CONVENED TO FINALISE THE INFORMATION. PLEASE ENSURE YOU COME TO THE MEETING WITH COMPLETE INFORMATION.

DHO (27)
16-1-2001

SANJAY KAUL

DISTRICT HEALTH & F.W. OFFICE, BLDG. BLOCK

V. D (H&P) for information and necessary action.

JD(H)
16/1/2001

HNP file

DRAFT

Review of Project Proposal:
Karnataka Integrated Health, Nutrition and Family Welfare Services Development Project

1. A World Bank team of Christopher Lovelace (HNP Sector Director), Tawhid Nawaz (team leader), David Peters, and Hnin Hnin Pyne met with the Karnataka Health, Nutrition, and Family Welfare team, led by A. Sengupta (Principal Secretary, Department of Health and Family Welfare), S. Kaul, Commissioner, HFW, and consultants from the Community Health Cell to review the draft project proposal for a Karnataka Integrated Health, Nutrition, and Family Welfare Services Development Project. The team also met with the Karnataka Health Task Force to discuss key sectoral concerning health financing and roles of the public and private sector in Karnataka, that would need to be addressed in the context of a proposed project. This note summarizes the proposed next steps.

2. The Karnataka team was congratulated on the quality of the initial project proposal. The draft outlines some of the main goals, health outcomes, values and principles for a proposed project, including a large set of activities that would be planned in the HNP sector. It provides a good basis for further development of health sector plans and a potential project. The preparation team intends to reformulate a Project Implementation Plan for a discrete project, which would support a comprehensive HNP policy and program.

3. The Karnataka team outlined their early thinking on what types of project goals and components would be included. The Karnataka team discussed the relative merits of different project and program approaches, and concluded that a discrete project would be proposed, based in a comprehensive health policy and strategy. The main goals would be to... The main components proposed include: .... The Bank team supported these general directions, and also discussed some of the critical aspects of the health system that have been under-developed in the past. These include developing a vision and first steps to address the long-term health financing distortions; taking steps to capture the energies of the private sector while counteracting its market failures; taking meaningful steps to take demand-side interventions in addition to making the health system more responsive to people.

4. Some of the key next steps planned are:

a. Approval from Union Ministries of Finance and Health and Family Welfare. The Karnataka DOHFW would seek endorsement of a proposed HNP project from the Union Ministries to proceed with a project proposal to submit for potential IDA funding.

b. Development of a Project Implementation Plan (PIP). The key components of a PIP are discussed below (para 5).

c. Health Policy Framework. The preparation team would prepare a comprehensive state HNP policy. Some of the proposed features of a health policy framework are outlined in para 6.

d. Financial and Economic Analysis. As part of the preparation, the resource flows into the health sector in Karnataka should be assessed. This should fit within the medium term expenditure framework of the state. The analysis should not only assess the state's ability to

finance incremental recurrent costs of the proposed project, but map all the main sources and uses of resources available to the health sector in Karnataka.

e. Institutional Analysis. The preparation team should review the organizational mandates, management systems, organizational structures, and relationships of the health sector, including the public sector and key actors of the private sector. Some questions to be addressed include: What types of responsibilities, authorities, resources, and accountabilities are held at central, state (and local) levels for HNP responsibilities? What types of decisions are actually being made at the different levels? How should responsibilities, authorities, resources, and accountabilities change?

f. Social Analysis. An assessment of the potential impact of the project and health policy on different stakeholders of the state should be conducted. A special focus should be on the poor, scheduled tribes, and other vulnerable groups.

Project Implementation Plan

5. The following are the key components of the Project Implementation Plan:

a. A summary situation analysis of the health sector in Karnataka, including health status, epidemiology, organization of the health care system (public and private), service utilization rates, financing, institutional, management, technical and quality issues in the sector, linkages of the proposed state health project with other donor assisted and government programs in health, nutrition and population.

b. A clear articulation of the rationale for the overall project approach (i.e. why components are included and why they are phased as proposed), including the risks and benefits from the proposed interventions. The PIP should include a description of the long term vision for the health sector, and what is expected to be achieved over the life of the project.

c. A description of the project objectives, measurable indicators, means of monitoring, and critical assumptions. Baseline and target levels should be determined.

d. A description of the project management arrangements with respect to who will manage and implement the project at the State, district and local levels. This should outline the decision-making processes, responsibilities and accountabilities, and structure. In particular, financial management and procurement arrangements should be described. Financial management should be in accordance with the Loan Administration Change Initiative.

f. A description of the major project components and activities. The implementation schedule should be detailed for the first two years of the project, and outlined for the remainder of the project. This should cover all components, benchmarks for major inputs, achievements and monitoring and evaluation

g. A detailed breakdown of project costs by components and sub-components.

h. A detailed procurement plan for the first year of the project. Bidding documents requiring prior clearance with the Bank would be developed as part of the preparation process.

i. An outline of an environmental action plan addressing health care waste management.

Health Policy Framework

6. The state plans to develop a comprehensive state health, nutrition and population policy, which would also provide a basis for the proposed project. The mission discussed some of the key issues to be addressed by the policy, which would include identifying:

- HNP outcomes as goals
- how to protect interests of vulnerable groups
- the long term health financing system toward which the state will work
- criteria for resource allocation of public funds, and how private funding of health will be influenced
- how to monitor and improve targeting of public resources on the poor
- the role the public will play in keeping the health system accountable
- how to bring convergence between health, family welfare, women and child development programs
- how centrally sponsored schemes will be managed at state, district, and local levels
- how the state will work with the private sector, including formal and informal for-profit providers, and non-profit NGOs
- the roles of water and sanitation programs in health, and how to coordinate with HNP
- how performance of the health sector will be monitored
- key innovations and pilot tests to be conducted

IEC Strategy Matrix

Sr. No	Communication strategy	Target group	Nature of Message	Media	Timing When to Do ?	Action initiated under KHSDP
1.	Increase awareness of the services provided by First referral hospitals particularly on lower income and disadvantaged groups such as tribals and their by increased utilisation of the system	Individuals 1. Anganwadi worker 2. School teacher 3. Mahila Swastha Sanghas 4. ANM 5. Multipurpose health worker 6. Agriculture assistants 7. Grampanchaya t Secretaries 8. Patients in the hospital 9. Z.P./G.P. Members	Inform about the renovations and the new equipments, new facilities created at the hospitals. Bring awareness about the referral system. Distribute a copy of the hospital layout with the Do's and Don'ts.	Hand bills to be given to the individuals	This should be a hospital specific area linked activity to be taken up as and when the physical equipment and man power facilities improve. It should not be initiated before bringing in the improvements.	The KHSDP has completed the civil work and equipment installation in sixty hospitals. It has been recently possible for the KHSDP to take care of the mis-match in the posting of the technical personnel to a great extent. In these developed hospitals and in the health care establishments in the surrounding area referral linkages are being established. Printed materials have been supplied/is being supplied to Schools/Anganwadis/Multipurpose health workers/Grampanchayats. Now onwards hospital link IEC activities would be given greater emphasis. It's time for KHSDP to begin its IEC activities in these six health facilities.
		Groups 1. Citizens 2. SC/ST Population	Inform about the renovations and the new equipments, new facilities created at the hospitals. Bring awareness about the referral system. Bring awareness about Yellow Card Programme	Posters Video Street Plays Organise tours for the Media Personnel	Start preparing the posters and video presentations about Yellow Cards before the programme is launched. Commence the street plays after improving the first referral unit.	Posters have been prepared on Yellow Card scheme. They have been displayed in all hospitals of the state. Further through the taluka medical officer the same has been sent to the sub centre also. At the District level the district health committee is printing and distributing details of the Yellow Card programme for the members of the SC/ST community. Tours have been organized for the media personnel. A video presentation has been prepared on Yellow Card scheme. Steps have been initiated to organize street play on this. Major facility linked IEC activity has been initiated in the name of the hospital raising day celeorations. Detailed guidelines are also issued.

2.	Improve access to the expanded range of all reproductory health services among whom	1. All women 2. Teachers 3. Anganwadi Workers 4. Women Patients in the hospital	About the women's health check-up programme under KHSDP.	Hand bills for individuals and Video presentation Street Play Organise tours for the Media Personnel	Finalise the format of handbills and the video presentation six months after implementing the pilot project in Mysore District.	Training Manuals and information booklets have been prepared. Handbills have been prepared and distributed to target beneficiaries in the pilot district of Mysore. A videocassette has been prepared on this subject. Maintaining menstrual hygiene has emerged as a very important issue and a number of activities have been planned in this regard with the help of an NGO.
3.	Motivate all hospital staff and maintain good standards of patient care in terms of care, courtesy and comfort so that the quality of services received patients is enhanced.	1. Doctors 2. Nurses 3. Ward boys 4. Maintenance Staff and 5. Other Paramedics	Messages about providing proper care, courtesy and comforts to the patients in the hospital.	Training to the staff to be patient and visitor friendly. Preparing persuasive posters.	Prepare hospital specific instruction labels and stick them immediately after completion of civil works. Should be done as and when the individual hospitals are complete.	They have been displayed at the most appropriate places in the sixty developed hospitals. Samples are presented in the IEC album.
4.	Sensitise hospital staff to hospital equipment maintenance issues.	Doctors Nurses Paramedics and Patients	1. Print equipment use and caution guidelines and paste it near all equipments. Put appropriate stickers in the hospital at appropriate places 2. Prepare appropriate labels on management of waste in the hospital.	Stickers Stickers	Prepare hospital specific instruction labels and stick them immediately after completion of civil works. Should be done as and when the individual hospitals are complete.	Stickers have been prepared to sensitize the hospital staff for hospital equipment maintenance issues. They have been displayed in the hospitals that are being commissioned. This has been done in all the sixty hospitals. Samples of the label are presented in the IEC album.
5.	Promote hospitals services to specific groups in a manner that increases their willingness to utilise this services and where possible to share the cost of service delivery.	Private practitioners, shop keepers and persons living in pucca houses.	Information about special wards and new facilities created	Hand bills, News paper bulletins	This should be a hospital specific area linked activity to be taken up as and when the physical equipment and man power facilities improve. It should not be initiated before bringing in the improvements.	This is basically a hospital-linked activity and will be initiated from year 2000 onwards. This will also be a part of the hospital day celebration activity.
6.	Address specific public health issues such as road	K.S.R.T.C		Posters	Can be taken up at any time.	These activities are already initiated by the Traffic Police

Additional 2+1

List of Furnitures Equipments proposed to be supplied to PHCs

	I	*Furniture - Office / Hospital*	
✓	1	Executive revolving Chair	2
✓	2	"S" Type Continuous arm chair	18
✓	3	Office Table - Steel	6
✓	4	Steel cup board/ Almirah	10
✓	5	Revolving Stool with stainless steel top	6
	6	Attendant stool	4
	7	Wooden Stool	-
✓	8	Rack Slotted Angle with 5 compartments	8
	9	Operation table	2
✓	10	Examination table	2
	11	Delivery table	2
✓	12	Foot Steps	8
	13	Bed side screen	4
	14	Bed side lockers Fibre/Stainless steel	6
✓	15	Iron Cot Adult	6
✓	16	Mattress	6
✓	17	Pillows	6
	18	Saline stand	6
	19	Dressing trolley	2
	20	Instrument Cabinet	2
✓	21	Wash basin with stand	4
	22	Dressing table	1
Add.	23	Stretcher	1
Add.	24	Wheel Chair	1
	II	*Equipments*	
	1	Autoclave with burners - 2 bin (4)B	2
	2	Foot suction apparatus	2
	3	Instrument sterilizer	2
	4	B.P Apparatus	3
	5	Weighing machine - Adult	2
	6	Weighing machine - Baby	1
	7	Oxygen cylinder - IOL	3
	8	Oxygen cylinder trolley - IOL	3
	9	Kidney tray 6" + 10"	6 + 6
	10	Dressing / Instrument tray with lid	3
Add.	11	Nebulizer	2
	12	Anbu Bags	
Add.	13	Ambu Bags 200 CC, 500 CC & Adult	2+1+1
Add.	14	Laringoscope with blades (Infant, Child and Adult)	1 Each

List of Furnitures Equipments proposed to be supplied to PHCs

15	Enema can set	2
16	Urine pot	2
17	Bed Pans	2
18	PM Kit Box	2
III	*Surgical Kits*	
1	Delivery kits	2
2	Episitomy kits	2
IV	*Surgical Instruments*	
1	Curette uterine sharp/blunt	2/2
2	Dilator uterine double ended Heggars	2 sets
3	Forceps - tissue holding young 170mm soft rubber jaws - ss	6
4	Forceps - uterine velselum - straight jacombs 250 mm	2
5	Knife handle for major surgery	6+6+6
6	Knife blade for major surgery	3 do 3+3D+3F
7	Speculum vaginal bivalve cusso's graves, small, medium	
8	Retractor viginal SIMS medium blade 31 X 80 mm - ss	Large 3 Small 2
9	Speculum vaginal double handed SIMS 165mm long ss	Large 3 Small 2
10	Sound uterine simpon 300 mm graduated in 20 mm	2
11	Speculum nasal SS	2
12	Forceps Kellys ST 140mm S.S	-
13	Forceps Sponge holding St 228 mm SS	6
14	Allis forceps tissue with teeth 150 mm SS (3 sizes)	12+6
15	Forceps sterilizer (utility) 280 mm vaughen SS	2
17	Scissors curved 140 mm/ Sharp/ blunt	6
18	Scissors - surgical straight 140 mm sharp SS	6
19	Scissors - surgical straight 140 mm blunt SS	6
20	Needle holder straight narrow jaw mayo heggar 180 mm	3", 4" & 6" -6 each
21	Thermometer (Clinical) Digital	2
22	Toungee Depressor	2
	Farming Equipments	
1	Crow Bar 51/2" X 1/4" Dia	1
2	TATA	1
3	Pick Axe	2
4	Iron Blading	1
5	Mumti	1

C.S.S.

(Dr. C.S. Sadagopada)
Additional Director
Primary Health Care
Directorate of Health & F.W.S
Bangalore.

Bangalore
Date:

List of Furnitures Equipments proposed to be supplied to PHCs

I	*Furniture - Office / Hospital*	
1	Executive revolving Chair	2
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3	Office Table - Steel	6
4	Steel cup board/ Almirah	10
5	Revolving Stool with stainless steel top	6
6	Attendant stool	4
7	Wooden Stool	-
8	Rack Slotted Angle with 5 compartments	8
9	Operation table	2
10	Examination table	2
11	Delivery table	2
12	Foot Steps	8
13	Bed side screen	4
14	Bed side lockers Fibre/Stainless steel	6
15	Iron Cot Adult	6
16	Mattress	6
17	Pillows	6
18	Saline stand	6
19	Dressing trolley	2
20	Instrument Cabinet	2
21	Wash basin with stand	4
22	Dressing table	1
23	Stretcher	1
24	Wheel Chair	1
II	*Equipments*	
1	Autoclave with burners - 2 bin (4)B	2
2	Foot suction apparatus	2
3	Instrument sterilizer	2
4	B.P Apparatus	3
5	Weighing machine - Adult	2
6	Weighing machine - Baby	1
7	Oxygen cylinder - IOL	3
8	Oxygen cylinder trolley - IOL	3
9	Kidney tray 6" + 10"	6 + 6
10	Dressing / Instrument tray with lid	3
11	Nebulizer	2
12	Anbu Bags	
13	Ambu Bags 200 CC, 500 CC & Adult	2+1+1
14	Laringoscope with blades (Infant, Child and Adult)	1 Each

List of Furnitures Equipments proposed to be supplied to PHCs

15	Enema can set	2
16	Urine pot	2
17	Bed Pans	2
18	PM Kit Box	2
III	*Surgical Kits*	
1	Delivery kits	2
2	Episitomy kits	2
IV	*Surgical Instruments*	
1	Curette uterine sharp/blunt	2/2
2	Dilator uterine double ended Heggars	2 sets
3	Forceps - tissue holding young 170mm soft rubber jaws - ss	6
4	Forceps - uterine velselum - straight jacombs 250 mm	2
5	Knife handle for major surgery	6+6+6
6	Knife blade for major surgery	3 do 3+3D+3F
7	Speculum vaginal bivalve cusso's graves, small, medium	
8	Retractor viginal SIMS medium blade 31 X 80 mm - ss	Large 3 Small 2
9	Speculum vaginal double handed SIMS 165mm long ss	Large 3 Small 2
10	Sound uterine simpon 300 mm graduated in 20 mm	2
11	Speculum nasal SS	2
12	Forceps Kellys ST 140mm S.S	-
13	Forceps Sponge holding St 228 mm SS	6
14	Allis forceps tissue with teeth 150 mm SS (3 sizes)	12+6
15	Forceps sterilizer (utility) 280 mm vaughen SS	2
17	Scissors curved 140 mm/ Sharp/ blunt	6
18	Scissors - surgical straight 140 mm sharp SS	6
19	Scissors - surgical straight 140 mm blunt SS	6
20	Needle holder straight narrow jaw mayo heggar 180 mm	3", 4" & 6" -6 each
21	Thermometer (Clinical) Digital	2
22	Tounge Depressor	2
	Farming Equipments	
1	Crow Bar 51/2" X 1/4" Dia	1
2	(TATA)	1
3	Pick Axe	2
4	Iron Blading	1
5	Mumti	1

C.S.S

(Dr. C.S. Siddegowda)
Additional Director
Primary Health Care
Directorate of Health & F.W. Bang.

Bangalore
Date:

Sl.No.	Item	Required As per norms	Serviceable stock	Required Augmentation	ipp alloted
RNITURE FOR OFFICE/HOSPITAL					
1	Executive Revolving Chair				
2	S-Type Continuous Arm Chair				
3	Office Table				
4	Steel Cupboard				
5	Revolving Stool with Stainlesssteel top				
6	Attendant stool				
7	Wooden Stool				
8	Rack Sloted Angle with 5 compartments				
9	Operation Table				
10	Examination Table				
11	Delivery Table				
12	Footsteps				
13	Bed side Screen				
14	Bed side Lockers				
15	Iron Cot - Adult				
16	Matress				
17	Pillows				
18	Saline Stand				
19	Dressing Trolley				
20	Instrument Cabinet				
21	Wash Basin with Stand				
22	Dressing table				
II	UIPMENTS				
1	Auto clave with burners-Two bins				
2	Foot Suction Apparatus				
3	Instrument Steriliser				
4	B.P. Apparatus				
5	Weighing Machine Adult				
6	Weighing Machine Baby				
7	Oxygen Cylinder				
8	Oxygen Cylinder Trolley				
9	Kidney Tray				
10	Dressing/Instrument Tray with Lid				
	SURGICAL KITS				
1	Delivery Kit				
2	Episiotomy Kit				
SURGICAL INSTRUMENTS					
1	Currette Uterine sharp /Blunt				
2	Dilator Uterine double ended heggars				
	Forceps				
	tissue				
	holding				
	young				
	170mm				
	Soft				
	rubber				
3	jaws-ss				

NP26

TRAINING PROGRAMMES CONDUCTED AND PROPOSED TO BE CONDUCTED BY STATE INSTITUTE OF HEALTH AND FAMILY WELFARE, BANGALORE - 23.

The State Institute of Health and F.W., Bangalore has conducted the following Training Programmes for various Categories of Personnel working in the Department of Health and F.W.Services, during the years 1997-98, 1998-99, 99-2000 and 2000-2001.

I. INDUCTION TRAINING PROGRAMME:- (UNDER KHSDP)

Induction Training Programme is being conducted to the Newly Appointed Doctors of the Department with a view to make them familiar with the day-to-day functioning of the PHCs/PHUs and to introduce them to the different National Health Programmes being Implemented in the State. During 1998-99, the Induction Training Programme was for a period of six days. As the participants felt it was inadequate and in their suggestions to include more Programmes, it was increased to 12 days. During these 12 days both Programme and Hospital Management Topics were covered and the participants were given practical Training by taking them to a PHC and Sub-Centre.

Cover all doctors

A total of nine batches in which 205 Doctors were trained during 1998-99 and two batches of 45 Doctors were trained during 1999-2000. The Expenditure incurred is shown in the Annexure-I. Total batches 11, persons trained 250.

II. HOSPITAL ADMINISTRATION AND MANAGEMENT TRAINING PROGRAMME:- (UNDER KHSDP)

This Training Programme is being conducted to the Medical Officers of Community Health Centres/Taluk Medical Officers for a period of six days. This Training is conducted with a view to update and improve the Administrative and Management Skills of Medical Officers of Community Health Centres and Taluk Hosp.

One batch of 14 Doctors was trained in 1997-98, five batches totalling 109 Doctors were trained during 1998-99 and 04 batches totalling 96 Doctors were trained during 99-2000. The Expenditure incurred is shown in the Annexure-II. Total batches 10, persons trained 219.

Both these Training Programmes were funded by the Karnataka Health System Development Project, Bangalore.

III. TRAINING OF TRAINERS(T.O.T) IN INTEGRATED SKILL BASED TRAINING IN RCH UNDER I.P.P. - IX(K):-

Training of Trainers Programme under RCH in Skill Based Training for District Level Trainers for 12 days is being conducted with a view to equip the trainers to give Training to the 6 Categories of Staff i.e., 1. Medical Officer 2.ANMs, 3.LHVs, 4.Sr.H.A.(M), 5.Jr.H.A.(M), 6. Staff Nurses.

A total of four batches with 91 persons have been trained during 2000-01, between July 2000 and October 2000. The Expenditure Statement is shown in the Annexure-III. This Integrated Skill Based Training is funded by IPP-IX(K) Project both for T.O.T. and District Level Training.

IV. ORIENTATION TRAINING PROGRAMME TO FACULTY OF ANMTC/ LHVTC AND DNOs IN R.C.H.:-

Orientation Training to the Faculty of ANM Training Centres/LHV Training Centres and District Nursing Officers in RCH was conducted for three batches during 1999-2000. A total of 78 persons was trained for 12 days each and this Training was funded by the Family Welfare Training, Research Institute, Mumbai. The Expenditure incurred for this Training is shown in the Annexure-IV.

V. TRAINING OF TRAINERS(T.O.T) FOR DISTRICT LEVEL OFFICERS UNDER INDIA POPULATION PROJECT - IX(K):- IN TRAINING TECHNOLOGY

Training of Trainers Programme for District Level Trainers (Paediatricians and Obstetricians) and Faculty of ANMTC/HSWTC/LHVTC for 5 days was conducted during the years 1997-98 and 1998-99. During 1997-98, a total of 8 batches totalling 210 was trained and during 1998-99, 5 batches totalling 107 persons were trained. The Expenditure Statement for this is given in the Annexure-V. Total batches 13, persons trained 317.

TRAINING IN HEALTH ADMINISTRATION AND MANAGEMENT;-

The State Institute of Health and Family Welfare, proposes to conduct Training in Health Administration and Management to District Health and F.W.Officers, District Programme Officers and Taluk Health Officers. This is for a period of 12 days.

The State Institute of Health and Family Welfare, proposes to conduct Training to D.H.E.Os and Dy.H.E.Os for a period of three days during November 2000 in operationalising joint RCH and IPP, IEC activities.

ANNEXURE - I

STATEMENT SHOWING THE EXPENDITURE OF INDUCTION TRAINING FOR NEWLY APPOINTED DOCTORS UNDER KARNATAKAH HEALTH SYSTEM DEVELOPMENT PROJECT, HELD AT STATE INSTITUTE OF HEALTH AND FAMILY WELFARE, BANGALORE-560 023.

Batch	Period	Target	Attended	Amount drawn	Expenditure	Balance remitted to R.B.I.	Remarks
			FOR THE YEAR 1998-99				
I	13-07-98 to 18-07-98	30	16	67,000	37,372	29,628	
II	27-08-98 to 02-09-98	30	27	73,600	48,768	24,832	
III	14-09-98 to 19-09-98	30	21	71,200	41,832	29,365	
IV	12-10-98 to 17-10-98	30	21	78,200	43,615	34,585	
V	16-11-98 to 21-11-98	30	25	78,200	50,772	27,428	
VI	14-12-98 to 19-12-98	30	25	78,200	48,604	29,596	
VII	01-02-99 to 06-02-99	30	21	85,400	46,494	38,906	
VIII	15-02-99 to 20-02-99	30	27	85,400	47,989	37,411	
IX	01-03-99 to 06-03-99	30	22	85,400	47,249	38,151	
	Total	270	205	7,02,600	4,12,698	2,89,902	
			FOR THE YEAR 99-2000				
X	19-07-99 to 31-07-99	30	19	1,45,100	66,001	79,099	
XI	16-08-99 to 28-08-99	30	26	1,45,100	84,775	60,325	
	Total	60	45	2,90,200	1,50,776	1,39,424	

ANNEXURE - II

STATEMENT SHOWING THE EXPENDITURE OF HOSPITAL ADMINISTRATION AND MANAGEMENT TRAINING FOR CHC/TALUK LEVEL MEDICAL OFFICERS UNDER KARNATAKA HEALTH SYSTEM DEVELOPMENT PROJECT, HELD AT STATE INSTITUTE OF HEALTH AND FAMILY WELFARE, BANGALORE-560 023.

Batch	Period	Target	Attended	Amount drawn	Expenditure	Balance remitted to R.B.I.	Remarks
			FOR THE YEAR 1997-98				
I	15-12-97 to 20-12-97	30	14	1,12,000	62,292	49,708	
	Total	30	14	1,12,000	62,292	49,708	
			FOR THE YEAR 1998-99				
II	20-07-98 to 25-07-98	30	24	88,000	61,034	26,966	
III	21-09-98 to 26-09-98	30	18	88,000	52,421	35,579	
IV	26-10-98 to 31-10-98	30	20	95,000	56,644	38,356	
V	23-11-98 to 28-11-98	30	21	95,000	57,182	37,818	
VI	22-02-99 to 27-02-99	30	26	95,000	59,674	35,326	
	Total	150	109	4,61,000	2,86,955	1,74,045	
			FOR THE YEAR 99-2000				
VII	12-07-99 to 17-07-99	30	22	1,11,900	54,555	57,345	
VIII	02-08-99 to 07-08-99	30	25	1,11,900	55,973	55,927	
IX	20-09-99 to 25-09-99	30	27	80,000	61,448	18,552	
X	25-10-99 to 30-10-99	30	22	80,000	53,750	26,250	
	Total	120	96	3,83,800	2,25,726	1,58,074	

ANNEXURE - III

STATEMENT SHOWING THE DETAILS OF TRAINING OF TRAINERS TRAINING PROGRAMME UNDER RCH IN INTEGRATED SKILL BASED TRAINING AT STATE INSTITUTE OF HEALTH AND FAMILY WELFARE, BANGALORE-560 023.

Batch	period	Target	attended	Amount Draw	Expenditure	Balance Remitted	Remarks
I	17-07-2000 to 29-07-2000	30	16	70,000	64,057	5,943	
II	17-08-2000 to 30-08-2000	30	26	1,00,000	95,330	4,670	
III	11-09-2000 to 23-09-2000	30	24	1,05,000	1,03,500	1,500	
IV.	09-10-2000 to 21-10-2000	30	25	1,05,000	1,05,000	-	
	Total	120	91	3,80,000	3,67,887	12,113	

ANNEXURE - IV

ORIENTATION TRAINING PROGRAMME TO THE FACULTY OF ANMTC/LHVTC AND D.N.O'S HELD AT STATE INSTITUTE OF HEALTH AND F.W., BANGALORE-23, DURING THE YEAR 1999-2000

Batch	period	Target	attended	Amount Draw	Expenditure	Balance Remitted	Remarks
I	21-10-1999 to 4-11-1999	27	26	1,83,150	1,59,379	23,771	
II	25-11-1999 to 8-12-1999	26	25	1,83,150	1,16,820	66,330	
III	27-12-1999 to 8-01-2000	27	27	1,76,900	1,29,160	47,740	
		80	78	5,43,200	4,05,359	1,37,841	

Director,
State Institute of Health and
Family Welfare, Bangalore -23.

ANNEXURE - V

STATEMENT SHOWING THE EXPENDITURE OF TRAINING OF TRAINERS PROGRAMME HELD AT STATE INSTITUTE OF HEALTH AND F.W., BANGALORE UNDER IPP-IX(K) IN TRAINING TECHNOLOGY

T.O.T. Batch	Period	Target	Attended	Budget Alloted	Drawn	Expenditure	Remittance	Guest Lecturers
			FOR THE YEAR 1997-98					
I	08-09-97 to 10-09-97	30	25	51,900	33,694	28,466	5,228	1,600
II	25-09-97 to 27-09-97	30	23	51,900	38,000	33,392	4,608	2,000
III	05-11-97 to 07-11-97	30	30	51,900	40,000	38,487	1,513	1,000
IV	13-11-97 to 15-11-97	30	30	51,900	38,000	35,921	2,079	1,600
V	19-11-97 to 21-11-97	30	28	51,900	36,000	31,754	4,246	2,000
VI	22-12-97 to 24-12-97	30	25	51,900	39,000	33,032	5,968	1,800
VII	22-01-98 to 24-01-98	30	22	51,900	30,000	28,153	1,847	2,400
VIII	05-02-98 to 07-02-98	30	27	51,900	37,000	33,021	3,979	2,600
	Total	240	210	4,15,200	2,91,694	2,62,224	29,468	15,000
			FOR THE YEAR 1998-99					
I	27-07-98 to 31-07-98	30	22	67,000	57,000	43,934	13,066	3,600
II	10-08-98 to 14-08-98	30	19	67,000	55,000	43,974	11,026	3,600
III	07-09-98 to 11-09-98	30	21	67,000	50,000	37,337	12,663	2,800
IV	05-10-98 to 09-10-98	30	22	67,000	67,000	43,769	23,231	3,000
V	03-11-98 to 07-11-98	30	23	67,000	50,000	42,682	7,318	3,000
	Total	150	107	3,35,000	2,79,000	2,11,696	67,304	16,000
			FOR THE YEAR 99-2000					
	NIL							

DEVELOPMENT OF CURRICULUM / SYLLABUS

The State Institute of Health and Family Welfare has developed / prepared Curriculum / Syllabus for the following category of Health Personnel in the year 1997-1999 for Training Programmes under IPP-IX(K). viz.,

Sl. No.	Personnels	Duration
01.	Medical officers of PHCs/PHUs	06 Days
02.	Sr. Health Assistant Male	09 Days
03.	Sr. Health Assistant Female	12 Days
04.	Jr. Health Assistant Male	08 Days
05.	Jr. Health Assistant Female	12 Days
06.	Block Health Educators	08 Days

This was followed by all the Training Centres in the Training of above mentioned Category of Health Staff during 1998-1999.

DEVELOPMENT OF TRAINING MODULES

The Institute has developed / prepared the Training Modules with the involvement of Faculty of State Institute of Health and Family Welfare and other Training Centres for the following category of staff. Via.,

01. T.O.T. Modules - Both in English & Kannada
02. Medical Officers of PHCs - in English
03. Sr. Health Assts. (M & F) - in Kannada
04. Jr. Health Assts. (M & F) - in Kannada

NP 27

Subject: [mfriendcircle] Universal Access
Date: Sat, 23 Dec 2000 02:49:32 +0530
From: "Amar Jesani" <lara1984@bom5.vsnl.net.in>
Reply-To: mfriendcircle@egroups.com
To: "MFC-eGroup" <mfriendcircle@egroups.com>

Dear All,

Here are two files, both generated in the internet by a campaign for universal access to health care in the US of A. For the next meet, they have relevance.

Amar

Amar Jesani
(Home) 310 Prabhu Darshan, S. Sainik Nagar
Amboli, Andheri West, Mumbai 400058, India
Tel:(91)(22) 623 0227. Email: jesanl@vsnl.com

First They Came for the Uninsured.htm	**Name:** First They Came for the Uninsured.htm **Type:** Hypertext Markup Language (text/html) **Encoding:** quoted-printable
Competition in Health Care Poses Grave Dangers.htm	**Name:** Competition in Health Care Poses Grave Dangers.htm **Type:** Hypertext Markup Language (text/html) **Encoding:** quoted-printable

First They Came For the Uninsured

by Bob Griss,
Director of the Center on Disability & Health in Washington, DC
and a board member of UHCAN!

This piece was inspired by Martin Niemoller, a German Protestant minister and a leader of the church's opposition to Hitler who was interned by the Nazis and who wrote:

"In Germany they first came for the Communists, and I didn't speak up because I wasn't a Communist. Then they came for the Jews, and I didn't speak up because I wasn't a Jew. Then they came for the trade unionists, and I didn't speak up because I wasn't a trade unionist. Then they came for the Catholics, and I didn't speak up because I was a Protestant. Then they came for me, and by that time no one was left to speak up."

First they came for the **uninsured** (by passing an unenforceable health insurance portability bill that prohibits private health insurers from imposing preexisting condition exclusions beyond twelve months, but not guaranteeing access to the same benefits or limiting the premiums that can be charged).

But my family and I have health insurance, so I wasn't concerned.

Then they came for **Medicaid recipients** (by allowing states greater flexibility to get around federal standards designed to ensure that low income persons had access to a comprehensive benefit package). Now states can force Medicaid recipients into low cost Medicaid-only managed care plans with minimal federal oversight. One Medicaid program has resorted to an exclusive list of durable medical equipment without exceptions to restrict this benefit regardless of the type of equipment that can improve function and is medically necessary according to the doctor. The Second Circuit Court of Appeals initial ruling in the Desario case is to judge the adequacy of Medicaid benefits by whether they meet the needs of the "average patient" not the needs of persons with rare, unusual or costly treatment needs, even if it imposes a "death sentence" on some Medicaid recipients).

But I have private insurance, so I wasn't concerned.

Then they came for **Medicare beneficiaries** (by capping total reimbursement to Medicare providers based on previous utilization levels that create incentives for Medicare providers, like home health agencies, to withhold care from persons with the greatest needs who are less profitable to serve; healthy Medicare beneficiaries will be encouraged to set up Medical Savings Accounts to ensure control over the health care services they think they need, and to seek services from physicians who are not satisfied with the Medicare payment fee schedules by using a private fee for service contract, even though this undermines public leverage over provider reimbursement in the Medicare program).

But they told me I would have more "choices" so I wasn't concerned.

Then they came for **persons with private insurance** (when my employer told me that I could only choose between two policies in a low cost health plan selected by my employer).

But I thought I was generally healthy so I wasn't concerned.

Then I developed a chronic illness which led to a disability that required some durable medical equipment.

But my health plan decided that it was not part of the benefit package even though my doctor thinks it is medically necessary.

Unfortunately, there is no one left to speak up for me.

UHCAN -- Tel: 216/241-8422 or 800/634-4442 -- www.uhcan.org

1/30/0

September 2000

Competition in Health Care Poses Grave Dangers

by Donald W. Light, PhD

(abridged)

Editor's Note: Under pressure to come up with a specific policy proposal for prescription coverage under Medicare, Republican Presidential candidate George W. Bush recently resurrected the Breaux-Frist Medicare managed competition model. The annual exodus of managed care companies from Medicare raises doubts about the practicality of this proposal. In addition, there are grave theoretical concerns about making competition a central part of a health care system.

Economic competition has transformed the modern world and spurred unparalleled economic growth. While it rewards efficiency in the short run within a given sector or industry, its main effect is to provide rich rewards for the invention of new products, the discovery of new markets, and the creation of new demands.

Adam Smith and other distinguished economists became acutely aware of the shortcomings of economic competition. It creates a society that rewards people for seeking their own best advantage, rather than looking out for one another, and will *only* be beneficial if there are conditions that prevent people from taking advantage of one another.

Beneficial competition requires there to be **many independent buyers and sellers who can enter and exit the market easily, good cheap or free information about the qualities and prices of what is being bought, and full use of this information.** If these and related requirements are not met, then competition can be damaging to individuals or to the community. This happens because the easy ways to win are not by coming up with something new and better, but by colluding, fixing prices, skimping on services or quality, deceiving customers, and other tricks of sharp sellers.

Competition seems so foreign to health care. In commercial life, the law of the land is *caveat emptor*, ***let the buyer beware***. In health care, the law of the land is *confidat emptor*, ***let the buyer trust***. Patients go to doctors because when they are hurting, scared or anxious they want an expert they can trust to put their interests first. Markets here are a paradigm misfit. No other nation with an advanced health care system has embraced competition, and no other nation has turned its services over to investors seeking profits.

Nevertheless, American business executives and politicians have aggressively promoted the transformation of health care into commercial competitive markets. Furthermore, up until 1999, they declared that this transformation was completely successful in halting years of escalating costs. In fact, about a third of the slowdown in health care costs was due to the general slowdown in overall inflation rates. Another third was due to cutbacks in services offered by health insurance. And the final third was due to shifting costs back to employees. None of this can be attributed to competitive health care.

Against these mythical or very modest gains, **competition in health care poses grave dangers because it can:**

1. **Undermine professional trust**, the foundation of health care -- distrust drives out trust;
2. **Fragment health care into "products,"** organizational complexity and sub-budgets -- opportunistic

products and markets feed on themselves;

3. **Encourage cost shifting** as different parts of the whole attempt to minimize their costs and maximize gains;
4. **Encourage gaming** in the highly imperfect markets in a wide variety of ways;
5. **Increase transactional costs,** to market, contract, monitor, and coordinate;
6. **Emphasize short-term "show-and-tell" gains,** to the detriment of mid-term and long term projects;
7. **Create "managerialism,"** the proliferation and elevation of managers to the detriment of clinical service;
8. **Privatize vital information** on the performance and costs of different providers and facilities;
9. **Fragment and undermine public health programs** and their funding; and,
10. **Fail to fund education and research,** on which the system depends.

Donald Light is on the graduate faculty in sociology at Rutgers University and is a professor at the University of Medicine and Dentistry of New Jersey. In 1999, he won the William Foote Whyte Distinguished Career Award for contributions to sociological practice in his work on health care reform.

Annexure - II

(Rs. In Lakhs)

Sl. No.	Name of the District	No. of Sub Centre Buildings to be constructed	Amount required	No. of PHC Buildings to be constructed	Amount required	No. of CHC Buildings to be constructed	Amount required	Total amount required - Total of Col. No. 4 + 6 + 8
1	2	3	4	5	6	7	8	9
1	Bangalore Urban							
2	Bangalore Rural	88	396.00	31	558.00	4	300.00	1,254.00
3	Chitradurga	54	243.00	25	450.00	4	300.00	993.00
4	Davangere	38	171.00	30	540.00	3	225.00	936.00
5	Kolar	74	333.00	15	270.00	0	-	603.00
6	Tumkur	190	855.00	28	504.00	5	375.00	1,734.00
7	Shimoga	105	472.50	26	468.00	3	225.00	1,165.50
8	Belgaum	160	720.00	31	558.00	3	225.00	1,503.00
9	Bijapur	105	472.50	16	288.00	1	75.00	835.50
10	Bagalkote	63	283.50	10	180.00	4	300.00	763.50
11	Dharwad	50	225.50	4	72.00	1	75.00	372.50
12	Gadag	90	405.00	10	180.00	1	75.00	660.00
13	Haveri	98	441.00	17	306.00	4	300.00	1,047.00
14	Uttara Kannada	223	1,003.00	10	180.00	4	300.00	1,483.00
15	Gulbarga	265	1,192.50	59	1,062.00	3	225.00	2,479.50
16	Bellary	107	481.50	13	234.00	2	150.00	865.50
17	Bidar	103	463.50	3	54.00	1	75.00	592.50
18	Raichur	170	765.00	9	162.00	5	375.00	1,302.00
19	Koppal	102	459.00	13	234.00	2	150.00	843.00
20	Mysore	203	913.50	61	1,098.00	3	225.00	2,236.50
21	Chamarajnagar	161	724.50	0	-	3	225.00	949.50
22	Kodagu	66	297.00	0	-	4	300.00	597.00
23	Mandya	170	765.00	18	324.00	5	375.00	1,464.00
24	Hassan	259	1,165.50	33	594.00	5	375.00	2,134.50
25	Chickmagalur	220	990.00	22	396.00	2	150.00	1,536.00
26	Dakshina Kannada	0	-	2	36.00	3	225.00	261.00
27	Udupi	289	1,300.50	23	414.00	1	75.00	1,789.50
Total		3453	15,538.50	509	9,162.00	76	5,700.00	30,400.50

Table 4: Posts of technical categories to be created

Sl. No.	Category	No. of posts required as per norms	Posts already created	Post to be created
1	Medical Officers	1991	1718	273
2	Staff Nurses	3714	2714	1000
3	Lab. Technicians	454	401	53
4	X-ray Technicians	288	273	16
5	Pharmacists	671	572	99

(This is based on data from 212 hospital out of 253 project hospitals)

Table 5: Posts of technical categories to be filled up

Sl. No.	Category	No. of posts as per norms	Posts already filled up	Post to be filled up
1	Medical Officers	1991	1146	845
2	Staff Nurses	3714	2234	1480
3	Lab. Technicians	454	189	265
4	X-ray Technicians	288	187	101
5	Pharmacists	671	365	306

(This is based on data from 212 hospitals out of 253 project hospitals)

The financial implication for creating the aforementioned posts is given in the table below:

Table 6: Financial implications

Sl. No.	Category	No. of posts to be created	Annual Budgetary requirement (Rs.)
1	Medical Officers	273	3,52,17,000
2	Staff Nurses	1000	6,78,00,000
3	Lab. Technicians	53	52,27,920
4	X-ray Technicians	16	12,67,200
5	Pharmacists	99	78,40,800
Total			**11,73,52,920**

Gulbarga Division	RAICHUR	LINGSUGUR	Primary Health Centre, Anwari
Gulbarga Division	RAICHUR	LINGSUGUR	Primary Health Centre, Mudgal
Gulbarga Division	RAICHUR	LINGSUGUR	Primary Health Centre, Nagaral
Gulbarga Division	RAICHUR	LINGSUGUR	Primary Health Centre, Maski
Gulbarga Division	RAICHUR	MANVI	Primary Health Centre, Sirwar
Gulbarga Division	RAICHUR	RAICHUR	Primary Health Centre, Matmari
Gulbarga Division	RAICHUR	RAICHUR	Primary Health Centre, Idapnuru
Gulbarga Division	RAICHUR	RAICHUR	Primary Health Centre, Kalmala
Gulbarga Division	RAICHUR	RAICHUR	Primary Health Centre, J.Mallapura
Gulbarga Division	RAICHUR	SINDHNUR	Primary Health Centre, Ragalaparvi
Gulbarga Division	RAICHUR	SINDHNUR	Primary Health Centre, Balagnooru
Gulbarga Division	RAICHUR	SINDHNUR	Primary Health Centre, Jawalgera

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Gulbarga Division	RAICHUR	SINDHNUR	Primary Health Centre, Jawalgera

DIVISION	DISTRICT	TALUK	NAME of PHC requiring upgradation to CHC
	BELLARY	BELLARY	Primary Health Centre, Orubayei
Gulbarga Division	BELLARY	BELLARY	Primary Health Centre, Moka
Gulbarga Division	BELLARY	BELLARY	Primary Health Centre, Emmiganuru
Gulbarga Division	BELLARY	HADAGALLI	Primary Health Centre, Holalur
Gulbarga Division	BELLARY	HAGARIBOMMANAHALI	Primary Health Centre, Hampasagara
Gulbarga Division	BELLARY	HOSPET	Primary Health Centre, Kaamalapura
Gulbarga Division	BELLARY	HOSPET	Primary Health Centre, Kampli
Gulbarga Division	BELLARY	HOSPET	Primary Health Centre, M.M.Halli
Gulbarga Division	BELLARY	HOSPET	Primary Health Centre, Gadhiganuru
Gulbarga Division	BELLARY	KUDLIGI	Primary Health Centre, Kottur
Gulbarga Division	BELLARY	SIRUGUPPA	Primary Health Centre, Sirigere
Gulbarga Division	BELLARY	SIRUGUPPA	Primary Health Centre, Siraguppa
Gulbarga Division	BIDAR	AURAD	Primary Health Centre, T.Kushanur
Gulbarga Division	BIDAR	AURAD	Primary Health Centre, Santapura
Gulbarga Division	BIDAR	BASAVAKALYAN	Primary Health Centre, Hunasura
Gulbarga Division	BIDAR	BASAVAKALYAN	Primary Health Centre, Rajeshwara
Gulbarga Division	BIDAR	BASAVAKALYAN	Primary Health Centre, Muchalamba
Gulbarga Division	BIDAR	BHALKI	Primary Health Centre, Bhatambra
Gulbarga Division	BIDAR	BHALKI	Primary Health Centre, Chincholi
Gulbarga Division	BIDAR	BHALKI	Primary Health Centre, Mehakara
Gulbarga Division	BIDAR	BIDAR	Primary Health Centre, Aanadura
Gulbarga Division	BIDAR	BIDAR	Primary Health Centre, Mannalli
Gulbarga Division	BIDAR	BIDAR	Primary Health Centre, Janawada
Gulbarga Division	BIDAR	HOMNABAD	Primary Health Centre, Ghataborala
Gulbarga Division	BIDAR	HOMNABAD	Primary Health Centre, Hallikeda(B)
Gulbarga Division	BIDAR	HOMNABAD	Primary Health Centre, Hallikheda(K)
Gulbarga Division	BIDAR	HOMNABAD	Primary Health Centre, Dubalagundi
Gulbarga Division	GULBARGA	ALAND	Primary Health Centre, Kadaganji
Gulbarga Division	GULBARGA	ALAND	Primary Health Centre, Jidaga
Gulbarga Division	GULBARGA	ALAND	Primary Health Centre, V.K.Salagara
Gulbarga Division	GULBARGA	CHINCHOLI	Primary Health Centre, Sulepet
Gulbarga Division	GULBARGA	CHINCHOLI	Primary Health Centre, Chimmanchodh
Gulbarga Division	GULBARGA	CHINCHOLI	Primary Health Centre, Chandanakera

Gulbarga Division	GULBARGA	CHINCHOLI	Primary Health Centre, Inapura
Gulbarga Division	GULBARGA	CHITAPUR	Primary Health Centre, Hebbal
Gulbarga Division	GULBARGA	GULBARGA	Primary Health centre, Mahagao
Gulbarga Division	GULBARGA	JEVARGI	Primary Health Centre, Aralagundagi
Gulbarga Division	GULBARGA	JEVARGI	Primary Health Centre, Yadrami
Gulbarga Division	GULBARGA	JEVARGI	Primary Health Centre, Nelogi
Gulbarga Division	GULBARGA	SEDAM	Primary Health Centre, Kolakunda
Gulbarga Division	GULBARGA	SEDAM	Primary Health Centre, Mudhol
Gulbarga Division	GULBARGA	SEDAM	Primary Health Centre, Malakhed
Gulbarga Division	GULBARGA	SHAHPUR	Primary Health Centre, Sagara
Gulbarga Division	GULBARGA	SHAHPUR	Primary Health Centre, Hayyal(B)
Gulbarga Division	GULBARGA	SHAHPUR	Primary Health Centre, Gogi
Gulbarga Division	GULBARGA	SHAHPUR	Primary Health Centre, Doranahalli
Gulbarga Division	GULBARGA	SHORAPUR	Primary Health Centre, Huniseegi
Gulbarga Division	GULBARGA	SHORAPUR	Primary Health Centre, Kembhavi
Gulbarga Division	GULBARGA	SHORAPUR	Primary Health Centre, Kodekal
Gulbarga Division	GULBARGA	YADGIR	Primary Health Centre, Honagera
Gulbarga Division	GULBARGA	YADGIR	Primary Health Centre, Gajarkot
Gulbarga Division	KOPPALA	GANGAWATI	Primary Health Centre, Sriramanagara
Gulbarga Division	KOPPALA	GANGAWATI	Primary Health Centre, Kanakagiri
Gulbarga Division	KOPPALA	KOPPAL	Primary Health Centre, Batageri
Gulbarga Division	KOPPALA	KOPPAL	Primary Health Centre, Kinnala
Gulbarga Division	KOPPALA	KOPPAL	Primary Health Centre, Hiresindhogi
Gulbarga Division	KOPPALA	KUSHTAGI	Primary Health Centre, Hanumasagara
Gulbarga Division	KOPPALA	KUSHTAGI	Primary Health Centre, Hanumanala
Gulbarga Division	KOPPALA	KUSHTAGI	Primary Health Centre, Dotihala
Gulbarga Division	KOPPALA	YELBARGA	Primary Health Centre, Bannikoppa
Gulbarga Division	KOPPALA	YELBARGA	Primary Health Centre, Mudhola
Gulbarga Division	KOPPALA	YELBARGA	Primary Health Centre, Bevoora
Gulbarga Division	KOPPALA	YELBARGA	Primary Health Centre, Mangalura
Gulbarga Division	RAICHUR	DEVADURGA	Primary Health Centre, Arkera
Gulbarga Division	RAICHUR	DEVADURGA	Primary Health Centre, Gabbur
Gulbarga Division	RAICHUR	LINGSUGUR	Primary Health Centre, Gurugunta
Gulbarga Division	RAICHUR	LINGSUGUR	Primary Health Centre, .Hatti

Annexure - 1

Sl. No.	Name of the District	No. of existing Sub Centre	No. of existing PHCs	No. of existing CHCs
1	2	3	4	5
1	Bangalore Urban	140	31	3
2	Bangalore Rural	286	73	11
3	Chitradurga	458	57	12
4	Davangere		70	7
5	Kolar	375	82	13
6	Tumkur	418	97	10
7	Shimoga	380	55	9
8	Belgaum	598	135	15
9	Bijapur	456	65	8
10	Bagalkote		46	10
11	Dharwad	596	28	3
12	Gadag		29	6
13	Haveri		50	11
14	Uttara Kannada	316	61	12
15	Gulbarga	512	105	19
16	Bellary	264	54	9
17	Bidar	231	41	6
18	Raichur	378	47	5
19	Koppal		43	9
20	Mysore	690	96	15
21	Chamarajnagar		52	4
22	Kodagu	163	29	7
23	Mandya	376	71	9
24	Hassan	463	81	15
25	Chickmagalur	335	51	8
26	Dakshina Kannada	708	64	7
27	Udupi		63	6
Total		8143	1676	249

Annexure - II

(Rs. In Lakhs)

Sl. No.	Name of the District	No. of Sub Centre Buildings to be constructed	Amount required	No. of PHC Buildings to be constructed	Amount required	No. of CHC Buildings to be constructed	Amount required	Total amount required - Total of Col No. 4 + 6 + 8
1	2	3	4	5	6	7	8	9
1	Bangalore Urban							
2	Bangalore Rural	88	396.00	31	558.00	4	300.00	1,254.00
3	Chitradurga	54	243.00	25	450.00	4	300.00	993.00
4	Davangere	38	171.00	30	540.00	3	225.00	936.00
5	Kolar	74	333.00	15	270.00	0	-	603.00
6	Tumkur	190	855.00	28	504.00	5	375.00	1,734.00
7	Shimoga	105	472.50	26	468.00	3	225.00	1,165.50
8	Belgaum	160	720.00	31	558.00	3	225.00	1,503.00
9	Bijapur	105	472.50	16	288.00	1	75.00	835.50
10	Bagalkote	63	283.50	10	180.00	4	300.00	763.50
11	Dharwad	50	225.50	4	72.00	1	75.00	372.50
12	Gadag	90	405.00	10	180.00	1	75.00	660.00
13	Haveri	98	441.00	17	306.00	4	300.00	1,047.00
14	Uttara Kannada	223	1,003.00	10	180.00	4	300.00	1,483.00
15	Gulbarga	265	1,192.50	59	1,062.00	3	225.00	2,479.50
16	Bellary	107	481.50	13	234.00	2	150.00	865.50
17	Bidar	103	463.50	3	54.00	1	75.00	592.50
18	Raichur	170	765.00	9	162.00	5	375.00	1,302.00
19	Koppal	102	459.00	13	234.00	2	150.00	843.00
20	Mysore	203	913.50	61	1,098.00	3	225.00	2,236.50
21	Chamarajnagar	161	724.50	0	-	3	225.00	949.50
22	Kodagu	66	297.00	0	-	4	300.00	597.00
23	Mandya	170	765.00	18	324.00	5	375.00	1,464.00
24	Hassan	259	1,165.50	33	594.00	5	375.00	2,134.50
25	Chickmagalur	220	990.00	22	396.00	2	150.00	1,536.00
26	Dakshina Kannada	0	-	2	36.00	3	225.00	261.00
27	Udupi	289	1,300.50	23	414.00	1	75.00	1,789.50
Total		3453	15,538.50	509	9,162.00	76	5,700.00	30,400.50

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Gulbarga Division	RAICHUR	LINGSUGUR	Primary Health Centre, .Hatti

DIVISION	DISTRICT	TALUK	NAME of PHC requiring upgradation to CHC
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Gulbarga Division	GULBARGA	ALAND	Primary Health Centre, Jidaga
Gulbarga Division	GULBARGA	ALAND	Primary Health Centre, V.K.Salagara
Gulbarga Division	GULBARGA	CHINCHOLI	Primary Health Centre, Sulepet
Gulbarga Division	GULBARGA	CHINCHOLI	Primary Health Centre, Chimmanchodh
Gulbarga Division	GULBARGA	CHINCHOLI	Primary Health Centre, Chandanakera

ROTARY IN KARNATAKA

Contact persons for any information/assistance in polio eradication activities:

District Meeting for SNID of 14th Oct 2001 held at Krishna Hall on 15 Sep 2001.

1. Dr. P. Narayana.
   Vice – Chairman, National Polio Plus Committee
   Sharavathi Nursing Home. B.H.Road.
   SHIMOGA 577 201
   Tel: 08182 23560[O] 78693 [R] 73737[Fax]
   E-mail **dr_p_naryana@yahoo.com**
2. Rtn. M.K.Panduranga Setty.
   Vice- chairman, South Asia Regional Polio plus Committee.
   14, Bull Temple Road,
   BANGALORE 560 004
   Tel: 080 3317653[O] 6610695[R] 3317665[Fax]

R.I.District 3160

Covering revenue Districts of Bidar, Gulbarga, Raichur, Koppal, Bellary and Davangere. [4 Districts of Andhra also included]

DISTRICT GOVERNOR:
Rtn. Dr.K.G.Kulakarni.
Dr. Simpi Linganna Road
KOPPAL 583 231
Tel: 08539 20464[O] 20868[R]
E-mail: kulkarnikg @yahoo.com

POLIO PLUS CHAIRMAN
Rtn. Dilip A Gadgil
C/O Comtech. D.No. 212
IV Ward. Station Road.
HOSPET 583 201
TEL: 08394 28794[O] 27193 24108[R]

SURVEILLANCE CHAIRMAN
Rtn. Anil Mansubdar.
Shree Electricals, 10-6/15, N.V.Complex
GULBARGA 585103 Tel: 08472 27626 [S] 22030 [R] 29658 {Fax]

R.I.District 3170

Covering revenue Districts of Belgaum, Dharwad, Bijapur, Bagalkot, Gadag, Haveri and Uttara Kannada. [4 Districts of Southern Maharashtra and Goa also included]

DISTRICT GOVERNOR:
Rtn. Pratap Puranik
D-18, MIDC. Shiroli
KOLHAPUR 416 122
TEL: 0231 656281[O] 651566[R] 653734[FAX]
E-mail: **pratappuranik@vsnl.com**

POLIO PLUS CHAIRMAN
Rtn. Dr.Mohan Biradar
Dr.Biradar's maternity & nursing Home
MUDHOL 587 313
Tel 08350 20244[O] 20167[R]

SURVELLANCE CHAIRMAN:
Rtn. Dr.Ashok Chougule
Trimurthy Building, Dr. Chougule complex A/P Peth Vadgaon Tal. Hatkangale.
Kolhapur Dist. Tel: 0230 471456[O] 471044[R]

R.I.District 3180

Covering revenue districts of Shimoga, Chikmagalur, Hassan, Mysore, Kodagu, Chamarajanagara, Dakshina Kannada and Udupi.

DISTRICT GOVERNOR:
R.Krishna.
Vasu Agarbathies.
New Sayyaji Rao Road.
MYSORE 570 021
Tel: 0821 490693 490694 491653[O]
543754[R] 497804[Fax]
email: **rkgov@eth.net**

POLIO PLUS CHAIRMAN
Rtn.K.Balakrishna Rao.
'Sindhoora' Eashwara Nagara II Cross
Opp. Manipal Dairy Road.
MANIPAL 576 119
TEL:08252 71121/36[O] 70568[R]
71141[Fax]
email: **kbrao@mpl.icdsltd.com**

SURVEILLANCE CHAIRMAN
DR.A.Basavannaiah.
Vijaya clinic
CHANNAGIRI 577213
TEL: 08189 28416[O] 28145[R]

R.I.District 3190

Covering revenue districts of Bangalore [urban & rural], Kolar, Tumkur and Mandya.
[Chittur District of Andhra pradesh also included]

DISTRICT GOVERNOR.
Rtn. Srivatsan.C.
Sampathkumaran&co
Chartered Accountants
28/29. Shringar Shopping Centre.
M.G.Road. BANGALORE. 560 001
TEL: 080 5587172/5587479/5586035[O]
5243846/5243847[R]5587177[FAX]
Email: **srivatsan@mantraonline.com**

POLIOPLUS CHAIRMAN
Rtn. Prasad Sundaram
#33, 3rd Cross, I Main.
Vinayaka Layout. RMV II Stage
BANGALORE 560 094
TEL: 080 3412535
Email: **prasad_sundaram@yahoo.com**

SURVEILLANCE CHAIRMAN:
Dr.S.T.Kantharaj,
Kanaka Nursing Home
J.C.Extension.
KANAKAPURA 562 117
TEL: 08117 22326[O]22330[R]

GULBARGA DISTRICT CONTACT
Rtn. Nitin Thuse.
Pragathi Agencies.
96. Super Market.
GULBARGA 585 101
Tel:08472 27753 / 27536[O] 33717[R]

RAICHUR DISTRICT CONTACT
Rtn. Shabbir Broachwala
City Talkies Circle.
RAICHUR. 584 102
Tel: 08532 43528/23281

BELLARY DISTRICT CONTACT
Rtn.B.L.Ananda Rao
3rd Road Gandhi Nagar
BELLARY 583 101
Tel: 08392 70452[O]55052[R]

KOPPAL DISTRICT CONTACT
Rtn.P.Mallikarjuna.
Asst.Manager, Safal House. KOF.
Agadi Complex, Jawahar Road.
KOPPAL 583 231
Tel: 08539 21548[O] 20471[R]

DAVANGERE DISTRICT CONTACT
Rtn. Roop Kumar M.K.
139. Sri Dham. 2nd Main.
P.J.Extension.
DAVANGERE 577 002
Tel: 08192 31464[O] 31518[R]

BIJAPUR AND BAGALKOT DISTRICTS
Dr.Yarnal Shrikanth
A-7, Shantinikethan Colony
Bagalkot Road.
BIJAPUR 586 101
Tel: 08352 77878[O] 50186[R]

GADAG AND HAVERI DISTRICTS
Dr.S.B.Javai.
Sangam Nursing Home.
LAXMESHWAR. 582 116
Tel:08487 72326

11.	**Diuretics**		
	1.	Furosemide	Tab 40mg
	2.	Furosemide	Injection 10mg/ml in 2ml ampoules
12.	**Gastrointestinal drugs**		
12.1	*Antacids and other antiulcer drugs*		
	1.	Aluminum hydroxide	Tablet, 500 mg
	2.	Magnesium Trisilicate	Tablet, 500 mg
	3.	Ranitidine	Tablet, 150 mg
12.2	*Antiemtic drugs*		
	1.	Metaclopromide	Tablet, 10 mg (Hydrochloride)
12.3	*Antispasmodics*		
	1.	Dicyclomine	Tablet, 10 mg
12.4	*Laxatives*		
	1.	Bisacodyl	Tablet, 5 mg (enteric coated)
12.5	*Drugs used in diarrhoea*		
	Oral rehydration salts (for glucose electrolyte solution powder 27.9 g/l		
	Components		g/l
	Sodium chloride		3.5
	Trisodium citrate dihydrate		2.9
	Potassium Chloride		1.5
	Glucose		20.0
12.6	*Stomotological Preparation*		
	1.	Chlorhexidine	Mouthwash, 0.2% (digluconate)
13	**Hormones, other endocrine drugs and contraceptives**		
13.1	*Adrenal hormones and synthetic substitutes*		
	1.	Dexamethasone	Injection, 4mg dexamethasone phosphate (as disodium salt) in 1 ml ampoule.
	2.	Hydrocortisone	Powder for injection, 100 mg (as sodium succinate in vial)
	3.	Prednisolone	Tablet, 5 mg
13.2	*Contraceptives*		
13.2.1	*Hormonal contraceptives*		
	1.	Ethinylestradiol + Levonorgestrel	Tablet, 30 mg + 50 mg
	2.	Ethinylestradiol + Norethisterone	Tablet, 35 mg + 1.0 mg
13.2.2	*Intrauterine devices*		
	1.	Copper containing device	
13.2.3	*Barrier methods*		
	1.	Condoms	
13.3	*Estrogens*		
	1.	Ethinylestradiol	Tablet, 50 mg

Requirements	Cost per unit	Per month requirement	Costs	
Centrifuge (Kemi)	2400=00			
Water bath (small) - Kemi	3300=00			
	12,690=00			
CONSUMABLES / EXPENDABLES				
Sulphosalicylic acid (100 gm)	125=00	200gm	250=00	
Benedicts Reagent quanitative (5 litre)	275=00	1000 ml	275=00	
Sulphur powder (500 gms)	60=00	500 gm	60=00	
Fouchets reagent (125 ml)	70=00	125 ml	70=00	
N/10 HCl (500 ml)	42=00	500 ml	42=00	
WBC fluid (500 ml)	60=00	500 ml	60=00	
Leishman stain (500 ml)	237=00	1500 ml	711=00	
3.8% Sodium citrate (500 ml)	42=00	500 ml	42=00	
5 mm Test tubes (12 x 75) per piece	4=50	1000	450=00	
JSB stain 1 (125 ml)	43=00	625 ml	215=00	
JSB Stain 2 (125 ml)	43=00	625 ml	215=00	
ZN Stain (Strong) (125 Ml)	53=00	625 ml	265=00	
VDRL Kit (For 50 tests)	285=00	50 tests	285=00	
Widal Kit (4 x 5 ml for 35 tests)	387=00	35 tests	387=00	
Blood grouping kit (3 x 5 ml for 35 tests)	320=00	35 tests	960=00	
Distilled water (1000 ml)	40=00	5litrres	200=00	
Test tube holder (each)	10=00	5 nos	50=00	
Lancet (each)	2=00	100	200=00	
Filter paper (9cm x 100)	28=00	400	112=00	
Cover slip (superior quality - Blue star)	52=00	400	208=00	
Spirit (400ml)	28=00	20 litre	560=00	
Sodium hypochlorite solution (1000 ml)	90=00	2 litre	180=00	
Glass slides (72s)	48=00	500	300=00	
Anti-septic Solution (1000 ml)	90=00	1 litre	90=00	
Test tubes (each 20 ml 18 x 150 mm)	8=50	500	4250=00	
Depression slides	4=00	100	400=00	
Xylene for cleaning (500 ml)	92=00	500 ml	92=00	
Liquor ammonia (50 ml)	55=00	500 ml	55=00	
Sodium Nitroprusside (100 gm)	230=00	25 gm	230=00	
Hydrogenperoxide (400 ml)	22=00	1 litre	65=00	
Ammonium sulphate (powder (500 gm)	60=00	200 gm	60=00	
Acetic acid Glacial (500 ml)	80=00	500 ml	80=00	
Liquid paraffin (400 ml)	90=00	1000 ml	235=00	
Pipette (10 ml) each	60=00	5	300=00	
			11954=00	
One time purchase		12,690=00		
Consumables / Expendables		11,954=00		
TOTAL		**24,644=00**		
(rupees twenty four thousand six hundred and forty four only)				

It may be noted that the cost of Autoclave, hotair oven, electricity, running water, Laboratory furniture; fuel source for the steriliser; costs for the gloves and other per sonal protective measures have not been included.

Requirements	Model	Qnty/year	cost	remarks
ONE TIME PURCHASE				
Sahlis Haemoglobinometer (imported) Including 4 extra tubes	German Surplus		850.00	
Neubauer Chamber (imported)			650-00	
WBC Pipette			120-00	Each
ESR Stand with Tubes			150-00	
Monocular Microscope (Indian Body; Imported lens)			6000-00	
Steriliser (Rectangular)		12"x6"	675-00	
Reagent stand		Each	225-00	
Spirit Lamp			25-00	
Waste containers (for Slides; cotton; others)			375-00	
Wire loop			100-00	Pkt of 10
Centrifuge		4x5ml	2600-00	Each
Water bath (small)		2 Racks	2650-00	
BP knife/scalpel			25-00	Each
CONSUMABLES / EXPENDABLES				
Sulphosalicylic acid		100gm	180-00	
Benedicts Reagent quanitative		500ml	30-00	
Sulphur powder		500-gm	60-00	
Fouchets reagent		125-ml	70-00	
N/10 HCl		500ml	52-00	
WBC fluid		125ml	37-00	
Leishman stain		250ml	98-00	
3.8% Sodium citrate		500ml	52-00	
5 mm Test tubes / per piece		Each	5-00	
JSB stain 1		125ml	47-00	
JSB Stain 2		〃	47-00	
ZN Stai		〃	47-00	
VDRL Kit		25's	330-00	
Widal Kit		4x5ml	385-00	
Blood grouping kit		3x5ml	375-00	
Distilled water		5 litr	120-00	
Test tube holder		Each	10-00	
Lancet		Each	1-25	
Filter paper		Each	2.50	
Cover slip		10 100's	30-00	
Spirit		4x50ml	30-00	
Sodium hypochlorite solution		1 litr	72-00	
Glass slide		Pkt	35-00	
Anti-septic Solution Cidex		1 litr	150-00	
Test tubes Each		Each	6-00	
Depression slides		Each	5-00	
Xylene for cleaning		500ml	95-00	
Liquor ammonia		500ml	35-00	
Sodium Nitroprusside		100gm	192-00	
Hydrogenperoxide		1 litr	70-00	

	Ammonium sulphate (powder			500 GM	30-00
	Acetic acid Glacial			500 ML	110-00
	Liquid paraffin			500 ML	85-00
X	Pipette (10 ml) each		Borosil	Each	45-00
	Lugols Iodine			125 ML	45-00
	NaCl soln			500 ML	45-00
	Barium chloride soln			500 ML	48-00
	Glass pencil			Each	3-50
	Glass rods		Sml	Each	15-00
	Sputum collection cup			Each	(1-00)
	Stool collection cup Disposable			Each	5-50
	Urine collection cup Disposable			Each	5-00
X	Urinometer With Jar			Each	45-00
X	Hot air oven	14×14"×14"	S. S Chan	Each	5450-00
X	Pressure cooker steel 12" Auto clave Alco		Sunlab	Each	2400-00
X	Test tube stand Metal for 12 tube			Each	65-00

Total 25,357:00

Government of Karnataka
TASKFORCE ON HEALTH AND FAMILY WELFARE
Ground Floor, Public Health Institute Building Annexe,
Sheshadri Road, Bangalore - 560 001
Ph: 2271021: Fax: 2277389; email: khsdp@vsnl.com

NP 29

The Chief Minister has constituted the Task Force on Health and Family Welfare under the chairmanship of Dr. H Sudarshan. The Task Force submitted its Interim Report. A major component is strengthening of the Primary Health Centres particularly with respect to making available good quality Basic Laboratory services.

The following tests to be carried out at the PHC:

a) Urine analysis: Albumin, Sugar, Bile Salts, Bile Pigments, Ketone bodies, Microscopy

b) Stool analysis: Ova and Cysts (Normal and Saline preparation)
Test for occult blood

c) Haemotology:
- Hb% by Sahlis Heamoglobinometer
- TC / DC / ESR
- Bleeding time and Clotting time
- Smear Microscopy for Malaria, Tuberculosis, Leprosy, Microfilaria
- Serology – VDRL, Widal, Blood grouping and cross matching

d) Hanging drop Cholera, Trichomonas

e) Other smear study Gonococci, Paps Test

The following are the requirements:

Requirements	Cost per unit	Remarks		
ONE TIME PURCHASE				
Sahlis Haemoglobinometer (imported) Including 4 extra tubes @ Rs 60 per tube	1000=00			
Neubauer Chamber (imported)	750=00			
WBC Pipette (4 nos)	120=00			
ESR Stand with Tubes (6 nos + 6 spare)	420=00			
Monocular Microscope (Indian Body; Imported lens)	13,500=00			
Steriliser (Rectangular)	850=00			
Reagent stand (local purchase)	200=00			
Spirit Lamp (3 nos)	120=00			
Waste containers (for Slides; cotton; others)	150=00			

Dr Kamat – (KGHOA) Y/o Jr Div PHI (1st room, left side) - since 1.11.

Requirements	Cost per unit	Per month requirement	Costs	
Centrifuge (Kemi)	2400=00			
Water bath (small) - Kemi	3300=00			
	12,690=00			
CONSUMABLES / EXPENDABLES				
Sulphosalicylic acid (100 gm)	125=00	200gm	250=00	
Benedicts Reagent quanitative (5 litre)	275=00	1000 ml	275=00	
Sulphur powder (500 gms)	60=00	500 gm	60=00	
Fouchets reagent (125 ml)	70=00	125 ml	70=00	
N/10 HCl (500 ml)	42=00	500 ml	42=00	
WBC fluid (500 ml)	60=00	500 ml	60=00	
Leishman stain (500 ml)	237=00	1500 ml	711=00	
3.8% Sodium citrate (500 ml)	42=00	500 ml	42=00	
5 mm Test tubes (12 x 75) per piece	4=50	1000	450=00	
JSB stain 1 (125 ml)	43=00	625 ml	215=00	
JSB Stain 2 (125 ml)	43=00	625 ml	215=00	
ZN Stain (Strong) (125 Ml)	53=00	625 ml	265=00	
VDRL Kit (For 50 tests) × 4	285=00	50 tests	285=00	
Widal Kit (4 x 5 ml for 35 tests) × 2	387=00	35 tests	387=00	
Blood grouping kit (3 x 5 ml for 35 tests)	320=00	35 tests	960=00	
Distilled water (1000 ml)	40=00	5litrres	200=00	
Test tube holder (each)	10=00	5 nos	50=00	
Lancet (each)	2=00	100	200=00	
Filter paper (9cm x 100)	28=00	400	112=00	
Cover slip (superior quality - Blue star)	52=00	400	208=00	
Spirit (400ml)	28=00	20 litre	560=00	
Sodium hypochlorite solution (1000 ml)	90=00	2 litre	180=00	
Glass slides (72s)	48=00	500	300=00	
Anti-septic Solution (1000 ml)	90=00	1 litre	90=00	
Test tubes (each 20 ml 18 x 150 mm)	8=50	500	4250=00	
Xylene for cleaning (500 ml)	92=00	500 ml	92=00	
Liquor ammonia (50 ml)	55=00	500 ml	55=00	
Sodium Nitroprusside (100 gm)	230=00	25 gm	230=00	
Hydrogenperoxide (400 ml)	22=00	1 litre	65=00	
Ammonium sulphate (powder (500 gm)	60=00	200 gm	60=00	
Acetic acid Glacial (500 ml)	80=00	500 ml	80=00	
Liquid paraffin (400 ml)	90=00	1000 ml	235=00	
Pipette (10 ml) each	60=00	5	300=00	
			11554=00	
One time purchase		12,690=00		
Consumables / Expendables		11,554=00		
TOTAL		24,244=00		
(rupees twenty four thousand one hundred and forty four only)				

It may be noted that the cost of Autoclave, hotair oven, electricity, running water, Laboratory furniture; fuel source for the steriliser; costs for the gloves and other personal protective measures has not been included.

ಕರ್ನಾಟಕ ಸರ್ಕಾರ

Laboratory Services
Primary Health Care

ನಿರ್ದೇಶಕರವರ ಕಛೇರಿ(ಪ್ರ),
ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ,
ಬೆಂಗಳೂರು, ದಿನಾಂಕ 24-5-2000

ವಿಷಯ:— 500—1000 ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳ
ಪ್ರಯೋಗಾಲಯಗಳನ್ನು ಉನ್ನತೀಕರಿಸುವ ಬಗ್ಗೆ.

ಉಲ್ಲೇಖ:— ಪಿಎಲಿನಿ. 1112:2000—2001 ರ ಸಂಖ್ಯೆಯ
ನಿರ್ದೇಶನಾಲಯದ ಪತ್ರದ ದಿನಾಂಕ: 25—4—2000ರ ಬಗ್ಗೆ

— — —

ಕರ್ನಾಟಕ ಸರ್ಕಾರವು 2000—2001ನೇ ಸಾಲಿನಲ್ಲಿ 500—1000 ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳ ಪ್ರಯೋಗಶಾಲೆಯನ್ನು ಉನ್ನತೀಕರಿಸಲು ಯೋಜಿಸಿದೆ.

ಇದರ ಸಂಬಂಧ ಮಾನ್ಯ ನಿರ್ದೇಶಕರು, ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳು, ಇವರು ಮೇಲ್ಕಂಡ ಪತ್ರದಲ್ಲಿ ಪ್ರಯೋಗಾಲಯಗಳಲ್ಲಿ ಹಾಲಿ ಇರುವ ಸಾಗೂ 2000—2001ನೇ ಸಾಲಿನಲ್ಲಿ ಅಗತ್ಯವಿರುವ ಉಪಕರಣ:ರಾಸಾಯನಿಕಗಳ ಬಗ್ಗೆ ಸೂಚಿತ ತಿಂಸಿ, 500—1000 ಪ್ರಯೋಗಾಲಯಗಳಿಗೆ ತಲಾ 10,000:5000 ರೂ ಪಟ್ಟಿಯಲ್ಲಿ ಅಗತ್ಯವಿರುವ ಉಪಕರಣ:ರಾಸಾಯನಿಕಗಳನ್ನು ಒದ[illegible]ಕ್ರ ಕ್ರಮ ಕೈಗೊಳ್ಳಲು ಕೇಳಿರುತ್ತಾರೆ.

ಸಂಬಂಧಿಸಿದ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳ ಪ್ರಯೋಗಾಲಯಗಳಲ್ಲಿ ನಡೆಸಲಾಗುವ ಮತ್ತು ನಡೆಸಬೇಕಾದ 15 ಪರೀಕ್ಷೆಗಳ ವಿವರವನ್ನು ಹಾಗೂ ಅದಕ್ಕೆ ಬೇಕಾಗುವ ರಾಸಾಯನಿಕ: ಉಪಕರಣ ಸಾಮಾನು ಸಾಮಗ್ರಿಗಳ ವಿವರ, ಅಂದಾಜು ಪಟ್ಟಿಯನ್ನು ಸಿದ್ಧಪಡಿಸಿರುವ ಪತ್ರ ಲಗತ್ತಿಸಲಾಗಿದೆ.

ಜಿಲ್ಲಾ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಅಧಿಕಾರಿಗಳು ಪ್ರತಿಯೊಂದು ಪ್ರಯೋಗ ಶಾಲೆಗೆ ಬೇಕಾಗುವ ರಾಸಾಯನಿಕ:ಉಪಕರಣ ಇತ್ಯಾದಿಗಳ ವಿವರವನ್ನು—ರೂ.5000ಗೆ ನಿಖರವಂತೆ ತಯಾರಿಸಿ, ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ, ಬೆಂಗಳೂರು, ಇಲ್ಲಿಗೆ ಮುಂದಿನ ಕ್ರಮಕ್ಕಾಗಿ ಕಳುಹಿಸಬೇಕಾಗಿದೆ. ~~ಆಯಾ~~ ಎಲ್ಲಾ ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳ ಪ್ರಯೋಗಶಾಲೆಗಳಲ್ಲಿ ನಡೆಸುವ 15 ಪರೀಕ್ಷೆಗಳಿಗೆ ಸಂಬಂಧಪಟ್ಟ ಎಲ್ಲಾ ರಾಸಾಯನಿಕ:ಉಪಕರಣಗಳ ಒಂದು ಪಟ್ಟಿಯನ್ನು ರೂ 5000ದ ಒಳಗೆ ತಯಾರಿಸಿದುದ, ಇದನ್ನು ಜಿಲ್ಲಾ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಅಧಿಕಾರಿಗಳ ಗಮನಕ್ಕೆ ಈ ಮೂಲಕ ತರಲಾಗಿದೆ. ಹಾಗೂ ತ್ವರಿತಕರವಿದಂತೆ ಈ ಪಟ್ಟಿಗನುಸಾರವಾಗಿ ಕೊಳ್ಳಲಿಕೆ ಸಲ್ಲಿಸಬೇಕಾಗಿದೆ.

ಈ ವಿಷಯದಲ್ಲಿ ಜಿಲ್ಲಾ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಅಧಿಕಾರಿಗಳ ಅಭಿಪ್ರಾಯವನ್ನು ಆದಷ್ಟು ಶೀಘ್ರವಾಗಿ ನಿರೀಕ್ಷಿಸಲಾಗಿದೆ.

ನಿರ್ದೇಶಕರು(ಪ್ರಯೋಗಾಲಯ)

ಕ್ಕಂಬ.

To the State for HNP report
JN
30/4/01

The test which are normally conducted at Primary Health Centre Laboratories

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1) Under National Health Programmes

Malaria - Examination of Blood smear / Plasma — Microfilaria

Tuberculosis - Examination of sputum

Leprosy - Examination of skin smear

RCH - Urine analysis

Clinical haematology (TC DC ESR Hb%) BT CT

Diagnostic test - Test for typhoid

VDRL

Jaundice

Stool examination

Hanging drop. - Cholra. Trichomonal Vaginals

O/h. smears study : Gonococci. P.A.P. smear

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nt,

With in Rs. 5000.00 (Approx.)

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1) Sodium Citrate	500gms	130.00
2) Hydrochloric acid	500ml	150.00
3) Sulfosalycilic acid	100gms	120.00
4) Leishman stain	500 x 5 bottle	600.00
5) Benediets' reagent	500 x 15	750.00
6) Fouchet's reagent		130.00
7) Sulphur powder		50.00
8) VDRL Test kit		300.00
9) Widal test kit		200.00
10) Urine strips for ketone body		300.00
11) Glass slides	5 box	200.00
12) Test tubes	200	800.00
13) ESR Tubes	10	150.00
14) Cover slips	x5	100.00
15) Haemoglobino meter	1	250.00
16) Test tube stand	2	100.00
17) Spirit lamp	1	25.00
18) Hb Pipette	3	100.00
19) Lancets	500	700.00

Approx. cost 5000/-

Z.N. stain and Sulfuric acid are not included in this list as they may be obtained from concerned department. Microscopesare also not included because the cost of one Microscope exceeds cost of all the chemicals and glassware

Test which are routinely done at Primary Health Centre Level and the chemicals & glassware required to conduct the same.

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1. Urine analysis

Test : Albumin : Sulfosalycilic acid

Sugar : Benedicts reagent

Ketone bodies ✓

Bilesalt : Sulfur powder

Bilepigment: Fouchets' reagent

Microscopy : Glass slide

coverslip

2. Stool exam : Glass slide

coverslip

3. Routine Haematology:

Hb : Haemoglobin meter

Hydrochloric acid N/10

TC : Neubaur chamber

WBC Pipette , WBC Fluid

DC : Leishman stain

ESR : ESR Tubes, Sodium citrate 3.8%

Bleeding time : Lancet, Filter paper

Clotting time : Test tube 5mm

Malaria : JSB stain I & II

TB : Ziel Neils.ons stain

Leprosy : Z.N. Stain, Spirit lamp

Serology : VDRL Kit, Widal kit, Blood grouping Kit

Microscop : Binocular

Test tube stand, ESR stand, sterliser/ shelf for keeping reagent, waste disposable bin with, Hypochlorite solution/powder, antiseptic lotion, spirit

KARNATAKA RURAL WATER SUPPLY PROJECT (MASTER PLAN)

Habitations Considered for Master Plan

Sl.No	Particulars	Revenue Divisons				Karnataka State Total
		Bangalore	*Mysore*	*Belgaum*	*Gulbarga*	
1	Total No. of Villages as per 1991 Census	12103	7852	5068	4011	29034
2	No. of Uninhabitated Villages	1231	622	94	276	2223
3	No. of inhabitated Villages (1-2)	10872	7230	4974	3735	26811
4	No. of hamlets identified as per Survey	10140	12097	5507	2211	29955
5	Total No. of habitations (3+4)	21012	19327	10481	5946	56766
6	No. of habitations included in externally aided projects	1019	652	457	567	2695
7	No. of habitations in Greater than 55 LPCD Category	6172	4114	2079	761	13126
8	No. of habitations Chemically affected	1637	498	85	1517	3737
9	No. of habitations considered for Master Plan (5-6-7-8)	12184	14063	7860	3101	37208
10	No. of habitations in Less than 10 LPCD Category	619	569	2047	151	3386
11	No. of habitations in 10 - 20 LPCD Category	1167	2020	971	538	4696
12	No. of habitations in 20 - 40 LPCD Category	4719	5694	2580	1366	14359
13	No. of habitations in 40 - 55 LPCD Category	3060	3315	1381	696	8452
14	No. of habitations >55 LPCD for 2001 Population but < 55 LPCD for 2021 Population	2619	2465	881	350	6315
	Total of 10 to 14	12184	14063	7860	3101	37208

KARNATAKA RURAL WATER SUPPLY PROJECT (MASTER PLAN)

Habitations Considered for Master Plan

Revenue Division : BANGALORE

Sl.No	Particulars	ZPE DIVISONS						
		Bangalore (U)	Bangalore (R)	Ramanagara	Bangalore (R) District	Kolar	Chickballapur	Kolar District
1	Total No. of Villages as per 1991 Census	720	1039	818	1857	1802	1519	3321
2	No. of Uninhabitated Villages	49	111	69	180	232	206	438
3	No. of inhabitated Villages (1-2)	671	928	749	1677	1570	1313	2883
4	No. of hamlets identified as per Survey	461	328	1423	1751	377	513	890
5	Total No. of habitations (3+4)	1132	1256	2172	3428	1947	1826	3773
6	No. of habitations included in externally aided projects:	0	32	46	78	306	28	334
7	No. of habitations in Greater than 55 LPCD Category	169	361	933	1294	703	473	1176
8	No. of habitations Chemically affected	26	88	586	674	67	364	431
9	No. of habitations considered for Master Plan (5-6-7-8)	937	775	607	1382	871	961	1832
10	No. of habitations in Less than 10 LPCD Category	22	12	48	60	5	36	41
11	No. of habitations in 10 - 20 LPCD Category	110	27	42	69	48	67	115
12	No. of habitations in 20 - 40 LPCD Category	432	281	226	507	232	326	558
13	No. of habitations in 40 - 55 LPCD Category	231	263	165	428	263	239	502
14	No. of habitations >55 LPCD for 2001 Population but < 55 LPCD for 2021 Population	142	192	126	318	323	293	616
	Total of 10 to 14	937	775	607	1382	871	961	1832

KARNATAKA RURAL WATER SUPPLY PROJECT (MASTER PLAN)

Habitations Considered for Master Plan

Revenue Division : BANGALORE

Sl.No	Particulars	ZPE DIVISONS						
		Tumkur	Madhugiri	Tumkur District	Chitradurga	Davanagere	Harapannahalli	Davanagere District
1	Total No. of Villages as per 1991 Census	1519	1199	2718	1048	673	245	918
2	No. of Uninhabitated Villages	91	88	179	124	96	37	133
3	No. of inhabitated Villages (1-2)	1428	1111	2539	924	577	208	785
4	No. of hamlets identified as per Survey	1596	1088	2684	647	182	194	376
5	Total No. of habitations (3+4)	3024	2199	5223	1571	759	402	1161
6	No. of habitations included in externally aided projects:	49	95	144	245	42	11	53
7	No. of habitations in Greater than 55 LPCD Category	603	643	1246	401	188	79	267
8	No. of habitations Chemically affected	74	345	419	30	24	4	28
9	No. of habitations considered for Master Plan (5-6-7-8)	2298	1116	3414	895	505	308	813
10	No. of habitations in Less than 10 LPCD Category	125	6	131	3	6	9	15
11	No. of habitations in 10 - 20 LPCD Category	332	96	428	54	12	44	56
12	No. of habitations in 20 - 40 LPCD Category	1056	436	1492	393	175	150	325
13	No. of habitations in 40 - 55 LPCD Category	486	281	767	272	172	72	244
14	No. of habitations >55 LPCD for 2001 Population but < 55 LPCD for 2021 Population	299	297	596	173	140	33	173
	Total of 10 to 14	2298	1116	3414	895	505	308	813

KARNATAKA RURAL WATER SUPPLY PROJECT (MASTER PLAN)

Habitations Considered for Master Plan

Revenue Division : BANGALORE

Sl.No	Particulars	ZPE DIVISONS			Bangalore
		Shimoga	Sagara	Shimoga District	Revenue Divison
1	Total No. of Villages as per 1991 Census	600	921	1521	12103
2	No. of Uninhabitated Villages	33	95	128	1231
3	No. of inhabitated Villages (1-2)	567	826	1393	10872
4	No. of hamlets identified as per Survey	1537	1794	3331	10140
5	Total No. of habitations (3+4)	2104	2620	4724	21012
6	No. of habitations included in externally aided projects:	78	87	165	1019
7	No. of habitations in Greater than 55 LPCD Category	1209	410	1619	6172
8	No. of habitations Chemically affected	22	7	29	1637
9	No. of habitations considered for Master Plan (5-6-7-8)	795	2116	2911	12184
10	No. of habitations in Less than 10 LPCD Category	13	334	347	619
11	No. of habitations in 10 - 20 LPCD Category	31	304	335	1167
12	No. of habitations in 20 - 40 LPCD Category	209	803	1012	4719
13	No. of habitations in 40 - 55 LPCD Category	244	372	616	3060
14	No. of habitations >55 LPCD for 2001 Population but < 55 LPCD for 2021 Population	298	303	601	2619
	Total of 10 to 14	795	2116	2911	12184

KARNATAKA RURAL WATER SUPPLY PROJECT (MASTER PLAN)

Habitations Considered for Master Plan

Revenue Divison : MYSORE

Sl.No	Particulars	ZPE DIVISONS							
		Mysore	K.R.Nagar	Mysore District	Chamaraj nagara	Mandya	Hassan	C.R.Patna	Hassan District
1	Total No. of Villages as per 1991 Census	464	868	1332	511	1462	1548	985	2533
2	No. of Uninhabitated Villages	37	93	130	108	104	103	80	183
3	No. of inhabitated Villages (1-2)	427	775	1202	403	1358	1445	905	2350
4	No. of hamlets identified as per Survey	253	505	758	415	589	1425	443	1868
5	Total No. of habitations (3+4)	680	1280	1960	818	1947	2870	1348	4218
6	No. of habitations included in externally aided projects:	37	38	75	28	110	64	38	102
7	No. of habitations in Greater than 55 LPCD Category	124	212	336	186	472	571	273	844
8	No. of habitations Chemically affected	58	141	199	1	221	0	77	77
9	No. of habitations considered for Master Plan (5-6-7-8)	461	889	1350	603	1144	2235	960	3195
10	No. of habitations in Less than 10 LPCD Category	16	43	59	3	20	17	8	25
11	No. of habitations in 10 - 20 LPCD Category	29	97	126	16	88	126	120	246
12	No. of habitations in 20 - 40 LPCD Category	149	404	553	237	381	992	447	1439
13	No. of habitations in 40 - 55 LPCD Category	162	200	362	226	337	612	223	835
14	No. of habitations >55 LPCD for 2001 Population but < 55 LPCD for 2021 Population	105	145	250	121	318	488	162	650
	Total of 10 to 14	461	889	1350	603	1144	2235	960	3195

KARNATAKA RURAL WATER SUPPLY PROJECT (MASTER PLAN)

Habitations Considered for Master Plan

Revenue Divison : MYSORE

Sl.No	Particulars	ZPE DIVISONS				MYSORE
		Chickmagalore	D.Kannada	Udipi	Kodagu	Revenue Divison
1	Total No. of Villages as per 1991 Census	1110	358	250	296	7852
2	No. of Uninhabitated Villages	92	0	0	5	622
3	No. of inhabitated Villages (1-2)	1018	358	250	291	7230
4	No. of hamlets identified as per Survey	2267	2787	3161	252	12097
5	Total No. of habitations (3+4)	3285	3145	3411	543	19327
6	No. of habitations included in externally aided projects:	0	55	282	0	652
7	No. of habitations in Greater than 55 LPCD Category	847	748	638	43	4114
8	No. of habitations Chemically affected	0	0	0	0	498
9	No. of habitations considered for Master Plan (5-6-7-8)	2438	2342	2491	500	14063
10	No. of habitations in Less than 10 LPCD Category	275	1	81	105	569
11	No. of habitations in 10 - 20 LPCD Category	444	575	400	125	2020
12	No. of habitations in 20 - 40 LPCD Category	957	884	1069	174	5694
13	No. of habitations in 40 - 55 LPCD Category	443	519	537	56	3315
14	No. of habitations >55 LPCD for 2001 Population but < 55 LPCD for 2021 Population	319	363	404	40	2465
	Total of 10 to 14	2438	2342	2491	500	14063

KARNATAKA RURAL WATER SUPPLY PROJECT

Habitations Considered for Master Plan

Revenue Divison : BELGAUM		ZPE DIVISONS						
Sl. No	Particulars	Belgaum	Chikkodi	Belgaum District	Dharwad	Gadag	Haveri	Bijapur
1	Total No. of Villages as per 1991 Census	694	475	1169	349	299	682	643
2	No. of Uninhabitated Villages	13	10	23	4	1	7	4
3	No. of inhabitated Villages (1-2)	681	465	1146	345	298	675	639
4	No. of hamlets identified as per Survey	229	201	430	23	43	70	457
5	Total No. of habitations (3+4)	910	666	1576	368	341	745	1096
6	No. of habitations included in externally aided projects	67	68	135	38	30	62	59
7	No. of habitations in Greater than 55 LPCD Category	44	20	64	36	100	185	149
8	No. of habitations Chemically affected	0	0	0	12	62	0	0
9	No. of habitations considered for Master Plan (5-6-7-8)	799	578	1377	282	149	498	888
10	No. of habitations in Less than 10 LPCD Category	1	38	39	12	0	6	109
11	No. of habitations in 10 - 20 LPCD Category	49	151	200	44	12	32	163
12	No. of habitations in 20 - 40 LPCD Category	412	281	693	141	42	206	358
13	No. of habitations in 40 - 55 LPCD Category	278	88	366	55	42	146	162
14	No. of habitations >55 LPCD for 2001 Population but < 55 LPCD for 2021 Population	59	20	79	30	53	108	96
	Total of 10 to 14	799	578	1377	282	149	498	888

KARNATAKA RURAL WATER SUPPLY PROJECT

Habitations Considered for Master Plan

Revenue Divison : BELGAUM		ZPE DIVISONS				BELGAUM
Sl. No	Particulars	Bagalkote	Karwar	Sirsi	U.Kannada District	Revenue Divison
1	Total No. of Villages as per 1991 Census	600	539	787	1326	5068
2	No. of Uninhabitated Villages	2	20	33	53	94
3	No. of inhabitated Villages (1-2)	598	519	754	1273	4974
4	No. of hamlets identified as per Survey	135	2100	2249	4349	5507
5	Total No. of habitations (3+4)	733	2619	3003	5622	10481
6	No. of habitations included in externally aided projects	133	0	0	0	457
7	No. of habitations in Greater than 55 LPCD Category	111	449	985	1434	2079
8	No. of habitations Chemically affected	10	0	1	1	85
9	No. of habitations considered for Master Plan (5-6-7-8)	479	2170	2017	4187	7860
10	No. of habitations in Less than 10 LPCD Category	68	521	1292	1813	2047
11	No. of habitations in 10 - 20 LPCD Category	69	418	33	451	971
12	No. of habitations in 20 - 40 LPCD Category	196	696	248	944	2580
13	No. of habitations in 40 - 55 LPCD Category	123	288	199	487	1381
14	No. of habitations >55 LPCD for 2001 Population but < 55 LPCD for 2021 Population	23	247	245	492	881
	Total of 10 to 14	479	2170	2017	4187	7860

KARNATAKA RURAL WATER SUPPLY PROJECT (MASTER PLAN)

Habitations Considered for Master Plan

Revenue Divison : GULBARGA

Sl. No	Particulars	ZPE DIVISONS					
		Gulbarga	*Yadgir*	*Gulbarga District*	*Bidar*	*Raichur*	*Koppal*
1	Total No. of Villages as per 1991 Census	626	747	1373	602	878	628
2	No. of Uninhabitated Villages	40	54	94	22	83	40
3	No. of inhabitated Villages (1-2)	586	693	1279	580	795	588
4	No. of hamlets identified as per Survey	363	300	663	280	606	156
5	Total No. of habitations (3+4)	949	993	1942	860	1401	744
6	No. of habitations included in externally aided projects:	60	65	125	175	51	111
7	No. of habitations in Greater than 55 LPCD Category	101	183	284	28	236	96
8	No. of habitations Chemically affected	63	193	256	341	410	226
9	No. of habitations considered for Master Plan (5-6-7-8)	725	552	1277	316	704	311
10	No. of habitations in Less than 10 LPCD Category	26	24	50	49	41	3
11	No. of habitations in 10 - 20 LPCD Category	191	58	249	56	152	24
12	No. of habitations in 20 - 40 LPCD Category	343	248	591	133	271	148
13	No. of habitations in 40 - 55 LPCD Category	102	172	274	48	145	93
14	No. of habitations >55 LPCD for 2001 Population but <55 LPCD for 2021 Population	63	50	113	30	95	43
	Total of 10 to 14	725	552	1277	316	704	311

KARNATAKA RURAL WATER SUPPLY PROJECT (MASTER PLAN)

Habitations Considered for Master Plan

Revenue Divison : GULBARGA

Sl. No	Particulars	ZPE DIVISONS			GULBARGA
		Bellary	*Hadgali*	*Bellary District*	Revenue Divison
1	Total No. of Villages as per 1991 Census	337	193	530	4011
2	No. of Uninhabitated Villages	28	9	37	276
3	No. of inhabitated Villages (1-2)	309	184	493	3735
4	No. of hamlets identified as per Survey	252	254	506	2211
5	Total No. of habitations (3+4)	561	438	999	5946
6	No. of habitations included in externally aided projects:	72	33	105	567
7	No. of habitations in Greater than 55 LPCD Category	75	42	117	761
8	No. of habitations Chemically affected	159	125	284	1517
9	No. of habitations considered for Master Plan (5-6-7-8)	255	238	493	3101
10	No. of habitations in Less than 10 LPCD Category	3	5	8	151
11	No. of habitations in 10 - 20 LPCD Category	26	31	57	538
12	No. of habitations in 20 - 40 LPCD Category	116	107	223	1366
13	No. of habitations in 40 - 55 LPCD Category	64	72	136	696
14	No. of habitations >55 LPCD for 2001 Population but <55 LPCD for 2021 Population	46	23	69	350
	Total of 10 to 14	255	238	493	3101

Project Concept Document

TNP31

South Asia Regional Office
Country Department

Date:	**Team Leader:** Tawhid Nawaz
Country Manager/Director: Edward Lim	**Sector Manager/Director:** Richard Lee Skolnik
Project ID:	**Sector:** HY - Other Population, Health & Nutrition
Lending Instrument: Specific Investment Loan	**Theme(s):** Health/Nutrition/Population
	Poverty Targeted Intervention: [X] Yes [] No

Project Financing Data

[X] Loan [] Credit [] Grant [] Guarantee [] Other [Specify]

For Loans/Credits/Others:

Total Project Cost (US$m) Cofinancing:

Total Bank Financing (US$m)

Borrower: Government of Karnataka

Guarantor: Government of India

Responsible agency: Department of Health and Family Welfare Services

Project implementation period:

Implementing Agency:

Contact person:

Address:

Tel: Fax: E-mail:

A: Project Development Objective

1. Project development objective: (see Annex 1)

The objectives of the proposed project are:

- to improve efficiency in the allocation of health resources through policy and institutional development
- to enhance performance of the health systems at the primary level.

2. Key performance indicators: (see Annex 1)

- Increased public resources to health sector, with increased share to primary and secondary levels of care
- Increased referral between levels of care, between health, family welfare, and nutrition programs, and between private and public sectors
- Increased utilization of primary health services, especially by the poor
- Increased patient and community satisfaction with primary health services

B: Strategic Context

1. Sector-related Country Assistance Strategy (CAS) goal supported by the project: (see Annex 1)

Document number: Date of latest CAS discussion:

The objectives of this proposed project reflect the goals and priorities identified by the CAS and India's Ninth Five-Year Plan and National Population Policy, 2000. The CAS recommends focusing Bank-Group financed investments on states that are undertaking economic restructuring programs and supporting sectoral policy reform. Karnataka is one of the states that have initiated important fiscal, sectoral, and governance reforms. Furthermore, it supports the CAS objectives by strengthening institutional capacity, improving governance, engaging the private sector, expanding access to services, upgrading effectiveness and quality of services and enhancing community participation and empowerment. Furthermore, the project's objective to meet the health needs of under-served populations, such as the poor, scheduled castes and tribes (SC/STs), women, and children, is at the core of poverty reduction strategies in India.

2. Main sector issues and Government strategy:

HNP Sector Issues in India

India has made considerable progress in improving the health status of its population over the past fifty years. The State of Karnataka reflects some of this gain, standing slightly above average in improvements in life expectancy and declines in fertility, infant mortality, maternal mortality, and severe and moderate malnutrition. Despite these broad favorable trends in both the country and the state, a significantly high proportion of the population, particularly those living in poverty, continue to suffer and die from preventable infections, pregnancy- and childbirth-related complications, and under-nutrition. An epidemiological transition is also taking place in which there are simultaneously high rates of communicable and non-communicable diseases and where rapid urbanization is resulting in new health problems. Furthermore, disparities between regions, men and women, and the poor and non-poor

continue to widen.

Experience with project implementation and findings of the sector work indicate that the principal constraints in the health, nutrition, and population (HNP) sector in India include: (i) inadequate institutional arrangements and weak program management; (ii) limited financial resources; (iii) poor governance; (iv) low quality of HNP services in both the public and private sectors; (v) limited access to health services for the poor; and (vi) inadequate framework for engaging the private sector.

Inadequate institutional arrangement and weak program management. The existing fiscal and administrative set up is complex, thereby hindering effective financing and accountability for decentralized management of health facilities and deterring effective coordination across the health, population, and nutrition sectors. More field level integration of the various health programs and coordination of HNP services at the primary level are critical to improving health outcomes. In addition, management skills at all levels are poor.

Limited financial resources. Overall spending on HNP services in India is sizeable, albeit lower than in comparable countries, and far less than the amount recommended to provide basic services. Spending on preventive and promotive primary care services has not kept up with the growing need for services, particularly for people below the poverty line. In addition to overall revenue constraints, weak mechanisms for reallocating resources according to priorities, particularly operating and maintenance expenditures, impede the delivery of effective public HNP services.

Poor governance. A major problem related to governance, which affects the performance of Karnataka's public sector in HNP is a lack of accountability and transparency in areas such as management of human resources, particularly with respect to staff recruitment, appointment and transfer.

Low quality of health services. Most Indians expect little, and receive little, from their health services. Health facilities are often in disrepair, poorly equipped, and under-supplied, reflecting the low levels of health spending. They are further constrained by staffing limitations, particularly in poor and remote areas, by inappropriate skill-mix as well as by shortages of drugs and supplies and lack of attention to supervision and maintenance. In both the public and private sectors, there are few standards and quality improvement systems in place. Quality private health services are inaccessible for the poorest and most vulnerable sections of society, and they do not address public health issues of national significance. As a result, substantial gaps remain in the effective delivery of health care services that are provided to the population, especially for the poor and vulnerable populations.

Limited access for the poor. Those comprising the most vulnerable sections of society suffer the deepest from the inadequacies of the public health system. (Rural populations, women, children, the disabled, and people belonging to the scheduled tribes and scheduled castes have the worst health outcomes, are allocated the least resources, and receive the fewest services to compensate for their increased risks. The poor also pay relatively more for health care and receive worse care.

Inadequate framework for engaging the private sector. The private sector in India accounts for about 80 percent of overall health expenditures, one of the highest proportions of private expenditure on health in the world. Services provided by the private sector are highest for primary health care, such as visits to formal and informal health providers, and are financed almost entirely by out-of-pocket sources, placing a disproportionate burden on the poor. The private sector, however, remains largely neglected in the government's policy formulation and program implementation. Appropriate policies to engage the private sector, particularly with respect to providing information, (licensing) and regulations to protect and empower consumers, especially poor consumers, need to be clearly articulated and implemented.

Government of India

India has made substantial progress in improving the health status of its population over the past two decades. GOI has determined that public investments in health are critical for the sustainability of development and poverty alleviation in India. Health is one of the six priority areas identified in the Ninth Plan (1997-2002) which emphasizes successful preventive and promotive activities, better control of communicable and non-communicable diseases, strengthened community and beneficiary participation, and improved surveillance and systemic efficiency. The Central Council of Health and Family Welfare has noted the importance of linking preventive and promotive care with selective aspects of curative care as well as highlighted the importance of a well functioning referral system. Since the states are largely responsible for the financing and implementation of health programs, these issues need to be addressed at the state level.

Government of Karnataka

The Government of Karnataka (GOK) has had a long standing commitment to human development and public health. In 1999 the GOK, prepared its first Human Development Report outlining developmental disparities based on gender, income and region, as well as bringing to the fore issues of access and equity. Building on the report, in early 2000 the Chief Minister of Karnataka commissioned a review of the health system to ensure "Health for All", with an emphasis on equity and quality. In order to ensure a participatory process, a Task Force on Health consisting of key stakeholders in the government and civil society was formed. The Task Force has developed a proposal outlining priorities for the health sector. The priorities include developing an integrated health, nutrition and population project for the State building on the gains of the existing Health System Development project, improving the existing primary health care system with a special emphasis on equity and quality, increasing the health sector's responsiveness to the needs of populations with special needs, strengthening management, and developing a comprehensive health management information system.

3. Sector issues to be addressed by the project and strategic choices:

Achieving health and nutritional goals set by the Government of Karnataka —reduced infant and maternal mortality, reduced malnutrition, control of communicable diseases—will require concerted action from the health sector, as well as from other sectors such as education, water, sanitation, and rural and social development. Important determinants of poor health and nutritional status include extreme poverty, low educational status of women, lack of access to clean water and sanitation, and gender and caste-based inequities; these factors cannot be adequately or directly addressed by interventions in the health sector. To assist the GOK in reaching the state's desired health and nutritional outcomes for its people, the Bank has adopted a systemic and broad based approach to addressing the health system and has financed projects and programs which include centrally sponsored disease control, nutrition, and family welfare, as well as state health system development that focuses on increasing efficiency of resources and enhancing the performance of health systems at the secondary level of health care.

The proposed project will establish an integrated and responsive primary health care system supported by a well functioning referral. It will build upon and expand the investment operation financed by the Bank, Karnataka State Health Systems Development Project (KHSDP), and integrate delivery of health services with family welfare services and disease control at the primary level. Furthermore, it will complement fiscal and governance reforms planned under the economic restructuring program, which is also supported with the Bank assistance.

The project will address the key sector issues in the following way:

Strengthening institutional arrangement and program management. The project will address institutional problems through improving overall planning and management, manpower development, procurement of

drugs and equipment, referral, HMIS, surveillance, and training. Furthermore, the project will strengthen institutions to enable integration and coordination between health, nutrition, and family welfare services, as well as to work with the private sector at the primary care level.

Increasing financial resources. The project will supplement ongoing efforts by the Bank-financed investment KHSDP, to (i) ensure adequate budgetary allocations to the health sector, (ii) increase the share of health sector resources provided to the primary and secondary levels; and (iii) allocate adequate resources for drugs, essential supplies, and operations and maintenance. In addition, under the fiscal reforms supported by the Bank, Government of Karnataka (GOK) Medium Term Fiscal Plan envisages increased spending on priority social sector programs, of which health is one. The project will also address regional (intra-state) disparities in allocation of resources within the health sector, by intensifying interventions in under-served areas.

Improving governance. GOK has initiated measures to improve governance, such as civil service reform and human resource management, which will be expanded under the Bank's structural adjustment program. Within the health sector, KHSDP has already made considerable progress in increasing transparency in the transfer of medical personnel and contracting out non-clinical services at secondary level hospitals to private agencies. The proposed project will also adopt measures to improve governance in the health sector, such as providing incentives for medical personnel to work in remote areas and with vulnerable populations, mechanisms to establish merit-based selection and increase transparency in the performance rating of personnel, and promoting the role of the public in monitoring health services.

Enhancing quality of health services. The project will support policies and activities to improve the quality of health services through supply-, as well as demand-side interventions. Supply side interventions include upgrading primary health care facilities, putting in place service norms, and addressing manpower gaps and skills mismatches, and strengthening linkages between public and private providers. Furthermore, this project will empower communities with information and mechanisms for redress and quality improvement. The role of the community in increasing accountability of the health systems will also be strengthened.

Expanding access for poor and vulnerable populations. The project will increase access by expanding services in areas where poverty is concentrated, and health status poor. The project will intensify interventions with respect to physical infrastructure, staffing, IEC, and community involvement in the northern districts of Karnataka, which have suffered from neglect and therefore, exhibit the lowest human development. Furthermore, NGOs and community based organizations (CBOs), in addition to local private practitioners, will be engaged to deliver clinical and non-clinical services, such as IEC and outreach, to communities difficult to access by the public health system.

Partnering with the private sector. The proposed project will promote private sector participation through innovative schemes to involve traditional healers, NGOs, and other private practitioners in areas such as referral, training, health financing, development of accountability and transparency measures, and monitoring and evaluation.

C: Project Description Summary

1. Project components: (see Annex 1)

The project consists of three main components:

1. Management development and institutional strengthening component would consist of (i) strengthening management and implementation capacity, in the areas of financial management, procurement, technical management, and monitoring and evaluation; (ii) strengthening disease surveillance and management information system; and (iii) improving institutional framework for policy

development. The component would finance professional services, local training, vehicles, equipment, including computers, furniture, studies, fellowships, workshops, operational expenses, and salaries of incremental staff on a declining basis. This component

2. **Improving access and service quality and effectiveness** component would consist of (i) upgrading primary health care facilities; (ii) improving human resource development and management, and curative, preventive and support services; (iii) strengthening referral system between levels of care, between HNP programs, and between public and private sectors; and (iv) expansion of health services in underserved areas. The component would finance civil works, professional services, furniture, medical and other equipment, local training, workshops, vehicles (purchase, hire, and maintenance), IEC, operational expenses, and salaries of incremental staff on a declining basis.

3. **Innovations to enhance partnership with communities and private sector** component would consist of (i) strengthening community capacity to identify health needs and solutions and to monitor and evaluate health services; (ii) piloting community driven schemes in the areas of health financing and health promotion; and (iii) piloting public-private partnership schemes. It would finance professional services, NGOs, local training, IEC, workshops, studies, vehicles (purchase, hire, and maintenance), operational expenses, and salaries of incremental staff on a declining basis.

Component	Sector	Indicative Costs (US$M)	% of Total	Bank financing (US$M)	% of Bank financing
1. Management development and Institutional strengthening					
2. Improving access and service quality and effectiveness at the primary care level					
3. Innovations to enhancing partnership with communities					
Total		0	0	0	0
Total Project Costs					
Interest during construction					
Front-end fee					
Total Financing Required					

2. **Key policy and institutional reforms to be sought:**

Many of the following key policy and institutional reforms have been initiated by GOK with the support of KHSDP. The Task Force on Health and Family Welfare has also commissioned studies, financed by KHSDP, to help inform these policy decisions and reforms. In addition to increasing support for current efforts, the proposed project would expand particularly in the areas affecting primary care and involvement of communities to improve health services and financing.

- Increasing financing and improving resource allocation to the health sector, in particular primary and secondary levels

- Developing policy and strategy to promote public-private partnerships, including traditional health care providers
- Improving manpower policy and procedures within the health sector by improving recruitment, deployment, transfer, training, performance appraisal, sanctions, and incentives
- Improving technical efficiency by developing and strengthening management systems in the areas of planning and budgeting, finance, information, manpower, equipment procurement, and maintenance
- Strengthening institutions to better manage and deliver integrated health, family welfare, and nutrition services at the primary level
- Improving financial protection for the poor
- Enhancing role of community based organizations (CBOs) in health promotion, service delivery, and monitoring and evaluation and financial protection
- Enhancing public involvement and accountability of health services and financing

3. Benefits and target population:

Add

4. Institutional and implementation arrangements:

Institutional arrangements are currently under preparation. Our experience from implementing health systems development projects indicates the following arrangements. The top of the proposed structure would be composed of Project Governing Board, chaired by the Chief Secretary and including other Principal Secretaries from other concerned departments of GOK—Health and Family Welfare, Women and Child Development, Indigenous Medicine, Education, Sanitation (and possibly representatives from the private sector, consumer groups, and NGOs), which would have responsibility for overall project coordination and policy. A Project Steering Committee (PSC), led by the Secretary, Health and Family Welfare Services, and composed of high level managers from the State Health and Family Welfare Directorates, would be the second tier. The PSC would supervise and guide the implementation of the project, in addition to coordinating with other health sector projects. The next tier would be the Project Management Unit (PMU) to be headed by the Project Director. The Unit would consist of Financial Management Wing, Equipment Procurement and Maintenance, Engineering and Architectural Wing, Quality Improvement Cell, HMIS Cell, Community Empowerment Cell, and Training Cell, all composed of professionals. The PMU situated at the Department of Health and Family Welfare Services, would work with Directorates of Health, Medical Education, and Family Welfare and would be responsible for day-to-day project implementation.

D: Project Rationale

1. Project alternatives considered and reasons for rejection:

The major alternatives considered include:

(a) **Focus on selected parts of the State.** Implementing exclusively in selected parts of the state would be politically infeasible, and would miss the opportunity to address key state-wide policy issues such as increasing financing and improving resource allocation in the health sector, allocating adequate resources for drugs, essential supplies and operations and maintenance, and institutional strengthening such as rationalized service norms, referral mechanism, health care waste management system, equipment management system, HMIS and surveillance of major diseases, procurement and financial management arrangements. By addressing needs in only parts of the state, this alternative would not address the health needs in a coherent and effective manner. Experience in the six states where State Health Systems

Development projects are currently being implemented indicates that the broad-based approach is the appropriate mechanism to address systemic health sector issues.

(b) Leave the provision of basic services entirely to the private sector. There are several rationale for undertaking this operation through the public sector: (i) the private sector provides mainly curative care, and does not provide the most appropriate services to those in greatest need; (ii) both sector work and beneficiary assessment studies in several states in India indicate that more than 60% of the beneficiaries belong to the poorest sections of society and much of the remaining 40% are marginally above the poverty line. They are unable to afford the costly fees for private services, which are paid almost entirely from out-of-pocket sources. Since this project wishes to address the needs of the poor leaving the provision of services to the private sector will fail to In addition, public health measures and essential interventions is an important priority for government financing.

(c) Use an Adaptable Program Loan (APL). The advantage of the APL is that it encourages progress against defined benchmarks, adds flexibility, cuts down on subsequent preparation time by focusing on implementation and monitoring, signals a long-term commitment to assisting on long-term problems, while keeping the whole problem under consideration in a phased manner. Due to limits on program loans in the overall lending program, Regional Management prefers to use flexible lending instruments such as the APL for sectors which are more conducive to phased reform monitoring, such as the power sector (?).

(d) Use a Sector –Wide Approach (SWAp) was considered but rejected as a feasible alternative due to the GOK's weak institutional capacity to implement disparate elements of health sector operations under one umbrella program. The GOK has clearly outlined as its' main priority in the health sector to build its' own technical and managerial capacity and strengthen the existing health system. The government has opted for a systems development approach within the framework of a broad based sector dialogue.

2. Major related projects financed by the Bank and/or other development agencies (completed, ongoing and planned):

Sector issue	Project	Latest Supervision (Form 590) Ratings (Bank-financed projects only)	
		Implementation Progress (IP)	Development Objective (DO)
Bank-financed			
✓	Population VIII	S	S
✓	Population IX	S	S
✓	Reproductive and Child Health	S	S
	Immunization Strengthening	S	S
✓	State Health Systems II	S	S
	Andhra Pradesh First Referral Health System	S	S
	Orissa Health Systems Development	S	S
	Maharashtra Health Systems Development	S	S
	Utter Pradesh Health Systems Development	S	S
✓	National HIV/AIDS Prevention and Control	S	S
✓	Cataract Blindness Control	S	S
✓	Malaria Control	S	S
✓	Tuberclosis Control	U	U
Other development agencies			
KfW ✓	Secondary Health Development (Gulbarga)		

IP/DO Ratings: HS (Highly Satisfactory), S (Satisfactory), U (Unsatisfactory), HU (Highly Unsatisfactory)

3. Lessons learned and reflected in proposed project design:

The project design takes into account key lessons learned from implementation of social sector projects in India, and specifically four State Health Systems Development Projects currently under implementation in six states, findings from sector work, and evaluations from Operations Evaluation Department (OED).

Lessons from implementation of State Health Systems Development Projects: (i) maintain continuity in project management and key project actors; (ii) empower Project Management Unit and Project manager appropriately to ensure timely and adequate flow of funds, especially when the project is implemented by a government line department; (iii) strengthen project management by providing greater autonomy with respect to management and supervision, adequate staffing of key project management personnel and improving management procedures; (iv) pay attention to quality aspects of the project through development of staffing and technical norms, referral mechanism, clinical and management training programs, incentives for medical personnel, staff selection based on merit, and addressing skill-mix during preparation; (v) emphasize software aspects, such as IEC, quality, and referral, to be implemented in conjunction with hardware; (vi) improve HMIS to facilitate policy and institutional strengthening and ensure information collected through M & E be used for management decision-making; (vii) use independent agency in areas of M & E and IEC; and (viii) undertake early preparation of procedures and mechanisms to select and monitor NGOs and other private agencies contracted by the project.

Findings from sector work:

Keys lessons from implementation of social sector and other HNP projects in India: (i) ensure timely and adequate flow of funds to the project entity; (ii) undertake advanced preparation of hardware and software aspects of the project prior to approval; and (iii) speed up implementation and increase supervision by strengthening implementation capacity of the line agency to resolve problems in procurement and disbursement early in the project cycle, and develop detailed implementation plans prior to appraisal.

Key recommendations from OED: (i) place greater emphasis on institutional development and governance issues in order to make a greater impact on development; (ii) engage in policy development and debate; (iii) tackle the personnel problems and incentives structures in the sector; (iv) support integration of referral system; (v) engage the private sector; and (vi) introduce performance-based budgeting.

4. Indications of borrower commitment and ownership:

Political commitment and ownership for the project are high. The commitment of GOK to health sector reform is reflected in the constitution of the Task Force on Health and Family Welfare, which is composed of prominent persons in the field of medicine and public health from academia, and the private and NGO sectors. The principal responsibility of the Task Force is to provide strategic vision and formulate recommendations for improving the health care system in the State. Furthermore, Karnataka is one of the states partnering with the Bank to undertake broad reform measures, mainly fiscal, sectoral, and governance changes to strengthen the enabling environment for poverty reduction.

5. Value added of Bank support in this project:

IDA is best suited to provide funds to complement the medium and long-term policy initiatives of the government. IDA's approach to policy dialogue, which includes up front, and long-term engagement, are useful in supporting the types of changes envisaged. The project would help consolidate the investment made by a number of other IDA and donor-supported projects in the health, nutrition, and population

sector, and provide a critical link to these investments. The project would also strengthen IDA's strategy of poverty reduction in India through its focus on the poor and under-served populations.

E: Issues Requiring Special Attention

1. Economic

[ ] Summarize issues below (e.g., fiscal impact, pricing distortions)
[ ] To be defined (indicate how issues will be identified) [ ] None

Economic evaluation methodology:

[ ] Cost benefit [X] Cost effectiveness [X] Other [specify]

The following economic analysis will be completed by appraisal and will contribute to project design (i) a public expenditure review in the health sector addressing financial sustainability and the ability to increase resources and protecting non-salary recurrent items. (ii) an analysis of private sector provision and financing to assure that public investments are not simply trying to substitute for private services, and to examine who is benefiting from the proposed investments.

2. Financial

[X] Summarize issues below (e.g., cost recovery, tariff policies, financial controls and accountability)
[ ] To be defined (indicate how issues will be identified) [ ] None

Project preparation will pay special attention to the fiscal impact of the proposed project as it relates to the medium term expenditure framework and to issues relating to financial controls, accountability, and sustainability, including (i) recurrent cost implications of the project, with the understanding that the project would finance recurrent costs on a sliding scale (ii) an assessment of the resource flows into the health sector . This analysis will examine issues of sustainability and the ability of the state to finance incremental recurrent costs of the proposed project as well as the sustainability of IPP VIII, IPP IX and the Karnataka Health System Development Project.;(iii) mechanisms to ensure adequate flow of funds; (iv)an assessment of financial control mechanisms to identify capacity, to collect and analyze financial information, handle cash flow/disbursement issues, procure goods, and contract services. The assessment will examine staffing and systems development and the need to develop financial management capacity to better understand and manage public budgets, and improve financial accountability and controls. There will also be an analysis conducted to outline feasible alternatives for health financing that will be piloted during the project.

3. Technical

[X] Summarize issues below (e.g., appropriate technology, costing)
[ ] To be defined (indicate how issues will be identified) [ ] None

Technical issues to be analyzed by project preparation include (i) integration of the health, family welfare and nutrition services at the primary health care level, supported by a well functioning referral system. (ii) the development of a comprehensive management information system (iii) human resource management particularly in the area of skill mismatch, disruptive staff vacancies, performance based rewards and incentives. A series of workshops and consultations will be held to clarify these issues. These workshops will build on the workshops on staffing and service norms conducted under the State Health Systems Development Project II

4. Institutional

[X] Summarize issues below (e.g., project management, M&E capacity, administrative regulations)
[ ] To be defined (indicate how issues will be identified) [ ] None

An institutional assessment is being planned to provide guidance on how to implement the proposed institutional reforms for the project. An analysis of the existing relationship between the public and private sectors will be conducted to better identify and plan how the government can work with the private sector in the area of referral, quality improvement and disease surveillance. As well, a study will be conducted to examine the institutional arrangements needed to increase community involvement and increase the community's capacity to provide feedback and monitor and evaluate the health system.

Executing agencies:
The project will build on existing arrangements developed through the Karnataka Health Systems Development Project

Project Management
The project will build on existing arrangements developed through the Karnataka Health Systems Development Project

Procurement Issues
As a result of the existing KHSDP project, the GOK is well versed in the Bank procurement guidelines thus there are no foreseen problems in this area.

Financial management issues
As a result of the existing KHSDP project, the GOK is well versed in the Bank procurement guidelines thus there are no foreseen problems in this area.

5. Social

[ ] Summarize issues below (e.g., significant social risks, ability to target low income and other vulnerable groups)
[ ] To be defined (indicate how issues will be identified) [ ] None

One of the key issues to be addressed in this project is how to overcome socio-economic and cultural barriers, as well as gender discrimination and thereby increase access for vulnerable populations. Additionally, an assessment of the potential impact of the project and any changes in health policy on the various stakeholders will be conducted. A special focus will be on the poor, SC/ST, women, disabled groups and under-served districts in North-East Karnataka. A mapping exercise will also be conducted in these under-served areas. The project preparation will also review the evaluation of the Yellow-Card Scheme implemented under KHSDP to expand access to the scheduled tribes.

6. Environmental

a. Environmental issues:
[ ] Summarize issues below (distinguish between major issues and less important ones)
[ ] To be defined (indicate how issues will be identified) [ ] None

Other:

b. Environmental category: [] A [] B [X] C

c. Justification/Rationale for category rating:

The project is expected to have no adverse environmental impact given that the project only involves upgrading of existing facilities. With regards to waste management, the project will ensure that it complies with WHO standards

d. Status of Category A assessment: EA start-up date:
Date of first EA draft:
Current status:

e. Proposed Actions:

f. Status of any other environmental studies: Government has conducted audits of each secondary level facility.

g. Local groups and NGOs consulted (list names): Not Applicable

h. Resettlement Not Applicable

[ ] Summarize issues below (e.g., resettlement planning, compensation)

[ ] To be defined (indicate how issues will be identified) [ ] None

i. Borrower permission to release EA: [ ] Yes [ ] No [ ] N/A

j. Other remarks:

7. Participatory Approach:

a. Primary beneficiaries and other affected groups:
[X] Name and describe groups (how involved, and what they have influenced or may influence.)
[ ] Not applicable (describe why participatory approach not applicable with these groups)

End beneficiaries, community groups, NGOs, private providers and local government officials, will participate in the preparation phase through consultation workshops, exit interviews at health facilities, and focus group discussions to define performance indicators and plans for monitoring and evaluation during the course of the project, to identify needs and barriers to obtaining quality care and expanding access. Monitoring of use by end beneficiaries, and of patient and community satisfaction with the health services will be incorporated into the HMIS and will be used for local planning and management and performance assessment of the project.

MOH will prepare the Project Implementation Plan (PIP)

b. Other key stakeholders:
[X] Name and describe groups (how involved, and what they have influenced.)
[ ]Not applicable (describe why participatory approach not applicable with these groups)

Local academic groups will be involved in the design and preparatory studies and in advising technical elements of the drafting of the PIP. NGOs, and other technical agencies, WHO and KfW will be consulted in the design phase and their inputs will be coordinated and shared.

8. Checklist of Bank Policies

a. Safeguard Policies (check applicable items):

	Policy	Risk of Non-Compliance (H, M, L)
	Environmental Assessment (OD 4.01)	
	Natural Habitats (OP/BP/GP 4.04)	
	Forestry (OP 4.36)	
	Pest Management (OP 4.09)	
	Cultural Property (OPN 11.03)	
√	Indigenous Peoples (OD 4.20)	
	Involuntary Resettlement (OP 4.30)	
	Safety of Dams (OP 4.37)	
	Projects on International Waterways (OP 7.50)	
	Projects in Disputed Areas (OP 7.60)	

b. Business Policies (check applicable items):

√	Financing of recurrent costs (OMS 10.02)
	Cost sharing above country 3-yr average (OP/BP/GP 6.30)
	Retroactive financing above normal limit (OP/GP/BP 12.10)
√	Financial management (OP/BP 10.02)
√	Involvement of NGO's (GP 14.70)
	Other (provide necessary details)

c. Describe issue(s) involved, not already discussed above:

F: Sustainability and Risks

1. Sustainability:

Financial, social, technical, and managerial sustainability is being addressed in the design and preparation of the project. The economic analysis and monitoring of expenditures will determine whether the incremental costs of the project are affordable, and whether they will remain so as the program develops. Institutionalizing a process to justify major capital investments is intended to maintain a sustainable program. Social sustainability is addressed by instituting mechanisms to increase the involvement and voice of consumers in the design of the project, and in routine provision of health services in both public and private sectors. Updating the technical paradigms, streamlining services and integrating the referral chain, working with the private sector, and focusing on management training and systems are steps taken to ensure that the system is more technically and managerially sustainable than before the project.

2. Critical Risks: (reflecting assumptions in the fou olumn of Annex 1)

Risk			
From Outputs to Objective			
Institutional arrangements are not effective in integrating centrally sponsored health and family welfare and state health concerns (M)			Institutional strengthening will be emphasized in the proposed project. Financing would be linked to performance
Productive institutional linkages with the private sector are not established (G,M)			Information sharing, pilot studies, and self-regulation will be encouraged. Financing would be linked to performance.
Competent staff and managers are not placed in project management units and health facilities (M)			Address through Letter of Health Sector Development Program, appoint key personnel prior to negotiations
Provider behavior cannot be changed (S,O)			Emphasize consumer feedback and provider incentives as part of the projec: design
Strategic approach to behavior change communication will not increase demand for and accountability of health services (S)			Use research-based communications and monitor results carefully
From Components to Outputs			
Flow of funds from GOI to State project are inadequate			Address through Letter of Health Sector Development Program, and financial monitoring
Staff and consultants are not assigned in a timely manner			Appoint key staff prior to negotiations
Key staff and managers are not retained for sufficient time			Include provision at negotiations to retain well-performing staff
Procurement is not managed in a timely manner			Develop robust procurement plans and appoint key staff prior to negotiations
Funds are not made available for non-wage recurrent expenditures, especially drugs and mobility			Address through Letter of Health Sector Development Program, and continued monitoring of health expenditures. Link financing to performance
Overall Risk Rating:			

Risk Rating - H (High Risk). S (Substantial Risk). M (Mode: isk). N (Negligible or Low Risk)

G: Project Preparation and Processing

1. Has a project preparation plan been agreed with t: borrower: (see Annex 2 to this form)

[X] Yes, date submitted: MM/DD/YY [ ] No, date ex: cted: MM/DD/YY

2. Advice/consultation outside country department:

[√] Within the Bank:
[ ] Other development agencies:

3. Composition of Task Team: (see Annex 2)

Tawhid Nawaz (Team Leader-Task Manager)
David Peters (Sr. Public Health Specialist)
Sadia Chowdhury (Sr. Public Health Specialist)

Preeti Kudesia (Sr. Public Health Specialist)
Hnin Hnin Pyne (Public Health Specialist)
Maj-Lis Voss (Economist)
Abdo Yazbeck (Economist)
Tazim Mawji (Health Specialist)
Rajat Narula (Financial Management Specialist)
Mam Chand (Procurement Specialist)
_____ (Legal Officer)
Vijay Rewal (Architect)
Shrelata Rao (Social Scientist)
Pradeep Kakkar (IEC)

4. Quality Assurance Arrangements: (see Annex 2)

External Peer Reviewers:
Internal Peer Reviewers

5. Management Decisions:

Issue	Action/Decision	Responsibility

Total Preparation Budget: (US$000) Bank Budget: (US$000) Trust Fund: (US$000)
Cost to Date: (US$000)

[ ] GO [ ] NO GO Further Review [Expected Date]

(signature)
Team Leader: Tawhid Nawaz

(signature)
Sector Manager/Director: Richard L. Skolnik

(signature)
Country Manager/Director: Edwin R. Lim

Annex 1: Project Design Summary
India: Karnataka Integrated HNP Services Development

Hierarchy of Objectives	Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
Sector-related CAS Goal: Health and nutritional status of Karnataka's population, particularly the poor, women, children, and schedule castes and tribes, is improved.	**Sector Indicators:** Decline in infant mortality Decline in maternal mortality Decline in malnutrition Decline in anemia Increase in immunization coverage Increase in TB case detection and cure	**Sector / Country Reports:**	**(from Goal to Bank Mission)** Focusing on reforming states ar human development will contribute to poverty reduction India Improving quality of life and health and nutritional status wil increase opportunities and productivity
Project Development Objective: Improve efficiency in the allocation of health resources through policy and institutional development Performance of health system strengthened through improvements in quality, effectiveness, and coverage of primary health care services	**Outcome / Impact Indicators:** 1. Increased public resources to health sector, with increased share to primary and secondary levels of care 2. Increased utilization of primary health facilities, esp. by the poor and SC/STs* 3. Increased patient and community satisfaction with primary health services* 4. Increased referral between levels of care, programs, and private and public providers)	**Project Reports:**	**(from Objective to Goal)** Political commitment continues Continuing investment in other sectors, such as water and sanitation, and education, affect health and nutritional status* Continuing support for centrally sponsored programs, currently assisted by the Central Government, the Bank, UN agencies, and bilaterals Continuing support for improvin quality, effectiveness and cover of secondary level care, currentl financed by the Bank

	Indicators need further input: QQT		
Output from each component: 1. Access to primary health services expanded, particularly in under-served districts and tribal areas.	**Output Indicators:** 1.1. Increased awareness of primary health services offered, particularly among SC/STs, women, and poor* 1.2. Increased number of primary health care facilities (functioning according to service and staff norms) in underserved districts and tribal areas* 1.3. Increased number of NGOs contracted to conduct outreach and deliver services in tribal and remote areas*	**Project Reports:**	(from Outputs to Objective) Competent staff and managers are placed project management units and health facilities, particularly i remote areas Synchronization of project inputs: flow of funds, provision of training, development of norms and contractual arrangements. Timely start-up of civil works, training programs, and other soft ware components, such as IEC and HMIS, and procurement of drugs and equipment.
2. Effectiveness and quality of primary health services improved	2.1. Number of primary health care facilities rehabiliated, equipped versus planned 2.2. Percentage of facilities meeting staffing, equipment, and medicines norms 2.3. Increased number of medical staff trained (clinical, management, patient-provider communication, MIS, referral, waste management) 2.4. Use of disease surveillance and HMIS		
3. Well functioning referral system (between levels of care and between programs) in place	3.1. Increased referral between levels of care 3.2. Increased referral between HNP programs 3.3. Increased referral between private and public providers		
4. Human resource development and management capacity at the primary level strengthened	4.1. IT system developed 4.2. FM system in place 4.3. Manpower gaps filled, esp vacancies in underserved areas 4.4. Transparency in transfer of medical staff (% of counseling used for transfer) 4.5. Incentives system in place		
5. Communities involved and empowered to demand better services and to identify health needs and problems	5.1. Mechanisms/channels for communities to voice complaint and demand for better services ?? 5.2. Involvement of CBOs in M&E (rating of services, etc.) 5.3. Training of CBOs and community leaders in identifying health problems/needs and barriers to access		
Project Components/Sub-components: 1. Management development and institutional strengthening 2. Improvements in access and service quality and effectiveness 3. Innovations to enhance partnership with communities and private sector	**Inputs: (budget for each component)**	**Project Reports:**	(from Components to Outputs) Flow of funds from GOI to State project are inadequate Staff and consultants are not assigned in a timely manner

~~NOT II~~
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TERMS OF REFERENCE FOR THE HUMAN RESOURCE DEVELOPMENT STUDY FOR THE KARNATAKA INTEGRATED HEALTH, NUTRITION AND FAMILY WELFARE SERVICES PROJECT

1.0 Background

1.1. The Government of Karnataka has received a TA grant from the PHRD fund for preparation of an integrated Health, Nutrition and Family Welfare Services Development Project (Po71160). The proposed grant is primarily to finance key studies required for the finalisation of the project.

1.2. The Government of Karnataka has built up a vast primary health care and first referral network in the State comprising 8173 sub-centres, 1676 Primary Health Centres, (including 9 urban Primary Health Centres), 582 Primary Health Units and 359 Community Health Centres. Under the World Bank assisted Karnataka Health Systems Development Project (KHSDP) there have been major improvements made to the first referral infrastructure. Despite these improvements, the Task Force on Health set-up by the Government of Karnataka has identified many lacunae in the functioning of the primary health care and first referral institutions. The primary health care system is expected to deliver a wide range of services including maternal and child health, and nutrition services, general curative care, management of communicable diseases, health education & promotion and promote community involvement. A major gap in the system is the poor quality of manpower and low levels of management capacity in the delivery of primary health care services. The levels of motivation and morale of the work force has been a significant factor in the low level of utilisation of the infrastructure already built up. Needs assessment for training the work force to enhance their skills and improve the management capacity is required to be carried out. There is also need to assess the needs from the community perspective and identify HRD capacity-building required for the elected representatives and NGOs in building a strong community-based primary health care system. There is also need to assess the capacity of the existing training infrastructure and identify the upgradation in manpower and infrastructure needed to face the HRD challenges of the sector.

2.1 General objectives of the Study

The general objective of the Study is to make an objective appraisal of the existing levels of skills and awareness of the health care providers as well as the community representatives, appraisal of the training institutions, conduct a training needs-assessment of all the stake-holders and finalise a comprehensive HRD Plan. The Study is expected to feed into the planning process of the Department of Health and Family Welfare of the Government of Karnataka, most directly through the proposed Karnataka Integrated Health, Nutrition, Family Welfare Services Project. In this context the Specific Objectives are spelt out in the succeeding paragraphs.

2.2 Specific objectives

Within the general objectives enumerated in 2.1 above, the specific objectives will be 1) Training needs-assessment of the front-line health workers and para-medical staff; 2) Training needs-assessment of PHC medical officers and specialists working in first level referral institutions; 3) Training-needs assessment of community representatives; 4) Institutional analysis of training institutions and recommend an infrastructure and manpower plan for these institutions; 5) Assessment of the management capacity of the Health system and recommend improvements.

2.2.1 Training-needs assessment of frontline health workers

The following categories of workers are critical in Karnataka's primary health care system, viz., a) Junior health assistant (female), b) Junior health assistant (male), c) lab. technicians, d) pharmacists, e) lady and male health supervisors f) health educators, g) anganwadi workers, and, h) traditional birth assistants (Dais).

a) *Junior health assistants (female) (ANMs)* are the most valuable personnel amonst all health workers. They undergo an 18 month training before entering the work-force. There is need to assess the existing curriculum, training materials, training methods and assessment procedures and incorporate modifications to ensure their pre-service training is effective. ANMs also receive periodic in-service training at District Training Centres with IPP and RCH funds. There is need to assess the suitability and adequacy of this training and suggest additions/modifications, periodicity and duration of such training programmes, especially in view of the recent CNA approach and the need to focus on the nutritional status of women and children.

b) *Junior health assistant (male) (male health workers)*- Male health workers have not been effectively used in the system, and their lack of effectiveness is a major weakness in the system. There is need to re-orient the male health workers and ensure they provide services expected of them. The pre-service training structures for male health workers have virtually become defunct. There is need to have a complete re-look into the training infrastructure required and finalise the curriculum, periodicity and duration of both the pre-service and in-service training programmes for male health workers.

c) *Lab. Technicians* provide the crucial laboratory services in Primary Health Centres. They require training at the time of their induction into service as well as periodic training to hone their skills.

d) *Pharmacists* also need to update their knowledge on the new generic drugs entering the market and require tra ining on rational drug use, inventory and stores management, and related areas.

e) *Lady and male health supervisors* provide the first level management supervision structure and their proper training and motivation is crucial for effective supervision.

f) *Health educators* – Health education is critical in a public health approach; unfortunately this aspect has remained neglected; health educators continue to be perceived as support only to the family welfare programme. There is need to train them effectively in the new communication and community empowerment strategies and provide proper communication skills.

g) *Anganwadi workers* provide critical services in the area of child nutrition and health as in looking after the needs of pregnant women. Their training needs also need to be assessed.

Monitoring & Evaluation – Similar to DASI, DMI visits.

h) *Traditonal birth attendants (Dais)* attend to almost 30-40% of all deliveries in most districts and there is need to ensure that they are recognized and given skills to ensure safe deliveries.

2.2.2 Training-needs assessment of Doctors – There is need to look at the training needs of Doctors working at PHCs/PHUs as well as those working in the first level referral system. There is also need to look at other categories such as Taluka health officers, programme officers, DHOs etc. and assess ~~at~~ the existing training programmes and the gaps. There is also a need to equip the system for providing both short and long term programmes in public health as also in the area of programme and hospital management.

2.2.3 Training needs-assessment of community representatives – Community empowerment for health can take place only if the local community leaders such as Grama Panchayat members are properly oriented and sensitized.

2.2.4 Training needs assessment for trainers – The Health department has so far not conducted a review of the existing capacities of training faculty. This is a pre-condition to the successful implementation of any meaningful HRD Plan.

2.2.5 Institutional analysis –There are currently the following categories of training institutions – ANM training centres, District Training centres, Regional HFW Training centres, and the State Institute for Health and Family Welfare (SIHFW). A SWOT analysis of each of these institutions is required as well a recommended integrated structure with the SIHFW the apex.

- AWTC's also
- CR's also important for HRD.

2.2.5 Assessment of management capacity – A major weakness of the existing Primary Health Care System is the weak management capacity; consequently Programme implementation falters. There is need to prepare a proper HRD Plan that focuses on capacity building at all levels.

2.2.6 HRD Plan – An objective assessment of the above issues will provide the basis for developing a comprehensive HRD Plan for the department that takes into account the existing structures and budgets, identifies the gaps, and recommends a Plan with detailed time-phasing, costs and supportive infrastructure required.

3. The Tasks

3.1 The selected agency will be expected to constitute a core full time Project team comprising a Human Resource Development specialist and a Public Health manager that will function until the Agency submits its Final Report. This team will be responsible for the designing, and implementation all the activities contemplated in the study.

3.2 The Agency will carry out a needs assessment study through questionnaires, interviews and focus group discussions. The questionnaire will be addressed to all categories of health care providers as well as to elected representatives, including Gram Panchayat members, members of self-help groups and members of Mahila Swasthaya Sanghas. Interviews will be both structured as well as unstructured.

3.3 The Agency will conduct 4-5 Workshops in various parts of the State to discuss institutional strengthening, strengthening of management capacities, improvements in the quality of services, and measures to make the system more responsive. The participants could be "mixed" or different Workshops could be held for health providers, local elected representatives and NGOs.

3.4 The Agency will visit a sample of each category of training institutions, viz. ANM training centre, District Training Centres, and Regional Training Centres. The Agency will also make a detailed study visit of the State Institute of Health and Family Welfare

3.5 The questionnaires, interviews, focus group discussions and the Workshops and study visit will be properly tabulated and documented.

3.6 The data from the Study visits, questionnaires, interviews, focus group discussions, and the Workshops will be collectively utilised for developing a set of strategies for preparing a comprehensive HRD Plan.

4.0 DELIVERABLES

The Needs assessment and Workshops should result in the following reports, which should be presented to s to the Review Committee at various stages of the Study.

4.1 A Status Report containing an Institutional Analysis for each type of training institution.

4.2 A Status Report containing a needs-assessment for each level and each type of health care provider, Doctors, ANMs, male health worker, lab technicians, health educators, pharmacists, etc.

4.3 A Report on the Quality of existing training programmes.

4.4 A Synthesis Report of the above individual reports, accompanied with a set of Recommendations containing a comprehensive HRD Plan for the department focusing on the primary health care system.

5.0 Resource support and review

5.1 The consultants will receive assistance and support from a Working Group of knowledgeable individuals drawn from the various functional areas of the Karnataka Health, Nutrition & Family Welfare Services units.

5.2 A Review Committee of the Karnataka Health, Nutrition & Family Welfare Services will be responsible for the review, supervision, and approval of the Plans. This committee will be chaired by the Commissioner of Health & Family Welfare and consist of senior government officials, and selected Task Force members.

5.3 The consultants will be provided necessary assistance from the Health & Family Welfare Department for smooth conduct of the Study.

6.0 Work Plan

A tentative schedule of the Work Plan is presented below. Once approved by the Review Committee the schedule will require to be adhered to strictly.

Name of the Activity	Description Of the Activity	Deliverables	Time Frame
Appointment of core Project team	Appointment of a core Project team	Core team to be appointed and approved by Review Committee.	1 week
Identify Tasks	Listing of all the tasks that come under the purview of the study.	Activity list	3 weeks
Finalise sampling design	The Core Project team will finalise the sampling design, structure of questionnaires, interviews, focus group discussions and workshops.	Finalisation of Study design and time-phasing	2 weeks
Prepare a Study Document	Prepare document that will list the responsibilities, deliverables and time frames; in short an MOU.	MOU	3 weeks
Finalisation of Workshop design	This will be done in close consultation with the Department	Workshop formats and workshop time table	3 weeks
Appointment of Study teams	Appointment of full time Study teams comprising of two public health specialists, including one training specialist.	Approved Study teams	3 weeks
Conduct of workshops	Workshops along with medical officers, NGOs, elected representatives and health staff	Workshop Reports	8 weeks
Conduct of Survey of identified facilities	On site visits to randomly selected institutions	Institutional Analysis Reports	16 weeks
Conduct of training needs assessment	The assessment will be conducted through questionnaires, interviews, focus group discussions, visits and Workshops	Needs Assessment Reports	16 weeks
Finalisation of Recommend ations	An approved set of recommendations and strategies.	Final Report including institutional Analysis, Needs Assessment and a comprehensive HRD Plan with costs and time -phasing	18 weeks

7.0 Review Committee:

The review committee will consist of

Chairman: Commissioner of Health &Family Welfare.
Members:

- Project Director IPP IX
- Director HFW
- Director SIHFW
- Additional Director PHC
- Project Director RCH
- Dr. C. M. Francis, Member Task Force
- Dr. Thelma Narayan, Member Task Force

71. Selection criteria

Selection of the Agency will be through National Competitive bidding on the basis of quality based selection, providing for negotiating with the highest ranked bidder.

STUDY FOR KARNATAKA HEALTH, NUTRITION & FAMILY WELFARE SERVICES PROJECT

***TERMS OF REFERENCES* (Revised)**

Review of Regulations concerning Civil Service employment and transfers for health department

1. Background

The Government of Karnataka has received a TA grant in response to preparation of an integrated Health, Nutrition and Family Welfare Services Development Project (Po71160). The proposed PHRD fund is primarily to finance key studies required in the finalization of the project.

To improve health outcomes of the Karnataka's population, especially among the poor and vulnerable groups, the State Government has requested the Bank to support and finance a health sector operation that aims to strengthen primary health care and public health services. Agreement was reached over a few key sector reform initiatives, which include the following:

- Making infrastructure more cost effective and linking it more clearly to stated health outcomes;
- Exploring other forms of service delivery (outreach/NGO/private sector);
- Improving GOK's oversight over the whole health sector, including development of new mechanisms to monitor and upgrade service quality;
- Strengthening health financing through development of better information systems, strengthening of insurance schemes, and improved financial management;
- Increase accountability and enhancing the incentive system in the public system.

The Review of Regulations concerning Civil Service employment and transfers for health study is meant to contribute to item number 5 above. Quality of health care (promotive, preventive, curative, caring and rehabilitative) depends largely on the clinical, technical and managerial skills, the ethical and social behaviour, motivation and commitment, and knowledge of the health personnel. To improve the health services, there is a need to increase accountability and change the incentive structure within the public system. Professional merit, commitment to serve the community, and good practice should be adequately rewarded, accountability levels should be enhanced and, particularly at the primary care level, transparent and needs-based recruitment, transfer and promotion criteria should become established. Primary care providers must be rooted and feel a responsibility towards the communities they serve and this is impossible to achieve if they arte continuously transferred.

2. Objectives

Key Objective:

Strengthen Primary Care Services: ***Transform Human Resources Management***

A. HR polices to increase accountability and improve services
B. HR polices to reduce bias in HR deployment
C. Enhance quality of human resources/training
D. Reduce corruption

Review the existing polices that guide decisions over new capital investments

E. Increase the efficiency of the delivery systems at the primary level (PHC, PHU, CHC level)

F. Incorrect utilization and duplication of services in referral chain

G. Reduce compartmentalization and segmentation of different programmes.

Specific objectives:

i. Review the existing recruitment, transfer and promotion criteria to develop transparent needs-based recruitment and promotion process and to enhance accountability levels particularly at the primary care level

ii. Reward professional merit, commitment to serve the community, and good practice

iii. Analyzing the existing data on absenteeism to see if issues like levels of vacancies, the state of the facilities, or the capacity of local management affect the level of absenteeism experienced in a particular District.

iv. Conducting focus groups of health personnel to ascertain the what motivates them and affects their performance. Whilst many of the factors are in a sense well understanding the behaviours of health personnel is an essential prerequisite to the introduction of any incentive scheme.

v. Establishing the current state of supply and demand of health personnel. It has been suggested for example that there is a surplus of doctors.

vi. Decrease vacancies, decrease skill mismatch

vii. Engage and contract NGOs and private sector providers to serve underserved arrears.

viii. Strengthen DHOs' management capacity

ix. Enhance knowledge of both public & providers on good practices and clinical protocols

x. Strict enforcement of anti-corruption laws and regulations.

xi. Develop clear and realistic regulations for extra hour private practice in public facilities

xii. Grievance mechanisms set up

xiii. Implementation of the most cost effective strategy to achieve planned health gains in underserved arrears.

xiv. Central, state and externally funded programmes are to be integrated

3. Measurable Outputs

Increased efficiency and quality of services, measured by

- Quality:
- Better clinical results
- Increase inpatients' satisfaction
- Decreased absenteeism
- Decreased skill mismatch
- Increase efficiency, reduce costs, reduce waste and duplication
- Reduce costs. Improve health outcomes, reduce maternal mortality

- Improvement in all priority health indicators

- Independent evaluation should also improve quality of services

4. Outputs /An outline of the task to be carried out

n) Under take a detailed review of the existing recruitment, transfer and promotion criteria in the Health & FW Department and suggest transparent needs-based recruitment and promotion process to enhance accountability levels particularly at the primary care level

o) Collection of data and materials pertaining to the study from Heath Department and Government.

p) Consider the effect of existing transfer policy and suggest transfer polices to be adopted to avoid frequent transfer of Officers and Officials in the department

q) Suggest measures to be taken to reward professional merit, commitment to serve the community, and good practice

r) Suggest HR polices to Transform Human Resources Management for cadre development, health human power planning, identifying and responding to current and future health personnel requirements.

s) Share the key findings with the departmental Officers that will be used

t) Suggest ways and means to contract NGOs and private sector providers to serve under reserved arrears

u) To find out the facilities available to the staff of Health department in rura & urban areas

v) To find out deficiencies in procedures in imposing penalties to inefficient and erring Officials/Officers.

w) To indicate e-governance for implementation of Regulations concerning Civil Services.

x) To carry out any other task assigned in pursuance of objectives and give feed back.

y) The consultant should provide periodical reports on all issues assigned to him.

5. Schedule for Completion of Tasks

Outputs	Amount of time for task after signing of contract
Identify Tasks: Listing of all the tasks that come under the purview of study	1 week
Make document: Preparing a document that will the responsibilities deliverables time frames	2 weeks
Out line of work plan	2 weeks
Review of existing Systems: A study of the existing mechanisms in the State and Collection of data and materials	4 weeks
Monthly progress reports.	
First Draft Report	4 weeks
Revised & Final Report should include Final Summary	2 weeks
Total	**15 weeks**

The final report must include accessible summary on the principal conclusions, policy implications and recommendations for wider implementation to the Government/department.

6. Data Services and Facilities to be provided by the Client

The Department of Health and Family Welfare will provide consultancy with documents available in a timely manner, including reports of studies that have been undertaken under KHSDP. . The consultant would make efforts to collect the required data and information from the concerned Directorate or the Secretariat as required by the Project Administrator. Facilities to undertake work would also be provided by issue of a circular from a competent authority.

7. Payment Schedule

10% Signing of contract
15% Summary of desk review/Inception report and Out line of work plan
40% Draft reports
35% Final Reports

Total compensation includes all cost of work such as communication, travel, lodging, food, materials, printing, etc.

8. Composition of the Review Committee

Review Committee will consist of following members.

- Commissioner of Health & FW Services.
- Project Administrator, Karnataka Health Systems Development Project
- Director of Health & FW Services.
- Additional Director SPC, Karnataka Health Systems Development Project
- Chief Administrative Officer, Directorate of Health & FW Services
- Chief Administrative Officer, Directorate of Medical Education
- Deputy Secretary to Government, Health & FW Department
- Deputy Secretary to Government, Department of Personnel & Administrative Reforms
- Deputy Secretary to Government, Finance Department
- Deputy Secretary to Government, Planning Department
- Joint Director, Health & Planning, Directorate of Health & FW Services.
- Chief Administrative Officer, Karnataka Health Systems Development Project
- Chief Finance Officer Karnataka Health Systems Development Project
- Deputy Director (Training), Karnataka Health Systems Development Project
- ***Special Invitees***: (a) President, IMA, Karnataka Branch (b) President, Red Cross Society, Karnataka Branch

There will be a monthly meeting of the Review Committee with the consultants for monitoring the progress of the studies per time schedule and directions. All final out puts submitted by the Consultant including reports will be reviewed.

9. Consultant's Qualifications

The Consultancy will comprise of a team of experts well versed with:

a) Civil services rules and regulation of Karnataka Government with regards to recruitment, transfer and promotion of Karnataka State Government Officers/ Officials. The consultant should have minimum qualification of graduation and have minimum 10-15 years of experience handling civil service regulations of Karnataka Government employees.

b) Manpower Management / Human Resource Management with specific reference to Health Sector. He/She should be a postgraduate in Manpower Management / Human Resource Management with specific reference to Health Sector or A Ph.D in Demography and specialised in Human Resource Management. He / She should have at least ten years of experience in Manpower Planning related to any department at the National / State level. It is desirable that the Consultant has experience in working with the health sector.

UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases (1997) "Prospects for elimination: Chagas' disease, Leprosy, Lymphatic filariasis, Onchocerciasis" (TDR/GEN/97.1).

UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases (1998) "Tropical Disease Research: Progress 1997-98: Fourteenth Programme Report of the UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases", World Health Organization, Geneva, Switzerland.

Wall J.F. (1970) Andrew Carnegie. University of Pittsburgh Press, Pittsburgh.

Wehrwein P. (1999) Pharmacophilanthropy. Harvard Public Health Review. 32-39 Summer issue.

World Health Organization (1996) "Guidelines for drug donations". Geneva: World Health Organization. WHO/DAP/96.2.

W.H.O. (1998) Health For All in the Twenty-First Century World Health Organization Document A51/5 Geneva.

World Health Organization. (1999a) "Building Partnerships for Lymphatic Filariasis": World Health Organization, Geneva.

World Health Organization. (1999b) "Guidelines for Drug Donations". (Revised): WHO/EDM/PAR/99.3; 1-23 World Health Organization, Geneva.

Selected web sites

Organisation	Internet Address
Baby Milk Action	http://www.inbc.org/
Global Forum for Health Research	http://www.globalforumhealth.org/
International Trachoma Initiative	http:/www.trachoma.org/abouttrachoma.html
Malarone Donation Programme	http://www.malaronedonation.org/
Mectizan Donation Programme	http://www.taskforce.org/MDP/
Task Force for Child Survival & Development	http://www.taskforce.org/
UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)	http://www.who.int/tdr
World Health Organization	http://www.who.int/
WHO Control of Tropical Diseases (Filariasis)	http://www.who.int/

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Main Identity

From: S Rajan <s.rajan@cilonline.org>
To: <sochara@vsnl.com>
Sent: Saturday, June 28, 2003 12:16 PM
Attach: health.doc
Subject: Round Table Consultation on Health

Chanda Singh 28 June
2003

Chairperson

Social Development Sub-Committee

Dear Dr. **Narayan,**

Round Table Consultation on Health

The Confederation of Indian Industry (CII), has been invited by the Department for International Development (DFID) to organise a series of Round Tables to seek private sector views on pro-poor economic growth through public-private partnerships. The recommendations from these consultations will help in developing DFID's Country Assistance Plan (CAP) for poverty reduction in India

DFID is the British government department responsible for Britain's contribution towards international efforts to eliminate poverty.

One of the issues to be addressed is education. Governments face a problem in delivering public services even when it has the ability to deliver, because the high constituency demands outstrips government capacity in many cases. The private sector can play a proactive role and best practices in privatisation and partnership strategies need to be worked out. I am pleased to invite you for the **Round Table on health** scheduled for **2nd July 2003, Wednesday at CII Institute of Quality, Near Bharat Nagara, 2nd Stage, Magadi Main Road, Vishwaneedam Post, Bangalore.**

The consultation is designed to solicit effective participation from experts in the field of health. It can give DFID an understanding of how the private sector can be leveraged to achieve outcomes favorable for pro-poor economic growth.

Your enriching experience on the issue will add value to the consultation and go a long way in developing a realistic Country Assistance Plan for DFID's interventions in India. A brief background paper is attached for your reference.

I look forward to your participation in the Round Table. Please confirm your participation at the earliest to facilitate logistical arrangements.

Lib - Public Private Partnership in Health file

Yours sincerely,

Chanda Singh

** Please confirm your acceptance by mail to

Ms Navanita Bhattacharya at navanita.bhattacharya@ciionline.org or

Mr S Rajan at s.rajan@ciionline.org

S.Rajan

==========

S Rajan
Confederation of Indian Industry, Southern Region-Karnataka
#1080, 12th Main, HAL 2nd Stage
Indiranagar, Bangalore 560 008
Tel: 80-5276544 / 545 / 706 / 707
Fax: 80-5276709
email: s.rajan@ciionline.org

Please visit our web site at:
www.cii-karnataka.org
www.ciionline.org

The Private Sector in Health

Background

1) Approximately 80% of healthcare in India is provided for by the private sector. The sector covers the entire spectrum from: large equipped hospital care (barely 2% of the market); smaller hospital services (which can constitute a large part of care in some states such as AP); private formally qualified doctors practising allopathic medicine; smaller practitioners in indigenous medicine; over the counter (OTS) drugstores (providing unauthorized diagnosis and prescription along with medicine sales); and Rural Health Providers (or quacks) who provide by far the largest element of care . The NGO sector by comparison appears very small and marginal to the health of most people.

2) DFID's work in India concentrates upon central and state level. It pursues strategies to improve service delivery, reform and strengthen health system operations and enhance the quantum and quality of health financing. The private health sector is important in all these aspects, most particularly as an additional means of delivering services, as an issue for stewardship and regulation and as a challenge to mitigating catastrophic shock and poverty. In addition to the work of many other agencies, we have undertaken a number of analytical studies to better understand the behaviour of both providers and consumers of private health care. These studies have looked, amongst other things, at motivating influences, quality of care, access and affordability, the public private interface, the feasibility of reform and institutional arrangements in the private sector.

3) There are a number of macro-level issues that it is worth exploring with the private sector. These are described below:

a) The bulk (some 50-60%) of primary curative care that poor people access is through less than fully qualified (LTFQ) practitioners. Global and Indian experience would strongly suggest that this is unlikely to change even in the medium to long term. There appears to be a significant and troubling impasse on this subject: the IMA and other professional bodies resisting dialogue with representatives for LTFQ providers; State Governments and external agencies seeing LTFQ providers as one of the means of reaching the poor.

i) **Question: How can this impasse be constructively resolved so that poor people can access services?**

b) The private sector offers the potential to address the health care needs of the better off, this freeing up time and space for the public sector to provide services to the poor. This however requires conscious decisions to be taken by policy makers, as the market still needs to be carefully managed if distortions (such as large scale movement of human resources into the private sector) are the to be prevented.

i) **Question: what are the plans of large scale providers and insurers in the health market in the medium term and how positively do they see the medium-term future**

ii) **Question: what mechanisms and processes need to be put in place to manage a plural health system, so that the benefits are shared equally?**

c) Systems of regulation and accreditation are currently quite weak in India. The primary form of regulation of qualified allopathic doctors is self-regulation by State and Central Medical Council in accordance with Indian Medical Council Act, 1956. However, the functioning of the Council is hampered by not being able to provide compensation for damages or malpractice to patients and having weak powers of deterrence as far as malpractice or unethical practice is concerned. The lack of a large-scale accreditation system undermines the potential of both the public and the private sector to work effectively within the country and in an increasingly global market where India could benefit.

i) **Question: How can the regulatory framework for qualified doctors and clinical establishments be improved and effectively implemented?**

d) Private out of pocket expenditure for health care in India is amongst the highest in the world. This impacts most catastrophically upon the poor and introduces inflationary pressures into the health care market. The government and private providers (for profit and not-for-profit) have instigated a number of measures to facilitate the introduction of pre-payment mechanisms. The potential from such approaches may be significant, however in practice the schemes are limited in coverage and evidence suggests that it is difficult to provide real cover to rural populations.

i) **Question: what options are there for pre-payment schemes that can reach out and include the urban and rural poor?**

e) India has become a dominant force in the global Pharmaceutical market. WTO agreements have the potential to have a mixed impact upon the domestic market. At the same time market pressures are resulting in less research on drugs for common conditions amongst the poor.

i) **Question: what expectations are there for the future of the industry after the introduction of TRIPS related legislation?**

ii) **Question: what role is there for public private partnerships to explore treatments for the diseases of the poor?**

In the changing dynamics of globalisation, there is a convergence of interests of government and business. In South Asia, governments have begun to look at the private sector as engine of growth. Best practices in privatisation and partnership strategies (outright privatisation of facilities and service delivery, public ownership, private management, micro-privatisation, and/or build own transfer modalities) need to be worked out.

The consultation is designed to give DFID an understanding of how it can usefully enable the private sector's role in India to achieve outcomes favourable for pro poor economic growth.

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TERMS OF REFERENCES
INFORMATION SYSTEMS STRATEGY PLANNING (ISSP) STUDY FOR KARNATAKA HEALTH, NUTRITION & FAMILY WELFARE SERVICES PROJECT

1.0 Background

1.1 The Government of Karnataka has received a TA grant in response to preparation of an integrated Health, Nutrition and Family Welfare Services Development Project (Po71160). The proposed PHRD fund is primarily to finance key studies required in the finalization of the project.

1.2 The rapid technological advances in connectivity, bandwidth availability WEB based technologies, local area networks (LAN) and Client/Server-computing environment creates a great opportunity for Karnataka Health, Nutrition & Family Welfare Services to strategically plan its future information technology (IT) investment for a great return in better Health management information, increased staff productivity and enhanced Health, Nutrition & Family Welfare services.

1.3 Currently, IT enabling in Karnataka Health, Nutrition & Family Welfare Services program consists of limited computerization in fragmented technology architecture. There is no integrated Management Information Systems (MIS) that could facilitate in coordinated monitoring and management decision-making across the entire Health, Nutrition and Family Welfare Services program. If an uncoordinated information technology deployment were to be put in place without the guidance of a well-defined strategy plan, it could result in incompatible hardware and software systems, which would, in the future, be costly to maintain and implement. Other difficulties would involve staff training and fungibles across the Health, Nutrition & Family Welfare Services.

1.4 As one of the first steps in IT enabling, the Karnataka Health, Nutrition & Family Welfare Services Development Project develop a strategic information systems plan (ISSP). This plan will define the long-term information requirements of the program, recommend a technology architecture, and prepare long-term system implementation, equipment acquisition and staff training plans. The ISSP will be a foundation upon which Karnataka Health, Nutrition and Family Welfare Services information systems will develop in an integrated, orderly manner to support key sectoral and institutional priorities.

1.5 The ISSP must be prepared in an abbreviated time frame (around 4 months) and format, and be particularly concrete in outputs. Since the information systems strategy is expected to be cross-cutting across various agencies, it will be sponsored through the Office of the Commissioner of Health & Family Welfare, GOK with participation and inputs by all related agencies and departments.

2.0 Objective of the Information Systems Strategy Plan

2.1 With above background, there is an imperative and immediate need for a long term information technology (IT) strategy study for Karnataka Health, Nutrition & Family Welfare Services program to identify the medium term and long term information needs of that sector and to establish a technical set of standards that all proposed solutions must adhere to. The study should address the following areas for IT enabling of the existing systems:

2.1.1 The pace of Telecom Industry developments in driving development of more intelligent communication technologies as well as bandwidth capability and ensure compatibility of various electronic systems.

2.1.2 Examine the development and maintenance of links with other agencies that deal with Health, Nutrition & Family Welfare Services issues.

2.1.3 To develop Integrated IT enabled Health Care Systems.

2.1.4 To review the IT enabling activities of Karnataka Health Department and Modalities for strengthening it.

2.1.5 Work out strategies for data validation from Primary Health Centers (PHCs) to District and District to State.

2.1.6 A system to monitor various information systems in the department for coordinating with existing National Health Programmes.

2.1.7 To incorporate Decision Support Systems for Recruitment, transfer, and inventory management.

2.1.8 To incorporate information and document system using computer networking facilities

3.0 Scope of the Information System Strategy Plan-ISSP

3.1 To study the existing computerization activities in Health Department identify the gaps in information and bring out the extent of re-engineering required for an overall Integrated ISSPfor the Department.

3.2 To study the present computerization activity in HR system to include Personnel recruitment, Promotion, transfers and training, various Governmental Policies on the subject and propose a IT enabled Decision Support System for development of Human Resources for the long term needs of the department.

3.3 To study the information systems in Institutional facilities that are available in KHFWS for their functionalities, requirements and performance monitoring and propose IT measures required which will improve their efficiency, better management and enhanced health services.

3.4 To study the Disease Surveillance system, epidemic Surveillance and reporting system, Reproductive Child Health Care (RCH) systems and suggest an IT Structure for effective Speedy Information flow, close monitoring and early warnings on outbreak of epidemics.

3.5 To study the progress of programmes, projects that are underway in KHFWS under State, Central and International agencies and suggests information requirements, data requirements necessary for speedy implementation and integration.

3.6 To study the logistic system for supply of drugs, equipments, transport, inventory management in KHFWS and suggests measures for automation of inventory management for automatic invoice generation for supply of drugs, equipments and management of transport.

3.7 To study the financial system, budgeting, forecasting and suggest an automated Financial Management System.

3.8 To study the availability of raw data, data entry, input validation, updation and suggest a suitable data base system which can provide smooth information flow.

3.9 Study the availability of Hardware, Software, Network Connectivity and suggests a system architecture for a responsive online server client information system which can integrate the entire IT activities in KHFWS and facilitate easy interaction from PHC to KHFWS.

3.10 To study the system requirement, accessibility, and ownership of systems with responsibilities for updation and maintenance of data, System administration, security standards bringing out clear-cut responsibilities at all levels.

3.11 Assess the skill set requirements, availability of manpower, short and long term training needs for technical staff and identify suitable agency to implement the IT enabling in KHFWS.

3.12 To study the requirements of developing various application software, identify suitable operating systems, case tools for implementing various IT initiatives being proposed and identify standard set of Core Applications for day-to-day functions.

3.13 Propose long-term plan for technology acquisition, system development and deployment and periodic updation and modernization.

4.0 DELIVERABLES

The study should result in following reports, which should be presented to review committee of KHFWS for their approval.

4.1 Report on all available Information Systems in KHFWS, their functionality, gaps in information and extent of re-engineering required for integrating the same with the proposed Information System.

4.2 Report on the IT initiative in present HR practices in KHFWS and suggest a Decision Support System for an Integrated HR system, which can cater to the short and long term, needs of KHFWS.

4.3 Report on institutional facilities available, their monitoring systems possible improvement and propose an IT system for better management, increasing efficiency to enhance Health Services in KHFWS.

4.4 Report on Disease Surveillance 'early warnings on outbreak of epidemics, Reproductive Child Health Care' System and IT measures to enhance their responsiveness and for better Disease Management.

4.5 Propose an IT model for effective monitoring and implementation Report of existing programmes, projects on health in KHFWS.

4.6 Report on existing logistics system to include supply of drugs, equipments, transport and inventory management and suggest an Inventory Management system for automatic invoice generation, movement of drugs and equipments and level of inventory in all the hospitals.

4.7 Specification for an IT package for automating the finance department.

4.8 Specification of data requirement, their availability, data entry methods, sectoral, institutional and appropriate database system.

4.9 Specifications of Hardware, Software, Network connectivity for meeting the online requirements of IT initiative being proposed.

4.10 Specifications of the proposed information systems to include functionality, internal & external data sources, outputs.

4.11 Processing and storage volumes, data recovery, backup data, disaster management, security standards, access rights, system administration.

4.12 Recommendation on procurement of proposed technology acquisition to include software, application software, tentative cost and timetable for acquisition.

4.13 Recommendation on training programmes to include types of training, identification of personnel for training and tentative cost involved.

4.14 A plan of action for implementing the overall IT enabling strategy for KHFWS after discussing with officials, World Bank regional informatics team. The proposed action should lay down priorities, project management, various milestones, costing, testing and acceptance for smooth completion of project in correct time frame.

5.0 Resources & Management Oversight

5.1 The consultants will prepare the ISSP Plan, with the assistance of a Working Group of knowledgeable individuals drawn from the various functional areas of the Karnataka Health, Nutrition & Family Welfare Services agencies. Staff in the working group will be assigned to this task for a maximum of four months on a part time basis.

5.2 A Review Committee of the Karnataka Health, Nutrition & Family Welfare Services will be responsible for the sponsorship, supervision, and approval of the ISSP. This committee will be chaired by the Commissioner of Health & Family Welfare GOK and consist of senior government officials to be determined by the GOK. It will also include some senior technical staff from all user departments to provide requisite input and in particular to sponsor and monitor the ISSP.

5.3 The consultants may be provided necessary help from Karnataka Health & Family Welfare Department for smooth conduct of study. The consultants must provide any specialized software ad hardware technology needed to document the ISSP, as well as the necessary training to Karnataka Health, Nutrition & Family Welfare Services support staff in the operation of this technology.

6.0 WORK PLAN

The work plan is arrived at after noting that the proposed study should encompass the study of the activities of all the functions that are involved with the HMIS under the various programs right from the process of data collection for the monitoring of the diseases to the drugs distribution and equipment maintenance to the transfer of employees and the performance monitoring of the hospitals. It is imperative that all the activities that are to be undertaken be listed out, agreed upon with active user participation.

A tentative schedule is presented with a note that the time frames mentioned hereunder are critical and must be adhered to with a high degree of participation and co-operation from the concerned members.

Name of the Activity	Description Of the Activity	Delive rables	Time Frame	Responsibility	Man Mont hs
Appoint Consultant	Appointment of a consultant with key personnel having the expertise in the concerned areas of IT, Public Health, Epidemiology and who has familiarity With the existing systems and processes.		4 weeks	Health	1
Identify Team	The team must comprise of members from the Consultant company and also members from the Health Department with considerable experience on all the functions, who will undertake to impart correct information to the information gatherers.	Consul tant Team Health Team	2-3 Days	Health/Consultant.	0.5
Identify Task	Listing of all the tasks that come under the purview of the study.	Nil	4 weeks	Consultant/Health	1
Make Document	Preparing a document that will list the responsibilities deliverables time frames commercial aspects in short an MOU.	MOU	2 weeks	Consultant	0.5
Review Existing System	A study of the existing mechanism in the state vis a vis the ones in developed/developing countries to improve the existing system. This would include the study of the various programs, Financial Management Systems, HR Related practices.	4.1, 4.2, 4.3, 4.5, 4.6,4.7	30 weeks	Consultant/Health	7.5
Study Institutions, and their performance monitoring.	This would involve the in-depth study of the performance parameters, the facilities available, the reporting and the monitoring systems.		28 weeks	Consultant/Health	4
Study logistics	The method of distribution of the drugs their inventory the method of disbursing of the facilities to the various agencies under the Health Department		28 weeks	Consultant/Health	4
On site visits Travel	A travel plan that will comprise of visits to four reprentative districts and Taluks to study the functioning of the institutions. (PHCs and SCs)		28 weeks	Consultant/Health	4

Study existing IT infrastructure	To study the existing hardware and Software (that will include an account of the existing numbers) and connectivity. (LAN, NICNET) and associated hardware.	4.8, 4.9, 4.11,	20 weeks	Consultant/Health	5
Propose an IT plan	The proposal shall include the short term and the long term plans, recommendation for a technology architecture with plans and estimates for putting it in place, a plan for the implementation of the above system, a list of applications that could be developed for decision support by the Government.	4.14	12 weeks	Consultant	3
Action Plan for Procurement of the above.	Should include what all to be procured equipment and software, connectivity, faxes, applications, scanners, modems, where to be installed, cost of the activity, concerned vendors, models cost comparisons so on...	4.12	8 weeks	Consultant.	2
Plan inputs for Disease Surveillance.	Develop detailed information schedules, proforma for the Disease surveillance, National Health programs and a monitoring system.	4.4,	12weeks	Consultant/ Health	3
Training plan.	Who should be trained, on what they have to be trained, duration of the courses, tentative fees, who can be the trainer etc	4.13	12weeks	Consultant/ Health	3
Make a draft report.	Include findings of the study, list recommendations, plans which were made etc.	Draft Copy	8weeks.	Consultant.	2
Final report.	Refine the above and give the final copy.	Final Copy	4 weeks.	Consultant.	1
				Total Man-Months	41.5

7.0 Review Committee:

HNP Pre project Studies review committee will consist of
Chairman: Commissioner Of Health &Family Welfare GOK.
Members:

- Director Of Health &Family Welfare Services.
- Demographer Of Health & FW services.
- One member of the KTF on Health (Dr. C.M. Francis)
- Joint Director Of Communicable Diseases, Director of Health & FW.

8.0 Inputs from the clients:

- Existing HMIS proformas, protocols of the National Health Programs.
- Details of the SCs, PHCs, Taluk Hospitals, District Hospitals, and Channel of communication.
- HMIS inputs and Surveillance activities from the KHSDP.

9.0 Study Progress Monitoring

There will be a monthly meeting of all the key consultants with the commissioner for monitoring the progress of the studies as per the time schedules.

10.0 Costing and Payment Schedule

Total INR-45.0 Lacs.
The breakup is as follows:
Man months estimated: 41.5
Industry standard per man month: 1.2 Lac.
Travel and accommodation : 2.0 Lacs.
Total Cost : 51.8 Lacs.

The agency will be paid
40% of the contracted amount on signing the agreement
40% on submission of the draft final report.
20% upon acceptance of the final report.

BPL INNOVISION BUSINESS GROUP PROFILE

Bplinnovision Group, which is into Mobile and Convergent Network Service Provision, is part of the well known BPL group. Bplinnovision has technical collaborations with leading companies across the world, ensuring immediate access to the world's most advanced technologies. Some of the Strategic Partners in Telecom are US West, France Telecom. Through its group company, BPL Telecom it has 3 Decades of Telecom Experience. Bplinnovision offers a wide and diverse range of services in four important areas, namely

Wireless, IT Services, Internet Services, Global Technology Solutions

WIRELESS – It has installed GSM Cellular Network and providing Services in Mumbai, Maharashtra, Goa, Kerala, Tamilnadu and Pondichery. It is India's largest Cellular Network and Covers 41 District Head Quarters in addition to Mumbai. It covers a population of 182 million and has commissioned five Main Switching Centres, 35 Base Switching Centres, 390 Base Terminal Switch and 465 Microwave hops. It also has Microwave backbone covering 6000 kms and is the second largest network after Dept, of Telecommunication.

IT SERVICES - The group has been providing focussed IT Solutions, leveraging on its domain expertise and software development skills. This portfolio has a large pool of skilled and competent software professionals delivering development, support and maintenance projects. Both on-site, at customer locations in Europe and USA and offshore at development centers in Bangalore, India. bplinnovision's IT services is presently focused on the following areas:

Internet Solutions

- e-commerce end –to-end solutions
- web enablement of legacy systems
- web solutions
- web content

Systems Integration & Network Solutions

- LAN/WAN Planning and Implementation
- E-mail and workflow solutions
- Lotus Notes/Domino Based Intranets
- Network Management Systems and Network Security

INTERNET SERVICES – Bplnet.com, the Internet Company, is a national Internet Service Provider (ISP). As an end to end solutions and service provider, bplnet.com has built a wide range of products and services portfolio. These include innovative access solutions through Digital Subscriber Lines (DSL), leveraging the GSM backbone, Radio, Leased Lines. With a strong focus on service excellence, the company has Account Managers for dedicated relationship building, Solutions Architects for customized internet & connectivity solutions, and Net Assist, a 24 hour customer care center. Bplnet.com is poised to provide every internet solution that a corporate may require.

GLOBAL TECHNOLOGY SOLUTIONS –
bplinnovision provides leading edge solutions in Design & Development and Technical Services. Signaling Protocols, Web Enabled Solutions and SS7 / "IN". Technical Services provide project/product support on site in the sphere of Telecom, Datacom, and Internet. These services can be extended or migrated to an offshore model. The group is presently working on the following :

Telecom Business Solutions

- Network Management System, Operating support System, Base Station System
- Offshore Development Centre for Motorola
- Geographical Information Systems (GIS)
- e-governance. Presently working on Karnataka Health & Management Information System (KHMIS).

In pursuit of excellence, bplinnovision's cornerstone is quality, adopting the best practices in Software Engineering. It has well defined and documented Project Management and Software Development processes. Periodic reviews, audits and proactive measurements are part of the critical Quality Assurance activities, supported with state-of-the-art tools. This leads to better project tracking and management, resulting in a Quality Product that meets critical time-cost requirements. Bpl Innovision focuses on training to continuously improve the skill sets of its employees, which in turn results in core competency development.

Bplinnovision provides an environment where team members enjoy their work and where learning is a continuous process that elicits proactive organizational support. A place where targets and their delivery make for superior business performance. Over a period of time, each individual experiences personal growth and prosperity. The people policies of bplinnovision are firmly focused towards achieving

- A happy and open work atmosphere
- A continuing focus on learning, education and training for each team member

BPLinnovision, based in Bangalore, has established a 'Ready-to-use' Facility consisting of requisite office space and infrastructure, including PCs on LAN, with e-mail, Fax and Internet, allowing employees to work on off-site projects for specific customers. The facility enables customer projects to be planned and initiated within a short span of time. In the near future, Bpl Innovision will move to a 15 acre campus in Bangalore. Innovatively designed to provide a stimulating environment to aid creative mind power in the fields of software and technology. It will have excellent landscaping including smart buildings with more than 150000 sq. ft of work area with world class work and recreational facilities.

Bplinnovision Business Group has got a separate division for IT Services headed by Ajay Bhatkal, the Head of Information System for the group. In an earlier assignment, Ajay Bhatkal assisted by five consultant has designed, tested, implemented the local and wide area network for 38 C&FA's, 11 branches of BPL and the Central Marketing Office for the implementation of oracle financials ERP. This included the local cabling at the C&FA's branches, forward infrastructuring hardware, training on ERP and wide area netowrk using a combination of VSAT's, leased links and dial-up modems. Besides the accounting system being put in place through the ERP, this team also implemented the messaging system and the intra net. Despite the project being live and running, regular periodic functional training is conducted for various model and enhancements therein.

This also covered the application and commissioning, installation, implementation of links to the net through which an E-commerce model was put in place for booking and buying white goods of the company through the distribution channels like the dealers. The project was designed with HP unix services at the centre (Bangalore) with built in redundancy through mirroring and local NT servers at the locations which replicate incremental data with central site using the VSAT links. The entire hardware and bandwidth sizing was done by this team and the methodology was outsourcing to vendors for actual cabling, hardware/VSAT delivery installation and commissioning after a detailed evaluation process wherein the vendors were examined on their capabilities, technical competence spread across the country for support and pricing.

Ajay Bhatkal's short profile is as follows :-

1. 1983 - 1996 Brooke Bond India Limited

- Design and development of SW applications
- IT operations for the corporate office at Brookefields
- Complete LAN cabling including VSAT network for the WAN across the country
- Computerising C&F agents across the geography including training on messaging, intranets and Mfg-PRO
- Voice and data communication networks

- Application systems for Factories and Sales and Marketing divisions

2. 1996 - 1998 Praxair India Pvt Limited

- Bring them up from one hired PC to a fully networked building of three floors
- IPLC connectivity into their Singapore office
- Implementation of JD Edwards and Lotus Notes for messaging and intranet
- IT operations and IT enabling for business benefits, office automation

3. 1998 - 2000 BPL Telecom Limited

- Local networks at Rockline and internets links and security
- Complete local area networks and wide area connectivity using leased lines and VSAT for 52 C&FAs of BPL
- Design and architecting the IT infra for Oracle Financials ERP to be deployed across the 52 locations
- Messaging systems and internet applications like billing on the net, payment gateways, etc

4. 2000 - 2001 Microland Limited

- Joined as the group CIO reporting to Pradeep Kar
- Put in place Radio Links and Leased Links/ISDN for the 7 group companies & their offices
- Bandwidth and hardware sizing, internet security, access and mail routing
- MS Exchange functionality across the group
- Implementation and enhancements on SAP as the ERP for the group
- Customising requirements on SAP for functional areas like Finance, Distribution, HR
- Conceptualizing and content management of the web sites on the net and the info management therein
- Spread of a groupwise intranet for use as a complete workflow automation and groupware, conferencing, etc

5. 2001 - currently at BPL Innovision Business Group

- Joined as the Head - IS for the group
- On board since 15th Feb'2001

With the above profile, bplinnovision is eminently capable of undertaking system study for Karnataka Government for its IT enabling initiative in Health and family welfare department. It has necessary expertise, infrastructure and manpower to undertake the study and capable of completing the task in a stipulated time. The following team structure is proposed to undertake the study.

a. Project Manager – One
b. System Analyst – Two
c. Chief Consultant IT – One
d. IT Consultants - Three

To, Dr Kapur 23/6/2000

This is the base note prepared by Mr. Sanjay Kaul. It has used the Task force Report extensively.

Draft outline
internal circulation only

~~NUT-11~~
ComH-69

Government of Karnataka

The Health, Nutrition & Population (HNP) initiative for Karnataka

towards equity and quality with focus on primary health care

May 2000

Office of the Commissioner, Health and Family Welfare Services

Draft outline
For internal circulation only

The Health, Nutrition & Population (HNP) initiative for Karnataka – towards equity and quality with focus on primary health care

A. SECTORAL DIAGNOSIS	The chief strengths of the health, nutrition and population sector (HNP) sector in Karnataka include:
Strengths of Sector	(i) an overall health status above the national average; (ii) a wide network of health care institutions at all the three levels – primary, secondary and tertiary levels have been established, even in excess of GOI norms; (iii) a state policy that has consciously fostered a large number of privately owned and managed medical, nursing, dental and other health educational institutions; (iv) an overall improvement in the health status of the people as evidenced by increased LEB from 26 years in 1947 to 66.3 years for women and 65.1 years for men in 1997, decline in CBR from 41 per 1000 to 22 in 1998, and, decline in CDR from 22 per 1000 to 7.5 in 1998, complete eradication of small pox and guinea worm infestation, control to a considerable extent of vaccine preventable diseases such as polio, whooping cough and measles, and, the effective couple protection rate has increased from 23.8 in 1981 to 57.7% in 1997; (v) capacity to well utilize externally assisted projects; a case in point is the satisfactory implementation of the World Bank assisted health system project.
Problems with sector	The main constraints in the health, nutrition and population (HNP) sector in Karnataka include (i) high levels of poverty in some parts of the state, contributing to and being aggravated by poor HNP outcomes (high fertility, mortality and malnutrition); (ii) gender inequities leading to overall poor health indicators; (iii) limited public information and capacity to make healthier choices and demand better health services; (iv) low quality and poor accountability of health services in public and private sectors; (v) poor infrastructure management; (vi) overall neglect of public health principles with inadequate emphasis on preventive, promotional and rehabilitative care, and even less on determinants of health including nutrition, water supply and sanitation (vii) inefficient and inequitable financing of health services; (viii) weak public sector management, and poor regulatory framework for private sector participation; (ix) poor governance and low morale in health team; (x) lack of focus on regional and inter-district disparities; (xi) widespread and growing corruption; (xii) inadequate attention to human resource development; (xiii) inadequate integration of externally assisted projects into health system planning.

B. GOALS	
Objectives for sector	The broad objectives are to; (i) improve HNP outcomes, namely the reduction of population growth, fertility, mortality and malnutrition levels, and reduce the overall disease burden; (ii) empower the public, particularly women, to make healthier choices and demand better HNP services; (iii) improve quality, effectiveness and coverage of services, especially for the poor and underserved – focus on improving quality of primary health care services; (iv) improve efficiency and equity in the financing of HNP services with focus on women, children, SC/ST, disabled, aged, and the poor; (v) improve the organization and management of health services in the public and private sector; (vi) significantly improve accountability and transparency; (vii) improve and strengthen urban health care, with focus on urban slums (viii) strengthen medical pluralism by promoting Indian systems of medicine and homeopathy, (ix) improve regulation of the private sector, (x) improve linkages and evolve meaningful partnerships with NGOs, other sectors and departments which impact on health.

Committees to access — How? — standards — disparities — what — who? how? where? — ? define and facilitation — intersectoral

C. SHORT TERM STRATEGIES	To achieve the above objectives the strategy will be translated, in the short term, into "an agenda for action" for implementation in the next one year as suggested in the Report of the Task Force.
C.1 Primary Health care	This will include strengthening PHCs and sub-centres (i) through filling up vacancies, (ii) increasing allotment of medicines by Rs. 25000 per PHC, (iii) providing phones to each PHC, and (iv) providing minimum required equipment. Action will also be taken to (v) fully utilize RCH and IPP IX funds (vi) make 200 PHCs fully functional and make them work round the clock, and (vii) widen scope of urban family welfare centres as providers of comprehensive health care;
C. 2 Secondary level	The strategy in the short term will be to (i) fully complete and make functional all secondary care institutions under KHSDP and Kfw and work out effective linkages with PHCs, (ii) strengthen blood banks and establish 8 banks in districts lacking them, (iii) empower consumers using public information; (iv) improve the quality of health services, including introduction of quality assurance systems. The above will be achieved using the KHSDP and Kfw project funds.
C.3 Reproductive and child health	In the short term the strategy will be to (i) vigorously implement the RCH project (ii) speed up work under IPP VIII and IPP IX and, (iii) introduce the Anganwadi system as an effective support institution at the village level.

Empowering people
People participation

when all PHCs to become functional in a short manner

referrals

Rational use of drugs
Antibiotic guidelines

C.4 Capacity building, including health planning, training, management and administration	In the next one year the department will (i) accelerate capacity building to support progressive decentralization to the district level including Zilla Panchayats; (ii) take concrete measures to further integrate health and family welfare programs; (iii) build better partnerships with the private sector and NGOs, and linkages with other sectors that affect health; (iv) focus on consolidation and impose a moratorium on new medical, dental, nursing, physiotherapy, ayurvedic, homeopathic and unani institutions for the next three years; (v) strengthen health human resource development by introducing courses on public health and upgrade the State Institute of Health Welfare into a premier autonomous institution; (vi) introduce transparent measures for personnel deployment and significantly reduce mismatch, and, (vii) put in place a comprehensive health monitoring system which will include (a) personnel MIS, (b) disease surveillance, (c) GIS for all medical institutions (d) infrastructure and facilities, and (e) RCH indicator monitoring.
D. SUSTAINABILITY Sustainability studies	Three externally assisted projects, namely KHSDP, IPP VIII, and IPP IX will come to a close in the next two years. Action is required to (i) finalise a sutainability plan for these projects identifying the activities which will need to be continued, the posts required to be continued, (ii) the annual funding required and (iii) strategies required to integrate these project initiatives into the main health system.

E. MEDIUM TERM STRATEGIES – THE HNP PROJECT INITIATIVE	While in the short term the above initiatives are expected to visibly impact on HNP indicators there will be need to go in for a major initiative to achieve the HNP goals. This initiative will require enhanced funding for the health sector and will in addition require another external financed project to supplement the state resources to meet critical gaps in achieving the HNP objectives for the sector. The following specific goals are proposed for achievment by 2007:
E1 HNP goals and objectives for the medium term	

1. Crude birth rate	17 per 1000
2. Crude death rate	7 per 1000
3. Total fertility rate	1.9
4. Infant mortality rate	30 per 1000 births
5. Immunisation coverage	100%
6. Institutional deliveries	> 80%
7. Maternal mortality rate	< 100 per 10,000 live Births
7. Couple protection rate	65%
8. Anaemia among women	< 20%
9. Anaemia among children	< 40%
10. Nutrition status of children	25% more than current Level
11. LEB	71 for women, 70 for men.
12. Overall burden of disease	reduce to East Asian level
13. HIV/AIDS	contain spread
14. Quality assurance	"equal to" or "better" than in private sector

E2. Primary and secondary health care	The medium term strategies will include: (i) making all PHCs and sub-centres fully functional by provision of buildings, equipment, consumables, drugs, addition to staff, filling up of posts and training inputs; (ii) a pro-active policy to reducing inter-district disparities in health indicators, specially the Northern districts, and within them the five districts of Gulbarga division; (iii) integration in the working of urban health care services with the regular health system; (iv) making all taluka and district level hospitals fully functional to diagnose and manage all communicable diseases and establish an integrated and effective computerized disease surveillance and monitoring system; (v) convergence and integration in the management of all "vertical" disease control programmes, (vi) strengthening facilities to tackle mental health and psychiatric disorders; (vii) introduce community based rehabilitation for persons with disability; (viii) support to traditional sytems of medicine and its introduction into the mainstream health structure; (ix) initiation of a rural cancer registry and linkage to all cancer treatment centres; (x) use of Anganwadi workers as village level community health workers on a large scale; (xi) introduction of effective coordination among rural development, water supply Boards, municipalities and the health department for monitoring of water quality and for improving sanitation and waste management, specially in urban areas;; (xii) introduction of a meaningful tribal health programme; (xiii) emphasis on health education that promotes a healthy life style, and launch of a massive IEC campaign using appropriate health education and communication materials; (xiv) strengthen and introduce an effective school health programme; (xv) review of the drug procurement and supplies system and its reorganization on modern lines with full transparency and backed by a fully computerized drug inventory management system.

What indicators will be used ?
mortality
morbidity
health

Alleviating causes of disability

School dropouts

health indicators
LE B
weight at birth
Growth and development

E3. Nutrition interventions	Medium term strategies will include (i) making nutrition an important concern in the health care system and making the health system fully accountable for poor nutritional status of the population, as opposed to the current practice of holding poverty responsible for this situation; (ii) giving nutrition education among all sections of the population, including school-age children, high priority; (iii) effectively tackling the high prevalence of mild and moderate malnutrition through imaginative and need based nutrition interventions with introduction of local-specific weaning foods for the < 2 year olds, regular child growth monitoring, and introduction of micro-nutrients where required;
E 4. Population and social development	The principal strategy in the area of population and social development is the recognition that the best strategy for population stabilization is through improved health and nutrition status backed by emphasis on female education. Specific strategies will include (i) vigorous implementation of the RCH initiative, (ii) meaningful community based interventions empowering and enabling households to making informed choices; (iii) fully meeting all "unmet" needs for family welfare services; (iv) improving service delivery at the village and sub-centre levels; (v) making gender inequalities the cornerstone of policy at all levels (vi) improve services for RTI/STI and HIV/AIDS; (vii) empowering women for health and nutrition in close collaboration with women and child development and education departments; (viii) significantly increasing participation of men in planned parenthood; (ix) close collaboration with NGOs and diverse health providers; (x) providing for the older population and equipping hospitals towards geriatic care (xi) launching and sustaining a massive holistic and integrated IEC campaign that converges family welfare, AIDS control, health and nutrition education.

E 5. Capacity building	The HNP project initiative will take note of the "risk" inherent in such projects of non-integration and will from the beginning be fully "grounded" in the main health system structure. The strategy will include (i) introduction of well defined health manpower planning policies with focus on public health, and use of professional medical colleges and Rajiv Gandhi Health University besides the State Institute on a large scale for training; (ii) full support to the State Institute to become a premier world class institution; (iii) restructuring of the strategic palnning cell and its integration into health system planning; (iv) redeployment of personnel according to need and qualification through a well functioning personnel information system; (v) restructuring of Directorate and injection of professional managerial inputs at all levels, specially at state and district levels; (vi) reviewing current procedures to make the system more transparent and accountable, (vii) setting of performance standards and measurement of "satisfaction" levels at all levels (viii) introduction of an effective regulatory mechanism for private health care institutions, with self-regulation and accreditation wherever feasible; (ix) utilizing a well functioning, fully networked HMIS and GIS for decision making at local, district and state levels.
E6. Evidence that existing strategic project interventions are working.	Overall the strategy is working as shown by the following; (i) improved health outcomes; (ii) improved intra-sectoral allocation of public funds; (iii) increased utilization of public health facilities in the SHS project hospitals; (iv) acceptance of technical paradigm shifts in disease control, RCH and nutrition projects; (v) improved project implementation in the state and in some centrally sponsored schemes; (vi) improvements in capacity in the area of civil works, procurements, and training; (vii) increased awareness of the need for involving NGOs (as in RCHand IPP IX) and the private sector (as in the SHS project); (viii) increased quality of services and improved morale of staff through implementing user charges and retaining and using such funds at the facility level.

able to meet the needs of Karnataka

F. NEXT STEPS	
What work needs to be done and when.	Immediate steps include (i) finalizing the strategic plan; (ii) commencing and completion of sustainability studies; (iii) implementation of all "short term" recommendations of the Task Force and strategies agreed on; (iv) identification of a committed group of professionals/organisation(s) to refine strategy and commence documentation; (v) holding work shops at various levels involving all clients to obtain inputs; (vi) commencement of pilot studies/trialling where required; (vii) finalisation of a calendar of activities with time schedules; and, (viii) conducting a survey to obtain current health, nutrition and demographic indicators on a district-specific basis; (ix) use of IT, including GIS in a big way for strategic planning and decision making;

Copy presented & discussed with World Bank team & DHFW - GOK, & CHC in New Delhi, 24/7/2000

To
DR. R.L. Kapur

~~NUT II~~
Com II-6(9)

Draft Outline
For Internal Circulation Only

Department of Health & Family Welfare

Government of Karnataka

Integrated Health, Nutrition & Family Welfare Services Development Initiative in Karnataka

Towards Equity & Quality In Health Care Services

July 2000

CONTENTS

1. INTRODUCTION

- The Government and the people of Karnataka have aspirations for a better quality of life and for overall development. Improved health status and better access to good quality health care services is integral to human development.

- The Government of Karnataka through a series of policy measures has attempted, over the years, to create an enabling environment through which this can be achieved. In recent times there has been an acceleration of these efforts.

- The health sector is to be addressed in its totality including public, voluntary and private health care services. This would require an approach covering all systems of medicine and local health care traditions.

- The role of public health and related services is critical in addressing basic determinants of health, in responding to public health problems and in protecting and promoting the health of the poor and of marginalised sections of society. The state also has a role in maintaining standards and in fostering the practice of ethical principles in medical care and public health.

- At the same time, along with the public sector, the private sector also plays an important role in providing medical care to the people.

- To improve the health care systems in the State, the Government of Karnataka set up the Karnataka Task Force on Health & Family Welfare (KTFH) in December 1999. The composition of the 14 member Task Force (13 outside experts and one senior officer) indicates the commitment of the State Government to develop partnerships with different sectors. The Task Force submitted its Interim Report in April 2000. Its final report is expected in a few months time (end 2000, early 2001).

- The Department of Health & Family Welfare, based on the recommendations in the Interim Report, and its own experiences and planning processes, is developing a plan for an integrated health care system. Vertical health programmes and ongoing externally aided projects, such as the KHSDP and IPP VIII and IX, will be sustained and integrated functionally into the health system.

- This paper addresses the identified gaps in the health care systems, public, private and voluntary and provides the conceptual framework for an integrated health care system.

2. CONTEXTUAL BACKGROUND OF KARNATAKA STATE:

2.1 *Historical Background*

Karnataka State (known till 1973 as Mysore State) was created during the reorganization of States in 1956. It incorporated the erstwhile princely state of Mysore; the northern districts of Bidar, Raichur and Gulbarga from Hyderabad State, previously under the Nizam's rule; Belgaum and Dharwad districts from Bombay Presidency; Dakshina Kannada and Bellary from Madras Presidency; and the autonomous princely state of Kodagu. The Presidencies had been part of British India, while the others were semi-autonomous. The political histories, traditions and administrations of these regions of the new State were very different. These continue to influence later development.

Health services had developed in the different regions in the pre-Independence era. Under the Mysore Maharaja and his visionary Diwans, health services grew within a liberal, welfare-oriented administration, evidenced by establishment of the Krishna Rajendra Hospital in 1876, the College of Indian Medicine (Ayurveda and Unani) in 1908, a medical college (Allopathy) in 1930 (all in Mysore city), besides hospitals in other cities and towns. The first primary health units, serving rural populations in India, were pioneered in the State in the 1920s, the first being established in Ramanagram. Thus, traditions of State runs health services had been established early.

After 1956, the State Government expanded its health care infrastructure on the foundations of the existing health units and hospitals. National health programmes, which were being formulated during this period, were implemented in the State. Guidelines and financial support from the Government of India strengthened the development of rural health services based on population norms.

Current State Profile:

Table 1 below gives the current profile of the State.

Table 1: State Profile

Variable	Current Status	Comment
Area	191,791sq.km.	5.38% of the area of the country, approx. equal to Germany
Population (2000 est.)	52 million	Current growth a little less than a million a year, with the rate steadily declining.
Rural-urban population distribution (1991)	69% rural (27,066 revenue villages inclusive of 48,000 habitations), 31% urban in 254 towns/urban areas.	Urban population has increased by 10% over 50 years
Scheduled caste population Scheduled tribe population (1991)	16.4%, Scheduled caste; 4.26%, Scheduled tribe.	This section constituting 20.7% of the population are the most vulnerable economically and also socially most backward.
Literacy rate (1996 est.)	Overall literacy rate - 63.4%. females 52.6%, males 73.7%; rural 47.7%, urban 74.2%.	Large inter-district differentials exist. Dakshina Kannada has a literacy rate of 85%, while Raichur is still at 40%. Total literacy drives since 1990 have achieved major gains in a few districts like Dakshina Kannada and modest improvements in others.
Per capita income (1995-96)	Rs. 7,155 at 1993-94 prices	Range is from Rs 20,120 in Kodagu to Rs 6,223 in Kolar District.
Average District Income (1995-96) at 1993-94 prices.	Rs. 58512 million in Bangalore and Rs. 6416 million in Bidar.	Inter-district variations affect human development.

Source: HDR-GOK, 1999.

Table 2 gives the health status indicators of the State. As is seen Karnataka is ahead of the all-India targets for the year 2000.

Table 2: Health Status Indicators in Karnataka, 1998 - Rural Urban

Indicator	Karnataka (1998-99)	India (1998)	India-Targets for 2000
Crude birth rate	22/1000	25.9	21.0
Crude death rate	7.5/1000	8.7	9.0
Infant mortality rate (per 1000 live births)	52 58 (SRS)	63	<60
Life expectancy at birth Male Female	 65.1 years 66.3years	 62.4 63.4	 64.0 64.0

Source: 1998-99 Annual Report DH&FWS, GOK, 1998 SRS, NFHS II, 1999

2.3 *Public and Private Health Services and Access to Care*:

Karnataka has developed a widespread network of services since 1951. The progress achieved during the period between 1951-1987 is indicated in Table 3, while the number of institutions existing at present is given in Table 4.

Table 3: Development of Public Sector Health Services in Karnataka, 1951 – 1987.

Health Institutions	1951	1987
Hospitals with above 30 beds	23	134
Teaching Hospitals	0	23
District and Major Hospitals	20	30
Hospital beds	5481	26646
Dispensaries + Primary Health Units	282+125	1310
Primary Health Centres	0	465
Primary Health Units with 6 beds	20	106
X-ray Plants	15	126
Nursing Schools	5	9
Health & Family Planning Training Centres	2	5
Auxiliary Nurse Midwife Training Schools	0	4
Laboratory Technician Training Units	0	4
X-ray Technician Training Units	0	10

Source: GOK 1998-99, Annual Report of DH &FW, SRS, 1998.

Table 4: Public Sector Health Services in Karnataka, 1998

Type of Health Service	Number
Hospitals – district, major (specialised, teaching), maternity *	176
Community Health Centres	252
Primary Health Centres	1676
Urban Primary Health Centres	9
Primary Health Units	583
Subcentres	8143
Public beds (1996)	43868
Private beds (1996)	40900

Source: GOK 1998-99, Annual Report of DH & FW, HDR 1999

* There are additional specialised hospitals for TB, leprosy, infectious diseases, mental health under the Directorate of Medical Education. Institutions run by municipal corporations in urban areas are not included, as they come under the respective local bodies.

Studies show that over 45% of patients utilizing public sector services in Karnataka had annual incomes below Rs 15,000/-, which is close to the official poverty line, while over 90% had incomes below Rs 50,000/- (World Bank, 1996).

Private sector medical services had a growth spurt during the 1980s. Located primarily in urban areas (80%), they account for 33% of hospital beds (*ibid*). A 1995-96 summary by STEM listed 1709 medical institutions (clinics to hospitals) in Karnataka (HDK 1999). The 1993 NCAER survey reports that 46% of out patients and 40% of inpatients were treated by the private sector (*ibid.*)

A majority of patients using private clinics in Karnataka were found to belong to the middle and upper socio-economic classes (World Bank, 1996). The quality of care in the private sector varies greatly from village and mofussil towns to the big cities (Narayan 1998).

The public sector has the most evenly distributed widespread services, covering all districts and rural areas, and is utilized to a larger extent by the poor. Accessibility and affordability of health care services, particularly for the poor, is one of the cardinal principles of primary health care.

2.4 Health Budgets & Expenditure

Nationally 80% of public spending on health is by the State, 20% being from the center. In Karnataka, about 18% of the state health budget comes from the center. According to an analysis by the Department of Health and Family Welfare (KHSDP, June 1999) the expenditure on health related services (which includes medical care, public health, family welfare, water supply& sanitation, housing and nutrition) has grown in real terms at the rate of 7.2 per cent per annum during the period 1990-91 to 1999-2000. However, there has been large variation in different components. The expenditure on nutrition declined in real terms at the rate of 4.3 per cent per annum. In overall terms, government health and family welfare expenditures continues to be low.

According to a study made by the World Bank (1996), the per capita expenditure on Health and Family Welfare has increased in 1980-81 prices from around Rs.19 to Rs. 30 during the period 1980-81 to 1993-94. The Health and Family Welfare budget as a percentage of the State Budget is around 5%.

Table 5: Expenditures on Health and Family Welfare in Karnataka

Category	80/81	85/86	89/90	90/91	91/92	92/93	93/94
Expenditure on H & FW as % of State Domestic Product	1.26	1.33	1.25	1.18	1.11	1.29	1.29
Per Capita expenditure on H & FW (in 1980/81 Rs)	19.00	22.12	26.00	24.12	25.01	27.83	30.20

Source: WB 1996

2.5 Externally Aided Projects:

Externally aided projects negotiated since 1994-95 include:

a) Rs 1508 million for India Population Project IX from World Bank, for development of rural primary health care infrastructure, to strengthen family welfare and MCH services.
b) Rs 5458 million from the World Bank for the Karnataka Health Systems Development project, (KHSDP) for strengthening secondary care institutions at CHC, Taluk and district levels.
c) Rs. 591 million from KfW (Germany), for secondary care at district, taluka and CHC level hospitals in Gulbarga division.
d) Rs 830 million for IPP VIII from World Bank for strengthening Family Welfare & MCH in Bangalore city and 11 other cities.
e) An OPEC grant of Rs. 292 million for a superspeciality hospital in Raichur.

+ certain projects
22nd April - TB, Malaria, Blindness
Detailed financial study ypd.

3 HEALTH SECTOR ANALYSIS

3.1 Strengths of the Health Sector in Karnataka

Strengths of the health sector in the State are:

i. Health gains made taking health status levels above national average. National Health Policy goals of 1983 were met, e.g.
   - Increased LEB from 26 years in 1947 to 66.3 years (women) and 65.1 years (men) in 1997.
   - CBR declined from 41/1000 from 1951 to 22/1000 (1998)
   - CDR declines from 22/1000 from 1951 to 7.5/1000 (1998)
   - Eradication of small pox & guinea worm infestation.
   - Control to a considerable extent of vaccine preventable diseases, polio, whooping cough, tetanus, diphtheria, and progress is being made to reduce measles disease.
   - Increased Couple Protection Rate from 23.8% in 1981 to 57.7% in 1997 with fairly rapid fertility decline.

ii. Development by the state of a widespread network of health care institutions at all three levels (primary, secondary, tertiary), even in excess of GOI norms.

iii. Support to innovations through research institutions – NTP through NTI, community mental health programmes through NIMHANS, bio-environmental control of malaria through MRC.

iv. State policy support to growth of voluntary and private sector in medical & health care and in health professional education, with some initiatives towards regulation.

v. Capacity to negotiate & utilize to a fair extent external assistance e.g. KHSDP, IPP VIII and IPP IX.

vi. Most recently the setting up of the Karnataka Task Force on Health & Family Welfare.

vii. Fairly active civil society groups and organisations.

viii. Premier academic and research institutions providing a sound knowledge base.

ix. Private and voluntary sector involved with a broad range of activities from primary medical and health care, secondary and tertiary care, health professional education, to research and medical informatics.

x. A project planning policy matrix was developed and is being used. Table 6 on the next page summarises the current position on the important issues identified and the Table shows that action is being taken on the major issues identified.

Table 6: Summary of the health sector development policy programme in Karnataka

Issues	Proposed Changes and Action Taken
1. Adequate budget for Public Health. Earlier only 5% of State budget and 1.48% GDP spent on Public Health.	Allocations stepped up progressively. Increased from Rs. 535.49 crores (1996-97) to Rs. 1112.64 crores (2000-2001) Increased from 5.9% to 6.1% of State budget.
2. Imbalances in expenditure on health with more emphasis on tertiary care.	Increased allocation to primary care (43.96%) & secondary care (40.9%) as against only 15.2% to tertiary care.
3. Regional imbalances with six districts Gulbarga, Bidar, Bijapur, Raichur, Dharwad and Bellary having poor health indicators.	Preferential health policy for these districts by increasing funding from state, IPP IX, KfW, OPEC and RCH.
4. Improving quality of hospital services and accessibility by women and SC's/ST's.	• Upgradation in 181 hospitals under K.H.S.D.P. • Skill development training for Doctors, nurses and paramedical staff. • Filling up of vacancies by recruitment or on contract basis. • Contracting out non-clinical services. • Yellow card scheme for SC's/ST's • Successful pilot project of Women's Health check-up at Mysore to be replicated in other districts. • No user charges for those below poverty line.
5. Strategic planning to reduce sub-optimal use of resources.	• Strategic planning cell established, published 9 bulletins and brought out booklets for improving health knowledge of Doctors & paramedical staff. • Improvement in hospital waste management • Networking with private health service providers. • Establishment of Task Force w.e.f. 10.11.99 studying all sectors relating to Health & submitted draft Interim Report to Govt. for approval and implementation.
6. Private sector and NGO's	• Bill for regulating nursing homes and private practitioners introduced. • Licensing of blood banks. • Enlisted NGO's for participation in Task Force, HIV/AIDS prevention and other Govt. Programmes.
7. Prevention and control of communicable diseases.	• Post of Addl. Director (Communicable diseases) has been filled up. • State surveillance lab at Bangalore has started functioning. • Improvement in district labs. • Manual on case definition, lab techniques and reporting formats (as per WHO guidelines) issued. • Disease surveillance system in advanced stages of development.

2 Problems & Constraints

i. Continuing high levels of poverty with 40% of people below the poverty line. This contributes to and is aggravated by undernutrition, high morbidity, mortality & fertility. These health indicators are still unacceptably high.

ii. Relative neglect of nutrition in the larger health strategy.

iii. Inadequate attention through multisectoral linkages to other basic determinants of health namely sanitation, potable water, waste management, education.

iv. Gender inequities leading to poor women's health status indicators (MMR 4.5/1000, anemia in women, violence against women.)

v. Other disparities – regional, caste, socio-economic groups, persons with disabilities.

vi. Neglect of public health principles & practice with inadequate emphasis on promotive, preventive & rehabilitative care, with resultant high burden of TB, malaria, HIV/AIDS, gastrointestinal problems, tobacco related problems.

vii. Poor quality, unethical practices & poor accountability with corruption in public and private services, leading to patient dissatisfaction & loss of public confidence in services.

viii. Poor governance & management of public health services.

ix. Inadequate regulation & facilitation of private sector

x. Inequitable financing of health services & inefficient financial & infrastructure/asset management.

xi. Inadequate human resource development and management with poor competencies, low morale & motivation.

xii. Inadequate community involvement in planning, decision making and feedback at local levels. Relationship with PRIs conflictual. Their potential in public health & primary health care unutilized.

xiii. Weak strategic planning, inadequate research base;

xiv. Inadequate integration of externally assisted projects into health system planning

4 GOALS

a) To further improve health status and increase access to health care for people, with an emphasis on the marginalised sectors of society, such as women, children, SC/ST, disabled and the elderly in Karnataka.
b) To strengthen public health systems and primary health care with community participation, NGO and private sector involvement.
c) To focus on equity, with quality of services, making explicit efforts to nurture and increase motivation and capacity of health care providers.
d) To work within a time frame, with regular reviews and transparency in functioning.

5 VALUES

The underlying **values** will be equity, medical and public health ethics, accountability, concern and respect for people, democratic functioning, respect for local health knowledge and culture. These values will form the basis for project planning and implementation. Reviews will consider how much these have been internalized and what difficulties are faced in these aspects.

6. GUIDING PRINCIPLES

The **guiding principles** for implementation will be:

- **Integration** – moving from vertical disease/problem oriented programmes to horizontal integration at primary care level (sub-centre, PHC, Taluka, general hospital) and more specialized referral and support services at district and state level.
- **Phased decentralization** – moving towards district and local planning and management using information from the HMIS. The elected representatives will also need to be sensitized and local bodies made accountable for responding to the health aspirations of the people.
- **Building partnerships** –
  a) by inter-sectoral linkages between and within departments;
  b) with NGOs for participation in planning, implementation and evaluation; and,
  c) with the private sector for participation in state health plans and in referral services, and, provision of secondary and tertiary level care.
  d) With peoples' organizations by providing access to information and encouraging feedback.
- **Social inclusiveness** – particularly of socially excluded groups and their involvement in all levels of care.
- **Community participation** – leading to the empowerment of the local community.
- **Gender sensitivity** across all levels of care.

7. OBJECTIVES

The general objectives for a six-year period (2001-2007) are outlined below. Indicators will be developed regarding achievement of objectives. The Logical Framework Analysis will be used for identifying means, resources, activities, persons responsible and time frames.

Problems are deeply embedded in social structures, therefore the choice of objectives is based on needs, feasibility of a health sector intervention, likelihood of making an impact and cost effectiveness, given the resource availability.

The objectives are broadly grouped under three categories, namely,

1. Public Health & Primary Health Care

2. Health System Issues – Management, Capacity Building, Finance, Institutional strengthening.

3. Partnerships – with private sector, NGOs, PRIs, local community and other sectors/departments.

7.1 Public Health & Primary Health Care

7.1.1 *a) Improve quality, effectiveness and coverage of primary health care.* Ensure access to care at all levels for the poor and under-served.
b) Strengthen the referral linkages with Secondary Health Care Services, and fill up gaps, especially in Gulbarga division.

7.1.2 *Improve nutritional levels*, particularly of children (focussing on under two's), adolescents and women, by reduction of undernutrition and nutritional deficiencies, such as Vit. A, Iron and Iodine.

7.1.3 *Improve health of school age going children and adolescents* through a mix of medical, health promotional and educational efforts.

7.1.4 *Health Promotion & Empowerment,* particularly of women and young people through sharing of information and health promotion activities enabling people to make healthier choices and to demand better health and nutrition services.

7.1.5 *Reduce Morbidity & Mortality resulting from priority public health problems. A public health approach* will be used to reduce unnecessary

suffering from TB, Malaria, HIV/AIDS, water borne diseases, disability etc. Priority will also be on decreasing infant, under-five and maternal mortality. Deaths due to accidents and violence (especially unnatural deaths of women) will also need attention. Measures for health promotion, prevention, early detection and cure, and rehabilitation to reduce the suffering and burden of diseases will be taken and encouraged by all health sectors.

7.1.6 ***Increase services for neglected & emerging health problems,*** namely, Mental health, care of the elderly, tobacco related problems, accidents, violence, particularly against women, and non-communicable diseases such as cancer, and, heart diseases.

7.1.7 ***Develop and sustain a comprehensive Health Information System including health surveillance.***

7.1.8 ***Redress Regional Imbalances & Disparities.*** Actively work to reduce regional imbalances with specific attention to Gulbarga division.

7.1.9 *Improve health of scheduled castes and tribes and those below the poverty line.*

7.1.10 ***Strengthen Urban Primary Health Care Services***, especially in smaller cities, towns and regions.

7.1.11 *Improve women's health*

7.1.12 ***Enhance further fertility decline by provision of reproductive health care through well functioning and credible general health services and by an educational approach.*** Focus on districts with continued high fertility rates, with emphasis on child growth and child survival, on overall women's health and women's empowerment. Avoid distortion of health services by excessive emphasis on a programme like sterilization of women.

7.2 Health Systems Issues – Management, Capacity Building, Finance and Institutional Strengthening

7.2.1 *Develop strategies for human resource development* that focus on capacity building, continuing education, motivation and morale of health teams at all levels. Encourage research and academic work.

7.2.2 *Improve the planning, organization, management and administration of the public health systems*, to cover management capacities, personnel management, strategic planning and evaluation, asset management, management of supply lines for equipment, drugs and other consumables, as well as information and communication systems. Decentralised mechanisms to be evolved/ reviewed. Introduce cadre development and management systems.

7.2.3 *Develop decentralised district level planning.*

7.2.4 *Improve equity and efficiency in health financing and financial management* maintaining a balance between primary, secondary and tertiary care, and between urban and rural based institutions. Safeguard and improve the health budget and ensure adequate utilization with accountable and transparent systems.

7.2.5 *Focus on implementation factors and processes* by building competence and morale of field staff, developing leadership abilities from PHC to State level, and having regular public and social audits to safeguard against non-action.

7.3 Partnerships - with private sector, NGOs, PRIs, local community and other sectors/departments.

7.3.1 Develop specific functioning mechanisms at local district and state levels for better *intersectoral coordination.*

7.3.2 *Strengthen capacity of Panchayati Raj and Nagarpalika Institutions* for greater responsibilities and roles in health and health care.

7.3.3 *Evolve mechanisms for involvement of the private sector* at different levels with quality assurance. Work actively with the NGO/voluntary sector.

7.3.4 *Promote and support Indian and other systems of medicine and local health traditions.*

8 EXPECTED OUTCOMES

8.1 *Quantitative Indicators of improved health and nutrition status:*

Table 7: Specific goals to be achieved over the next six years:

1.	Life expectancy at birth in years	71 for women, 70 for men
2.	Crude birth rate	17/1000
3.	Crude death rate	7/1000
4.	Infant mortality rate	25/1000
5.	Under - five mortality rate	< 35/1000
6.	Maternal mortality rate	< 199/100,000 live births
7.	Nutrition status of children	Progressive improvement Planned
	Severe undernutrition	< 0.5%
	Moderate undernutrition	10%
	Mild undernutrition	60%
	Normal	> 30%
8.	Anaemia among women	<20%
9.	Anaemia among children	<40%
10.	Newborns with low birth weight < 2500 gms	10%
11.	Immunisation coverage with maintenance of cold chain	> 95%
12.	Safe deliveries with access to Emergency Obstetric Care	> 85%
13.	Case detection and cure rates in TB	75% and 85% respectively
14.	Specific health programmes (HIV/AIDS, malaria, blindness, etc.)	as per programme guidelines, accelerated.

8.2 *Qualitative Indicators*: External cum internal reviews will be conducted using qualitative research methods. These reviews, among other things, will focus on:

1. Mechanisms for community involvement at local, district and State level. Participation of all sections of society.
2. Linkages with Gram Panchayats and Zilla Parishads.
3. People's feedback and perspectives on functioning of PHCs, CHCs, Taluk General Hospitals, District Hospitals and other health services. This would include staff attitudes, payment systems and quality of care. Feedback to be inclusive -- from women / SC/ST / poor / differently abled/ elder persons.
4. Gender perspectives – availability of privacy, toilets, harassment, recording of violence, gender disaggregated data.
5. Functioning of referral system.
6. Prescription audits.
7. Budgetary and infrastructural support to ISMs/ other systems. Their involvement in programme planning.

8. Planning processes, coordination and communication mechanisms, reviews and mid-course changes/ modifications in programmes, identification of learning points.
9. Reduction in regional disparities.
10. Analysis of expenditure by the three levels and urban- rural distribution.
11. Feedback from Government health personnel from all levels regarding working conditions, job satisfaction, continuing education, feeling of self worth.

8.3 *Health System Indicators*:

Staff positioning.
Condition of infrastructure through the GIS.
Supply systems for drugs, laboratory, reagents, and other consumables.
Transport – vehicles, drivers, POL.
Communication systems.
Utilisation of health services - outpatient and inpatient
Hospital Institutional morbidity, case fatality.
Management indicators.

8.4 Indicators for Equity & Quality:

Equity and quality indicators are critical and will need to be developed through a participatory method involving the stakeholders.

9 BROAD STRATEGIES

Develop a comprehensive Karnataka State Health Policy.
Update the Karnataka Public Health Act on the model of Public Health Act circulated by the Government of India in 1987.
Put in place an Act for private sector accreditation to ensure quality, ethics and standards of care among private sector health providers.
Use an evidence based and dialectical approach in the development and modifications of policies and plans. This will allow for constant learning from difficulties faced.
Move towards decentralized planning, management and monitoring cum reviews at the District level, within a framework and guidelines developed at the State level.
Allow for flexibility, creativity and local innovations/ initiatives in responding to health problems at the local level, but also ensuring accountability and responsibility.
Develop and nurture leadership and a critical mass of public health specialists and managers at all levels.
Use private health care specialists and professionals in the Health care system.
The fundamental thrust will be on capacity building at all levels, in all sectors.

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10. SPECIFIC STRATEGIES

These will be developed further using a consultative, participatory and evidence based approach.

10.1 Public Health and Primary Health Care

10.1.1 Access, quality & effectiveness of Primary Health Care Services will be improved by,

a) Filling in gaps in physical infrastructure for primary health centre and subcentres, including construction of quarters and undertaking renovation and maintenance where required. This would include provision of water supply, electricity and basic equipment and consumables required for diagnostic and therapeutic work. Findings of the facility survey being undertaken will be validated and used for cost estimation of requirements.

b) Filling up of gaps in health manpower by sanctioning / creating of required / additional posts in the existing / newly created health centers as per norms.

c) Selective upgrading of PHCs into FRUs and CHCs according to current norms, in Gulbarga division and other backward pockets of the State.

d) A well planned referral system that functions both ways to be implemented in a district and then expanded. Gaps in the existing secondary health care services to be filled up.

e) Steps to improve quality of services provided by the private sector through accreditations/ guidelines will be implemented.

f) Put in place a system for outcome and financial audit of primary health care institutions.

g) Ethics training.

10.1.2 Nutrition:

Good nutrition is an entitlement (Amartya Sen), with the need for adequate income or purchasing power. Nutrition is a basic determinant of health, has been grossly neglected by the health sector in Karnataka so far. Recent data from NFHS II and NNMB provides evidence of a high level of under nutrition in Karnataka. Therefore nutrition is taken up as a priority with specific interventions by the health sector, and with intersectoral linkages with the Departments of Women and Child Development, Food & Civil Supplies, Agriculture, Rural Development & Panchayati Raj & Education. The health system needs to be accountable for the poor nutritional status of the population.

Child Nutrition: particularly of under-twos, from the period of conception, will be given the highest priority. Strategic action points include:

a. Closer collaborative mechanisms between health, WCD (Women and Child Department) and Panchayats particularly at the local level in the functioning of Anganwadis (AWs).

b. Universalize AW centres for every 1000 population in rural areas and 1500 in urban areas. Priority will be given to Gulbarga division. Valuable lessons learnt

from the TINP programme of Tamilnadu will be studied and used where appropriate.

c. Vacancies of Anganwadi Supervisors to be filled urgently (currently there are approx. 660 in position out of 2000 posts to cover the existing 40,000 Anganwadis) and these supervisors will be provided refresher training.
d. As far as possible women to be appointed as CDPOs. Gender sensitization at all levels.
e. Persons with nutrition training and experience to be positioned at senior levels at state and district levels both in the Health & FW and W&CD departments.
f. Gram Panchayats to be involved more closely and decentralization monitored to ensure that the poor have access and benefit optimally.
g. The strategies for under two children include mothers' education and supplementary feeding in areas of need, especially in Gulbarga division.
h. ***Micronutrients*** iron supplementation for children, adolescent girls, women and men when required, regular deworming, Vit. A supplementation and Iodine where required.
i. ***Education regarding nutrition*** at all levels of the health, WCD and education systems. Nutrition education to be seen as part of health promotion.

10.1.3 Improving health for school age children and adolescents

A blue print for a programme for improving health for school age children that includes out of school children. (The existing programme does not cover school dropouts. This will include:

- Physical health – health cards for children, including medical checkups and follow-up treatment
- Health preventive and promotive education and activities. This would involve:
    - teacher training – in teacher training schools and through in-service programmes,
    - development of modules, manuals for teachers development of educational material for children, building on what already exists.
    - use of child to child methods to reach out of school children
    - adolescent health education

This shift in emphasis will require close collaboration between the departments of Health and Education. This effort will be tested and phased in different districts.

10.1.4 Health Promotion & Empowerment

a) This will include training of leaders of women's groups, from Mahila Samakhya, agricultural women's Sanghas, DWCRA, NGO women's groups, self-help groups, etc.
b) Training of youth groups, opinion leaders, etc.
c) Reaching out to the marginalized and unreached sections of the population using different methods of communication from interpersonal modes, and mass communication modes.

d) Launching of a comprehensive and coordinated IEC campaign covering all sectors and levels of the Health System. To the extent possible, the campaign will focus on local area specific problems and issues.

10.1.5 Reduction in Morbidity and Mortality

The system will be strengthened for control of public health problems (TB, Malaria, HIV/AIDS etc.) through integration at primary care level, with specialized referral and technical support at secondary/tertiary levels. Provisions will be made to fill in gaps in the existing system and for response to sudden needs, including outbreaks.

10.1.6 *Increased services for neglected and emerging health problems.*

a) *Mental Health Care* - This is an orphan subject with very limited resource provisions in Karnataka. Research studies in the State show that at least 2% of the population suffer from severe mental morbidity, and at least 10% from neurotic conditions, alcohol & drug addition & personality problems. While mental health care needs to be provided at PHC level in the long term, during the next 5 years it is necessary to

i. Improve training in psychiatry & psychology in the MBBS course & in general nursing training.
ii. Strengthen psychiatric and counseling services at district hospital level and subsequently at Taluk Hospital.
iii. Organize training programmes for PHC – MO's and staff using manuals prepared by NIMHANS. Ensure provision of psychiatric and epileptic drugs.
iv. Encourage/make provision for care/ facilities for chronically mentally ill persons, as in the present context family members are unable to do so.
v. Develop working links with NGOs, traditional healers, religious organisations, etc.

b) *Care of the elderly* – Developing geriatric services/units in secondary and tertiary care institutions; developing training programmes for health personnel with the Health University; providing support to developing long term, home based programmes.

c) *Tobacco* and substance abuse programmes – support to public education and advocacy programmes and to tobacco quitting.

d) *Accidents* – support to research, legal measures, trauma centres and rehabilitation. Intersectoral coordination with dealing in transport, industry, roads and highways.

e) *Violence* – training programmes for health professionals for recognition of the problem, introducing recording and reporting systems, support to care homes and rehabilitation centres. Violence against women to be specially addressed.

f) Other non-communicable diseases – Non-communicable diseases such as cancer, diabetes and heart diseases, etc. will be addressed.

10.1.7 *Health Information System*:

Processes are already under way to rationalize recording and reporting systems from primary care levels upward, to develop comprehensive HMIS and GIS and a disease surveillance system. Support for development, maintenance, technical manpower and upgrading of the system will be required.

10.1.8 Reduction in Regional disparities

Specific efforts will be made to reduce ***Regional disparities*** by strengthening infrastructure, personnel and educational inputs. This will cut across most strategies.

10.1.9 Improve health of SC/ST and others below the poverty line

The initiative taken under KHSDP with the Yellow Card scheme needs to be sustained and deepened to include follow up, health promotion and full curative services. This programme will be expanded to cover all families below the poverty line as it has been an acknowledged effort at providing health care interventions for certain vulnerable sections of the society. Special effort will be made for improving health care for tribal families, especially with the help of NGOs.

10.1.10 Strengthening Urban Health Care Services

Due to historical reasons, urban health care services are administratively under the respective local municipal bodies. This is also mandated by the 74th Amendment of the Constitution. The large number of teaching, tertiary & specialist hospitals in urban areas come under the administrative purview of the Dept. of Medical Education. The private sector too has a large presence (80%) in urban areas with a range of services from corporate super-specialty hospitals and diagnostic centres to individual private practitioners. Most of the above institutions are providers of curative care.

There is an urgent need to strengthen public health interventions and provide primary health care services, particularly for the urban poor. The following steps are envisaged-

a) Support to Public health measures for provision of safe water, sanitation, solid waste disposal, and hospital waste disposal. This will include support to testing of water quality.
b) Existing municipal corporation dispensaries and IPP VIII centres to expand the scope of their work to cover primary health care. Add new urban primary health centres where necessary, especially in small towns.
c) Involvement of local communities through link workers, health committees, boards of visitors.
d) Involvement of NGOs in primary care, community mobilization, rehabilitation and in areas of their expertise evolving methods of financing, using their knowledge base, professional and managerial skills.

e) Developing referral links with private sector institutions evolving methods of financing, using their knowledge base, professional and managerial skills.

10.1.11 Improve Women's Health

Women's health status will be improved by:

a) gender and social sensitivity training for all staff
b) positioning of women medical officers at PHC's where possible
b) empowerment training for women leaders and communities
d) increased access to care and improved reporting of women's health problems

10.1.12Fertility Decline:

It is recognized that the best strategy for population stabilization is through improved health and nutrition status.

a) The burden of contraception so far has been on women. Participation of men will be increased through community education and provision of facilities and expertise for men's sterilization.
b) In districts with high TFR, especially in Gulbarga Division, women's literacy rates, utilization of antenatal care and childhood immunization rates are poor. Additional inputs and efforts will redress these disparities by improving service delivery to meet unmet needs.
c) Quality of contraceptive services will be ensured to minimize side effects. Systems to monitor complication and adverse reactions will be initiated. Only safe contraceptive technology will be used.
d) Increase in the age at marriage and postponement of the first pregnancy will be a key strategy.
e) Compulsory registration of births and marriages will be attempted.

10.2 Health System Issues – Management, Capacity Building, Finance and Institutional Strengthening

10.2.1 *Human Resource Development*

This forms the core thrust of this project, and is critical coming as it does along a period of infrastructure development. Orientation courses, in-service training, continuing education and skill development will be part of the efforts to make the DH & FW a learning organisation. Steps to be taken will include:

a) Developing working links with the Rajiv Gandhi University of Health Sciences with medical colleges, nursing schools and other allied health science educational instructions for training. Medical colleges to take charge of 3 PHCs and associated sub-centres.
b) Full support to the State Institute of Health & Family Welfare to become a premier training institution in public health, health management & administration, medical and public health ethics.

c) Orientation and in-service training for PHC Medical officers ANMs, Junior Health Assistants Females, and male, laboratory technicians, lady health visitors & nurses. PHC team training could be considered and undertaken at taluk / district level.

d) Private sector professionals and institutions to be involved in training, and skills development..

10.2.2 *Management Development*

a) Strengthen management capacity at all levels through training
b) Introduce non medical health managers and hospital administrators
c) Health cadre planning & management to be systematically undertaken
d) Drug equipment procurement and supplies systems to be modernized and made transparent with development of district stores.
e) Critical issues of morale and motivation of government health personnel to be addressed, using a research based approach to see what works. Decentralized small working units with independent decision making powers to be tried.
f) Strategic planning & evaluation cell to be given high priority and adequate infrastructure

10.2.3 *Develop capacity for decentralised district level planning by*

a) Developing district epidemiological units, of which the surveillance and HMIS units are a part.
b) Microplanning exercises at T.Narsipur Taluk to be studied and further developed / expanded.

10.3 Partnerships

10.3.1 *Intersectoral co-ordination*

This will be actively attempted with Dept. of Women & Child Development, Education, Rural Development and Panchayat Raj, Water Supply & Sewerage Boards, PDS agriculture, Social Welfare Board etc at the state, district and primary care level. These are required for

a) Monitoring water quality, improving sanitation and waste management
b) Nutrition, school health, rehabilitation, links with PRIs etc.

10.3.2 Empowerment of members of Panchayati Raj Institutions and Nagarpalikas for Health

Panchayati Raj institutions (PRIs) are mandated constitutionally to form part of governance structures for primary health care and public health. To enable and equip members to play an effective role, empowerment training of newly elected representatives of PRIs for health, will be conducted by the DHFW in collaboration with others.

Current numbers of elected representatives are as follows:

Table 8: Elected representatives in Karnataka (July 2000)

Elected Body	Female		Male	
	No.	%	No.	%
Gram Panchayat Members	35,187	44.85	43,273	55.15
Taluk Panchayat Members	601	15.25	3,340	84.75
Zilla Parishad Members	339	26.94	919	73.06
Total	36,127	43.14	47,532	56.86

These 78,460 elected gram Panchayat members commenced their five-year term in April 2000 and the 5,199 Taluk Panchayat & Zilla Parishat members assumed office on 1st July 2000. Training programmes on health conducted by the DH&FW will be refined and undertaken with the cooperation of NGO's, health science training institutions and other academic bodies. Women Panchayat members, especially at Gram Panchayat level, have a greater interest in health and will be selected first for training.

Training programme content will cover priority health problems, existing government health services and programmes and how to access them, health promotion messages, utilisation of local health traditions, when to refer etc. Kannada manuals have already been developed for the Women's Health Empowerment Training Programme at two levels for Training of Trainers and for Community Leaders. Other existing material in Kannada developed for the RCH, IPP VIII and other programmes could also be used. Training could be at two levels, namely, 'Training of Trainers' for district level teams, followed by training of GP members at sub-district level. The entire state could be covered over a period of 1 year.

10.3.4 ***Partnerships with the private sector, with NGO's and health professional bodies.***

This important strategy aims to increase access to health care to involve all sectors in state health plans and programmes; to bring in specialists and academics from the private sector to support implementation training, and research; and to increase quality of care. Strategies include:

a) Working links will be established or furthered with representative bodies such as the Indian Medical Association, Indian Association of General Practitioners (IAGP) Confederation of Indian Industries, FICCI, Federation of Obstetric & Gynecologic Societies of India (FOGSI), Associations of Surgeons, Pediatricians, Physicians, Ophthalmologists etc, with the Voluntary Health Association of Karnataka, FEVORD-K, AIDS Forum Karnataka, CHAIKA, and other bodies. This should provide additional professional and financial support to programmes.

b) A deeper study /cluster of studies of the private sector to understand its distribution, the type of work done, the strengths and weaknesses.

c) Quality assurance through the Accreditation Act, and the Consumer Protection Act.

d) Provision of referral services at FRUs for emergency and other obstetric & gynecological care through FOGSI members, to be introduced first in Bellary district and then in a phased manner.

e) Involvement of the private sector in non-clinical services such as transport, cleaning, equipment and asset maintenance, etc.

f) Pilot trialling of health insurance system for the poor in selected areas, with involvement of private health institutions.

g) Involvement of medical colleges through the ROME scheme (Reorientation of Medical Education) to run 3 PHCs & associated subcentres, with administrative control & freedom in staff appointment. This will require upgradation of buildings, equipment, transport, communication & HMIS systems to promote best practices as part of teaching/ academic institutions. Of the 23 medical colleges in Karnataka, 19 are private. Totally 69 PHCs would get covered in the state under this programme. This will assist colleges in meeting Medical Council of India & University requirements. It will also help develop / strengthen links between universities and health services. This strategy could potentially allow for involvement of state health service personnel in the training of medical undergraduates, which will have mutual benefits.

h) A body of experts drawn from relevant areas in the private/NGO sector to be considered for supporting the department's public health efforts.

10.3.5 ***Promote and support Indian Systems of Medicine and Homeopathy (ISM & H)*** by the following measures:

a. Progressive increase of budgetary allocation from the present level, which is less than 1% of the State health budget.

b. Involvement in planning processes and in service delivery by posting ayurvedic/ homeopathic physicians as Medical Officers in ISM & H units that will be established at District Hospitals and subsequently at taluk Hospital levels.

c. Support to education & research institutions for ISM & H.

10.4 Project Management

10.4.1 Project Monitoring Information System

To ensure all the project objectives are achieved project input as well as outcome indicators will be developed before the commencement of the project and woven into a comprehensive PMIS. This will include financial monitoring as well monitoring of physical benchmarks.

10.4.2 Project Implementation and Steering Committees

Structures designed in the context of the KHSDP have been found effective. Similar structures with appropriate modifications, as well as additional review structures at the Directorate and district levels will be set up.

10.4.3 Supervision and inspections

To ensure quality as well as speed of implementation, supervision and inspection mechanisms involving external agencies, consultants as well as the Health administration will be put in place.

10.4.4 *Consultancies, studies, fellowships and workshops*

Project implementation and capacity building will be supported throughout the project with consultancies, research studies, workshops and fellowships.

Tentative Costing for the Integrated Health, Nutrition and Family Welfare Services Development Initiative in Karnataka : 2001-2006 (by Strategies)(figs. in rs. crore)

Sl. No.	Project Strategies	Investment costs	Recurrent costs	Total costs
1.	**Public Health and Primary Health Care**			
1.1	Access, quality & effectiveness of primary health care services.	200.00	50.00	250.00
1.2	Improving nutrition levels.	30.00	40.00	70.00
1.3	Improving health for school age going children and adolescents.	10.00	10.00	20.00
1.4	Health promotion and empowerment.	10.00	10.00	20.00
1.5	Reduction in morbidity and mortality.	10.00	30.00	40.00
1.6	Increased services for neglected and emerging health problems.	10.00	10.00	20.00
1.7	Health information system.	10.00	10.00	20.00
1.8	Reduction in regional disparities.	10.00	30.00	40.00
1.9	Improve health of SC/ST and the poor.	20.00	10.00	30.00
1.10	Strengthening urban health care services.	30.00	20.00	50.00
1.11	Improving women's health.	0.00	10.00	10.00
1.12	Fertility decline.	10.00	10.00	20.00
2.	**Health system issues, training and management**			
2.1	Human resource development.	10.00	30.00	50.00
2.2	Management development.	10.00	10.00	20.00
2.3	Decentralised planning	10.00	0.00	10.00
3.	**Partnerships**			
3.1	Intersectoral collaboration.	10.00	0.00	10.00
3.2	Empowerment of members of PRIs and Nagarpalikas.	10.00	0.00	10.00
3.3	Partnerships with private and NGO sector.	10.00	0.00	10.00
3.4	Promoting and supporting Indian systems of medicine and homeopathy.	10.00	10.00	20.00
4.	**Project management**			
4.1	Project monitoring and supervision	10.00	0.00	10.00
4.2	Consultancy, studies and fellowships	20.00	0.00	10.00
	Total Base Cost	**450.00**	**290.00**	**740.00**
5.	**Price and physical contingencies**			
5.1	Physical contingencies	30.00	0.00	30.00
5.2	Price contingencies	20.00	10.00	30.00
	Project Total	**500.00**	**300.00**	**800.00**

Tentative Costing for the Integrated Health, Nutrition and Family Welfare Services Development Initiative in Karnataka : 2001-2006 (by Components)

(figs. in rs. crore)

Sl. No.	Project Components	Base costs
1.	**Investment Costs**	
1.1	Civil Works (Renovation)	150.00
1.2	Civil Works (Extension)	80.00
1.3	Professional services	20.00
1.4	Furniture	50.00
1.5	Equipment	20.00
1.6	Vehicles	10.00
1.7	Medicines	40.00
1.8	Other supplies	20.00
1.9	MIS materials	10.00
1.10	IEC and health promotion materials	10.00
1.11	Local training	10.00
1.12	Local consultants	10.00
1.13	Fellowships	10.00
1.14	Workshops	10.00
	Total investment costs	**450.00**
2.	**Recurrent Costs**	
2.1	Salaries of additional staff	160.00
2.2	Operational expenses	60.00
2.3	Building maintenance	40.00
2.4	Equipment maintenance	30.00
	Total recurrent costs	**290.00**
	Total BASELINE COSTS	
	Physical contingencies	30.00
	Price contingencies	30.00
	Total PROJECT COSTS	**800.00**