RF_COM_H_70_SUDHA

Mrs. Nafees Fazal
MINISTER OF STATE FOR
MEDICAL EDUCATION

TELEPHONE : OFF : 2269128
2092390
RES : 5471441

VIDHANA SOUDHA, BANGALORE - 1

DATED ..... 29.2.2000 .....

To,
Dr.H.Sudarshan,
Chairman,
Task Force on
Health & Family Welfare,
Government of Karnataka,
Bangalore.

Dear Dr.Sudarshan,

Reg: My suggestions to the Task Force on Health & Family Welfare.

I congratulate you for accepting the invitation of our Hon'ble Chief Minister to head the Task Force on Health & Family Welfare. Since, you are one of the reputed Doctors of our State working for the poor and tribals in Chamarajanagara Distirct, you are quite aware of the problems confronting the Health Department.

As regards improvement in the Hospital Administration, I have few suggestions to make. I have visited number of hospitals in Bangalore, Mysore, Hubli, Bellary, Belgaum, Mangalore and etc. There is no accountability at all levels in the hospitals. It is high time that we should fix responsibility on every staff member of the Hospital and a code of conduce should be framed. Disciplinary rules should be simplified to ensure quick action against erring doctors and officials working in the Hospitals.

All Hospitals should have a Hospital Advisory Committee instead of the present Board of Visitors with not less than 20 members (Non-Officilas) with powers to take decisions on some matters on the spot and to interact with patients, doctors and public in general. This Committee should have prominent people of that particular area.

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DATED .....

I suggest that each hospital should have a Hospital Welfare Fund were funds could be raised by the Hospital Advisory Committee from the citizens and Corporate bodies including Nationalised Bank where they have got funds to take up some of the Hospital Projects.

We have to stream-line the present system of Out-patient and In-Patients departments. Nominal fee should be prescribed at the time of First registration at the Out-patient Department. Similarly, at the time of admission as In-patient also some amount of fees should be prescribed. The amount so collected should be utilized for the improvement of the particular Hospitals only.

Entry of the visitors should be strictly regulated like private hospitals.

As regards to Medical Education, a workshop should be organized by the Task Force at the State and at the Divisional level, wherein Rajiv Gandhi University of Health Sciences, Medical Colleges of that particular area, teaching faculty, students and other experts could be invited to get new ideas to improve the Medical Education.

I wish to draw your attention to the Seminar on Health Care Industry held recently in Bangalore by the Asian Health Services, which made very valuable suggestions in Hospital Management. A copy of my Note sent to the concerned is enclosed for your reference.

I want the Task Force to review the achievements in regard to various Government of India and externally aided schemes in the Health Sector. It is possible to get sufficient funds from various foreign countries in the form of grants and loan with nominal interest, if responsibility is fixed on some officer at the State level who can be provided with sufficient staff and other powers.

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VIDHANA SOUDHA, BANGALORE - 1

DATED .....

In Karnataka, we have large number of eminent personalities, who have been doing wonderful work in their own field in the Health Sector-Hoemeopathy, Ayurveda. Some of these experts are not aware of the topics that the Task Force has been asked to examine. Therefore, advertisement through Electronic Media i.e., Udaya T.V. and Doordarshan be given inviting suggestions.

The Task Force may also formulate special schemes for the effective implementation of some of the programmes, like Pulse Polio Programme, Leprosy Eradication, AIDS Awareness, National Control of Blindness,etc, as there is duplication in the implementation of State and Central Programmes. Special Schemes should also be drawn up to get donations and financial assistance from Corporate Bodies, Philantropists, and General Public for the construction of Hospital Buildings, Dharmashalas, Blood Bank and other facilities. As in Bangalore City Corporation Area, we should impose penalty against those indulge in littering and spoiling the atmosphere of the Hospital.

At the entrance of the each hospital itself, Sign Boards with detailed description of various Department/Units in Kannada and English should be displayed to help the people visiting the Hospitals.

Chief Minister Medical Relief Fund should be given to all hospitals in the State to help the poor patients.

Thanking you.

Yours Sincerely,

Mrs. N Fazal

(Nafees Fazal)

MEDICAL OFFICER

Details of monthly Reports submitting to the D.H. and F.W. office → Madikeri → From Vivekananda Foundation P.H.C - Thithimathi"

COMH-70.1

1) Form No: 7
2) Special R.C.H. Report.
3) National Child Survival and safe Motherhood Programme.
4) I.C.D.S. Reports.
5) A.N.C. Balance.
6) 0-1 year Children Balance sheet.
7) Sex wise and cast wise Immunizations Reports.
8) School Health Programme Report.
9) School Health Education Report.
10) I.U.D. Incertion details Report.
11) Infent Death Report.
12) Metarnal death Report.
13) Immunization Advance Programme Reports.
14) Dais Training Programme
15) Worker wise R.C.H. Programme Reports.
16) Family welfare Progress Reports.
17) caste wise family welfare Progress Reports.
18) Age wise family Welfare Progress Reports
19) Oral Pills Progress Reports.
20) I.E.C. Reports.
21) Mahila Swastha Sanga Reports.
22) Anti Malaria Eradication Programme Reports
23) Passive Malaria Reports + Lab Reports.
24) Work wise Blood Smears Collection Reports.
25) Leprosy Reports
26) Tuberculosis Reports
27) Goiter Programme Reports.
28) Salt Test Reports.
29) Mental Health Programme Reports.
30) Communicable Diseases Reports
31) Guenee worm Reports.
32) Pipe line + Stock Register Book & Stock Balance Reports.
33) Communicable Diseases & O.P.D Reports.
34) New Cases + Old Cases + I.P.D Reports.
35) Dog Bite + Snake Bite Reports.
36) Tuberculosis Reports & O.P.D (T.B Paitenth only)
37) Communicable Diseaneses & weekly Reports.
38) Communicable Diseases & Annual Reports.
39) Cataract Operation (IOL) Reports

10/2/2000

CHIEF MEDICAL OFFICER
M.N.M. PRIMARY HEALTH CENTRE
VIVEKANANDA FOUNDATION
THITHIMATHI (COORG)
Pin Code - 571 254

Com H-70.2

VISIT TO TUMKUR DISTRICT HOSPITAL ON THE 21ST MONDAY FEBRUARY BY SWAMI JAPANANDA, MEMBER, TASK FORCE, HEALTH & FAMILY WELFARE SYSTEM :

MEETING :- During the visit there was a meeting organised by C.E.O. which included DHO, DTO, DLO, DS of Tumkur District. In the meeting there was many points which came up to be considered by TASK FORCE. All the health officials discussed regarding the improvement of services rendered by District hospitals PHC, PHU etc. The highlights of the meetings are as follows:-

a) In the entire district there are no lab technicians to work in the PHCs/PHUs etc. The district health officer pointed out that 91 lab technicians are needed immediately. Regarding the appointment of the lab technicians we noticed that there are confusions regarding the appointments of lab technicians. So even now after getting the G.O. from the Govt. to appoint lab technicians it has not been carried out.

b) Many PHCs are not having adequate man power to handle the patients. It is unfortunate to know even after repeated requisitions the Govt. is not able to appoint the necessary staff at PHCs and subcentres.

c) During the discussions it was noticed that there is no co-ordination/co-operation amongst the each PHCs and PHUs. This was highlighted during the discussions. There are many occasions that many of the PHCs are not sending the regular report as required by DHO office.

d) It appears that there is lack of organisational monitoring by the concerned officers. For example there is one PHC at Venkatapura, Pavagada Taluk, Tumkur District which has been closed for the last 6

months. Even though the hospital building is brand new and it did function for a quite period of time but, the concerned medical officer has gone in search of a job to Bangalore. While going away from the PHC he has not handed over his responsibilities to any one, instead he has also carried the key of the hospital along with him. When this incident was brought to the notice their, answer was not an encouraging answer. It shows that there is a lack of information and also there is a lack of knowledge about their powers i.e. medical officers, DHOs, DS powers. Nobody knows the capacity and the power which they owe by becoming incharge of particular departments.

e) During the discussions we found that many hospitals doesn't have any monitoring system of reporting. For example some talukas did not detect tuberculosis, leprosy cases during the entire year. This was brought to the notice of the concerned officers.

f) There was a suggestion by the Chief Executive Officer that to train the existing health workers to handle the microscope etc. so that the laboratory work can be managed with the available human resources. But this subject needs to be discussed thoroughly.

After the meeting we moved to district hospital situated at the centre of Tumkur. These are the following observations done by the Task Force Member.

a) It was at 4.30 pm we found that there were very less no. of staff available at the hospital. Many of them are already left the premises.

b) The entire hospital was not maintained properly. There were stincking smell in the corridors and also we observe that the toilets were not well maintained.

c) While walking in the corridors we found that burnt cases were kept out side without adequate covering. There were lot of people moving in and around of the patients. When we asked the officials said there is no proper maintenance staff to monitor the movements of the visitors in the hospital premises. We also found that there was no compound for the entire hospital.

d) The beds were not properly maintained and cleaned. We found that some lenins were badly kept.

e) When we visited the blood bank we found that it was some what cleaned but not up to the standard of maintaining the blood bank. The roads to the blood bank and wards are full of bushes and weeds.

f) It was also found that the operation theatre was locked from inside and when we enquired with the district surgeon that he was not sure about the activities of the operation theatre. It appears that there is no co-ordination amongst the officials and doctors regarding the activities of the hospitals.

g) When we entered the casualty centre it was not well maintained.

h) We found that there are the lists of drugs available in the hospital but it was not displayed.

h) The Tumkur general hospital which is having 300 beds and situated in the centre of Tumkur not having 24 hours service of X-ray, lab facilities. Even though they have 6 x-ray plants but they have only one x-ray technician who happens to be rarely found.

j) We also found that there was a vehicle for bringing the specialists from different parts of Tumkur on call, but we found that these doctors are staying away from the head quarters which is very difficult to reach the place immediately. The official informed that it would be nice that if these specialists stay nearby to the hospital.

We found that Rs.500/- per day is given to the in-charge officials for the maintenance of vehicles, generators etc. He was pleading that this amount should be raised.

These are the points observed by the Task Force member.

Dr. Renuka Vishwanathan, IAS

HUMAN DEVELOPMENT AND THE SECOND SEX

Women have lower levels of human development than men on account of gender alone

Some pointers on what it means to be a woman in Karnataka

- ✓ The sex ratio is adverse in all districts except Dakshina Kannada and it has worsened in the eighties
- ✓ 12.3% of women's deaths are between15 and 24 against 5.9% for men
- ✓ Women marry at 20 years, men at 26; 64% of the marriages between 10 & 14 years are in Bijapur, Belgaum, Gulbarga and Raichur
- ✓ The crude birth rate is high over most of north Karnataka
- ✓ Male and female literacy rates diverge by 23 % points; there is marked difference over most of north Karnataka
- ✓ 33% of girl children are out of school and the dropout rate for girls is 46% at the primary school level; in Raichur the dropout rate in lower primary schools for SC and ST girls is 44%

What equal opportunity means for women

- ✓ From 59% in 1959-60, the percentage of vasectomies in sterilisations has dropped to 0.1%; less than 2% of men with wives of childbearing age use condoms
- ✓ 1.28 lakhs out of 1.35 crore members of cooperatives are women; this is less than 0.1%
- ✓ 6 out of 224 members of the Karnataka Legislative Assembly are women(3 %)
- ✓ 3 out of 43 ministers Is a woman (7 %)
- ✓ There is only one woman Cabinet minister
- ✓ There is no woman member in any land reforms tribunal
- ✓ There is one woman among 32 High Court judges
- ✓ There is no mention of women in the agricultural policy of the State although women perform most agricultural operations

The truth beyond statistics

- ✓ Girl children are selectively aborted after amniocentesis
- ✓ Girls are withdrawn from schools for house and farm work
- ✓ Women and girls eat less than men and boys and are fed after them
- ✓ Dowry is demanded for getting girls married and wives are harassed and killed for gifts and property
- ✓ Women work more hours than men on unpaid, unrecognised chores
- ✓ Women are paid less than men for equally arduous work
- ✓ Women's mobility is controlled by others
- ✓ Women have much less power than men over their own lives and over family resources
- ✓ Women are used as fronts by men to corner legal and monetary benefits – for credit/land

There is ample proof of social and economic discrimination against women

TO TACKLE THIS, GOVERNMENT PROGRAMS SHOULD GO BEYOND TARGETING THE FAMILY AND CONSIDER THE REQUIREMENTS OF WOMEN

Government programs should not be planned with men alone in mind because

- ✓ we are ignoring the needs of half the population
- ✓ we get an incomplete picture of economic and social reality with the result that
- ✓ ** conclusions are wrong
- ✓ ** policies poorly formulated and
- ✓ ** expected results unrealised
- ✓ our programs change productive and social relations in such a manner that the conditions of women are worsened

effects on participants of production processes

TWO MAJOR CHANGES ARE REQUIRED

- ✓ Women's concerns must become central in the developmental strategy of every department not just of the Women and Child Welfare department
- ✓ This should go beyond routine earmarking of part of the departmental budget for "women's schemes"

IMPROVING WOMEN'S INCOMES

- ✓ Before formulating schemes, we must understand the paid and unpaid work women do in the sector & how decisions are made & tasks allocated eg.in agriculture,animal husbandry,industry,sericulture
- ✓ On this basis:
- ✓ *training and extension can be organised by adjusting timings etc:technical training, TRYSEM
- ✓ *technology improved: eg.in agriculture, industry,sericulture
- ✓ *facilities provided at work spots-the entire challenge of creches in industrial units, construction or agricultural work spots

INCREASING PRODUCTION AND IMPROVING PRODUCTIVITY

- ✓ By seeing women as producers, we can:
- ✓ *give them legal and real ownership of assets (productive assets and collateral)
- ✓ **we must take into account the fact that decisionmaking does not often follow on formal ownership
- ✓ *provide access to adequate credit for all needs-production as well as consumption
- ✓ **adjust bank timings, procedures and repayment schedules

INCOME GENERATION SCHEMES SHOULD MEET NEEDS OF WOMEN & IMPROVE THEIR DIGNITY AND STATUS

- ✓ They should pay equal and fair wages
- ✓ They should provide for adequate return and not treat women's income as merely a supplement to family income
- ✓ They should provide for movement to higher skills
- ✓ They should train women for leadership positions
- ✓ They should look at remunerative nontraditional skills with marketing potential-not just tailoring and(now) computers
- ✓ They should improve mobility,skills ofselfdefense, &selfreliance & dealings with the external world

WOMEN AND GOVERNMENT HEALTH PROGRAMS

✓GOVERNMENT'S ROLE IN HEALTH

PROGRAMS FOR WOMEN MUST BE TOTALLY REVIEWED LOOKING AT:

- ✓ *the role of doctors in selective abortion of female foetuses
- ✓ **looking at solutions beyond regulation
- ✓ *preventing and treating malnutrition among girl children due to gender bias — get data
- ✓ *advice to adolescent girls regarding hygiene

MODIFYING HEALTH PROGRAMS FOR WOMEN

- ✓ ALLOUT CAMPAIGN FOR FAMILY PLANNING BY MALES
- ✓ Sustained campaign to be launched
- ✓ *for delaying marriages
- ✓ *for delaying pregnancies
- ✓ *for nutrition during pregnancies
- ✓ Complete coverage through trained midwives of pregnant women
- ✓ Monitoring and prevention of maternity related ailments and deaths

WOMEN ARE PERSONS NOT MERELY CHILDBEARING MACHINES

- ✓ Provide medical support for non-maternity linked ailments
- ✓ Provide holistic health care for older women
- ✓ Sustained campaign to protect innocent women against men impregnating them with the AIDS virus
- ✓ Restructure health institutions to provide health service at PHC level and referral to CHCs and taluka level institutions

need for campaigning

CAN GOVERNMENT CHANGE PEOPLE'S ATTITUDES?

- ✓ Attitudes cannot be changed by regulation alone
- ✓ But government can be in the vanguard of change Abol. of Sati Act Shariatha Act
- ✓ We can induce change at the margin by three methods:
- ✓ **training from the top, Dept of Personnel - NTI, Hyderabad
- ✓ **sensitisation
- ✓ **media - good people not aired.

TRAINING IS ESSENTIAL FOR PERSONNEL AND POLICYMAKERS

- ✓ Programs should be properly prepared
- ✓ By qualified persons
- ✓ Closely reviewed on the basis of feedback
- ✓ Evaluated
- ✓ SENSITISATION IS ESSENTIAL FOR OFFICIALS AND USERS
- ✓ Programs should be prepared by experts
- ✓ All personnel and policymakers should be trained
- ✓ Feedback obtained and
- ✓ Programs reviewed

USE OF MEDIA TO CHANGE ATTITUDES

- ✓ Government has not fully exploited the media for its programmes
- ✓ Many departments have prepared effective presentations on gender issues eg.on DPEP, Panchayati Raj issues etc
- ✓ They should be disseminated on all media-prime time on TV and radio, through the I&B department and other methods
- ✓ Effective films made in other languages or by activist directors should be acquired and widely shown

Dr. Renuka Vishwanathan, IAS

HUMAN DEVELOPMENT IN KARNATAKA

HUMAN DEVELOPMENT REPORTS FOR INDIAN STATES

- ✓ The Human Development Index was developed by Dr. Mahboob ul Haq at the UNDP in 1990
- ✓ UNDP releases Human Development Reports every year
- ✓ The Central government has not prepared such a report for the country so far — this discussed. May be dangerous ; using anomalies bas. fund allocations + backwardness – will help maintain stability
- ✓ Karnataka is the second State in India to prepare a Human Development Report; the first was Madhya Pradesh — MP. – 1995 & 1998, Kar – 1999 inspired by MP.

The Human Development Report is different from the usual Plan and budget documents because:

- ✓ it looks only at human development (including trends in economic growth, per capita income, employment & poverty) but not at productive sectors
- ✓ it uses official as well as nonofficial studies and data
- ✓ it assesses both successes and failures
- ✓ it evaluates not only initiatives taken by the public sector but also the efforts of individuals and NGOs

THE HUMAN DEVELOPMENT INDEX IS A BETTER INDICATOR OF DEVELOPMENT THAN PER CAPITA INCOME BECAUSE

- ✓ people are the real wealth of a nation; we need "people-centred growth"
- ✓ enlargement of people's choices is the objective of growth
- ✓ the benefits of growth may not reach all segments of the population
- ✓ often mass poverty persists even when incomes are rising due to unequal income and wealth distribution and dislocations caused by structural changes in the economy
- ✓ we must also look at other requirements of welfare-a long and healthy life, access to knowledge and control over resources to ensure a decent standard of living

KARNATAKA USES THE UNDP METHODOLOGY FOR CALCULATING THE HUMAN DEVELOPMENT INDEX

- ✓ the HDI is a composite index using three unweighted variables:
- ✓ ~~the standard of living is measured by using per capita income
- ✓ ~~educational attainment is measured by using two indicators: adult literacy with two-thirds weightage and the gross enrolment ratio of children in primary schools with one-third weightage
- ✓ ~~health status is measured by using life expectancy at birth

UNIQUE FEATURES OF THE KARNATAKA HDR

- ✓ the first HDR prepared by an official inhouse group
- ✓ the first Statelevel HDR
- ✓ --to fully use the UNDP methodology
- ✓ --to calculate district level poverty ratios by pooling Central and State samples of the NSSO's survey of household consumption
- ✓ --to calculate district level Sen's welfare indices using Gini coefficients of household consumption expenditure
- ✓ --to compare HDIs based on per capita income with those based on Sen's welfare indices

KARNATAKA-IN A NUTSHELL

- ✓ Area-191791 sq. kms.
- ✓ Population-50 million (5.27% of the country)
- ✓ Density-261/sq. km. (India-289/sq. km.)
- ✓ Urbanisation-31% (India-26%)
- ✓ **WHEN THE STATE WAS FORMED,
- ✓ IN HYDERABAD-KARNATAKA
- ✓ literacy was 8.5% (for females 7%)
- ✓ enrolment ratio (6 to 11 years) was 27%
- ✓ area and population per secondary school and per college were high
- ✓ road length per sq. km. was low

KARNATAKA, MAJOR STATES AND INDIA

	Karnataka	India	Rank among major States
IMR -97	53	71	4
MMR -92	450	453	9
Sex ratio-91	960	927	5
LEB-91 to 95	62.5	60.3	6
Literacy-91	56	52.2	7
Female literacy -91	44.3	39.3	8
Per capita NSDP at current prices 95-96	9384	9578	6
HDI-91-92 (Shivkumar)	0.448	0.423	7
GDI (do)	0.417	0.388	5
Human development expenditure ratios:			
*PER Public expenditure Ratio	18.74		9
*SAR Social Need Ratio	37.92		6
*SPR Social	44.08		9

1. Unedited data

INTERNATIONAL RANKINGS FOR STATE AND DISTRICTS

* Karnataka's international HDI ranking in 1991 is 131 against country's ranking of 134

* Highest ranked district in HDI, Kodagu, is 104 and lowest, Raichur, is 142 disparity

* Karnataka's international GDI ranking in 1991 is 93 against country's ranking of 99

* Highest ranked district in GDI, Kodagu, is 65 and lowest, Raichur, is 101

Ranking of Districts by Health - Education Index, Income Index and HDI, 1991.

District	Ranking		
	Health and Education Index	Income Index	HDI
Bangalore Urban	3	2	2
Bangalore Rural	9	10	8
Belgaum	8	6	9
Bellary	18	7	17
Bidar	17	20	18
Bijapur	14	15	14
Chikamagalur	5	3	5
Chitradurga	10	12	10
Dakshina Kannada	1	4	3
Dharwad	11	16	11
Gulbarga	19	11	19
Hassan	6	14	7
Kodagu	2	1	1
Kolar	12	19	15
Mandya	14	13	13
Mysore	16	9	16
Raichur	20	18	20
Shimoga	6	8	6
Tumkur	13	17	12
U.Kannada	4	5	4

Comparison of HDIs based on Sen's Welfare Index and GDP 1990-1991.

DISTRICT	HDI BASED ON			
	Sen's Welfare Index		GDP	
	Value	Rank	Value	Rank
Bangalore	0.565	2	0.601	2
Bangalore Rural	0.457	8	0.472	8
Belgaum	0.454	9	0.471	10
Bellary	0.410	17	0.429	17
Bidar	0.402	18	0.414	18
Bijapur	0.430	13	0.443	14
Chikmagalur	0.503	5	0.524	5
Chitradurga	0.447	10	0.471	9
D.Kannada	0.565	3	0.592	3
Dharwad	0.444	11	0.459	11
Gulbarga	0.387	19	0.401	19
Hassan	0.460	7	0.473	7
Kodagu	0.584	1	0.630	1
Kolar	0.430	14	0.443	15
Mandya	0.428	15	0.444	13
Mysore	0.426	16	0.440	16
Raichur	0.372	20	0.383	20
Shimoga	0.467	6	0.486	6
Tumkur	0.440	12	0.456	12
U.Kannada	0.513	4	0.533	4
STATE	0.449		0.470	

more or less the same

THE GENDER-RELATED DEVELOPMENT INDEX

- ✓ The Gender-related Development Index measures the divergence in development levels of men and women in the three areas selected for the HDI
- ✓ The GDI is the HDI adjusted downwards for gender inequality

Comparative ranking of HDI and GDI for districts of Karnataka 1991

District	HDI Rank	GDI Rank	HDI Rank minus GDI Rank
Kodagu	1	1	0
Bangalore Urban	2	3	- 1
D.Kannada	3	2	+ 1
U.Kannada	4	4	0
Chikamagalur	5	5	0
Shimoga	6	6	0
Hassan	7	7	0
Bangalore Rural	8	8	0
Belgaum	9	10	- 1
Chitradurga	10	9	+ 1
Dharwad	11	11	0
Tumkur	12	12	0
Mandya	13	15	- 2
Bijapur	14	13	+ 1
Kolar	15	14	+ 1
Mysore	16	16	0
Bellary	17	17	0
Bidar	18	18	0
Gulbarga	19	19	0
Raichur	20	20	0

not much diff in Kar
but in MP + other countries
there were big diff in
HDI + GDI

LIMITATIONS OF THE INDEX APPROACH

- ✓ districts could have same index for different reasons
- ✓ * the proxies selected do not cover all issues; examples:
- ✓ ~~literacy is defined in the census as the ability to read and write one's name
- ✓ ~~unpaid work of women is not counted in per capita income
- ✓ * indices could have interlinkages leading to distortions in findings
- ✓ * there are no weights given for the indices
- ✓ * the indices have value only in relation to one another
- ✓ * the selection of maxima and minima affects values and range

Need for continuing claimant to use the report
Voice of locally unpicked.

Information regarding State Sector & Central Sector (Including C.P.Schemes) – 2210 – Medical and Public Health (HEALTH WING)

(Rs. in lakhs)

	State Schemes (Excluding CSS) Outlay Budget Estimate	Revised Estimate	Expd. upto	Central Schemes outlay: State Share Budget Estimate	State Share Revised Estimate	Central Share Budget Estimate	Central Share Revised Estimate	Total Budget Estimate	Total Revised Estimate	Expd. Upto: State Share	Central Share	Total	Outlay (Col.2 + Col.6) Budget Estimate	Revised Estimate	Expd. upto (Col.3 + Col.9)	1999–2000 proposed: State Outlay	State Share	Central Share	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
D.H.S.	1165.78	1125.78	1752.66	1334.22	1334.22	2812.18	1443.45	4147.40	2777.68	165.77	603.49	769.26	5313.13	3913.46	2521.92	840.10	1314.90	1579.45	3734.45
District Sector	2812.13 + 33.25	2812.13 33.25	–	–	–	–	–	–	–	–	–	–	2812.13	2812.13	[illegible]	2821.04	–	–	2821.04
I.S.M.	200.00	200.00	128.69	–	–	26.00	26.00	26.00	26.00	–	4.23	4.23	226.00	226.00	132.92	270.00	–	8.00	278.00
District Sector	247.41	247.41	150.36	–	–	–	–	–	–	–	–	–	247.41	247.41	150.36	238.07	–	–	238.07
Drugs Control	100.00	80.00	50.15	–	–	40.00	40.00	40.00	40.00	–	23.10	23.10	140.00	120.00	73.25	75.00	–	40.70	115.70
Family Welfare	60.00	60.00	87.36	–	–	–	–	–	–	–	–	[illegible]	60.00	65.00	87.36	100.00	–	–	100.00
District Sector	181.51	181.51	127.86	–	–	–	–	–	–	–	–	–	181.51	181.51	127.86	126.68	–	–	126.68
a) Non-RCH	–	–	–	–	–	8884.09	8884.08	8884.08	8884.08	–	6888.42	6888.42	8884.08	8884.04	6008.42	–	–	9690.39	9690.89
b) RCH	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
i) National component	–	–	–	–	–	3600.00	3600.00	3600.00	3600.00	–	2509.80	2509.80	3600.00	3600.00	2509.80	–	–	3460.00	3460.00
ii) Sub-Project Bellary	–	–	–	–	–	115.00	115.00	115.00	115.00	–	5.00	5.00	115.00	115.00	5.00	–	–	667.00	667.00
iii) 4211 Bldg.	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	932.00	932.00
IPP-VIII	–	–	–	100.00	100.00	900.00	900.00	1000.00	1000.00	117.64	1058.72	1058.72	1000.00	1000.00	1058.72	–	100.00	1530.00	1700.00
IPP-IX	–	–	–	170.00	470.00	1530.00	4230.00	1700.00	4700.00	158.95	1430.48	1589.43	1700.00	4700.00	1589.43	–	400.00	3600.00	4000.00
E.A.P. 1. KHSDP	8000.00	13455.00	9255.00	–	–	–	–	–	–	–	–	–	8000.00	13455.00	9255.00	13200.00	–	–	13200.00
2. CPEC	2200.00	2200.00	2000.00	–	–	–	–	–	–	–	–	–	2200.00	2200.00	2000.00	900.00	–	–	900.00
3. KFW	400.00	400.00	16.00	–	–	–	–	–	–	–	–	–	400.00	400.00	16.00	400.00	–	–	400.00
Total	15366.83 + 33.25	20771.83 + 33.25	13568.08	1604.22	1904.22	17908.26	19593.54 + 33.25	19512.45 + 33.25	21142.76 + 33.25	442.36	12523.24	12847.96	14579.13 + 33.25	41914.59 + 33.25	26416.04	18970.89	1001.90	21556.04	42411.03
AIDS Prevention Society	–						577.25				515.36	515.36						1631.40	1631.40

1998-99

	State plan	CSS	Total
State Sector	13730.00	17,908.26	31,638.26
Dist. Sector	3274.30	–	3,274.30
	17004.30		34,912.56
	170.04 Crores		349.13 crores

1998-99 (RE)

State plan State Sector · 19435.00

District Sector 3274.30

22709.30

CSS 19598.54

Total 39033.54 (S.S)

3274.30

42307.84

Total plan budget 423.08 Cr

1999 - 2000

	State plan	CSS	Total
State Sector	17,670.00	21556.04	39226.04
Dist. Sector	3219.04	–	3219.04
	20889.04		42,445.08
	208.89 Crores		424.45 Crores

COM H-30.4

STAFF POSITION OF A.B.C.D GROUP OF THE DEPARTMENT OF HEALTH AND FAMILY WELFARE SERVICESINCLUDING K.H.S.D.P., AS ON 30/4/99

Sl. No.	Name of the cadre	Sanctioned	Working	Vacant	5% Cut in sanctioned	Vacant	To be Recruited	Vacant After Recruitmen	Remarks
				GROUP 'A'					
1	2	3	4	5	6	7	8	9	10
1	Director of Health & FWS services	1	1	0	0	0	0	0	
2	Director of Health & trg Institution	1	1	0	0	0	0	0	
3	Additional Director	8	6	2	0	2	0	2	
4	Joint Director	19	18	1	(-)4	3	0	0	
5	Health Officer Class 1 Senior	144	92	52	(-)6	46	0	46	
6	Surgeons								
7	T.B Hospital Superintendents								
8	Chief Administrative Officer	1	1	0	0	0	0	0	
9	A. Special Officer: Legal Cell	1	1	0	0	0	0	0	
10	Cheif Accounts Office-cum-Financial Advisor	1	1	0	0	0	0	0	
11	SSPL/DCMO/SPL/SMO/GDMO	4,788	4,049	739	(-)63	676	573	103	
12	Joint Director (IEC)	1	1	0	0	0	0	0	
13	Deputy Director (Pharmacy)	1	1	0	0	0	0	0	
14	Deputy Director (Transport)	1	0	1	0	1	0	1	
15	Deputy Director (SME)	1	1	0	0	0	0	0	
16	Dental Surgeons	2	2	0	0	0	0	0	
17	Deputy Dental Surgeons	33	21	12	0	12	0	12	
18	Assistant Dental Surgeons	185	40	145	(-)4	141	115	26	
19	Chief Chemist & Public Analyst	1	1	0	0	0	0	0	
20	Chief Pharmacists ( )	19	14	5	0	5	0	5	
21	Senior chief Chemist & Public Analyst ( )	7	4	3	0	3	0	3	
22	Health Equipment Officer	2	0	2	0	2	0	2	
23	Accounts Officer (FW)	1	1	0	0	0	0	0	
24	Assistant Executive Engineer Vaccine Institute Belgaum	1	1	0	0	0	0	0	
25	Sr. Asst. Director (Nursing)	1	0	1	0	1	0	1+1	
26	Biochemist	1	0	1	0	1	1	0	
27	Senior Entomologist	3	0	3	0	3	0	3	
28	Administrative Officer	4	0	4	0	4	0	4	
29	Deputy Director (Nutrition)	1	1	0	0	0	0	0	
30	Planning Officer	2	1	1	0	1	0	1	
31	Principal (College of Nursing)	1	0	1	0	1	0	1	
32	Professor (College of Nursing)	4	1	3	0	3	0	3	
33	Assistant Professor (College of Nursing)	5	2	3	0	3	0	3	

1	2	3	4	5	6	7	S	9	10
34	Statistical Officer-I	2	2	0	0	0	0	0	
35	Demographer	1	1	0	0	0	0	0	
36	Material Manager	1	0	1	0	1	0	1	
37	Screen Pathologist of Adiologist	1	1	0	0	0	0	0	
	GROUP 'A' TOTAL	5,246	4,266	980	(-)77	906 (-)3 *	697	226	*

Sl. No.	Name of the cadre	Sanctioned	Working	Vacant	5% Cut in sanctioned	Vacant	To be Recruited	Vacant After Recruitmen	Remarks
				GROUP 'B'					
1	2	3	4	5	6	7	8	9	10
38	Lay Secretary/Gazetted Asst.	128	73	55	('-) 4	51	0	51	
39	Graduate Pharmacist	39	27	12	0	12	12	0	
40	Chemist/Food Analyst	11	7	4	('-) 2	2	2	0	
41	Assistant Nutrition Officer	5	1	4	0	4	4	0	
42	Scientific Officer	1	1	0	0	0	0	0	
43	Technical Officer (FSDC)	1	0	1	('-) 1	0	0	0	
44	Assistant Deputy Director (HE & SH)	1	0	1	0	1	0	1	
45	Technical Officer (Exhibition)	1	1	0	0	0	0	0	
46	Junior Physicists	2	0	2	0	2	2	0	
47	Assistant Entomologist	28	7	21	0	21	21	0	
48	Medical Record Officer	4	1	3	0	3	0	3	
49	Technical Officer (Goitre)	1	1	0	0	0	0	0	
50	Service Engineer	20	7	13	0	13	0	13	
51	Lecturer College of Nursing	5	1	4	0	4	0	4	
52	Principal School of Nursing	10	3	7	0	7	0	7	
53	Nursing Superintendent Grade I	51	18	33	0	33	0	33	
54	Assistant Leprosy Officer	13	9	4	(-) 1	3	0	3	
55	Senior Health Supervisor	13	11	2	0	2	0	2	
56	Nursing Superintendent Grade I (PH)	71	36	35	0	35	0	35	
57	District Health Education Officer	24	17	7	0	7	0	7	
58	Health Education Officer/Health Education Inspector/Health science Instructor	12	6	6	(-) 1	5	0	5	
59	Social Scientific Editor	1	0	1	(-) 1	0	0	0	
60	Assistant Director (Press)	1	1	0	0	0	0	0	
61	Statistical Officer	2	2	0	0	0	0	0	
62	Micro Biologist	21	1	20	0	20	20	0	
64	Clinical Psychologist	17	6	11	0	11	11	0	
65	Entomologist	22	1	21	0	21	21	0	
66	Cold Chain Officer	1	0	1	0	1	0	1	
67	Statistical Officer Gr.II	5	5	0	0	0	0	0	
68	Communication Officer	2	2	0	0	0	0	0	
69	Clinical Instructor	4	4	0	0	0	0	0	
	GROUP 'B' TOTAL	517	249	268	10	258	93	165	

Sl. No.	Name of the cadre	Sanctioned	Working	Vacant	5% Cut in sanctioned	Vacant	To be Recruited	Vacant After Recruitmen	Remarks
				GROUP 'C'					
70	Deputy Health Education Officer	90	89	1	0	1	0	1	
71	Block Health Educator	726	505	221	(-) 2	219	221	0	
72	Projection List	41	37	4	(-) 10	6	6	0	
73	Junior Projectionist	20	16	4	0	4	0	4	
74	Lady Health Visitors	1,219	1,066	153	0	153	0	153	
75	Nursing Superintendent Gr.II (P.H)	51	37	14	0	14	0	14	
76	Junior Health Asst. F.	9,590	9,026	564	('-) 116	448	0	448	
77	Senior Health Asst.M	1,317	933	384	('-) 7	377	0	377	
78	Health Superivisor	81	51	30	('-) 9	21	0	21	
79	Senior Non Medical Supervisor	98	93	5	('-) 5	0	0	0	
80	Junior Non Medical Supervisor	157	112	45	('-) 10	35	0	35	
81	Junior Health Asst.M	5,662	4,455	1,207	('-) 63	1144	242	902	
82	Para Medical Worker	1,231	938	293	('-) 216	77	266	0	•
83	Staff Nurses	4,673	4,102	571	0	571	0	571	
84	Clinical Instructor (College of Nursing)	4	3	1	0	1	0	1	
85	Senior Staff Nurses	600	480	120	0	120	0	120	
86	Nursing Superintendent Gr.II (P.H)	354	283	71	0	71	0	71	
87	Nursing Tutor	90	47	43	0	43	0	43	
88	Sr. Pharmacist	463	387	76	0	76	0	76	
89	Jr. Pharmacist	2,164	1,365	799	('-) 58	741	799	0	•
90	Drivers	1,520	1109	411	('-) 20	391	410	0	•
91	Skilled Tradesman	75	44	31	('-)10	21	0	21	
92	Skilled Assistant	90	46	44	('-) 15	29	0	29	
93	Asst. Statistical Officer	31	26	5	0	5	0	5	
94	Office Superintendents	375	314	61	('-) 18	43	0	43	
95	First Dv. Assistant	2,170	1,588	582	('-) 91	491	0	491	
96	Second Dv. Assistant	1,576	1,526	50	(-) 82	(0) 32	0	0	•
97	Clerk Cum Typist	391	287	104	(-) 60	37	0	37	
98	Stenographers	118	104	14	(-) 6	8	0	8	
99	Stenographer Junior	79	69	10	0	10	0	10	
100	Typists	284	229	55	(-) 9	46	0	46	
101	Lady House Keeper	17	12	5	0	5	0	5	
102	Sr. Librarian Gr. I	6	5	1	0	1	0	1	
103	Librarian Gr. I	3	2	1	0	1	0	1	
104	Librarian Gr. II	5	3	2	0	2	0	2	
105	Library Asst.	3	1	2	0	2	0	2	
106	Jr. Lab. Technicians	1,884	701	1183	0	1183	281	902	
107	Sr. Lab. Technicians	380	137	243	0	243	0	243	
108	X-Ray Technicians	352	271	81	(-) 12	69	0	69	
109	Radiographer	51	20	31	0	31	0	31	
110	Refractionist	582	428	154	(-) 4	83	69	14	
111	Orthopist	7	7	0	0	0	0	0	
112	Asst. Medical Recored Officer	11	7	4	0	4	0	4	

1	2	3	4	5	6	7	8	9	10
113	Physiotherapist (General)	69	18	51	(-)19	28	51	0	
114	Electrician	48	38	10	0	10	6	4	
115	Clinical Psychologist	18	7	11	0	11	0	11	
116	Dental Mechanic	31	26	5	(-) 4	1	0	1	
117	Junior Chemist	24	8	46	(-) 5	11	0	11	
118	Dental Hygienist	9	8	1	0	1	0	1	
119	Physiotherapist(Leprasy)	52	28	24	0	24	0	24	
120	Dietician	14	5	9	0	9	0	9	
121	Social Worker (STD)	33	22	11	0	11	11	0	
122	Mechnic Class I (Junior)	4	4	0	0	0	0	0	
123	Occupational Therapist	5	0	5	0	5	0	5	
124	Modeller	4	0	4	0	4	0	4	
125	Artist-Cum-Photographer	8	1	7	0	7	5	2	
126	Artist	4	0	4	0	4	4	0	
127	Draftsman	2	1	1	0	1	0	1	
128	Phyical Culture Instructor	4	4	0	0	0	0	0	
129	Auto clave Mechnic	2	1	1	0	1	0	1	
130	Pathological Assistant	5	0	5	0	5	0	5	
131	Scientific Assistant	4	3	1	0	1	0	1	
132	Aircondition Operator	2	1	1	0	1	0	1	
133	Superintendent (Technical)	1	1	0	0	0	0	0	
134	Printing Instructor	1	1	0	0	0	0	0	
135	Weaving Instructor	1	1	0	0	0	0	0	
136	Loom Mechanic	3	0	3	0	3	0	3	
137	Health Equipment and Repaired Supervisor	4	1	3	0	3	0	3	
138	Junior Engineer	1	1	0	0	0	0	0	
139	Sub-Editor	1	1	0	0	0	0	0	
140	Home Science Asst.	1	0	1	(-) 1	0	0	0	
141	Orthoptic Technician	2	0	2	0	2	0	2	
142	Optical Mechnic	1	1	0	0	0	0	0	
143	Teacher	1	0	1	(-) 1	0	0	0	
144	Speech Pathologist	1	0	1	0	1	0	1	
145	Speech Therapist	1	0	1	0	1	0	1	
146	Refrigerator Mechanic	3	0	3	0	3	0	3	
147	Reaserch Assistant	1	0	1	0	1	0	1	
148	Needle Work Teacher	1	0	1	0	1	0	1	
149	Electrical Supervisor	1	0	1	0	1	0	1	
150	Dialysis Therapist	2	0	2	0	2	0	2	
151	Medical Record Technicians	38	27	11	0	11	0	11	
152	Psychotric Social worker	5	1	4	0	4	4	0	
153	Equipment Technician	187	0	187	0	187	0	187	
154	Senior Compositer	1	0	1	(-) 1	0	0	0	
155	Junior Compositer	4	1	3	(-) 3	0	0	0	
156	Compositer	1	1	0	(-)3	0	0	0	
157	Junior Computer	1	0	1	(-) 1	0	0	0	
158	Food Analaysts				(-) 2				
159	Insect collector				(-) 1				
160	E.C.G. Tech.	15	0	15	0	15	0	15	
161	Offset Plate maker	1	-	1	(-)1	-	-	-	
162	Senior Printer	1	-	1	1	-	-	-	
163	Health educators				(-) 10				
164	Iterate Attender				(-) 3				
165	Superior Field Worker				(-) 48				
	GROUP 'C' TOTAL	39,264	31,173	8,091	927	7,164	2,373	4,791	

Sl. No.	Name of the cadre	Sanctioned	Working	Vacant	5% Cut in sanctioned	Vacant	To be Recruited	Vacant After Recruitmen	Remarks
				GROUP "D"					
1	2	3	4	5	6	7	8	9	10
166	Pump Mechanic	2	2	0	0	0	0	0	
167	Wireman	1	1	0	0	0	0	0	
168	Boiler Attender	1	1	0	0	0	0	0	
169	Dark Room Assistant	69	3	67	0	67	0	67	
170	Silk Sreen Technician	1	1	0	0	0	0	0	
171	Leather Worker	2	1	1	0	1	0	1	
172	Carpenter	4	0	4	(-) 1	3	0	3	
173	Cleaners	145	123	22	(-) 1	21	0	21	
174	Junior Lab. Attender	71	0	71	0	71	0	71	
175	Plumber	1	0	1	0	1	0	1	
176	Cook	71	0	71	0	71	0	71	
177	Wireless Operater	90	0	90	0	90	0	90	
	GROUP 'D'	16787	14126	2661	(-) 439				
	No. Of posts of Group 'D' Vacant(Proposed not be filled up)				(-) 1495	728	0	728	
	GROUP 'D' TOTAL	17245	14258	2988	1936	1052	0	1052	

STAFF POSITION GROUP A , B, C, & D OF THE DEPARTMENT OF HEALTH AND FAMILY WELFARE SERVICES AS ON 30/4/99

ABSTRACT

Category	Sanctioned	Working	Vacant	5% Cut in sanctioned	Vacant	To be Recruited	Vacant After Recruitment	Remark
1	2	3	4	5	6	7	8	9
GROUP 'A'	5,246	4,266	980	77	906	689	217	
GROUP 'B'	517	249	268	10	258	93	165	
GROUP 'C'	39,264	31,173	8,091	927	7,165	2,373	4,792	
GROUP 'D'	17245	14258	2988	1936	1052	0	1052	
Total	62,272	49,946	12,327	2,950	9,381	3,155	6,226	

NUTRITION PROGRAMME

OBJECTIVES:

The major Goal to be achieved under Nutrition is reduction of severe and Moderate malnutrition of children below 5 years of age by 2000 A.D with the following specific Goals:

1. Control of vitamin 'A' deficiency and its consequences including blindness.
2. Reduction in the incidence of low birth weight babies.
3. Universal consumption of Iodised salt.

Vitamin 'A' prophylaxis programme:

Vitamin 'A' prophylaxis programme is one of the Nutrition programmes implemented in the state in order to prevent severe forms of vitamin 'A' deficiency leading to blindness.

A Mega dose of vitamin 'A' concentrate is administered orally to the children of 9 months to 3 years one Ml of vitamin 'A' concentrate containing one lakh I.U is given to the children of 9 months along with Measles immunisation and 2 Ml of vitamin 'A' concentrate containing 2 lakh I.U is given to the children of 1-3 years at 6 monthly intervals. vitamin 'A' concentrate is supplied by Government of India free of cost. The statements showing the progress for 97-98, 98-99 and 99-2000 is enclosed herewith

The Integrated Child Development Services Scheme:

This programme is being implemented with the co-ordinated efforts of Health & F.W. Services of Department of Women & Child Development. A package of services like Immunisation, Supplementary Nutrition, Health Checkup, Referral Services, Non-formal pre-school Education, Nutrition and Health Education are provided. The beneficiaries of this programme are 0-6 year children and pregnant of lactating Mothers. At present 184 projects are being implemented and the Health and Nutrition sectors are being monitored regularly. The progress Reports are computerised at the Directorate every month and sent to Central Technical Committee, New Delni and other officers concerned.

VITAMIN 'A' REPORT FOR THE YEAR 97-98 IS AS FOLLOWS :

District	Measles linked vit 'A' programme			Prophylaxis programme for 1-3 year children		
	Target	Achievement	%	Target	Achievement	%
Bangalore(U)	22000	20668	130	58000	55601	96
Bangalore(R)	38000	24591	64	106000	100614	95
Chitradurga	60000	43125	72	60000	115911	193
Kolar	49000	52060	106	135000	104093	77
Shimoga	43000	40707	94	117000	132240	113
Tumkur	57000	51394	90	135000	142129	105
Belgaum	95000	94302	99	209000	157409	75
Bijapur	77000	70705	92	171000	93253	54
Dharwad	93000	71026	76	203000	204602	101
Kannada	25000	19801	79	79000	77934	98
Bellary	53700	27827	52	107000	87778	82
Bidar	38000	34338	90	74000	58835	66
Gulbarga	75000	39720	53	149000	54390	36
Raichur	69000	57845	84	139000	117583	84
Chikmagalur	20000	17381	87	60000	31101	52
D.Kannada	56000	23569	42	161000	56213	33
Hassan	34000	25590	75	102000	29022	28
Kodagu	10000	9325	93	30000	31280	104
Mandya	39000	17775	49	108000	42468	39
Mysore	67000	25866	38	155000	22441	14
State total	1017000	775696	76	2437000	1705857	70

VITAMIN 'A' REPORT FOR THE YEAR 98-99 IS AS FOLLOWS

District	Measles linked vit 'A' programme			Prophylaxis programme for 1-3 years children		
	Target	Achivement	%	Target	Achievement	%
Bangalore(U)	22000	15762	71	58000	24074	41.5
Bangalore (R)	38000	35170	92	106000	86688	81.7
Chitradurga	60000	32305	54	60000	61079	101
Kolar	49000	49179	100	135000	67465	50
Shimoga	43000	29352	68	117000	89306	76.3
Tumkur	57000	44336	77.7	135000	112306	83
Belgaum	95000	81150	85.4	209000	134481	64.3
Bijapur	77000	7000	9	171000	34687	20.2
Dharwad	93000	32503	35	203000	76236	37.5
U.Kannada	25000	20725	83	79000	99651	126
Bellary	53000	29822	56.2	107000	68411	64
Bidar	38000	30435	80	74000	53174	72
Gulbarga	75000	9536	12.7	149000	42670	28.6
Raichur	69000	35889	52	139000	54256	39
Chikmagalur	20000	15336	76.6	60000	48999	81.6
D.Kannada	56000	4975	8.8	168000	6038	3.5
Hassan	34000	3415	10	102000	2262	2.2
Kodagu	10000	1963	19.6	30000	2592	8.6
Mandya	36000	24354	67.6	108000	69560	64.4
Mysore	67000			155000		
State Total	1017000	503207	50.7	2437000	1133965	46.5

VITAMIN 'A' REPORT FOR THE YEAR 99-2000 IS AS FOLLOWS.(UPTO NOVEMBER-99)

District	Measles linked vit 'A' programme			Prophylaxis programme for 1-3 year children		
	Target	Achievement	%	Target	Achievement	%
Bangalore C.C	112000					
Bangalore (U)	26000					
Bangalore (R)	43000	22515	52	86000	67959	79
Chitradurga	31000	19985	64	62000	50377	81
Davangere	33000	19850	60	66000	49397	75
Kolar	57000			114000		
Shimoga	43000	10025	46	86000	64433	75
Tumkur	60000	30248	50	120000	85914	71
Belgaum	96000			192000		
Bijapur	41000			82000		
Bagalkote	39000			78000		
Dharwad	34000	19310	56	68000	59602	87
Gadag	23000	11965	52	46000	31122	67
Haveri	32000	20035	62	64000	33108	51
U.Kannada	25000	13488	54	50000	61994	124
Bellary	50000	16638	33	100000	35349	35
Bidar	35000			70000		
Gulbarga	76000			152000		
Raichur	40000	21317	53	80000	44735	56
Koppal	29000	6157	21	58000	9465	16
Chikmagalur	20000			40000		
D.Kannada	30000	13561	45	60000	64798	108
Udupi	21000	6551	31	42000	26533	63
Hassan	32000	12312	38	64000	50730	79
Kodagu	9000	6978	77	18000	27176	150
Mandya	34000	20541	60	68000	49062	72
Mysore	56000	25349	45	112000	77996	69
Chamarajnagar	22000	6982	31	44000	19121	43
State Total	1149000	313777	27	2298000	909871	39

The progress of ICDS programme for 97-98, 98-99 & 99-2000 (upto october-99) is as follows:

1997-98

(a) Sectoral level Training conducted by MOs:

Quarter	Target	Achievement	Percentage
I	5562	4137	74
II	5562	4291	79
III	5562	3016	54
IV	5562	4383	79

(b) Anganwadi centres visited by MOs for Health check-up:

Quarter	Target	Achievement	Percentage
I	39855	24627	62
II	39855	25417	64
III	39855	17815	44
IV	39855	28882	72

1998-99

(a) Sectoral level Training conducted by MOs:

Quarter	Target	Achievement	Percentage
I	5562	3841	69
II	5562	3042	54
III	5562	2781	50
IV	5562	3580	60

(b) Anganwadi centres visited by MOs for Health check-up:

Quarter	Target	Achievement	Percentage
I	39855	22127	55
II	39855	24001	60
III	39855	24111	61
IV	39855	25440	64

1999-2000

(a) Sectoral level Training conducted by MOs:

Quarter	Target	Achievement	Percentage
I	5541	2836	51
II	5541	2822	53

(b) Anganwadi centres visited by MOs for Health check-up:

Quarter	Target	Achievement	Percentage
I	39855	24898	62
II	39855	24472	61

National Iodine Deficiency Disorders Control Programme.

The National Iodine Deficiency Disorders Control programme was initiated during 1988-89 in the state Health Directorate as 100% centrally sponsored scheme inorder to control Iodine Deficiency Disorders.

In the first phase initial surveys were conducted in all the 20 districts and four districts i.e., Chikkamagalur, Dakshina kannada, Uttara kannada and Kodagu districts were identified as endemic districts having more than 10% prevalence of Goitre.

Implementation of the control programme.

In the second phase the programme was implemented in the identified four endemic districts through issue of Gazette Notification banning the sale of non-iodised salt under PFA and simultaneously arranging for provision of iodised salt, Since consumption of Iodised salt is the most effective and cheapest method of preventing Iodine Deficiency Disorders, The ban notification is in force in the entire state since August-95 at present

Educational activities/Training programme.

In order to create awareness among the community about the importance of iodised salt for prevention of Iodine Deficiency Disorder, intensive Health Education Activities have been takenup through printing and distribution of education materials like flip books, Posters, Flash cards, Danglers, stickers, Flukards Pamphlets etc.,

Motivation campaign were organised in the endemic districts inorder to develop interaction between the IDD experts and the officers concerned with NIDDCP.

District level and taluk level buyers and sellers meet were also organised in endemic districts to sort out the problems of the whole sellers and other merchants of salt.

11323 Health functionaries from 27 districts were trained on IDD Control programme and also about the methodology of testing iodised salt with the help of field testing kits.

During October 96 the state level convention on IDD was also held at Bangalore.

In view of the Global IDD day different Health Education activities were undertaken in the district as well as in the state head quarters.

Prevision of Iodised salt.

The Director of Food & Civil Supplies have been requested to supply iodised salt through PDS and also to ensure sufficient quantity of iodised salt in the entire state.

Quality control.

Inorder to monitor the quality of iodised salt supplied at different level also the district health and F.W. officer have been requested to collect samples of salt under PFA and also Non PFA and semt to Public Health Institute, Bangalore for analysis.

Samples of salt analysed under PFA.

Year	Total	Satisfactory	Not satisfactory
97-98	14	14	-
98-99	36	35	1
99-2000 (upto Nov 99).	16	16	-

Samples of salt analysed under Non-PFA.

Year	No. of salt samples analysed	satisfactory	Notsatisfactory
97-98	251	171 (68.1%)	80 (31.2%)
98-99	932	385 (62.8%)	349 (37.2%)
99-2000 (upto Nov 99)	477	278 (58.3%)	199 (41.7%)

Samples of salt tested with the help of field testing kits by Health functionaries.

No. of samples of tested	Total	above 15 PPM	Below 15 PPM	0 PPM
97-98	12,59,466	4,50,225 (35.8%)	3,76,248 (29.9%)	4,32,983 (34.3%)
98-99	10,19,702	4,09,511 (40.16%)	3,51,369 (34.40%)	2,58,822 (25.38%)
99-2000 (upto Nov 99)	5,29,355	2,04,185 (38.6%)	1,87,694 (35.4%)	1,37,676 (26%)

MOnitoring: The DH & FWO have been requested to review this programme during the monthly meeting and also report new goitre cases every month.

State level co-ordination committee.

State level co-ordination committee with Health Secretary as Chairman has been formulated during 1988 for reviewing the activities of NIDDCP. So far eight meetings were held.

ComH. 70.6

VIEWS SUBMITTED BY ME TO THE TASK FORCE COMMITTEE FOR HEALTH DEPARTMENT

by Dr Siddeppuda Mun Corp Health Offic

Administration in Health & Family Welfare Departments :

Since 1993 administrative skill has diminished both in Health Management & Medical Care.

Reason :- D.H.O's, Dy.Directors, Principals, District Surgeons and all other equalent posts are filled up purely on seniority basis (who have already got time bond promotion).

The above posts are occupied by Medical graduates who are in the fag end of their service and without any administrative exposure. As a result of this the Ministerial staff will take the upwhand & misguide the Administration.

Solutions suggested :- These posts should be filled up on promotion based on merit-cum-seniority.

For curative service :-

Clinical post graduation (1) degree or diploma if there are no eligible candidate in the I catogory.

For Health Administration & Training - Degree in community Medicine or if there are no eligible candidate diploma.

By doing as above, it can be ensured fair length of service and it is possible to give and ~~equanto~~ adequate training in the respective field.

The posts of District Surgeons, D.H.O.'s, Dy.Directors, Principals should be up graded to the level of Joint Directors to maintain proper Administrative Heirarchy.

The posts of Divisional Joint Directors should be made equal to Additional Directors.

This kind of arrangement will ensure ~~an~~ clinical P.G. course. to all

All posts starting from Secretary of Health & Medical Department should filled on promotion out of Health & Medical professionals only to avoid; the delay in technical matters

.....2/-

(1) Techno Administrative

(2) Frequent change of Secretaries

(3) Bring about uniformity & maintain it in this Techno administration

(4) Frequent change of top administration will bring ideas from previous departments & tries to implement and fail to do so - do to wide variation that exists between departments.

Departmental heads have to apprise the Secretary in every aspect, which consumes lot of his valuable time. Whatever may be the competition of the Secretary, we may aquire superficial knowlelge only. So it is necessary to have departmental officer as Head of the Department.

Rural Health / in the Z.P. set up

At present District Health Administration has almost collapsed, Since 1987. This is because Health Department at District Level comes under Z.P. There is lot of interference in Health Administration with regard to Transfer, C.C.D. & Desciplinary action etc. District Health Officer cannot devote much time for Technical work, - Supervision & Audit etc. This is because of immunerable number of meetings frequent Discussions of the Officers of Z.P.'s for discussion. As a result of this there is no respect for D.H.O.'s and there is no desciplance in the Department. accounts is a mess . Purchase of drugs is not on need based. There is interference in all aspects of administration.

Solution :- It is necessary to remove Health Department from Z.P. set up.

FOOD ADULTERATION :-

It is time to review the P.F.A. programme. At present adulteration rate Ranges between 1% to 20%. This is highly alraing. At present there is no broad based P.F.A. set up eighteen state Health Department or in the Municipalities.

.....3/-

It P.F.A. Act is not implemented in right earnestness. Food adultration will course visible public health hazards within a few years from 2000.

Suggestion :-

(1) Officers incharge of District Health Administration, should be the for carrying out P.F.A. Act. For this there must be one qualified food inspector for each of the Taluk, and the Taluk Melical Officer must be made local health authority.

(2) There must be one Health Officer in all Municipalities having more than one lakh population. Health Officer must discharge all the duties in the duties of Local Health Authority.

Health Administration in Municipalties:

More than 30% of population of the State live in the cities. Out of this 20% to 30% of live in slums.

Health programmes & sanitation is being under taken by local bodies. In most of the Municipalities there programmes are being implemented by non technical officers & officials. Therefore it is necessary to post one Health Officer with Medical graduation to each of the Municipalities having more than one lakh population and adequate para medical staff has to be provided. The Food Inspectors, Senior Health Inspector, Junior Health Inspector and A.N.M.'s etc.

P O L I C Y :-

1. (1) Staying in the respective Head Quarters to all Medical and Para Medical Officers & Officers must be made compulsory by giving adequate compensation. The movements of each such official has to be watched through Internet Programme and monitored by Divisional vigilance squad and action should be initiated against defaulters.

....4/-

(2) N.P.A. to the extent of 1/3 of the Basic Pay has to be given to all administration officers including District Surgeons, R.M.O.'s, D.H.O's, D.D's, Principals, J.D.'s A.D's etc., to bar them from practice.

(3) Rural allowance of 1/3 of Basic Pay may be given to rural Doctors to make them to stay in the rural areas.

(4) It should be made compulsory to make their own arrangements for residential accommodation in the absence of Government quarters.

II. Auditing of Accounts & Material is very very inadequate. It is necessary to establish Internal Audit team at District & Divisional level Headed by A.C. of State Accounts & Controll by the respective Head of the District.

III. There must be Divisional Vigilance squad headed by Divisional level Health Department Officers to check monitor & regulate the working of the department empowering the squad to take spot action on the defaulters/offenders/irregular, etc.

IV. All Officers should be equiped with computers for proper record keeping & easy to the records including statistics of staff expenditure & equipments etc., through computer programming.

C-518-4
29/11/2005

GOVERNMENT OF KARNATAKA

BASIC MINIMUM SERVICES

DEPARTMENT OF HEALTH AND FAMILY WELFARE SERVICES
BANGALORE

BASIC MINIMUM SERVICES

INTRODUCTION

1.1 A basic health care service is understood to be a new-work of co-ordinated peripheral and intermediate health units capable of peforming effectively a selected group of functions essential to the health of an area and assuring the availability of competent professional and auxiliary personnel to perform these functions.

1.2 The national norm for a sub-centre vary between 3000-5000 population depending upon terrain and location. Similarly, there should be one Primary Health Centre for every 30,000 rural population in the plains and one Primary Health Centre for every 20,000 population in hilly, tribal and backward areas for more effective coverage. There should also be one Community Health Centre, for every four PHCs, with 30 beds and specialists in Surgery, Medicine, Gynecology, Paediatrics,with X-Ray and Laboratory facilities. The District-wise number of Primary Health Centres and Community Health Centres in the State, is given in Annexure-I.

1.3 According to Section 184 of the Karnataka Panchayat Act,1993, read with Schedule 3 of the Act, management of the hospitals and dispensaries, excluding the hospitals and dispensaries under the management of the Government or any other Local Authority, implementation of Maternal and Child Health Programme, implementation of Family Welfare Programmes and implementation of Immunisation and Vaccination Programme are the functions of the Zilla Panchayats.

1.4. Establishment of new PHCs and CHCs are proposed by the Zilla Panchayats and sanctioned by the State Government. Sanctions are normally accorded on the last day of the financial year and many a times the PHCs sanctioned are different from those proposed by the Zilla Panchayats. A large number of PHCs, which have been sanctioned in the recent past, are yet to become functional. Buildings are yet to be constructed and the staff, as per the norms, is yet to be sanctioned to these newly sanctioned P.H.Cs.

1.5. Since the Sub-centres and PHCs in the State are much more than as per the national norms, the emphasis should be on making the already sanctioned Sub-

centres and PHCs functional by construction of buildings, sanction of staff, providing equipment, etc.

2. PLANNING COMMISSION ON BASIC MINIMUM SERVICES.

2.1. During discussions with the Planning Commission, it has been pointed out that taking cognisance of the widening disparities among the States in the availability of Basic Minimum Services(BMS),the Conference of Chief Ministers in July,1996, recommended that Additional Central Assistance(ACA) may be provided to the States for correcting the existing gaps in the provision of seven Basic Minimum Services; that of these, access to primary health care, safe drinking water and primary education were given higher priority with the mandate that universal access to these services is to be achieved by 2000 A.D., that unlike the Minimum Needs Programme, which provides funds only for rural primary health care, BMS includes primary health care in urban and rural areas; that in order to ensure that adequate investments are made for BMS sectors, minimum adequate provision(MAP) was calculated on the basis of Actual Expenditure for 1995-96 + ACA + 15 per cent of ACA as State's share, that the State Government must also ensure their share of 15 per cent for BMS; that failure to allocate and utilise MAP requirement would result in curtailment of Central Assistance in the following year; that during the Ninth Plan funds will be ear-marked for urban and rural primary health care under the name BMS(instead of MNP); that this ear-marked amount will include BMS allocation from state budget and that since primary health care is one of the priority areas identified under BMS the State Health Department may obtain upto 20 per cent of the ACA for BMS for bridging infrastructural gaps in primary health care.

2.2. The Planning Commission has, among other things, emphasised the following:

a) While computing the requirements for primary health care infrastructure for the growing population, the fact that the population increase has occurred in and around the already established centres have to be kept in mind. Since the already established physical infrastructure cannot be shifted, and it will be difficult to add additional centres to serve the population in geographically convenient locations, it would be more feasible to increase the number of functionaries required to cater to the population's need rather than increase the number of centres.

b) During the Ninth Plan period the States shall restructure the existing sub-district/taluk hospitals and block level PHCs into functioning CHCs to the extent possible.

c) Existing rural hospitals and dispensaries have to be restructured to PHC/Sub-centre.

d) The poorly peforming districts should be identified and essential funds provided to meet their requirements so that the existing gap in the health and demographic indices among these districts could be minimised.

e) A flexible approach to the recruitment of staff, if necessary on contract basis, will be adopted to ensure that the programmes do not suffer due to lack of key personnel.

f) There is a lack of critical manpower in primary health care institutions. The number of sanctioned posts of Male Multipurpose Workers is only half the number required. This has been cited as one of the major factors responsible for the suboptimal performance in Malaria and T.B.Control programmes. It is essential that necessary administrative steps are taken to fill the gap in Male Multipurpose Workers.

g) A substantial proportion of specialists posts even in functioning CHCs are vacant. Hence these CHCs are unable to function as First Referral Units. In view of serious implications of this lacuna in the establishment of referral system, as well as effective provision of health,MCH/ F.P.Care, there is urgent need to rectify this.

h) At the moment there is no post of Anaesthetist in the CHCs. Services of Anaesthetists are vital because without an anaesthetist emergency/routine surgery in CHCs will not be possible. Attempts may be made to provide this critical manpower.

i) Services in primary health care facilities are also affected due to lack of maintenance of equipment/vehicle and inadequate supply of drugs.

3. CONSTRUCTION OF BUILDINGS FOR SCs, PHCs and CHCs:

District-wise requirement of funds, for providing buildings to these centres, is shown in Annexure-II.

4.PROVIDING STAFF TO PHCs AND CHCs AS PER NORMS:

4.1 The PHCs sanctioned since 1989-90 and the CHCs have not been provided with full complement of staff. To make these centres fully functional, the following staff is required to be sanctioned.

For PHCs	For CHCs
1. Block Health Educator.	1. Paediatrician
2. Senior Health Assistant(Male)	2. Gynecologist
3. Senior Health Assistant(Female)	3. Surgeon
4. Staff Nurse	4. Dental Surgeon
5. Junior Health Assistant(Female)	5. Office Superintendent
6. First Division Assistant	6. X-Ray Technician
7. Second Division Assistant	7. Staff Nurse
8. Group 'D	8. Pharmacist
	9. Typist-cum-Clerk
	10. Second Division Assistant
	11. X-Ray Attender
	12. Lab. Attender
	13. Helper for every 3 beds
	14. Cook
	15. Dhobi

4.2. In addition, the post of Anesthetist is also required to be sanctioned to the CHCs. The recurring expenditure on the staff to be sanctioned, district-wise, is shown in Annexure-III.

5. MALE MULTIPURPOSE WORKERS:

As against the requirement of 8143 male multipurpose workers, there are only 6352 sanctioned posts. Hence, 1791 posts of male multipurpose workers will have to be sanctioned. The recurring cost, district-wise, for these posts are shown in Annexure-IV.

6. SUPPLY AND MAINTENANCE OF EQUIPMENT, FURNITURE, DRUGS, Etc.

Funds for supply and maintenance of equipment, furniture, drugs, etc., are now available, to some extent, under the Externally Aided Projects like I.P.P.-IX, KHSDP,

RCH, etc. However, once these projects are over, adequate funds, for this purpose,will have to be provided in the budget.

7. TOTAL ESTIMATED REQUIREMENT OF FUNDS FOR BMS (RURAL).

As of now, the total estimated requirement of funds for providing the basic minimum services, in rural areas, is Rs.389.52 crores (including recurring costs of Rs.85.51 crores). This amount may be provided over a period of 2-3 years. Since, as already pointed out earlier, primary health care services are basically in the Zilla Panchayat sector, the funds required will have to be provided to the Zilla Panchayats.

ANNEXURE-I

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		57	12
4	Davangere	458	70	7
5	Kolar	375	82	13
6	Tumkur	418	97	10
7	Shimoga	380	55	9
8	Belgaum	598	135	15
9	Bijapur		65	8
10	Bagalkote	456	46	10
11	Dharwad		28	3
12	Gadag		29	6
13	Haveri	596	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		47	5
19	Koppal	378	43	9
20	Mysore		96	15
21	Chamarajnagar	690	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		64	7
27	Udupi	708	63	6
	TOTAL	8143	1676	249

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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 con structed	Amount required	No.of CHC Buildings to be con structed	Amount required	Total amount required (Total of Col.No.(4)+(6)+(8)
1	2	3	4	5	6	7	8	9
1	Bangalore U	-	-	-	-	-	-	-
2	Bangalore R	88	396.00	31	558.00	4	300.00	1254.00
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	-	-	603.00
6	Tumkur	190	855.00	28	504.00	5	375.00	1734.00
7	Shimoga	105	472.50	26	468.00	3	225.00	1165.50
8	Belgaum	160	720.00	31	558.00	3	225.00	1803.00
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	225.00	4	72.00	1	75.00	372.00
12	Gadag	90	405.00	10	180.00	1	75.00	660.00
13	Haveri	98	441.00	17	306.00	4	300.00	1047.00
14	Uttara Kannada	223	1003.50	10	180.00	4	300.00	1483.50
15	Gulbarga	265	1192.50	59	1062.00	3	225.00	2479.50
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	1302.00
19	Koppal	102	459.00	13	234.00	2	150.00	843.00
20	Mysore	203	913.00	61	1098.00	3	225.00	2236.50
21	Chamarajanagar	161	724.50	-	-	3	225.00	949.50
22	Kodagu	66	297.00	-	-	4	300.00	597.00
23	Mandya	170	765.00	18	324.00	5	375.00	1464.00
24	Hassan	259	1165.00	33	594.00	5	375.00	2134.50
25	Chikmagalur	220	990.00	22	396.00	2	150.00	1536.00
26	Dakshinna Kannada	-	-	2	36.00	3	225.00	261.00
27	Udupi	289	1300.50	23	414.00	1	75.00	1789.50
	TOTAL	3453	15538.50	509	9162.00	76	5700.00	30400.50

ANNEXURE-III

Rs. in lakhs

Sl No	Name of the District	Amount required for the staff to be sanctioned to PHCs as per norms	Amount required for the staff to be sanctioned to CHCs as per norms	Amount required for the post of Anaesthetist to be sanctioned to CHCs.	Total amount required per annum as recurring expenditure.
1	2	3	4	5	6
1	Bangalore U	62.95	-	2.90	65.85
2	Bangalore R	255.65	76.68	8.70	341.03
3	Chitradurga	206.95	76.68	15.95	299.58
4	Davangere	243.52	58.26	5.80	307.58
5	Kolar	229.17	-	11.60	240.77
6	Tumkur	320.72	97.10	11.60	429.42
7	Shimoga	207.16	58.26	7.25	272.67
8	Belgaum	501.58	58.26	15.95	575.79
9	Bijapur	241.18	19.42	10.15	270.75
10	Bagalkote	152.22	76.68	10.15	239.05
11	Dharwad	98.28	19.42	4.35	122.05
12	Gadag	99.21	19.42	8.70	127.33
13	Haveri	147.92	76.68	15.95	240.55
14	Uttara Kannada	151.09	76.68	13.05	240.82
15	Gulbarga	346.99	58.26	23.20	428.45
16	Bellary	183.59	38.84	11.60	234.03
17	Bidar	107.96	19.42	7.25	134.63
18	Raichur	164.93	97.10	7.25	269.28
19	Koppal	151.87	38.84	13.05	203.76
20	Mysore	351.15	58.26	18.85	428.26
21	Chamarajanagar	141.82	58.26	4.35	204.43
22	Kodagu	76.40	76.68	4.35	157.43
23	Mandya	240.74	97.10	10.15	347.99
24	Hassan	298.14	97.10	17.40	412.64
25	Chickmagalur	156.84	38.84	5.80	201.48
26	Dakshina Kannada	176.52	58.26	8.70	243.48
27	Udupi	179.91	19.42	5.80	205.13
	TOTAL	5494.46	1469.92	279.85	7244.23

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ANNEXURE-IV

Rs. in lakhs

Sl No 1	DISTRICT 2	Total No. of Male MPWs required as per norms 3	Existing No. of sanctioned post 4	Balance No. of posts to be sanctioned 5	Recurring expenditure per annum for the post in Col.No.5 6
	BANGALORE DIVISION				
1	Bangalore	140	130	10	7.30
2	Bangalore Rural	286	235	51	37.23
3	Chitradurga	132	107	25	18.25
4	Davangere	326	198	128	93.44
5	Kolar	375	282	93	67.89
6	Shimoga	380	249	131	95.63
7	Tumkur	418	398	20	14.60
	TOTAL				
	BELGAUM DIVISION				
8	Bagalkot	161	121	40	29.20
9	Belgaum	598	416	182	132.86
10	Bijapur	295	284	11	8.03
11	Dharwad	174	125	49	35.77
12	Gadag	126	91	35	25.55
13	Haveri	296	211	85	62.05
14	Uttara Kannada	316	280	36	26.28
	TOTAL				

PTO

Sl No	District	3	4	5	6
	GULBARGA DIVISION				
15	Bellary	264	241	23	16.79
16	Bidar	231	182	49	35.77
17	Gulbarga	512	452	60	43.80
18	Koppal	172	163	9	6.57
19	Raichur	206	165	41	29.93
	TOTAL				
	MYSORE DIVISION				
20	Chamarajanagara	202	131	71	51.83
21	Chickmagalur	335	305	30	21.90
22	Dakshina Kannada	456	323	133	97.09
23	Hassan	463	332	131	95.63
24	Kodagu	163	94	69	50.37
25	Mandya	376	320	56	40.88
26	Mysore	488	330	158	115.34
27	Udupi	252	187	65	47.45
	TOTAL				
	STATE TOTAL	8143	6352	1791	1307.43

ANNEXURE-IV

Rs. in lakhs

Sl No 1	DISTRICT 2	Total No. of Male MPWs required as per norms 3	Existing No. of sanctioned post 4	Balance No. of posts to be sanctioned 5	Recurring expenditure per annum for the post in Col.No.5 6
	BANGALORE DIVISION				
1	Bangalore	140	130	10	7.30
2	Bangalore Rural	286	235	51	37.23
3	Chitradurga	132	107	25	18.25
4	Davangere	326	198	128	93.44
5	Kolar	375	282	93	67.89
6	Shimoga	380	249	131	95.63
7	Tumkur	418	398	20	14.60
	TOTAL				
	BELGAUM DIVISION				
8	Bagalkot	161	121	40	29.20
9	Belgaum	598	416	182	132.86
10	Bijapur	295	284	11	8.03
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12	Gadag	126	91	35	25.55
13	Haveri	296	211	85	62.05
14	Uttara Kannada	316	280	36	26.28
	TOTAL				

PTO

Sl No	District	3	4	5	6
	GULBARGA DIVISION				
15	Bellary	264	241	23	16.79
16	Bidar	231	182	49	35.77
17	Gulbarga	512	452	60	43.80
18	Koppal	172	163	9	6.57
19	Raichur	206	165	41	29.93
	TOTAL				
	MYSORE DIVISION				
20	Chamarajanagara	202	131	71	51.83
21	Chickmagalur	335	305	30	21.90
22	Dakshina Kannada	456	323	133	97.09
23	Hassan	463	332	131	95.63
24	Kodagu	163	94	69	50.37
25	Mandya	376	320	56	40.88
26	Mysore	488	330	158	115.34
27	Udupi	252	187	65	47.45
	TOTAL				
	STATE TOTAL	8143	6352	1791	1307.43

ನಿರ್ದೇಶಕರು
ಆರೋಗ್ಯ ಮತ್ತು ಕು.ಕ. ಸೇವೆಗಳು

Human Development in Karnataka 1999

Fulfilling Basic Human Needs – Issues and Concerns

Sanjay Kaul

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Fulfilling basic human needs - issues and concerns

Where do we stand?

HDI for major states

- Andhra Pradesh: 0.400 (9)
- Assam: 0.379 (10)
- Bihar: 0.354 (13)
- Gujarat: 0.467 (5)
- Haryana: 0.489 (4)
- Karnataka: 0.448 (7)
- Kerala: 0.603 (1)
- Madhya Pradesh: 0.349 (14)
- Maharashtra:0.523 (3)
- Orissa:0.373 (11)
- Punjab: 0.529 (2)
- Rajasthan: 0.356 (12)
- Tamilnadu: 0.438 (8)
- Uttar Pradesh: 0.348 (15)
- West Bengal: 0.459 (6)
- INDIA: 0.423

HDI Ranking of Districts

- Kodagu : 0.630
- Bangalore Urban: 0.601
- Dakshina Kannada: 0.592
- Uttara Kannada: 0.533
- Chikmagalur: 0.524
- Shimoga: 0.483
- Hassan: 0.473
- Bangalore Rural: 0.472
- Belgaum: 0.471
- Chitradurga: 0.466
- Dharwad: 0.459
- Tumkur: 0.447
- Mandya: 0.444
- Bijapur: 0.443
- Kolar: 0.443
- Mysore: 0.440
- Bellary: 0.429
- Bidar: 0.419
- Gulbarga: 0.388
- Raichur: 0.376

STATE: 0.471

Key Indicators

- Sex ratio – 960 (1991)
- Infant mortality rate – 51 (1998)
- Maternal mortality rate – 450 (1995)
- Life expectancy at birth – 62.5 (91-95)
- Literacy rate – 56% (1991 census)
- Per capita income – Rs. 2551 (80-81 prices)
- % children in age group 6-14 attending schools – 65.3 (rural); 82.4 (urban) (1995)

The major issues

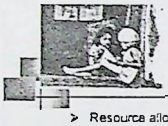
- Budget allocation – inadequacy and imbalance in expenditure
- Access and equity
- Quality of services
- Institutional framework
- The way forward

The major sectors

- Health
- Education
- Income, Employment and Poverty
- Housing and sanitation
- Drinking water

Social Sector Allocations

- Karnataka's Public Expenditure Ratio (PER) is 19% [PER is revenue expenditure as % of SDP];
- Of this, Social Allocation Ratio(SAR) is 39%. [SAR is revenue expenditure on social services as % of total revenue expenditure];
- Kerala and West Bengal are the only major states where SAR has been over 40%.
- Health: 5% of the state budget and 1% of GDP.
- Education:16% of state budget and 3% of GDP.
- Share of social sectors in plan outlays woefully small.



Imbalance in expenditure

- Resource allocations to districts governed by recommendations of State Finance Commission.
- 36% of non-loan gross own revenue receipts are transferred to rural and local bodies in the ratio of 85:15. This puts a cap on the resource flow: in a year when tax collections are poor as in the current year resource transfers are much less than budgeted.
- Non-plan expenditure is committed expenditure: districts which for historical reasons have better infrastructure and have higher ranks in human development have a greater share in non-plan outlays, which get protected during budget formulation.
- Allocations to districts are on a predominantly per capita approach. The relative needs of districts will have to become the starting point for rational and objective decisions on fund allocation.
- Better off districts must accept the economic interdependence of regions; faster growth in Raichur will have beneficial spin off effects on Dakshina Kannada and Raichur too.

Access - Health

- Number of PHCs per lakh population is 4.64 against norm of 3.33;
- Government medical institutions per lakh population is 5.13; total no:2624;
- Number of beds per lakh population is 86;
- Growth rate of institutions since 1960 is over 3%.
- However, uneven growth across districts – northern districts relatively poorly served.

Access - Education

- The number of primary schools has gone up from 25800 in 1960 to over 46900. Norms require setting up of a school for every habitation with a population >200.
- Over 96% of children have a primary school within one kilometre and over 85% have an upper primary school within three kilometres.
- Enrolment in primary schools exceeds 8.2 million.
- Drop-out rates have declined from 69% in 1950 to 16.5%. In respect of girls the decline has been from 73% to 17%
- Overall gross enrolment ratio for classes I to VII has gone up from 66 in 1980 to 92.
- Girls participation has moved up from 44.5 in 1980 to 48 in respect of classes I to IV and from 39 to 45 in respect of classes I to VII.
- And yet...2.6 million children comprising 28% of children in 6-14 age group are out of school.

Access- Housing

- The housing stock has almost doubled from 4.2 million to 7.9 million between 1961 to 1991.
- Housing stock has increased @ 30% in the last decade, with the annual growth rate being 3%.
- Housing shortage is 9.8% (0.3 million); does not include 8% kacha houses.
- Only 34% of households have access to toilets – in rural areas the position is dismal with only 6.85% having toilets – in urban areas the percentage is around 62.5%.

Access – Drinking Water

- 67% of rural population have access to safe drinking water of over 40 lpcd; 30% have access between 10-40 lpcd; 3% have no access or access less than 10 lpcd;
- 93% of the 205 urban towns have water supply less than prescribed norms – i.e. 135 lpcd for towns with population in excess of 1 lakh, 100 lpcd for towns between 20,000 and 1 lakh; and 70 lpcd for towns less than 20,000;

Access - Income

- Growth in incomes is inextricably related to:
- Earning capacity which is linked to educational and health status.
- Earning opportunities which is linked to the growth patterns, nature of employment, productivity and access to credit.
- State income (NSDP) has increased from Rs.2977 crore to Rs.13047 crore, > 4-fold increase (1980-81 prices). The fastest increase has been in the tertiary sector - share has increased from 25% to 43%.
- P/c income has only doubled in real terms from Rs.1273 to Rs.2668.
- Work force has increased from 15 million to 19 million – i.e @ 2.6% - Female work force has increased at a higher rate of 4%
- Share of females in main workers increased from 25 to 29%.
- 33% of the work force in secondary and tertiary sectors contributed 65% of the state income. However, 85% of work force continues to be in the primary sector.

Quality of Services - Health

- Only 38% of live births take place in institutions;
- Measles immunisation coverage less than 50%;
- Nearly 60% of children with diarrhoea are not given ORS;
- 54% of children under four are underweight
- Bed occupancy in PHCs is as low as 11.9%;Lack of proper integration of PHCs with higher level facilities;
- Many patients go directly to secondary and tertiary level facilities;
- Large vacancies aggravated by cumbersome recruitment procedures;
- Unauthorised absence and indiscipline in work force symptomatic of deeper malaise of dissatisfaction with postings and areas of work;
- Human resource development neglected;
- In the private sector lack of effective regulation of unlicensed and unregistered practitioners who cheat the public;
- In family welfare virtual absence of male participation;
- Limited access to poor, women and SC/ST.

Quality of Services – Literacy & Primary Education

- Literacy programmes not sustained despite good work in the early years; Rural female literacy in Raichur is a dismal 16.48%.
- Uneven quality of services in primary schools – teacher-pupil ratios vary across districts;
- 2.6 million children out of school engaged in work
- Majority of children do not achieve the prescribed achievement levels – multi-grade teaching is the norm and teachers are not equipped to deal with such situations;
- However, DPEP interventions have shown that remarkable results are possible in a short time with appropriate strategies;
- Lack of community participation – setting up of grama panchayats by themselves not enough;
- Many primary schools lack adequate classrooms;

Quality of Services – Secondary & Higher Education

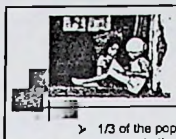
- In high schools only 49% have toilets, 37% have laboratories and 15% have libraries;
- Only 389 out of nearly 2000 pre-university institutions offer a science combination;
- Only 60 out of 148 government first grade colleges have their own buildings;
- Expenditure on libraries only 1.4% as against 15% of the budget spent on conducting examinations;
- Salaries take away another 67% leaving very little for infrastructure, training etc.

Quality of services – income, employment and poverty alleviation

- Employment generation programmes have had limited impact – no significant shift in work force away from the primary sector and only marginal increase in labour productivity inspite of 40% of plan allocations on agriculture and irrigation;
- Lack of an integrated approach and limitations of organisational and delivery systems;
- Corruption and lack of transparency in implementation of schemes has had adverse impact;
- Poverty alleviation requires a multi-dimensional approach;
- Programmes must be designed by involving civil society and poor people themselves;
- Inspite of large regional variations in poverty levels – from 56% in Bidar to 16% in Dakshina Kannada – employment and poverty alleviation programmes have adopted a per capita rather than a "needs-based" approach.

Quality of services – housing and sanitation

- Though there has been impressive growth in the number of dwelling units, quality of housing remains a matter of concern;
- In most districts, 70% of houses has one (or at best two) room;
- Only 30.5% houses in rural areas are made of 'pucca' materials – 20% are "kucha";
- Houses constructed under government programmes do not involve beneficiaries and result in poor quality construction by contractors;
- Only 41% of rural houses have electricity and only 7% have toilets; even when toilets are constructed dearth of water results in the toilet falling into disuse;
- In urban areas, the slum population, estimated at over 15% live without basic amenities – inadequate access to water and virtually no sanitation. Urban housing projects, both in public and private sectors do not cater to the urban poor; the so-called LIG housing can be accessed only by the lower middle class;
- Majority of population in Karnataka defecates in open public places;

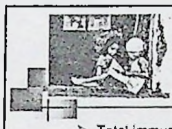


Quality of services – water supply

- 1/3 of the population does not have access to potable drinking water even unto the minimum 40lpcd;
- 1300 habitations do not have public sources of water supply;
- In 4500 habitations groundwater is not potable as it contains high levels of chemicals like fluoride and iron;
- As 97% of water supply schemes depend on ground water supply, progressive decline in the water table raises questions of sustainability;
- Another aspect of sustainability is the management of facilities; local communities have not been enabled to manage O&M; energy charges remain unpaid for months together.
- In urban areas the challenge is even greater – ground water has become contaminated – alternative sources of surface water require heavy investment – existing distribution systems require major rehabilitation with almost 40-50% being the distribution losses – revenue recovery is negligible and does not even pay for routine O&M.

Institutional Framework – basic propositions

- Bureaucratic structures are less flexible and responsive compared to structures which allow for public participation; government structures require to be brought closer to the people;
- Grassroots organisations have to be promoted and encouraged – both within government through local bodies and outside through NGOs;
- Increasingly public accountability is getting reduced and non-performers hardly ever brought to book; lack of transparency characterises implementation of most government schemes;
- Panchayat Raj has brought in improvements but the decentralised system has yet to fully mature and become accountable – several instances of local vested interests and caste considerations undermine the positive impact;
- Government must approach NGOs with trust and confidence recognising that while they may not provide replicable models of development (on account of the limited scale in which they operate) they do provide very rewarding learning experiences.
- Self-help groups provide another route to promote grassroots participation and empowerment specially among women.



The future beckons - Health

- Total immunisation coverage needs to be focused on – measles coverage needs special attention;
- Health education needs to be taken up in a campaign mode to combat killer diseases like diarrhoea, and AIDs;
- Better nutrition and health indicators for women can radically improve the health indices for the state;
- Health sector reform needs to focus on ensuring a proper integration and linkages at the three levels;
- Uneven development of health infrastructure compounded by a poor delivery system is a major reason for the poor health indicators in the Northern districts; a serious problem is to ensure staff go to less developed areas – perhaps a judicious combination of incentives and deterrents are required;

The future beckons – Education

- Much greater attention is required to increase girl participation rates specially in the Northern districts;
- Universalisation of elementary education will require a multi-pronged strategy to reach the 2.6 million out-of-school children;
- Major reform in the education sector will have to focus on making the system child-centred – supervisory mechanisms and "inspector raj" culture will have to be dismantled to make way for a system which child and community friendly;
- Hard decisions to re-deploy teachers where they are needed will need to be combined with teachers' training programmes to make them facilitators and enable them to operate in a multi-grade situation;
- Every family must be enabled to demand education as a matter of right;
- At the same time the tempo of literacy campaigns and post-literacy programmes needs to be stepped up to reach those who have missed out on schooling.

The future beckons – Income and employment

- The general level of stagnation in the manufacturing sector has to be addressed by improving infrastructure and entrepreneurship;
- The concentration of women in poorly-paid jobs as both main and marginal workers requires to be rectified;
- Productivity gains in the primary sector are a pre-condition to improving income levels in the rural areas;
- While poverty levels have come down, the alarmingly high levels of urban poverty has received marginal attention and requires to be immediately tackled.

The future beckons – Housing, sanitation and drinking water

- Large investments are required in the next decade to meet the unmet housing needs in both urban and rural areas;
- Sanitation, specially in urban slums needs special focus;
- Rural water supply schemes can be sustainable in the long run only through community ownership;
- Urban water supply and sanitation systems can become viable only through realistic and rational fixation of tariff;
- Government strategy requires to consciously promote awareness on the linkages across water, sanitation, and health.

In conclusion

- If a perceptible dent is to be made in Karnataka's social and economic indices, improvement in the status of women must become central to all policy making –
- The issue of gender cuts across sectors This implies focus on girls' education; women's health, housing schemes designed with the involvement of women, and income and employment strategies to improve the earning capacity of women workers;
- The close interdependence of all the social sectors requires to be recognised – hence need to promote convergence at the village and grama panchayat levels;
- Resource allocation must be need based;
- Eventually people not governments must seize the initiative for development

Thank You

ComH-70.10

BRIEF NOTE ON THE PROGRAMMES OF THE DEPARTMENT OF INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY.

Indian Systems of Medicine and Homoeopathy is rendering medical relief to the public in Ayurveda, Unani, Yoga, Nature Cure and Homoeopathy System of Medicines and regulates Medical Education, Drugs Manufacture and practice of medicine in these systems.

There are 93 hospitals, 582 dispensaries and 63 colleges functioning in the state. All the dispensaries and 55 hospitals (40 Taluk Level, 15 Rural) are under the administrative control of Zilla Panchayaths. The remaining hospitals are under the state sector. Out of 63 colleges 58 are private colleges of which 5 are under grant-in-aid. The remaining 5 colleges are Government Colleges.

The budgetory provisions and expenditure of the last three years are as follows:-

1996-97:-

(Rupees in lakhs)

Particulars	Non-Plan		Plan		C.S.S.	
	B.E.	Expr.	B.E.	Expr.	B.E.	Expr.
State Sector	1034.15	865.49	140.00	110.95	6.00	6.00
District Sector	580.85	580.85	343.00	307.62	-	-
Total	**1615.00**	**1446.34**	**483.00**	**418.57**	**6.00**	**6.00**

1997-98:-

(Rupees in lakhs)

Particulars	Non-Plan		Plan		C.S.S.	
	B.E.	Expr.	B.E.	Expr.	B.E.	Expr.
State Sector	1196.35	1037.07	150.00	99.05	6.00	2.17
District Sector	982.27	982.27	311.49	89.89	-	-
Total	**2178.62**	**2019.34**	**461.49**	**188.94**	**6.00**	**2.17**

1998-99

(Rupees in lakhs)

Particulars	Non-Plan		Plan		C.S.S.	
	B.E.	Expr.	B.E.	Expr.	B.E.	Expr.
State Sector	1266.12	1052.69	200.00	128.69	6.00	4.23
District Sector	1121.93	1121.93	247.41	150.36	-	-
Total	**2388.05**	**2174.62**	**447.41**	**279.05**	**6.00**	**4.23.**

1999-2000:-

(Rupees in lakhs)

Particulars	Non-Plan		Plan		C.S.S.	
	B.E.	Expr.(Oct)	B.E.	Expr(Nov).	B.E.	Expr.(Nov)
State Sector	1513.43	805.81	270.00	143.70	8.00	3.51
District Sector	1318.97	Not available	238.07	118.03		
Total	2832.40	805.81	508.07	261.73	8.00	3.51

The achievements of the last three years are as follows:-

1996-97:-

1. A Divisional Office of Indian Systesm of Medicine and Homoeopathy has been sanctioned and functioning at Mysore.

2. A 10 beded Homoeopathy wing has been sanctioned and started functioning at Mysore.

3. Three Govt.Ayurvedic Dispensaries have been started.

1997-98:-

1. A Divisional Office of Indian Systems of Medicine and Homoeopathy has been sanctioned and functioning at Belgaum.

2. A 15 beded Govt.Ayurvedic Hospital has been sanctioned and functioning at Raichur.

3. The bed strength of Taranath Hospital,Bellary has been increased from 85 to 100.

4. A 10 beded Homoeopathy wing has been sanctioned and functioning at Govt.District Ayurvedic Hospital,Shimoga.

5. 21 Teaching Posts(Professor:14, Asst.Professor:02, Lecturer:05)have been sanctioned to I.S.M.& H.Colleges.

6. 5 Taluk Level Hospitals, 43 Dispensaries have been sanctioned and functioning under District Sector Scheme (Z.P)

7. P.G. Course under 100% CSS has been sanctioned and started at Bellary.

8. Administrative approval has been accorded for the construction of Govt.Unani Medical College with an estimated cost of Rs.75.00 lakhs.

1998-99:-

1. 126 posts of Physicians have been selected by KPSC and appointed by Government..

2. 1 Post of Drugs Inspector(Homoeopathy) has been sanctioned to Directorate of Indian Systems of Medicine and Homoeopathy.

3. A Divisional Office of Indian Systesm of Medicine and Homoeopathy sanctioned and functioning at Bangalore and essential staff to Divisional Office,Belgaum have been created.

4. The bed strength of Sri.Jayachamarajendra Institute of Indian Medicine (Unani Wing) has been increased from 75 to 100 and a 10 beded Homoeopathy wing has been sanctioned to Govt.Ayurvedic Hospital,Bijapur.

5. Two Ladies Hostels have been sanctioned one each at Mysore and Bellary and constructed.

6. Essential teaching posts (7 posts) have been sanctioned to ISM&H Colleges

DIFFICULTIES FACED BY THE DEPARTMENT;-

The Department of Indian Systems of Medicine and Homoeopathy was bifurcated from the Health Department during 1972. Consequent on the bifurcation of the department, the developmental activities are on increasing trend. However the budgetory allocation are not sufficient to improve further. At present there are 18 District Level Hospitals of ISM&H functioning. But there are many places including District Level in the State where ISM&H hospitals and dispensaries donot exist. The department is not in a position to start such hospitals and dispensaries due to paucity of funds. In this connection the kind attention is drawn towards the Estimate Committee Report for the year 1998-99 wherein the Committee has suggested to start District Level Hospitals in the remaining districts within three years and Taluk Level Hospitals in all the Taluk places within a period of five years. With a view to implement the suggestions sufficient budget allocation under State and District Sectors is required. In many hospitals bed strength could not be increased due to shortage of funds though demands for such increase is being received.

The department is planing towards establishment of Sanjeevini Vanas at District and Taluk Levels in co-ordination with the forest department. To implement this scheme, sufficient budget provision is required.

Director
Indian Systems of Medicine
and Homoeopathy.

Minute of Discussions between Directorate staff and others with Karnataka Task Force on Health.

Dr. Angadi S M,
Director of the India Systems of Medicine and Homeopathy,
Government of Karnataka

- Covers the systems of Ayurveda, Homeopathy, Naturopathy, Yoga and Siddha
- Three components – Health Services, Medical Education, Drugs Control
- 63 colleges exists; this is more than any other state; 5 in government sector; Staff position not sufficient even as per Council guidelines (Sanctioned 3327; 932 vaccant
- Examination system uniform; But the question of employability remains
- Practitioners - 15.000 in Ayurveda, 2295 in Integrated system. 75 in Naturopathy, 5914 in Homeopathy
- Bed strength utilisation - 75% in Teaching Institutions; 60% in Hospitals
- No norms for ISM practitioners to be on PHcs and PHUs; currently clinical work including National Health programmes and no Public Health Activity
- Other Problems include: ?Inferiority complex (ISM doctors will be left to look after the Health Care Units
- The staff requirement for ONE ISM Dispensary is ONE Doctor and ONE Group D; can cover 10,000 population; costs Rs1,80,000 per year; Doctors are waiting for appointments
- Main defect is in Budgetary allocation less than 1%; Pay scales not on par; Paucity of funds; No external aid as other projects; Hospitals in 18 districts; 38 taluq level; 20 sub taluq level with a total of 582 dispensaries
- Drug Testing Facility only at Ghaziabad need noe centre for the southern region

CONCERNS discussed during the interaction

1. Employability of the ISM graduate - possible no opportunity
2. Every Medical College, District and Taluq level an ISM wing separte and integrated down below
3. Add on to the existing infrastructure; Do not think as replacing
4. Dispensary need to be within 5 km radius otherwise no one utilises; to keep this in mind; Political sanctions
5. Can manage the patients with Ayurvedic medicines and without Paracetamol and such other drugs;
6. Evidence based programme being implemented
7. Research needed to incorporate the ISM drugs
8. No Problem with regards to integration (Dr P N Halagi)
9. Drugs / Medicines in ISM - Expiry date variable some more valuable with ageing, Quality Control is mandated by in-house quality control BUT difficult to and costly to monitor

Dr. P N Halagi,
Director of Health and family Welfare Services,
Government of Karanataka

- No other State in the country has a State policy for health
- 27 districts, 175 Taluqa, 27065 Inhabited Villages in FOUR Revenue Divisions of Karnataka
- Five crore population : 1 crore in 18 cities
- Bed Popln ratio: 1: 1139 against the norm of 1:1000
- 242 CHCs; 1676 PHCs: 583 PHUs and 8143 Subcentres
- Regional variation ++++ (Concentrated more in South than in North)
- Doctors are there but not available
- State has its own norms: One PHC for 25-30,000; 50 bed Taluq Hospital; 250 Bed district hospital
- Single unified post of Director of Health and Family Welafre unlike other states
- 25% of Doctors are females
- It is better to have family welfare services integrated with the health services; A new post of Additional Director of Health Services has been created for Primary Health Care. There is mal distribution of institutions; more institutions are needed in Northern Karnataka.

CONCERNS discussed during the interaction

1. Inequitable distribution of Public Health Care Institution + Mismanagement
2. Human Resources Development - Reluctance to serve in Rural areas
3. (ANMs being given Rs 18,000 Interest free loan Taught driving); ANMs overburdened with work; 583 ParaMedical workers to become JrHA(M) after the 1 week training; All JrHA trained in Malaria Microscopy; Posts not filled due to being Non-revenue
4. Administration and Clinical work of Doctors to go together; concept of Mother PHCs being implemented for restructuring the PHCs; Foundation course needed; MBBS doctor can deliver the goods; Need for proper supervision and accountability; checks and balances to be linked up; Yearly assessments along with self appraisal / annual confidence report;
5. Periodic Inservice training; accreditation of Training Programmes; Current training is Hospital based so need additional training in PHC System
6. Appointments and transfer issues; Incentive for Rural / Tribal and hilly areas
7. Doctors Day akin Teachers day and award for meritorious service; how about for all category of staff
8. Co-ordination and integration needed - Directorate headed by IAS / Gen Administrator , Additional Director technocrat; Taluq Health Officer established; Additional District Health Officer abolished; Integration needed between Education, Practice and Service

9. HMIS system; currently 34 reports are being sent being modified through NICNET
10. Telephone facility being made at PHCs better still selected PHCs to be 24hour PHCs with Wireless facility
11. Corruption: Need for decentralistaion; KHSDP has documented efficiency and also methods; Corruption index to be developed; Nursing Homes develop around Government Hospitals; Most doctors pratcice; allowed to practice in ONE Nursing Home **[why take permision other professions do not; The policy regulating practice does not succeed]** Pay clinic concept when Government will pay for the poor But ? poor will be eliminated in the process
12. NGO involvement seen in Family Planning, AIDS, Leprosy, Blindness, TB
13. Rational drugs
14. 500 out of 615 disciplinary cases cleared; Probably a Retired Judge to be appointed for adjudication
15. There is a lack of Male multi purpose workers / Health assistants. There is a severe dearth of Laboratory technicians. This affects all the programmes.
16. There are PHCs of different kinds with different staff strength; can we have some uniformity?
17. Among the major changes required for improvement are
    - Motivation to work – all categories of staff
    - Selection and appointments policy, transfer policy
    - Incentives – Rural allowance / tribal allowance
    - Yearly performance appraisal for all staff
    - Training of Doctors

Dr. G V Nagaraj,
Project Director (RCH),
DHFWS, Government of Karnataka

- Traced the historical perspective of RCH programme - Birth Control clinic to Health of the mother and child - Numbers game untill 1995 when Target Free Approach implemented; Quality of Life has improved as evidenced by CBR, CDR and LE at Birth; Cairo conference made the difference when India criticised and paradigm shift took place - No more FP but RCH
- The triple indicators of CBR, IMR and CPR being very important
- High Perinatal mortality rate especially in the Northern parts of Karnataka probably due to Poor Post natal care
- Srilankan experience suggests with NO other clinical care ONLY MCH gave good benfits
- The THREE I s - Insitutional Deliveries; IUDs, Immunisation
- Dismal performance in Institutional deliveries - poor facilities
- Doctor recruitment and Training - need for a foundation course especially for Contract doctors
- Erosion of District level health management

- Non involvement of Male worker; their role needs to be deifined; separate head of account not opened continue with old MPW scheme ; so not involved in Family Welfare programme; currently no candidates available; gender issues of society also getting reflected
- A serious thought to be given to studying systems with No / complete Male worker
- Current allocation is based on Population and also distance allocation model (3-4 Km radius) weightage for both
- Sharing of Government assets with private practitioners; akin Business centre
- RCH is awareness and skill based
- Integration needed at implementation level (micro level); vertical systems at macro level
- Infant Mortality and Perinatal Mortality are high. Maternal Mortality rate is 453 in Karnataka
- Insitutional deliveries have to be increased. There are no facilities for delivery at the PHC (institutional deliveries: Tamil Nadu 72 – 75%; Kerala 90%; Srilanka 94%)
- Doctors recruited for service in PHCs have no experiencxe; there is a need for foundation course
- 2 years experience in rural service must be made compulsory for selection for Postgraduate courses

CONCERNS discussed during the interaction

1. Work extraction with Male and Female workers
2. Critical evaluation needed for the Public Private Mix model; the concerns include - Quackery / paying modalities/ Tax payers money being misutilised - should amount to abdicating responsibility alternatives have to be thought of
3. Choice of NGOs is a Policy matter - need to differenciate between Private and Voluntary Orgainsations
4. Need to evolve Accountability parameters - either behavouraial and or client satisfaction
5. Good home delivery vis-a-vis comparable institutional delivery- cannot promise subcentre delivery of standard
6. Why Instituoonal delivery - critical look needed at what the contribution is for IMR / MMR reduction; critical to differenciate between Insitutional delivery and home delivery - the benfits are either Direct or collateral

Why shortage / logistics - NO all India solution for all India's problems

a) Problems with IFA machines
b) Bypass Central government but what about re-imbursement
c) Dai Training stopped due to paucity of Funds

Sri Shivasailam,
Project Director (IPP VIII and IX)
DHFWS, Government of Karnataka

CONCERNS expressed and discussed during the interaction

- Why ANMs are being debased - ANM have a mandate
- ANM need to be considered as Institutions by themselves which is being done by default (number of ANMs = No of Subcentres)
- BASIS OF INSTITUTIONAL DELIVERY
- IPP 9 - Civil works - 1000 sub centres in 17 districts 270 MO quarters in 100 PHCs -HARDWARE; SOFTWARE - involvement of NGOs (VHAK, SOSVO , FOVORD (K)) Indicators being monitored is the Outcomes rather than Activity (MMR / IMR / CPR etc.,
- Financial and organisational support; evaluation after 3 years (Mid term and also Final) by external third party agencies; sustainable NGO Key area, so 3 years
- IEC away from posters; Multi media - local message and local level on campaign mode (Exhibition); service subsequently with local involvement
- Looking and involving existing CBOs - Of the 5000 Mahila Swasthya Sanghs 1500 active
- IEC - touch screen - Information to impact;
- HMIS - via SATCOM - Health pavillions to be visited not by passed; web based pragramme based indicators induces transparency
- Tribal ANM programme - identify reproductive health needs, train and send the them to their own Tribal area to serve
- Why Doctors are not using the quarters?
- Need to combine all IEC components under One Umbrella
- 85% of Preventive work by Government; corporate involvement could also be sought

Dr. M Jaychandra Rao,
Project Co-ordinator - IPP VIII,
Bangalore Mahanagara Palike

- IPP 8 main aim to decrease the fertility among the Urban poor
- 5 strategies - Upgrading existing infrastructure, Increasin\g service delivery, IEC for demand generation, MIES, Training support
- NGO involvement in terms of SHE Clubs (Social and Environment health clubs); Link Workers scheme - change agents from community
- 90% Physical targets met
- Specialist services enhanced
- Looking at NGOising the facility - handed over certain Centres to IMA, VHAK

- Graded user fees to be thought of
- Health centres have no mandate to conduct deliveries

CONCERNS discussed during the interaction

1. Sustainability of the Centres especially with the existing systems termed as corrupt
2. Referral network to be properly addressed
3. IPP VIII did not work through the department

Dr. Murugendrappa,
Additional Director (Primary Health Care),
And Joint Director (Malaria and Filaria)
DHFWS, Government of Karnataka

- All the districts of the State have Malaria and it is spreading / it is not just continuous spread but saltatory and outside also
- Involvement of Private Doctors in Notification - improved after made a Notifiable disease (progress more in Bangalore only)
- Continuous monitoring needed; Regional Dy Dir post vaccant
- Name to be changed to Vector Borne disease; The district surveillance officers to be also incharge of Vector Borne disease
- The Basic public health qualifications are not required currently for the posts
- 1873 Posts of Lab technicians – Most of the posts are vacant. 99% of Lab Tech do not know Malaria Microscopy; JOC courses Lack infrastructure
- 15 day Foundation course sponsored by WHO undertaken to train in Malaria Microscopy
- Need based posting not there; under Zilla parishat Lab tech works also as SDC, FDC (on grounds of Health)
- Vehicle for the newly formed district not there; so hampers movement of the Officers concerned; Then Centre now state has to supply
- Supply of Insecticides no sufficient; 60 5 DDT to be managed for both Malaria and JE; Schedule need modification
- 25 posts of Entomologists vaccant; so not able to obtain sensitivity and species
- Intersectoral Coordination intiated but biological control but limited impact health staff only undertaking the job
- ?70% Drug Resistance (II)

CONCERNS discussed during the interaction

1. Need for a Public health Training Institute; WHO Country representative willing to support + Support the existing State Health and Family Welfare Institute

2. Specialist Cadre and General cadre the Mysore experience - the ongoing and also tussles in future
3. Orient for 6 months and then post or else to forego promotion
4. Weak Public Health lobby failed to deliver goods
5. Posts not filled up even after drawing attention
6. If one is considering Evidence Based medicine then no Lab tech in PHC is shame on the system => No scientific basis
7. There is a delay in Diagnosis and smears collected for number sonly
8. The ISC with fisheries need to be made into an enterprise
9. Can attempt reimbursement if supply not on time
10. There are problems with respect to supply of Insecticide and spraying schedule.
11. Japanese encephalitis is present in 10-11 districts. Dengue has also become a problem

Dr. Makapur,
Director - State Institute of Health and Family Welfare, SIHFW
DHFWS, Government of Karnataka

- 19 District Training Centres + I SIHFW
- Orientation method like in JIPMER
- Induction Training for the New Recruits
- CMC Vellore is the Nodal agency for Training, SIHFW planning and coordinating
- Problems of Absenteeism abound; No follow up traing
- Shortage of faculty so only Certificate courses
- Institute is not recognized because of deficiencies of staff
- 3 month training programme could be intiated

Dr. Jayadevappa,
Joint Director (HET),
DHFWS, Government of Karnataka

- Involved in the training of Block health Educators and supervise the ANM training (currently stopped because funds not available)
- Only Education undertaken; materials given by existing programmes

CONCERNS discussed during the interaction

1. Need to look at the multiplicity of agencies giving Education and training - Field Publicity Offcier; Song and Drama Division et al.,.

Dr. Jangay,
Joint Director (Leprosy),
DHFWS, Government of Karnataka

- Need to continue with the Vertical programme for another Two years
- Formation of the District MDT society initiated
- Voluntary reporting improving
- Drugs supply more than adequate

CONCERNS discussed during the interaction

1. Need to look at future sustainability of the infrastructure under the Leprosy Programme; could the existing infrastructure be utilised for Burns Rehabilitation

Dr. Ananda Rajashekar,
Drugs Controller,
Government of Karnataka

- Formed as a separate department in 1962
- Consists of 3 wings - Enforcement, Drug testing laboratory, Pharmacy education
- Also Blood Bank Inspectorate; Government Blood banks nor brough before the committee but same procedure of Inspection applied to all the Blood banks
- The Inspection for granting and review done jointly by Centre and State government
- Majority of Blood Banks in Bangalore
- Only storage and usage permitted at peripheral level
- Drugs sample can be drawn at all level including Hospitals
- The maintenance amount for the Drug Testing Laboratory is sufficient for only TWO months
- There are no spurious drugs in the market only Low or Sub standard drugs
- The facilities only for Allopathic systems of Medicine
- There exists about 12,500 pharmacists in the state

CONCERNS discussed during the interaction

1. There need to be difference in application in Certifiying Blood Banks as it concerns the issues and concerns if saving Lives versus implementation of the rules

Chief Pharmacist,
On behalf of the Joint Director (GMS),
Government of Karnataka

- Purchases are only by Tender - Two cover system being adopted, Blister packs and printed as Government supply
- Every drug listed is in The WHO Essential drug list
- Joint Inspection by Centre and State while awarding Good Manufacturing Practices
- The IV Fluids unit is being closed down as per Got Order; It is cheaper to buy than manufacture

Sri Jyothi Ramalingam,
Secretary (Medical Education)
Government of Karnataka

CONCERNS expressed and discussed during the interaction

- The essential activities is the Quality of Medical Education in the 18 + 4 Medical College in the state and the Government Hospital Service Delivery
- Of the 20 Essentialities Certificate given 3 colleges have got Central Govt clearance
- The districts of Bidar, Raichur, Shivamogga, North Canara, Chikkamagalur, Hassan, Coorg, Chitradurga, Bagalkote, Haveri, Gadag, Koppa, Chamarajanagar do not have Medical Colleges
- Para from the IX Five year Plan document
- Public Health is in the state List and Medical Education is in the concurrent List
- There is very intense pressure on Government to sanction more Medical College; so there is a ver urgent need to document whether the number of Medical Colleges are more or less; there is a need to ensure Transparency and Distribution in the whole process and also to be need based
- There is aCabinet decision not to have any Medical Collge for the next FIVE years
- The Question of a University medical College was given up because the Central Government removed the bar on the intake of a Medical College. Instead of investing in a new Medical College it was thought to strengthen the existing one in Bangalore and increase the number of seats admissible
- Corruption in Medical Education - No comments
- Attempts are at coding of PG papers; formation of Ethical committees and Internal quality Assurance committees
- The convergence and integration of the department to be undertaken, vaccanies to be filled up; and those not fully qualified to be paid full salary and sent for PG with a promise of working for a specified number of years
- Accreditation programmes need to be taken up in full earnestness

Sri Nayak,
Commissioner of Health and Family Welfare,
Government of Karnataka

CONCERNS expressed and discussed during the interaction

- Support needed from the Task Force as it has been set up by the Chief Minister himself
- Redeployment of Specialists; need for Public Health qualification of specialist; seems that the Public health specialist jumps the order and so the change needed then - the current situation is that the specialist is lost and the DHO is bad
- The issue of Private Practive and Non practicing Allowance; need to amend the Conduct rules
- Provision for a Hospital Management Position at Big Hospitals
- Getting Doctors stay in the quarters - System failure and also because not implementing the conduct rules;
- Transfer Policy also affecting the quality of work; Disciplinary cases pending for > 20 years
- The kind element of Centrally sponsored schemes not in time - since we cannot compromise - can we ask for reimbursement later by initially creating a buffer fund with Government of India concurrence
- If programme exceeds target and does well will the Government of India reimburse
- Health Spending need to be move away from dispropotionate spending and allocate 50/50 for Tertiary sector and primary and secondary sectors
- The question of sustainability and maintenance of the externally funded projects need to be critically looked at
- The strikes by the Doctors - small vocal groups hold to ransom; How are the complaints are treated and not brushed aside i.e., Prevention modalities need to be initiated; Levels of consolation exists and must be exhausted before strikes; need to seriously think about alternative Health care Personnel during the strikes
- In this context RGUHS has started the Medical Ethics Cell and administering the Hippocratic oath
- Human resources Planning need to addressed; Economy orders stopped the recruitment and prolonged the vaccancy; which is why the external funders dictate the filling up of vaccancies; Need for Perspective Planning for Human Resources for the Health care delivery
- There is huge Wastage of Manpower coming to Bangalore for silly reasons could this be remedied

Sri A Sen Gupta,
Principal Secretary (Health and Family Welfare)
Government of Karnataka

- Problem of Quality - Doctors are much more man managers than just clinicians; they look at 10,000 or 2000 people working with them. Do not blame the individual but the system; raining from bottom with problems climbing up and with no training. Health Department has the largest number of Group A employees
- High pay is needed but will work for few hundred rupees less if in Bangalore; why the change in attitude
- Seniority and cadre management must be brought in
- No promotion if not qualified for the post
- Commisioner of health was brough in to bring about co-ordination - poor support from secretariat to us; data always different; need for a qualification in Planning. Thrre reasons seem to be uppermost - Kiiling of the initiative by either Central Government or external agencies or it is handed down, Training not considered important; Not Recognising both seniority and merit.
- Some one has to do this ; KHSDP is attempting this
- Need for some Public health training to all clinicians
- Staff not working in Rural areas: as do not come from Rural areas and there exists no Policy Planning wing. The stick and rod approach needed 2-3 years of rural service; Couselling at the time of entry with preference to Women, PWD; No further transfer for futher five years (transfer is not to be viewed as punishment); permiitng where quarters available and commuting to work place
- For the Quarters of the staff Non-health issues are also important
- QUESTION OF TRANSPARENCY in
  a) Transfer (? Creating Cadre and sub-cadre for specialist post);
  b) PG matrix needed (Currently DHS/DME decide); People do refuse plan for 2 to 3 years integrate; Integrate HMIS;
  c) Decentralise at Director Level the transfers
  d) Private Practice is in hundreds; disciplinary enquiries pending some even since 14 years; No review meetings have been undertaken; also the problem of Doctors as Government Servants escape through legal looholes; PHC audit-inspections and honesty both inborne and imposed to seriously implemented
- KHSDP is being integrated with DHFWS;
- When Non clinical services are being contracted the Group D are not targeted and there is no retrenchment
- Assets have been created and they cost less than the cost by PWD; so there is a need for a separate wing for Engineering for Health Serives with quality assurance from outside
- Coordination Psot of the commissioner with commanility of Pupose and identified roles have been evolved and need to be critically looked at in the future; a separate role as disciplinary authority and another for manpower need to be identified

- Little thinking seems to have gone into the issue CHCs are created from 1 out of 4 PHCs but what happens to the original PHC; this calls for a GIS and Political reasearch
- Interdicplinary committee for alternate systems of Medicine
- PHCs are centres of excellence more number of NGOs need to look at it in a bigger way
- GOK looks at the experts to guide and suggest
- Need to evolve a Sunset plan for the externally funded projects
- Leprosy id the only exception of success of a Vertical Preogramme
- DHS to be free of Personnel Management and Technical Capacity to be built into
- The Primary Health Care is outcome of Primary Health Centre and evolved with Community Needs Assessment

Indian Medical Association, IMA
Dr. Ramesh, President Elect,
Dr. Sheela Bhanumathy, Secretary,

- The three objectives of IMA are Safeguard the professional Interest of the Doctors, Decompartmentalise the system of Health Care Delivery and also the education system, and finally to involve and participate in the National Health Programmes, Health Check up camps and Health Education activities
- In view of its activities the IMA which is currently registered as Society will also register as Trade Union
- Currently 20% of the Medical Professional are members of IMA

The concerns discussed and expressed during the interaction

1. IMA would work in partnership with the Government agencies to deliver Health care, not in competition
2. No improvement in the situation to make the Doctors take up Rural service. The St Johns Medical College experience of 2 years of Rural experience is useful. The following steps may be considered to promote the Rural Services - Extra Points to be awarded during the Post graduate counselling sessions, Improve the general education system so that the Doctors Family will not suffer, Honour outstanding PHC Medical Officers on special occassions; The Rural allowance to be substanial and not token, consideration in the promotions
3. The larger question of why incentive only to the Doctors and not the Non-medical Health Workers need to be highlighted and considered. Alternatively why only MBBS persons to be considered - can we revive / start a cadre of Rural Doctors. The IMA expressed its serious reservation for such system saying that much was diluted and this would further dilute the role of the doctors. The Systems failure regarding doctors staying in the PHCs need to be looked at.

4. Indicating its willingness to be part of the decentralised machinery of Panchayatiraj, the IMA despite its concerns would be involved as resource persons to orient the Memebrs of the panchayatiraj system regarding the issues and concerns of health
5. Discusion regarding Quality assurance
6. IMA as part of the Surveillance system for Health; involve compulsorily in the monthly meeting of the PHCs
7. Private Practice of Government Doctors: Do not permit Private Practice; Sufficient NPA like that of Central Government i.e., 1/3rd of Basic
8. No more Private Medical Colleges
9. Tax relief for all life saving drugs
10. Need for Infrastructure support

Karnataka Medical Council, KMC
Dr. Chikkananjappa, President

The concerns discussed and expressed during the interaction

1. KMC is a quasi judicial body to look at negligence, misbehaviour, misconduct and moral turpitude of the professionals with MBBS background
2. Established in 1956 under IMC Act; 6 members by election, 4 from Medical Colleges and from University (2 each); 5 nominated members of which one is a non-medical person; Last election 5 ½ - 6 years back; Deputy Secretary has not attended even one single meeting; Council meets once in 2 months
3. No financial punishment only removal from Register; Quackery not possible to be booked; No jurisdiction over Nursing Homes and Hospitals; Drugs controller need to be strict to check quackery; Apex body at the District level need to be formed; organised quackery also need to be tackled. There is no dearth of qualified medical practitioners; Group pratcice to be encouraged.
4. There is no machinery for re-registration of the Doctors in KMC; Machinery will come up if implementation is decided; Funds not a constraint; 150 hours of CME has been laid down as requirement; IMA has taken the intiative; probably the RGUHS will be the apex body under which all these could be considered. CME Body exists; In each of the Divisions a identified medical college according to the specialities they are competent in (Preclinical, Paraclinical, Clinical, like wise); to conduct CME. Principal, BMC is the nodal Officer. There is also a need to involve all systems of Medicine and not just Modern System of Medicine
5. The doctors need to display and or write their registration number at all times
6. Those registered in other Medical councils need to register again; there can be no dual registration- they have to surrender the original / earlier registration;
7. Recommend the concept of SWATHI
8. Raid parties have been formed to check quacks

9. Nearly 2 crore rupees has been collected and all the debts cleared; Own land has been identified- building will come up
10. No more New medical colleges; The medical education need to be need based and of quality. Nothing bars from permitting to start a Medical college if prerequisites are fulfilled. Only clause is if it is not needed. There is to be a medical college for each district. Linguistic minority is being accorded special status. The so called deemed Universities are becoming Doomed Universities

Council of Indian Systems of Medicine and Homeopathy

The concerns discussed and expressed during the interaction

1. The Council was recognised since 1965, been awarding the BSAM degree from 1982 onwards; Board then now council
2. The total number of Practitioners are about 16,000 (BSAM - Integrated); 3,000 Traditional Practitioners [2346 - Integrated; 12,800 Ayurveda, 848 Unani, 2 siddha]
3. > 300 sent notices for those not registering; No complaints have been received; only from IMA. 20-25 of the pratciitoners have been penalised
4. Raiding party need to have a professional representation; Only ISM Council have powers to lodge Police complaints
5. Quality control under the directorate
6. Good Manufacturing Practices difficult to implement as Finger Printing too very costly

Dr. Shivaratna Sawadi,
Director of Medical Education,
Directorate of Medical Education, Government of Karnataka.

The concerns discussed and expressed during the interaction

1. To incorporate Preventive aspects in Medical education. To have more rural camps involving all specialities
2. To make participation in conference / presenting papers compulsory; need for monthly monitoring and performance evaluation. There is need to bring accountability/ surveillance and community orienttaion into Medical college
3. DME is Head Postmaster
4. The research grant of Rs 5 Lakh is already over
5. When even the Best students thinks to pay for passing; there is both hands needed for clapping
6. There is needed a survey on Medical Manpower requirement
7. Medical Education Cells have been set up
8. The Health Workers can co-ordinate the activities related to Dental health

6. Since Drugs supplied / availability is not sufficient at the Health Care Settings the Doctors take money for providing the medicines.
7. Private practice need to be banned upto certain level especially those with administrative responsibilities; but should be compensated adequately like in the Central Government i.e,. 1/3 of the Basic pay
8. Need to Regularise the Contract Doctors, enforce strictly the 7 years of Rural service, Provide proper quarters, have 3 doctors in every PHC
9. Can we think about a co-operative Pharmacy to overcome the problems of no drugs or doctors taking money for drugs?
10. Doctors to be forced to undertake Preventive services; so need for Administrative and management training at all levels; should forego promotion if not desirous of taking training
11. Total opposition for inclusion under Panchayatraj Institutions
12. Urgent need for Manual for the different staff - assigning specific job responsibilities
13. There is a difference of nearly 3-5,000 rupee in the pay scale between College Teachers and other Government Doctors; need for parity

Dr. Shivananda, President and team
Karanataka Government Medical and Dental Teachers Association

The concerns expressed and discussed during the interaction:

1. Hygienic Diet for the patients; No free food subside it; a single canteen for all including doctors and patients
2. Standards drugs needed
3. 24 hours Laboratory technician needed; not termed as essential service so not working for 24 hours
4. Building of Dharmashala for the patients attendants
5. All government ministers to compulsorily take treatment at Government institutions
6. Clear the entrance to Voctoria Hospital and Vanivilas Hospital
7. No basic amenities for the students; need for establisinh proper learning environment
8. Library facilities needed
9. Accerditation systems to be introduced
10. Bio-engineering department to take up maintenance of medical equipment
11. Health insurance to all staff (not ideminity but regualr Health insurance)
12. Facilities of Intercom; computer; photography to all staff; sabatical; deputation for conferences / seminars
13. Teaching and Training within the departments - HODs to be held responsible
14. Bribing to pass exams - poor morals and no integrity among the examiners is the reason; increased with opening up of Private medical colleges
15. Short term bring accountability; Long term select medical students / teachers with aptitude and No more new medical colleges; Government training doctors who do not serve in the rural areas

16. Implementation of Residency scheme; decentralisation of financial powers; government doctors do not go to the media with spetacular surgeries when they it as mater of routine unlike doctors in the private service
17. Nursing education need to be strengthened ; more theory than practice; sad state of affairs if the system has to rely on Nursing students for care delivery
18. Need for medical person in the governing council and the ex director
19. Condemnation of article to be after 5 years and the amount recovered to be used for development instead of waiting for 20 years and then getting very less money
20. All hospitals to have citizens charter
21. Transport facilites to Bowring Hospital
22. Need to improve the existing colleges than thinking about one more medical college
23. Need based and selective improvement of Departments
24. Corporation dispensaries also to be included for teaching purposes
25. Research and ethic to receive greater attention
26. Need for PRO/ receptionist in the Hospitals
27. Pay clinic system could be introduced or limited Private pratcie to permitted

Dr. Bhattacharjee,
Director, Population Centre

The concerns expressed and discussed during the interaction:

1. Population Centre Started under India Population Project 1 to cater to the research needs; set up in Bangalore as the IPP 1 covered District under the Bangalore Division. After the project wound upscope expanded and has taken up the evlaution work of existing programmes; cost being met under non plan expenditure under Karnataka Civil Service rules and also undertakes assignments for payment for the different projects
2. Staff strength is poor; No staff even to collect and collate data: Need to have such a unit in every district
3. Unfortunate that the studies undertaken have not resulted in action; No interface for such endeavour
4. The name of the centre should be changed to Centre for Health Studies
5. Some of the reports undertaken by the Centre was discussed: Immunisation ceverage; Pulse IUD programme; Yellow Card Scheme; Contraceptive usage; Incentive for FP, etc.,

Dr. Hemareddy M T
Formerly Director,
Directorate of Health and Family Welfare,
Government of Karnataka

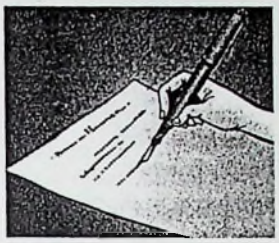
The concerns expressed and discussed during the interaction:

1. Need for improvement of the PHCs and Subcentres; The goal of each subcentre to have atleast two beds
2. Transfer policy
3. Officials are not visiting the districts
4. No comprehensive plan before Project formulation
5. Need for Trauma Care Centre
6. Need for Health Information system; and tightening of administration
7. Cadre like IAS for Health and medical services
8. Transfers after 4 years
9. Cleared 43,200 files in 5 years 2 months; of these 12,000 is for transfer / increment
10. Planning Cell - Budget based Planning and addiction to World bank Projects; enhanced / increased accessibility to Nirman Bhawan, Delhi; Perspective planning does not exist; state government does not create programmes

Dr. Malini,
Principal,
Government Ayurvedic College,
Bangalore

The concerns expressed and discussed during the interaction:

1. Rural Ayurvedic type of Treatment could be introduced
2. The ayurvedic teachers will participate in the camps; No objection to be along with in the PHCs
3. Lack of Staff members in the colleges
4. Lack of timely promotions
5. 40+ collegs exist and no more colleges needed
6. Poor prospects for the Ayurvedic graduate
7. Beneras Hindu University experience could be a good model
8. Reorientation needed
9. Disparity in pay scales to be addressed
10. Need for emphasis on research



Community Needs Assessment Approach for Family Welfare in Karnataka

Ramakrishna Reddy
P. Hanumantharayappa
K.M.Sathyanarayana

Background

Karnataka is one of the several progressive states in southern India. Even before independence it had moved to the forefront of the national family planning programme by establishing family planning clinics in Mysore and Bangalore in the 1930s which was the first official clinics in the country. The contraceptive prevalence rate 12 per cent in 1971 in the state. — increased to 55 per cent in 1998. The total fertility rate (TFR) dropped from 4.4 to 2.5 over the same period. Furthermore, there have been remarkable improvements in maternal and child health (MCH) indicators, especially in infant, child, and maternal mortality rates.[1]

Lately, however, family planning acceptance has remained more or less constant, and fertility levels have reached a plateau. There is also an enormous regional variation in the success of the programme. For example, while the divisions of Mysore and Bangalore are performing better than the state average, Gulbarga and Belgaum are not doing nearly so well. Major concerns include the availability of health facilities in rural areas and the often non-existent health structure in urban areas, vacant staff positions, and, more importantly, client accessibility to basic services. Realizing the need for improvement in these areas, the state has initiated several need-based projects. In the last five years, these

[1] Sample Registration System, Registrar General of India, 1998 and Population Research Centre and International Institute for Population Sciences, National Family Health Survey: Karnataka, Mumbai, 1995.

have included the Karnataka Health Systems Development Project, the KfW Project, India Population Projects VIII and IX, the Border Cluster Districts Project, and the Reproductive and Child Health (RCH) Services Project.[2]

The community needs assessment (CNA) approach, formerly known as the target-free approach (TFA), was introduced in 1995 on an experimental basis, in one district in accordance with the mandate of the Government of India (GOI). In the following year, again based on the decision of GOI, it was extended to all districts in the state. The way the state has gone about implementing the new approach from 1995 till the present and the modifications it has made in the process have been reviewed and documented.

The main objectives of this study are the following: (i) To describe the processes followed to implement the new system; (ii) To record the opinions of personnel at various levels on the new system and its implementation; and (iii) To analyze the potential effects of the new system on performance. Sample data were gathered in Mandya and Hassan districts from two primary health centres/community health centres/ PHCs/CHCs and four sub-centres. In addition, two PHCs that had an important role in executing the new approach were visited. Health personnel in the selected institutions were interviewed using broad guidelines prepared specifically for this purpose. All correspondence and other documents available at all levels from the Department of Family Welfare were collected and reviewed. Performance data were collected from the Directorate of Family Welfare and from districts as well.

The Community Needs Assessment Approach

Experimental Phase: 1995-96

The state became aware of the CNA approach in January 1995 after receiving a letter from the Secretary of Family Welfare, GOI. In the absence of any guidelines, state officers were not clear on just how to experiment with the new approach but, after a series of discussions, decided to try the new approach in one district. The criterion for selecting the district was consistent family planning performance. In addition, voluntary acceptance of family planning methods was given due consideration. Mandya was the obvious choice. Thus, in March 1995, the Additional Director for Family Welfare wrote the following to the District Health and Family Welfare Officer (DHFWO) in Mandya:

"In the financial year 1995-96, the GOI is thinking of implementing the target-free approach in one district of the state on an experimental basis, and therefore we have decided to make your district target free. Emphasis will be on providing quality services and hence you will have to ensure it. You are, therefore, requested to work out your performance goals and work accordingly."[3]

There was no further communication from the state for several months. Neither the state nor the district made any effort to discuss guidelines for implementing the new approach though they could have done so at monthly state-level meetings. Meanwhile, as part of its normal routine, Mandya carried out the eligible couple (EC) survey and updated the eligible couple registers (ECRs). After conducting this exercise, district and block officers and field workers were informed of the new approach in a monthly meeting and in a letter, which stated the following:

[2] Human Development in Karnataka, Planning Department, Government of Karnataka, Bangalore, 1999.

[3] Letter from the Additional Director, Family Welfare, to Mandya district, March 1995.

"During the year 1995-96, targets for the family planning programme have been removed. However, it is required that the workers should perform to the levels of last year."

Since the EC survey had already been completed, the district statistical officer collated the information and worked out the expected level of achievement (ELA) for each of the family planning methods. The yardstick for monitoring the performance of field workers was the previous year's performance and the performance in that particular month.

In August 1995, the first guidance on the implementation of the new approach arrived in the form of a letter from the Secretary of Family Welfare, GOI, to the State Secretary. It read as follows:

"As you are aware, an important decision was taken in the meeting of the state secretaries in charge of family welfare on April 3 and 4 1995, to exempt at least one district from the contraceptive targets.

The objective of exempting one district from targets was to improve the quality of services. To carry this message down to the grassroot workers, it would be necessary to sensitize the district level officers, the PHC Medical Officers (MOs) and the health workers on specific aspects of quality improvement and the steps to be taken in this regard. Such sensitization could be done during (i) monthly meetings of district level officers at state headquarters; (ii) meetings of PHC MOs at the district level; and (iii) meetings of male/female health workers at the PHC level. You may identify resource persons for conducting such sensitization of all personnel in the target-free district/areas.

The Government of Tamil Nadu has recently issued detailed instructions on the MCH approach to family planning and specific services that will be quantified and monitored. I am sending herewith a copy of the order issued by the Tamil Nadu government in this regard. This is an interesting experiment worth emulating.

We propose to conduct a concurrent evaluation of programme performance in the target-free districts/ areas through Population Research Centres. The concurrent evaluation will also study the qualitative improvement in services.

May I request you to take suitable steps to improve the quality of services in these district/areas and apprise me of the action taken."[4]

State officials in Karnataka reviewed the order mentioned and decided that the Tamil Nadu approach did not add anything worth considering. The state, therefore, did not inform the district of its contents nor did it make any effort to understand the implementation mechanism described therein.

Overall, family planning performance in Mandya in 1995-96 was more or less consistent with 1994-95. Sterilization and IUD acceptance definitely increased, but there was a decline in the use of oral pills and condoms. It would appear, therefore, that the only effect that the CNA approach had on the family planning programme was that the district worked out its own "targets" for the first time ever. However, it can be inferred that the new approach was not field-tested in the real sense because the district did exactly what it had been doing previously to work out ELAs. In contrast, there was substantial improvement in MCH indicators as more

[4] Letter from the Secretary, Family Welfare, GOI, addressed to the State Secretary of Karnataka, August 1995.

women received antenatal (AN), natal, and post-natal care. Immunization coverage for infants improved as well.

Expansion of CNA

The decision to expand the CNA approach was made in a meeting of State Secretaries in New Delhi on February 1 and 2, 1996. Without deliberating on the experiences of various states in the experimental year and despite strong opposition from many of them, GOI announced its plans to extend the approach to all districts in the country. Since the new approach had not really been tried out in Karnataka, and the officials present at the meeting were not aware of the methodology Mandya had used during the experimental year, they did not oppose the government's decision. In general, however, they thought that it would be difficult for field workers with limited academic qualifications to comprehend the approach and that the process of change from targets to target-free would require a considerable amount of time and a substantial obligation of resources. GOI insisted that the new approach would improve the quality of services and stated that proper guidelines and an implementation manual would be prepared and given to all states.

Subsequently, the Secretary of Family Welfare, GOI, wrote to all State Secretaries on February 14, 1996, about the use of the CNA approach in the family welfare programme. It stated the importance of the new approach, proposed the methodology for preparing plans at various levels of the service delivery system, and mentioned that the new approach would provide an excellent opportunity to make family welfare in India a truly people's programme.

The letter outlined the procedure for preparing plans in the following manner:

"A draft format for the PHC plan as is being used in Tamil Nadu, circulated in the February meeting as part of the agenda notes, may be used. You may like to initiate this exercise of involving all health personnel, village pradhans, primary school teachers, and NGOs working in each PHC in your state on the basis of this format or with such modification to it as you deem necessary. A detailed format for preparing the PHC/ FWHC plan is under preparation at our level and could be made available before the end of March 1996. However, the preparation of your FW and health care plan need not wait for this data format. The performance of each PHC would need to be evaluated against its own plan by the district health and FW system at the end of each quarter to advise them suitably. They would also need to tune the IEC activities in the PHC area and districts to prompt this bottom-up approach of planning and implementation of a sensitive programme like family welfare.

All the PHC FW plans would need to be aggregated into the district FW plans and the district FW plans would similarly need to be aggregated in the state FW plan. A timetable for preparation of the plans at various levels may be set. I would suggest that the PHC plans may be finalized by April 30, 1996, the district plans by May 15, 1996, and the state plans by May 31, 1996. We would like to have your state FW plan by the first week of June 1996.

A system of evaluating the performance of each district every quarter may be worked out at the state level. A similar exercise to evaluate the performance of each state would be carried out at the national level. This exercise would need sensitization of the entire health and family welfare organization in the state with the deputy commissioners/ district magistrates playing a leading role along with the district health and FW system in active collaboration with

panchayati raj dignitaries, primary school teachers and active NGOs." [5]

The state directorate forwarded the Secretary's letter to all DHFWOs and asked them to follow the instructions carefully. However, before the February letter from GOI reached the districts, the district magistrates received a different letter sent directly from the GOI Secretary of Family Welfare dated March 4, 1996.[6] In it, the Secretary discussed sensitization workshops, the budget for conducting them, and a set of guidelines. The budget for sensitization was released to the districts on an average basis without considering the number of PHCs and had to be collected from the regional director's office. The state was unaware of the March-letter and, surprisingly, none of the districts reported it. On April 4, 1996, the Joint Secretary of Family Welfare, GOI, wrote a letter to the State Secretary about the sensitization workshops with a copy of the March 4, letter attached.[7] The state later corresponded with the regional director and determined the exact budget for each district. One-day sensitization workshops at the state, district, and block levels were ultimately conducted between July and September 1996, for all health personnel, representatives of NGOs, members of panchayati raj institutions (PRI), anganwadi workers (AWW), and National Swayam Sewika (NSS) volunteers.

The GOI sent a detailed plan of the bottom-up approach to all states on March 27, 1996. After reviewing it, Karnataka felt that the districts should follow the government's instructions exactly and should estimate perceived needs and service requirements. The GOI data collection format included 17 questions on antenatal care (ANC), deliveries, post-natal care, immunization of children, acute respiratory infections (ARI), diarrhoea in children, and family planning. The GOI coverage norms were tagged to these indicators with the exception of those for family planning. The states were advised to prescribe their own family planning norms to arrive at total service requirements. The format provided an idea of the magnitude of the task of restructuring demand for reproductive and child health (RCH) services and family planning in terms of perceived needs instead of as a function of the previous year's performance.

The Implementation of the CNA Approach

Traditionally, data collected annually in the ECRs were to be used for working out MCH and family planning targets; however, because targets were set by the state, this locally gathered information was rarely used. With the introduction of the CNA approach, however, the state expected that ECR data would become quite valuable. Hence, the districts were asked to collect the data and use the GOI-prescribed coverage norms to arrive at the ELA for various MCH indicators. These calculations were simplified by uniformly applying a birth rate of 19 per 1,000 population, despite the enormous regional variations within the state.

As there were no specified norms from GOI for calculating family planning ELA, the state used its own methodology. Districts were instructed to calculate the ELA on the basis of the perceived need or the

[5] Letter from the Secretary, Family Welfare, GOI, addressed to the State Secretary in February 1996 and subsequently marked to the districts March 1996.

[6] Letter from the Secretary, Family Welfare, GOI, addressed to district collectors/magistrates March 1996.

[7] Letter from the Joint Secretary, Family Welfare, GOI, marking the letter addressed to district collectors/ magistrates to the State Secretary April 1996.

unmet need. This led to confusion because the ECR Survey Format-HMIS Version 2.0, did not capture information on unmet need for family planning but nevertheless the state sent a letter to the districts. In the absence of a clearly stated methodology, the districts were informally asked to consider past performance while formulating their activity plans. A few districts considered only the previous year's performance while other districts considered the average of the past three years. Thus, there was no uniformity among districts in the preparation of activity plans. Nevertheless, the state had introduced the new approach, and the activity plans that were prepared by health functionaries were consolidated at the PHC, district, and state levels. A state-level plan was prepared and submitted to GOI by July 1996. State officials monitored progress in the preparation of the activity plans.

The implementation of the CNA approach in the first year of the expansion phase was limited to state and district officers only. This resulted in enormous confusion as they interpreted the TFA in various ways and calculated the ELA for family planning methods to suit themselves.

Although the activity plans were ready by the end of July 1996, staff orientation and the translation of the GOI manual into the local language had yet to be done. No effort was made to do either as a result of a delay in delegating responsibility to officers at the state level. In September 1996, the GOI organized a two-day CNA orientation workshop in New Delhi for state officers to discuss the various terms and definitions used in the manual. Three officers from Karnataka participated; on returning to the state, they were given the task of conducting orientation training for all health personnel.

In November 1996, a 10-day training session was conducted for state and DHFWO, senior programme officers, and chief executive officers (CEOs) of the Zilla Panchayats. (since Karnataka had already implemented the Panchayati Raj Act, the CEOs had assumed the role hitherto played by the district magistrates and were the chairpersons of the district health committees where public health and family welfare came under their purview. They were, therefore, included in order to familiarize them with the recent changes in the family welfare programme). The session focused on the roles and responsibilities of the district health committee, the essence of the manual, and the monitoring and compilation of progress reports. Also, a detailed plan for training staff was outlined. Trainers at district levels and below were identified from among the health officers attending, and a workshop itinerary was prepared. To facilitate training, state officers were assigned to districts. A 10-page booklet in the local language that outlined the concept of CNA and explained the methodology for estimating ELA was circulated to all the participants.

Thus, the implementation of the CNA approach in the first year of the expansion phase was limited to state and district officers only. This resulted in enormous confusion as they interpreted the TFA in various ways and calculated the ELA for family planning methods to suit themselves. This practice continued into the next half of the fiscal year until all remaining health professionals and functionaries were trained.

In the latter part of 1997-98, the state finally began district and *taluk*a level training and continued it until the end of June 1998. All health personnel, members of PRIs, child development officers, and AWWs were trained in these workshops, but in fact, the family welfare programme for 1997-98 had already been implemented. The activity plans and progress reports that had been introduced alongwith the new approach were already operational, and the sub-centres had already collected information according to the

prescribed formats that had been compiled at various levels to represent PHC, district, and state plans. Training should have preceded implementation, as it didn't, the health department had already implemented the CNA approach without understanding the concepts underlying the approach.

In 1998-99, the districts in which CNA training had been completed followed the procedures learned in the training sessions while other districts prepared plans based on the previous year's methodology. Also around this time, the birth rate previously used to calculate MCH indicators was revised from 19 to 18 per 1,000. This figure once again was uniformly applied—irrespective of the actual birth rate of the district. It is difficult to understand how the state arrived at this figure when the sample registration system for those years reported much higher rates. Due to the variety of methodologies being applied, confusion prevailed especially in the family planning programme.

During this time, GOI modified the new approach by revising the formats used to make activity plans and progress reports. The number of formats was reduced drastically from more than 30 to nine,[6] but Karnataka continued using all the old formats to avoid further confusion at the field level since the workers were reconciled to them. State officials introduced the new formats only at the PHC level and above, after conducting four regional workshops in Bangalore, Belgaum, Gulbarga and Mysore with financial assistance from UNICEF. In addition, two workshops, one in 1998 and the other in 1999, were conducted for statistical assistants. MOs and statistical assistants then started compiling information using the newly introduced formats, so their reports to GOI changed accordingly.

Due to the delay in training of lower-level health staff, the new approach could not be implemented in the true sense. GOI was unaware of this. As the state submitted activity plans and progress reports to GOI on time, the government presumed that the new approach was working well and that health personnel had understood the concept and were implementing it correctly. This practice of evaluating performance solely on the basis of the timely submission of forms did not bode well for the transition from targeted to target-free programmes.

Experiences in Implementing the CNA Approach

Health personnel from the selected districts, PHCs, and sub-centres were interviewed about the CNA approach. The processes followed and opinions given are summarized below.

The general feeling at the district level is that the new approach is a welcome change from top-down targets as it makes field workers more responsive and responsible. The methodology proposed by GOI is being followed along the suggested guidelines, and it seems to be working well. Instead of the state setting 'targets,' the districts set them through a consultative process. The feeling is that the approach is more useful than top-down target setting due to the participation of all staff in the process. The confusion that prevailed when targets were removed has given way to a more confident approach to programme implementation. Monitoring at the PHC and sub-centre levels has become easy.

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[6] Letter from the Secretary, Family Welfare, GOI, addressed to the State Secretary January 1998.

The DHFWO of Mandya district explained that despite initial fluctuations, the district has been able to maintain its performance levels. Even though acceptance of sterilization has dropped, the decline is insignificant compared to that elsewhere in the state. In this context, he stated the following:

"The interesting aspect in the district is that it is immaterial to people what approach the district is following because people over here come voluntarily for family planning services and demand quality services. Providing quality services is the major concern, and we at the district have taken measures to assure this."

Having said this, he informed us that the district has adhered to all instructions received from the GOI and has executed the programme accordingly. Although there were delays in training staff, efforts have been made to make them thoroughly understand the new approach. The concept of the CNA approach has been constantly reiterated in monthly meetings, and that has paid off. All staff members are aware of CNA and have participated in the preparation of the activity plans after discussing them with panchayati raj members and AWWs. The statistical assistants have played an important role in the compilation of the forms and in monitoring and have been the major link between the programme officers and the field workers. The DHFWO of Hassan district expressed similar views.

The auxiliary nurse midwives (ANMs) enthusiastically claimed that the CNA approach is better than the one with targets imposed from above. They explained that their task is now defined by benchmarks derived from the prevailing birth rate in their sub-centre areas instead of by targets based on population size.

Regarding family planning performance and the strategy of identifying perceived needs, both DHFWOs agreed:

"If you see the performance of the past few years and at present, there is nothing wrong in admitting that performance has remained more or less the same, but if the age and parity of acceptors are analyzed, they have come down considerably, and this is a positive sign for the programme. Even now there is no clarity on how the ELAs for family planning methods have to be arrived at. Based on past performance, the ELAs are being worked out. This methodology will not address client needs and hence a methodology that can look into this aspect should be developed and implemented."

They also mentioned that leadership at the local level, commitment of staff, and close monitoring of the programme were key factors to success and that their districts had been able to exhibit all of those characteristics. This was found to be true because the MOs of PHCs, who were knowledgeable about the CNA approach were able to provide direction to the programme. They had definite time slots for reinforcing the concept in monthly meetings, and therefore, the supervisory staff and sub-centre functionaries in their PHC areas had a clear understanding of what was expected of them. On the contrary, in PHCs in those districts where the commitment of the MO was weak, the understanding among staff members of the approach and its implementation was also weak. It was agreed that one-time training without constant reinforcement would not have much effect. This was demonstrated in the PHCs where the MOs lacked proper understanding.

The auxiliary nurse midwives (ANMs) enthusiastically claimed that the CNA approach is better than the one with targets imposed from above. They explained that their task is now defined by benchmarks derived from the prevailing birth rate in their sub-centre areas instead of by targets based on population size. However, regarding the use of birth rates for calculations, one of the ANMs remarked:

"In my area, the birth rate seems to be less than that proposed by the district or state. By applying this rate, the workload in my area gets over estimated, and it becomes difficult to achieve the ELAs. In spite of complaining about it, the medical officer has not been able to resolve the problem, and I am told that in the next year, we will try to work out something on the basis of which the calculations will be done. I think some alternative has to be developed or else the present approach will end up as a target-driven approach given in a different way. The pressure to perform still continues and temporary denial of salary/pecuniary benefits is recommended if the self-determined ELAs are not met."

Other ANMs endorsed this view as well.

The review team discussed these perceptions from the field with the Additional Director, who is also the RCH programme director and has been associated with the CNA approach since its inception. The Additional Director said the following:

"The new approach has a sound methodology and has a good philosophy associated with it. Although I was not convinced in the beginning, I developed a liking after I understood the concept of it thoroughly. For a person at my level it took some time, and you can imagine how much time and effort are required to change the mind-set of the health functionaries at the grassroot level. Proper training of functionaries supported by a well-equipped service delivery system form the essential ingredients of the programme. The only apprehension I had then, and I still have, is that the GOI hurriedly pushed the implementation of the new approach without paying much heed to training and strengthening service delivery systems."

The state was tasked with the implementation of the new approach, but it had not readied its resources. There were delays on all fronts. In the beginning, state officials did not have a clue about CNA as the training of master trainers had not taken place because funds were not released on time. In this context, it was difficult to implement something they were not confident about. Moreover, Karnataka's family planning programme performance had slipped. The fertility rate that was once comparable with those of the neighbouring states of Andhra Pradesh and Tamil Nadu had stabilized while the rates of the other states had moved closer to or had reached replacement levels. The Additional Director, therefore, remarked:

"With very little improvement in performance over the past few years, I feel that Karnataka has become the BIMARU (sick) state of South India. The state, unlike Andhra Pradesh, lacks political will and commitment at all levels, and that has resulted in inordinate delays in decision-making that have hampered the programme and its performance."

In order to maintain the tempo of family planning acceptance, the state must closely monitor the age, parity, and education levels of acceptors of sterilization and IUDs. The pressure on workers to perform remains despite the new methodology.

Hence, nothing new was attempted except for sharing the monitoring and activity formats to satisfy the immediate needs of GOI. All health personnel have since learned how to estimate ELA, yet the state still lacks a clear-cut methodology for addressing client needs. To help solve the problem, birth rates of 19 and subsequently 18 per 1,000 were used to calculate indicators throughout the state in spite of well-documented regional variations. The technique of surveying 100 mothers proposed as part of the approach was also tried out, but it did not give a clear indication of client needs.

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Additional Director was happy that in most regions of the state acceptance was voluntary, though that is not always the case in the northern part, where lower levels of acceptance have negatively affected the state average. In regard to lagging performance, the Additional Director was optimistic and said this:

"With more efforts by the Department, the state can surge ahead in the RCH and family planning programmes. Even though there are regional imbalances in the northern parts of the state, various innovative projects and schemes have been initiated, but it will take time before these districts yield the fruits of the interventions."

The state demographer added these comments:

"The statistical assistants have done an excellent job in carrying the message of the new approach down to the grassroot level. In the first year, in the absence of proper training, the responsibility for compiling the GOI forms was entrusted to them. In the subsequent year, they played an active role and were able to impart the necessary working knowledge to the ANMs. Scrutinizing, compiling and timely monitoring of activity plans were all done by them."

When asked about orienting health workers to the newly introduced forms, the state demographer said that Karnataka intends to do so as part of the overdue RCH training. Furthermore, the concept of unmet need will be taught, and the ECRs will be revised to include questions related to the estimation of unmet need. The ELAs for each method will be worked out on the basis of data collected in these ECRs.

In the light of these discussions, it can be inferred that Karnataka did make efforts to help workers understand the new concept, but discussions with health functionaries revealed that the pressure to perform, especially in sterilization, had actually increased.

Family Planning Performance

Limiting Methods

The annual acceptance of sterilization steadily increased in Karnataka from 371,535 in 1994-95 to 395,624 in 1997-98. However, in 1998-99, when the state actually implemented the CNA approach by training all field workers, acceptance dropped by six per cent from the previous year.

Sterilization acceptance in 1998-99 was comparable with the level of 1994-95. In other words, the decline in acceptance was marginal because the pressure to achieve ELA in sterilization has been maintained since the introduction of the new approach. The state claims to have taken measures to closely monitor the age, parity, and education of acceptors and notes that there has been a slight drop in the average age and parity for women. State officials are confident that if pressure on performance in general and on sterilization in particular is maintained, the state will be able to achieve better results in the years to come.

Table 1
Expected and Actual Level of Sterilization Performance in Karnataka from 1994-95 to 1998-99

Year	Annual Performance	Percentage Increase/ Decrease Over the Past Years Performance
1994-95	371,535	...
1995-96	381,571	2.7
1996-97	384,056	0.7
1997-98	395,624	3.0
1998-99	371,275	-6.2

Spacing Methods

The National Family Health Survey (NFHS) in 1992 found that in Karnataka, only one-tenth of modern contraceptive-users were using a spacing method. With over a third of the population in urban areas, the percentage of spacing-method use to total use is quite small. The state realizes the strong potential demand for spacing methods and is making a considerable effort to promote them by way of rigorous marketing, IEC campaigns, and area-specific interventions. Yet the levels as reported in the service statistics have not increased as expected. The performance in the last five years in terms of the percentage increase/decrease for each spacing method is summarized in Table 2.

IUDs

Acceptance of IUDs in the last five years has increased by 13 per cent; however, the pattern of increase has not been consistent. In 1994-95, there were 299,504 acceptors; that number rose to 345,937 in 1995-96, an increase of over 15 per cent. In the following year, acceptance increased by another nine per cent. It then declined by one per cent in 1997-98, and by nine per cent in 1998-99. This is a matter for concern. Unless the state takes proper measures, it will be difficult to sustain the present level of use and to motivate new acceptors. The state is now monitoring retention rates. Those rates will give a better idea of the number of births averted, which can have a considerable impact on reducing fertility.

Oral Pills

The common practice for setting the ELA for oral pills is in terms of the number of users. Performance records at the district and lower levels, however, provide information in terms of the number of cycles distributed. That number is aggregated at the state level and divided by 13 cycles to get the number of users. In other words, the calculations are restricted to distribution numbers without considering vital information on continuation rates. Oral pill acceptance has been similar to that of IUDs except for the fact that the extent of decline in acceptance has been smaller. Following the introduction of the new approach by the state in 1997-98, performance declined marginally; in 1998-99 it dropped by five per cent. Overall, however, acceptance increased by eight per cent during the reference period.

Condoms

The calculation of condom-users is based on a methodology similar to that used for determining oral pill-users, and identical problems exist. The annual number of users is arrived at by dividing the number of condoms distributed by 72. Unlike other spacing methods, condom-use in Karnataka has been declining steadily since 1994-95. In that year, there were 395,108 users. In the following year, the total

Table 2
Annual Performance and Percentage Increase/Decrease of Spacing Methods in Karnataka from 1994-95 to 1998-99

Year	IUD		Oral Pills		Condoms	
	AP	PI/PD	AP	PI/PD	AP	PI/PD
1994-95	299,504	...	138,232	...	395,108	...
1995-96	345,937	15.5	151,145	9.3	374,687	-5.2
1996-97	376,247	8.8	157,545	4.2	358,627	-4.3
1997-98	372,341	-1.0	156,494	-0.7	323,021	-9.9
1998-99	337,854	-9.2	148,931	-4.8	278,626	-13.7

AP= Annual Performance; PI/PD= Percentage Increase/Percentage Decrease over the past year

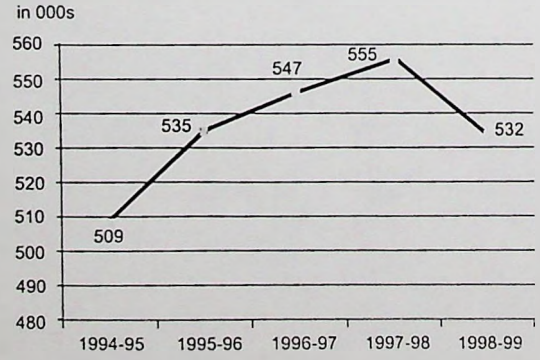
declined by five per cent. After that, the decline was much greater until in 1998-99, condom-use had fallen to 70 per cent of what it was in 1994-95.

Sterilization Equivalents

In order to provide a more holistic picture of programme performance, Karnataka routinely reports to GOI on sterilization equivalents as well as on the annual acceptance of each family planning method. Sterilization equivalents are calculated by combining sterilizations with spacing methods according to the following formula, supplied by GOI. **Sterilization Equivalents = Sterilizations + 1/3 the number of IUD insertions + 1/8 the number of condom-users + 1/9 the number of oral pill-users.** The results of this calculation for Karnataka are shown in Figure 1. All spacing method users are converted in this way and are added to actual sterilization statistics. The state has placed more emphasis on both limiting and spacing methods, but the pressure to increase the number of sterilization acceptors is greater.

An analysis of sterilization equivalents reveals that performance has been reasonably good. Acceptors increased from 509,000 in 1994-95 to 555,000 in 1997-98. In 1998-99, after the introduction of the CNA approach, the number dropped to 532,000, which was the performance level in 1995-96. In 1997-98, however, despite a decline in spacing method acceptance, the number of sterilization equivalents rose substantially, due mainly to increased sterilization acceptance.

Fig. 1
Sterilization Equivalents in Karnataka



If the state intends to monitor performance through sterilization equivalents, then the quality of data on spacing methods needs to improve. The number of regular users, the duration of use, and continuation rates for each spacing method will have to be collected and analyzed. To do this, monitoring formats will have to be redesigned. If not, inferences drawn from the existing data will be misleading.

Family planning service statistics clearly indicate a decline in performance for spacing methods since the effective introduction of the CNA approach, even though the acceptance of IUDs and oral pills increased over the five-year period. State officials attributed some of the decline to poor infrastructure in the northern region of the state but put the majority of the blame on CNA and the confusion that resulted from its introduction. Yet, there is still optimism at the state level because of various innovative interventions that have been undertaken.

Performance in Reproductive and Child Health

The family planning programme suffered from the CNA approach because there was no clear system for working out method-specific ELA. This was not the case for RCH indicators. ELA could easily be calculated by applying the state-determined birth rate to the GOI coverage norms. The result was performance better than the expected levels. In 1999 for instance, the coverage for ANC and child immunizations including DPT, polio, and measles was higher than the proposed levels. As a matter of fact,

the performance in RCH indicators improved over the previous year, and the infant mortality rate (IMR) in 1998 was 58 as compared to the national average of 72. Thus, overall performance in RCH seems to have improved considerably, but before drawing such an inference it is worthwhile to examine the GOI coverage norms and the birth rate used. The norms were generalized at the national level and the birth rate which the state used was low. Those two factors together could have resulted in underestimation of the ELA, thus, allowing achievement levels of more than 100 per cent to be reached.

Conclusion

Karnataka has made efforts to implement the CNA approach in light of the guidelines provided by GOI. Due to a delayed start, however, the approach could not be field-tested in the true sense for over a year and a half. When the health system was ready to absorb the new concept and implement it, GOI modified the existing data collection formats. MOs and assistant statistical officers were reoriented in their use, but field workers were not. The central government's monitoring of the implementation of the new approach in both the original and revised forms consisted solely of logging in the monthly reports that the state regularly submitted. Due to this, GOI failed to understand what was really happening.

Although the state did not impose any targets on the districts, there was no clearly defined system for setting ELA for family planning methods, so confusion about their calculation was widespread. There was a system for working out ELA for RCH indicators, though calculating coverage norms—based on a standardized birth rate lower than the actual one that further ignored regional and district variations—defied the very principles of bottom-up planning. Furthermore, although RCH ELA were set at the sub-centre and PHC levels, no effort was made to use the ECR data, and no thought was given to modifying the registers to capture missing information.

In the past five years, the overall number of family planning acceptors generally increased, but after the state implemented the CNA approach at the field level, acceptance rates began to fall. The extent of the drop in the rates for spacing methods was considerable. Although the state is monitoring acceptance independently and in terms of sterilization equivalents, continuation rates for oral pills and condoms and retention rates for IUDs have to be analyzed.

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The RCH programme begun in 1997 is not yet operational at the field level. The concept of the CNA approach must be integrated into the RCH training package and the ECRs must be modified to capture unmet need. The state needs to meticulously plan the integration process based on a long-term goal. In the absence of it, the state will find it difficult to implement bottom-up planning and to increase performance levels.